Canterbury
District Health Board
Te Poari Hauora ō Waitaha

2012-13

Annual Plan
& Statement of Intent

Annual Plan & Statement of Intent

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Canterbury District Health Board
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Our Mission

TĀ MĀTOU MATAKITE

- 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.

Our Values

Ā MĀTOU UARA

- 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.

Our Way of Working

KĀ HUARI MAHI

- Be people and community focused.
  Arotahi atu ki kā tākata meka.
- Demonstrate innovation.
  Whakaatu whakaaro hihiko.
- Engage with stakeholders.
  Tu atu ki ka uru.

our health system

Contents

Commitment from the Board

The Canterbury District Health Board is one of 20 Districts Health Boards (DHBs) established on 1 January 2001 under the *New Zealand Public Health and Disability Act 2000* (the NZPHD Act). DHBs were established as vehicles for the public funding and provision of health and disability services for specified geographically defined populations. Each DHB is categorised as a Crown Agent under the *Crown Entities Act 2004* and is accountable to the Minister of Health.

This Annual Plan has been prepared to meet the Minister of Health's expectations for DHBs as well as the requirements of sections 42 and 39 (8) of the *NZPHD Act,* section 139 (1) of the *Crown Entities Act* and the requirements of the *Public Finance Act*. It sets out the Canterbury DHB's goals and objectives and describes what the DHB intends to achieve and deliver in 2012/13 to meet those goals and objectives. The Plan also contains service and financial forecast information for the current and two subsequent years: 2012/13, 2013/14 and 2014/15.

The relevant sections of the Annual Plan are extracted to form a stand-alone Statement of Intent document which is presented separately to Parliament. At the end of the year, the forecast performance sections of the Statement of Intent are used to compare planned performance with actual performance. The results will be audited by auditors working on behalf of the Office of the Auditor General and reported publicly in the DHB's Annual Report.

The Minister of Health has been clear in setting his annual expectations for 2012/13 that DHBs must focus more strongly on service integration. The Minister highlights international evidence that integrating primary care with other parts of the health system is vital to better management of long-term conditions, an ageing population and patients in general. We have already demonstrated our commitment to integration with our 'whole of system' approach in Canterbury and our newly formed regional alliances. We have made real gains and progress over the past several years. With Canterbury's capacity stretched to the limit following the earthquakes, it is more important than ever that not only is every part of our system *working well*, but every part of our system is also *working together.*

The Minister of Health's expectations for 2012/13 include a number of other key priorities for DHBs which are reflected throughout this document:

- Shorter waiting times and improved access to services;
- Improved health services for older people;
- Regional integration and evidence of accelerated collaboration;
- Efficiency and containment of costs; and
- Achievement of national health targets.

Improving Māori health also continues to be a high priority. The Canterbury DHB's Māori Health Action Plan 2012/13 is a companion document to this Annual Plan and sets out key performance measures to improve Māori health and reduce inequalities. The Canterbury DHB has also strengthened internal and external monitoring systems so that key performance indicators and health targets are being reported and monitored by ethnicity.[1]

In signing this Annual Plan and Statement of Intent, we are satisfied that it represents the intentions and objectives of the Canterbury DHB for the period 1 July 2012 to 30 June 2015.

Bruce Matheson
Chairman

Peter Ballantyne
Deputy Chairman

Hon Tony Ryall
Minister of Health

Hon Bill English
Minister of Finance

Date: June 2012

[1] *All of Canterbury's accountability documents can be found under 'Publications' on the Canterbury DHB website: www.cdhb.govt.nz.*

Message from the Chief Executive

The 22nd February 2011 earthquake dealt the Canterbury Health System a huge blow. We lost people, friends and family, we lost buildings and like everyone else we lost access to roads, power, water and sewerage. But we didn't stop delivering.

The Canterbury Health system demonstrated a resilience that has left people in awe of what can be achieved: how rapidly we could react, how fast we could redesign services and deliver them anywhere we needed to (in the community, in the hospital or in Hagley Park) and how we developed new models and breakthrough innovations. In the space of hours, we were organised and connected across Canterbury. In the space of days, we had the whole system back on its feet and delivering free care to people in their communities.

We had a plan, a shared vision of where we were going and a system built on a foundation of trust and good relationships. We work hard on our shared direction in the easy times, and it certainly worked for us when we needed it most.

But the system we now have is fragile. Things are still far from normal. The earthquakes have displaced people from their homes, communities and health providers – interrupting usual support networks and exacerbating chronic illness. Our resources are severely stretched, and every day we juggle reduced physical capacity with required repairs, patient need and staff safety. Most of our 200 buildings are damaged, and more are being recognised as unsafe to occupy. Over 9,000 rooms across our hospitals are in need of repair.

The next few years will be extraordinarily challenging. Capacity that was already stretched is on a knife edge, and winter is coming. Buildings need to be fixed, but how do we do that and continue to deliver care? Over the last eighteen months we have managed this risk because the whole health system responds to the DHB's leadership and we have worked collectively as a single, integrated system. We need to maintain the momentum and confidence of the system. There is a real risk that parts of the system will fail and people will lose confidence in their health care if we don't get this right.

There is no question that we will continue to do our utmost to improve our population's health and meet the expectations of Government. We are working closely with healthcare providers, CERA and other organisations to keep people well and healthy in their own homes and communities. Our situation gives us the opportunity to innovate and accelerates the need to develop tailored local solutions in order to do more (and see more people) with the resources available.

This Annual Plan outlines our direction of travel and how we intend to meet the expectations set for us and the goals that we have set for ourselves over the coming year. Alongside this plan, we will implement our transitional recovery plan to address urgent demand and restore capacity across our health system.

However, as we move forward, we are acutely aware of the fragility of our system, our workforce and our population. None of the challenges we face are short-term pressures with 'quick fix' solutions, and while our plans are based on reasonable assumptions, our situation is unprecedented. There is no basis for predicting demand for health services after the disaster we have experienced, and this uncertainty creates a high level of risk.

As aftershocks continue and the colder winter months approach, our population faces crowded, damaged or temporary housing, damaged heating sources, disrupted social infrastructure, unemployment, uncertainty and increased stress – all of which is taxing their normal resilience. Any other major events, disruptions to the repair programme or a hard winter will put the achievement of our goals at risk as we focus on addressing our population's most urgent health needs.

With so much unknown, it is critical that we are able to respond rapidly and flexibly to changing circumstances - prioritising and redirecting resources to areas of immediate need. We must make the right decisions to meet the emerging needs of our population without compromising our immediate and future viability. With certainty of funding, flexibility about service delivery and certainty about facilities, we will be able to manage the risks in our environment and provide a model that can be tested for the rest of the country.

Our continued transformation is the key to regaining our lost capacity and rebuilding our health system, better than it was before. We are using new, innovative approaches to closely monitor demand and utilisation trends to identify where support is required to meet patient need and gauge how the system is functioning. A 'whole of system' perspective is vital to maintain service delivery and meet the goals and expectations set out in this plan.

It will not be easy, but I am heartened knowing that across the health system people are pulling together, realising that the solution is not more of the same services, but more of the *right* services – delivered in the *right place* at the *right time*.

David Meates, Chief Executive, Canterbury DHB - June 2012

Introducing the Canterbury DHB

Established in 2001, the Canterbury DHB is the second largest DHB in New Zealand by both geographical area and population size. We serve over 510,000 people (12% of the New Zealand population) covering 26,881 square kilometres and six Territorial Local Authorities.

1.1 What we do

DHBs receive funding from Government with which to fund and provide health and disability services for their population. The share of funding DHBs receive is based on the size and demographic mix of their population (age, gender, ethnicity and deprivation) and their population's historical utilisation of health services.

Canterbury received 11% of the total Vote Health funding allocated to DHBs in 2012/13: over $1.4 billon. With this, we meet our legislated responsibilities and:

- *Plan* the strategic direction of the Canterbury health system, in partnership with clinical leaders, stakeholders and our community and in consultation with other DHBs and service providers;
- *Fund* the majority of the health services provided in Canterbury, and through our partnerships and relationships with service providers ensure services are responsive, coordinated, and focused on what is best for the patient and the system;
- *Provide* hospital and specialist services for the population of Canterbury, and 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, education and evidence-based public health initiatives.

In addition to these responsibilities, the DHB is the largest employer in the South Island, employing 9,000 people across our services. Almost the same number of people are employed delivering health and disability services across the rest of the Canterbury health system, and are funded either directly or indirectly by the DHB.

1.2 The way we do things

Our vision is a Canterbury health system that keeps people healthy and well in their own homes – a system providing the right care and support, to the right person, at the right time, in the right place.

At its core, our vision is centred on everyone working together to do the right thing for the patient and the right thing for the system. The key measure of success is reducing the time people waste waiting.

We are achieving this by adopting a 'whole of system' approach to health care that means – more services that support people to stay well, highly capable primary and community providers delivering services closer to home, and specialist services freed-up to provide timely treatment for people who require more complex care.

The transformation of our health system is driven by empowered clinical leadership. Health professionals across Canterbury are developing and implementing innovative solutions to improve outcomes for our population and improve the way the system works.

We implement our vision through clinically led initiatives and programmes including *'Improving the Patient Journey'*, the *'Canterbury Initiative'* and the Canterbury Clinical Network's *'Better, Sooner, More Convenient'* business case. These innovative programmes have all resulted in improved productivity and performance right across the Canterbury health system.

The way we do things is guided by our values:

- *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.

1.3 Our structure

We have governance and organisational structures in place to enable us to meet our legislated responsibilities and achieve our vision. These structures are determined by our governing legislation and our commitment to participatory engagement and clinical leadership.

Governance and 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. The Board's core responsibility is to set strategic direction and policy that is consistent with Government objectives, improves health outcomes for the Canterbury population and ensures the sustainability of service provision.

The Board also ensures compliance with legal and accountability requirements and maintains relationships with the Minister of Health, Parliament and the Canterbury community. While responsibility for overall performance rests with the Board, operational and management matters have been delegated to the Chief Executive, who is supported by an Executive Team.[2]

[2] *Refer to Appendix 3 for an overview of the organisational structure of the Canterbury DHB.*

Planning and funding health services

The DHB is responsible for assessing the population's current and future health need and determining the best mix and range of services to be purchased with the funding available.

In line with Canterbury's vision, we do not do this in isolation. Our Planning and Funding Division works in partnership with clinical leaders, health professionals and service providers to understand our population, identify gaps in service delivery and prioritise investment that will improve health outcomes and enhance efficiencies.

We hold and monitor alliance contracts and service agreements with the organisations and individuals who provide the health services required to meet the needs of our population. This includes a large-scale district alliance with the Canterbury Clinical Network (CCN), an internal service agreement with our Hospital and Specialist Services Division and over 1,000 service agreements with external providers across Canterbury.

Some services are contracted directly by the Ministry of Health, such as breast and cervical screening, public health services and disability services for people under the age of 65. The DHB is still responsible for monitoring and evaluating service delivery in these areas.

Providing health services

The DHB also provides a significant share of health services delivered in Canterbury as an 'owner' of hospital and specialist services.

This is no small responsibility; there were over 109,503 people discharged from Canterbury hospitals in the past year, 6,175 babies delivered and 85,056 people presenting in our Emergency Departments.

We provide these services through our Hospital and Specialist Services Division covering: Medical and Surgical, Mental Health, Rural Health, Women's and Children's, Older Persons' Health and Rehabilitation, and Hospital Support and Laboratory Services.[3]

While most of our services are provided out of our 14 hospitals, some specialist services are delivered from community bases, through outreach clinics in rural areas and in other DHB facilities.

Promoting community health and wellbeing

Good health is determined by many factors that sit outside the traditional health system. The DHB's partnerships with other organisations are vital in creating and supporting social and physical environments that reduce the risk of ill health.

Our Community and Public Health Division provides guidance and support to help create healthier physical and social environments. We also support collaborative initiatives that focus on keeping people well by reducing behavioural and environmental risk factors – including improving nutrition, increasing physical activity and reducing tobacco smoking and alcohol consumption.

Working collaboratively to provide 'safe' social and physical environments for Canterbury's younger population groups is a focus, as are strategies to reduce health inequalities. Work is prioritised in areas of high need, such as education settings and Māori and Pacific communities.

The DHB also leads collaboration on safeguarding water quality, biosecurity (protecting people from disease-carrying insects and other pests), the control of communicable diseases and planning to ensure preparedness for a natural or biological emergency.

1.4 Our regional role

Because of our size, the Canterbury DHB provides an extensive range of highly specialised and complex services. While our responsibility is primarily for our own population, we provide many higher-level services on a regional basis - to people referred from other DHBs where these more specialised services are not available.

The specialist services we provide regionally include: brain injury rehabilitation; eating disorder services; child and youth inpatient mental health; forensic services; foetal medicine; gynaecological oncology; cervical cytology; paediatric neurology, surgery and respiratory services; specialist diabetes services; neonatal transport; cardiothoracic; gastroenterology; neurosurgery; plastics; haematology/oncology; and ophthalmology.

What did Canterbury provide on behalf of the rest of the South Island in 2010/11?

- Over 45,200 community laboratory tests, 16,400 of those for Nelson Marlborough DHB.
- 318 maternity consults or clinics, 145 of those for mothers from the West Coast.
- Mental health services for more than 674 patients, 293 of those from Southern DHB.
- Cancer radiotherapy services for 281 patients, 93 from South Canterbury DHB.
- Over 22,000 outpatient services including first specialist assessments, dialysis and sleep apnoea services.
- Over 3,700 inpatient services including cardiology, neurosurgery, orthopaedics, respiratory, paediatric oncology, neonatal, haematology and ophthalmology services.

[3] *Refer to Appendix 4 for a more detailed overview of the services provided under each service division.*

There are some specialist services which Canterbury provides on a national or semi-national basis. These include: endocrinology; paediatric oncology; spinal services; and laboratory services.

Canterbury also provides regional public health services on behalf of the Canterbury, West Coast and South Canterbury DHBs, covering the largest geographic area of any public health service in the country.

In all, Canterbury provides over $100m dollars worth of services to the populations of other DHBs around New Zealand and delivers just over half of all the surgical services provided in the South Island (51%).

Canterbury's regional role is particularly significant in light of the fragility of Canterbury's infrastructure post-quake and the strain under which our services are currently operating.

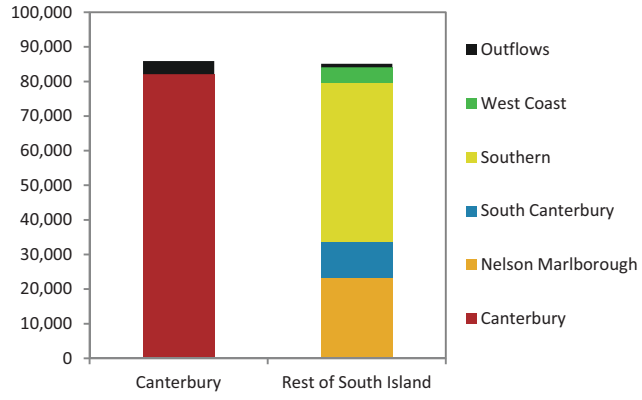
Following the September and February earthquakes, there was significant short-term pressure placed on almost every other DHB in the country - to cover for what we could not provide while we dealt with the quakes' aftermath. Our load was able to be supported during the emergency period. However, the pressure would have been unsustainable, had Canterbury not resumed core service delivery as quickly as we did.

It is critical that we maintain our current delivery levels. Acknowledging the regional and national risk we would create if we failed, this is a top priority for us.

Around 4,000 people a year travel to Canterbury from other parts of the South Island to access services their DHBs do not deliver. If for some reason we couldn't deliver to our population, over 86,000 people would have to be sent out to other DHBs.

FIGURE 1: NUMBER OF YEARLY DISCHARGES BY DHB

CDHB delivers half of the inpatient services delivered in the South Island.



1.5 Our transalpine approach

Canterbury has a longstanding relationship with the West Coast DHB. This has recently cemented by formal arrangements that have enabled closer clinical collaboration and joint 'back office' service provision.

As part of these formal arrangements, Canterbury and the West Coast now share senior clinical and management expertise including: a joint Chief Executive, Executive Director of Allied Health, Clinical Director of Mental Health and Senior Medical Officers, as well as joint project, human resources and information support.

Formalising our collaboration has allowed us to actively plan the assistance and services we provide to the West Coast and to build the most appropriate workforce and infrastructure in both locations. A number of training and secondment opportunities also support the development of an experienced and sustainable workforce in both regions.

Having recognised the value of this close collaboration, clinicians and senior staff from both DHBs met to consider how we can further support the provision of quality clinical services on the West Coast.

Key outcomes from this workshop were a commitment to a 'transalpine' approach to service provision and recognition that quality patient pathways are critical in assuring West Coasters can access the services they need as close to where they live as possible.

Clinicians from both Canterbury and West Coast DHBs will continue to focus on developing this transalpine approach over the next year.

The initial priority will be to clarify models of care, which will be incorporated into the business case for the redevelopment of the Grey Base Hospital campus. Clinical support networks, referral guidelines and the use of technology such as videoconferencing will enable clinical teams to make the best arrangements for their patients and help to reduce long waits for treatment. We will also develop clinically led patient pathways to improve the quality of the services provided – including a focus on orthopaedic services, paediatrics services, and health services for the elderly in the coming year.

Identifying our Challenges

Health system pressures - the key drivers for change

The need to change the way we designed and delivered health services was starkly apparent in our demographic forecasts, long before the Canterbury earthquakes. The age, ethnicity and economic status of our future population predicted some very serious implications for our health services.

1.6 Population profile

Analysing the demographics and health profile of our population gives us a baseline for measuring the impact of what we do. It also helps to identify areas where our population may be disadvantaged, or where one population group may be experiencing poorer health outcomes than others. This information is important, as it influences the choices we make in prioritising and allocating resources across our health system.

Population data shows the number of people enrolled at Canterbury general practices has fallen less than 2% – or 9,257 people – since February 2011. These post-quake general practice enrolment levels are consistent with a study into predicted population movement following a major disaster, and this small drop has been accounted for in our population projections.[4]

However, we are not able to predict the impact the rebuild will have: how many people will move to Canterbury, whether they will bring families, what their health will be like and how long they will stay. All of our predictions are based on known factors, and there is a high level of risk in terms of unpredicted demand.

Demographics[5]

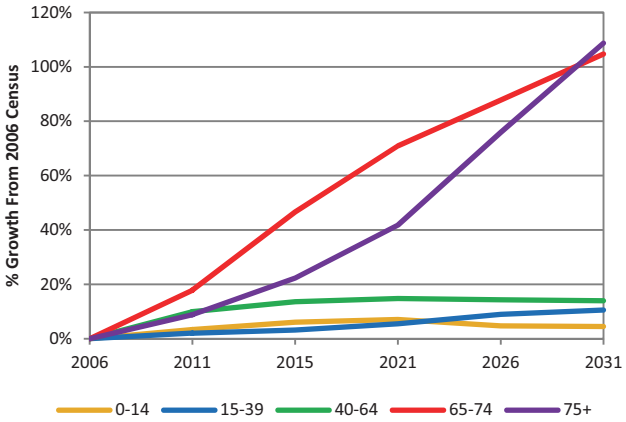
Canterbury is currently the second largest DHB in New Zealand by population, with a 10% growth in the total Canterbury population occurring between the 2001 and 2006 Census. In spite of the small drop after the earthquakes, our population is still projected to grow a further 8% by 2021 and 12% by 2026.

Our Asian population is proportionally our fastest growing demographic; projections suggest by 2026 Canterbury's total Asian population will have increased from 6.4% to 10.9%. Both Māori (8%) and Pacific populations (2%) have more youthful populations and higher fertility rates, meaning these populations are also growing faster than our total population.

We need to consider the unique needs of all of these population groups in future planning. Ethnicity is a strong indicator of need for health services. Māori and Pacific peoples (while having different needs and issues) are both over-represented in terms of long-term conditions and have higher rates of preventable hospital admissions.

FIGURE 2: CDHB POPULATION GROWTH RATE BY AGE

Canterbury's older population groups are growing at a much faster rate.



However, it is Canterbury's ageing population that will have the greatest impact on future demand.

Canterbury has the largest total population aged over 75 of any DHB. Between 2006 and 2026 our population aged over 85 will double, and by 2026 more than a fifth of our population will be 65 or older.

As we age, we develop more complicated health needs and co-morbidities (multiple health conditions), and therefore consume more health resources than people in younger age groups. There are growing trends of a number of long-term conditions that become more common with age, including heart disease, stroke, cancers, respiratory disease and dementia.

The total number of people aged over 75 will increase from 31,460 to 54,730 by 2026, and the number over 85 will double from 7,800 to 15,150. Our older Māori and Pacific populations are also increasing, with the proportion of the total Māori and Pacific populations aged over 65 projected to more than double between 2006 and 2026 - from 3.3% to 8.6% for Māori and 3.4% to 8.1% for Pacific.

The ageing of our population will put significant pressure on our workforce, finances and physical capacity. Older Persons' Health is a key priority area for us, along with Child and Youth Health and Whānau Ora.

[4] *Dr Tom Love, Population movement after natural disasters: a literature review and assessment of Christchurch data, Sapere Research Group, April 2011.*

[5] *Data is based on Statistics NZ population projections from the 2006 Census and PBFF population estimates.*

Canterbury health behaviours

- Canterbury has slightly lower obesity levels than the rest of the country, but nearly a quarter of our adult population (15+) are classified as obese (24.5%).
- 4,800 children in Canterbury were classified as obese in 2006/07.
- On average, our population is slightly more likely to drink in a hazardous manner (18.4%) than other New Zealanders (17.7%).
- 18.3% of our population regularly smoke, lower than the national average of 19.9%. However, smoking rates amongst Māori are significantly higher than non-Māori. Māori women are nearly two and a half times more likely to smoke.

Source: Ministry of Health NZ Health Survey 2006/07

Health behaviours and risk factors[6]

Compared to the rest of the country, the Canterbury population has lower obesity levels, eats more fruit and vegetables and is less likely to smoke regularly.

Nevertheless, the negative health outcomes associated with poor health choices and risk factors, such as poor nutrition, hazardous drinking and tobacco smoking represent a significant burden on our health system. International literature on disaster recovery also indicates that an increase in risk behaviours is typical in response to stressful events, and those more vulnerable prior to a major disaster have an increased risk of poor health afterwards.[7]

Tobacco smoking remains the major risk factor for several major long-term conditions, including cancer, diabetes, cardiovascular disease and respiratory disease. Smoking also disproportionately affects Māori and Pacific populations and is a substantial contributor to socio-economically based inequalities in health.

Social and economic factors, such as education, housing and income, are now widely accepted as contributing greatly to a person's health. This is a significant concern for us. Many of the most deprived suburbs in Canterbury were the hardest hit by the earthquakes. While we have no current statistics on the changes in people's circumstances, we do know that more deprived population groups, already with higher health needs, are now even more at risk.

Household overcrowding, for example, can lead to an increased risk of infectious illnesses such as rheumatic fever, meningococcal disease and ear, nose and throat infections. Prior to the earthquakes (2006), 6.6% of our total population, and over 30% of our Pacific population were living in overcrowded households.

Supporting our population to make healthier lifestyle choices and reduce risk behaviours presents an opportunity to significantly improve people's health and wellbeing and reduce inequalities in health status and the demand for complex health care. Disease Prevention is a priority area for the coming year.

Health status and service utilisation

Compared to national figures, the Canterbury population has significantly lower avoidable mortality (death) rates but similar leading causes of mortality.[8]

While mortality patterns are less amendable over the short term, many hospital admissions are considered 'avoidable', where earlier identification and treatment could have prevented the deterioration that resulted in admission. These identify more immediate opportunities for improving the health of our population.

The leading causes of avoidable hospitalisation in Canterbury are respiratory infections, angina, dental conditions and ear, nose and throat infections. Although lower than the national rate, falls are also a major cause of avoidable admission in Canterbury. In the past year 3,065 people aged 75+ were admitted to Canterbury hospitals as a result of a fall.

Cardiovascular diseases (CVD) of the circulatory system, including heart disease and stroke, are the leading cause of death in Canterbury (38%), followed by Cancers (28%) and Respiratory Diseases such as Chronic Obstructive Pulmonary Disease (9%).

Mental health and behavioural disorders are the sixth most common cause of death in Canterbury, and the World Health Organisation predicts depression will be the second highest cause of disability globally by 2020. The stress of the earthquakes and ongoing aftershocks will have a significant psychological impact on our population. Addressing the expected increase in mental health need is a key component of our planning for the next few years.

Diabetes is the eighth highest cause of death in Canterbury, but is also an underlying causative factor for many circulatory diseases. It therefore contributes significantly to avoidable mortality and is a focus for us.

We have identified Mental Health and Long-term Conditions as priority areas in the coming year. In both of these areas the focus is strongly fixed on supporting people to stay well and reducing the need for complex intervention.

Canterbury's focus on its identified population groups and disease priorities is evident throughout this document and in the goals and objectives we have identified for the coming year.

[6] *Data is sourced from Public Health Information Online, using 2006 data, www.phionline.moh.govt.nz.*

[7] *Bidwell, S. 2011. 'Long term planning for recovery after disasters: ensuring health in all policies – a literature review'.*

[8] *Ministry of Health. 2012. Mortality and Demographic Data 2009. Wellington: Ministry of Health.*

1.7 Operating environment

The trouble with the future is that it usually arrives before we're ready for it.

February 22nd dealt a huge blow to the Canterbury health system. We lost people, we lost buildings and we lost essential infrastructure.

But in the face of the most powerful seismic event in our country's history, we were able to rapidly respond and redesign the delivery of health services in a broken city. The Canterbury health system was organised and connected in a matter of hours, and within days we were delivering free care to our population.

Eighteen months on, we still have a fragile system, beset with uncertainties, but one that nevertheless continues to deliver. The next year will test us all as we balance the challenges of stretched capacity and damaged infrastructure with the opportunity to innovate.

The collective approach needed to maintain health services after the February quake has reinforced our strategic direction: building primary and community capacity to support people closer to home and releasing hospital and specialist capacity to focus on the delivery of complex care.

The earthquakes have also reinforced our strategic direction around facilities by significantly increasing the urgency. Each day we juggle reduced physical capacity with required repairs, patient demand and staff safety.

With limited funding available, we must ensure that scarce financial capital is not wasted on repairing buildings that have no future. Conversely, we need to be able to maintain service delivery to our population; we are very aware that each year we manage 86,000 inpatients in our facilities. There is no viable alternative capacity locally or within New Zealand.

Current operating environment summary

- General practice and pharmacies were lost, and more are likely to be closed as CERA requires in-depth engineering reports.
- Many NGOs were displaced and are still working from temporarily and makeshift facilities.
- 640 rest home beds were lost, and further facilities will still have to close.
- 106 inpatient beds were closed at Christchurch hospital, and office space had to be converted to create 73 replacement beds at Princess Margaret Hospital. We are still operating with fewer beds than before, with more reductions possible.
- 2 theatres were lost in Ashburton, and capacity for the surgeries and procedures delivered there has to be found elsewhere in the system.
- 200 DHB buildings were damaged, and more are being recognised as unsafe to occupy. Over 9,000 rooms need to be repaired across our hospitals, which will impact on our ability to deliver services.
- More than 3,000 homes have been vacated in the Red Zone, with similar numbers still to be evacuated.
- Many people have temporarily relocated out of Christchurch city or into rental properties, temporary villages or the homes of friends and relatives – making population-based care and screening challenging.
- This also makes maintaining viable health services in areas close to the Red Zone (which are therefore losing population base) challenging, while we deal with demand exceeding capacity in other areas.
- Over 700 of our own staff are still displaced.

How we are managing

Canterbury's performance is particularly strong in the context of national trends in acute care. Growth in acute admissions is a major source of pressure on hospital resources. A sustainable health system must manage acute demand by keeping people well, intervening earlier and providing the 'right' services.

In spite of the high level of age-related demand in Canterbury, we have the lowest age-standardised rate of acute medical admissions of any large DHB in the country. Canterbury has achieved a 13% reduction in the growth rate of acute medical admissions over the last 10 years – a significant achievement.

As a consequence of the strong support of our primary care sector and our 'whole of system' approach to acute demand management, we manage fewer acutely unwell people in hospital settings than similar-sized DHBs.

If Canterbury's acute medical admission rate had been as high as the national rate, we would have had to cope with an additional 10,750 acute medical admissions in our hospitals in 2010/11. With the loss of bed capacity after the earthquake, our system would have been in real trouble had we not already made such dramatic improvements in the way we manage acute demand.

Our ability to reduce acute medical admissions has been central to increasing our capacity to deliver elective surgery - as has our ability to manage more people in community-based settings rather than in hospital. Canterbury has a high percentage of elective vs. acute activity. This meant that in spite of the earthquakes, we were almost able to achieve our 2010/11 electives target (97% achievement) and anticipate meeting the 2011/12 target.

Acknowledging our system is fragile

However, we need to acknowledge the additional challenges we now face. The earthquakes have displaced many Canterbury people from their homes and communities, and consequently from their health providers and health records - interrupting the continuity of care and exacerbating chronic illness. Our resources are severely stretched and our circumstances are exceptional.

Managing in a new environment

Canterbury's Acute Demand Management Service has been extended to allow general practice teams to take preventative action with their more vulnerable patients. Capacity of the service has expanded by more than 20%, from 14,000 urgent episodes a year to over 18,000. This service is helping us to manage our fragile system by providing community-based acute admission avoidance and early discharge packages of care, which includes ambulance diversion triggered alongside a text to all general practices alerting them to hospital gridlock.

Canterbury's Community Rehabilitation Enablement and Support Team (CREST) was launched to support patients into appropriate home-based rehabilitation services after discharge from hospital. This service supported 987 people in the first year and will be expanded to take 1,100 people in 2012/13, including direct referrals from general practice to avoid hospital admission.

Increased access to restorative home-based support has allowed us to decrease bed days in Aged Residential Care (ARC) by 17% over the past two years. This contributed significantly to our ability to manage with fewer ARC beds when 635 were lost in the February quake. This restorative focus has been expanded to include an integrated community-based falls prevention programme and a medication management programme. These programmes will have the capacity to support 2,800 people this year and reduce hospital and ARC admissions by keeping people well in their own homes.

Free flu vaccinations will again be provided for anyone under 18 to reduce respiratory admissions over winter. Canterbury had a lower than national incidence of flu in 2011, which played an important part in our ability to manage demand. The vaccine is also free to those aged over 65, pregnant women and people with long-term health conditions.

Streamlined access pathways into mental health services (including alcohol and other drug, residential and community support services) have removed the requirement for a separate needs assessment processes to determine eligibility. Access now occurs via direct agreement between community and hospital clinicians, reducing duplication and wait times, and providing a system-wide view of capacity and demand. This has been so successful that a new model of care is being developed to support these processes long-term.

Electronic Shared Care Record View (eSCRV) is an electronic system designed to provide a secure way of sharing key patient information between health professionals involved in a person's care – no matter where the person presents for treatment. The system stores medical histories (such as allergies, medications and test results) and will support faster, more informed treatment, shorter waiting times and improved patient safety in emergency situations.

As the colder winter months approach, our population faces crowded and temporary housing, damaged heating sources, disrupted transport links and social infrastructure, unemployment, uncertainty about the future and increased stress, all of which is taxing their normal resilience.

We have been able to manage because we already had a shared vision of where we were going, had begun our transformation and had a foundation of trust, genuine integration and transparent partnerships.

We will need to address the increased level and immediacy of need across our population as we plan services for the next several years.

We also need to acknowledge the significant service disruption that will occur as we begin to make invasive structural repairs across all of our facilities. The repair schedule will significantly stretch our resources and put pressure on our workforce as we temporarily relocate and move services from site to site.

There is an expectation that we will maintain current levels of service delivery in 2012/13 and we will strive to achieve this goal. However, a severe winter season, unusual demand patterns, repair delays or further seismic events will put our goals at risk.

We also recognise the increased expectations being placed on our community and primary care partners and the similar unknown factors they face. We will work collectively to provide people with the care and support they need to stay well in their own homes and mitigate service delivery risks.

Workforce pressures

Our ability to meet this immediate and growing demand and to continue to transform our health system relies heavily on having the right people, with the right skills, in the right place.

Workforce is a critical asset and a critical issue for us. As the largest single employer in the South Island, we employ 9,000 people. On top of this, we indirectly rely on almost the same number of people to deliver health and disability services to our population through service contracts with public, private and charitable organisations.

As a greater proportion of our population reaches traditional retirement age, there is increasing concern over the continued availability of a sufficient workforce pool to meet predicted increases in demand. Changing workforce patterns, the expectations of younger workers, new technology and changing community expectations also put pressure on traditional service delivery models.

We understand the urgency of transforming the way we deliver services to meet the changing expectations of our future workforce and address the predicted workforce shortages as demand increases.

We are engaging our clinical workforce in the development of alternative models of care to ensure we can continue to provide quality services into the future.

We are also removing barriers to enable health professionals to work to the greatest extent of their scope and to spend more quality time with patients.

However, we are concerned about the effect the earthquakes will have on our ability to retain and attract the workforce we need. People have shown extraordinary commitment over the past 18 months, but ongoing disruption and uncertainty are taking their toll.

- 63% of our staff felt they or their families were 'seriously' impacted by the earthquakes;
- 48% of our staff have 'moderate' to 'severe' damage to their homes;
- 37% have had to permanently move;
- 400 staff attended financial support seminars; and
- 100 staff attended sessions to help parents to cope with children affected by the earthquakes.[9]

Understandably, staff turnover rates are higher than normal, up 2% on last year to 13.7%.

Recent staff survey results provide indications that our workforce feel supported and want to be here, but retaining current staff and attracting people back into Christchurch are key priorities for the coming year.

We are also acutely aware that this is not just about our own employees. Canterbury's ability to get through this period, and to cope with future demand, is reliant on having the right people with the right skills available across the whole health system.

A large focus of our workforce plan in 2012/13 will be redefining the 'Canterbury brand' in order to retain and attract people to the region. We will focus on expanding and integrating training and professional development programmes, supporting the creation and piloting of new roles and developing core leadership/management curricula to increase capability and release capacity across our health system.

Fiscal pressures

Sitting alongside increasing demand for services and workforce challenges, the health sector also faces increasing fiscal pressures. Government has given clear signals that we need to rethink how we deliver improved health outcomes in more cost-effective ways.

Having taken up this challenge, Canterbury was in a strong position prior to the earthquakes. We were on track to break even, were developing more effective ways of delivering services and, by integrating services, were removing waste and duplication from our system.

The earthquakes and ongoing aftershocks have already resulted in unplanned costs of over $26m. The total cost is still an unknown factor. We are unable to predict the final interplay between repair costs, insurance recovery and the financial impact of new building codes.

We are also unable to determine the likely level of increase in health demand from a vulnerable population under stress for more than 18 months, or the change in the population as a result of workers migrating to Canterbury for the rebuild – with some estimates suggesting 30,000 people.

This uncertainty creates an unprecedented level of financial volatility, particularly in regards to our long-term outlook. We will work closely with the Ministry of Health and National Health Board to achieve a more certain funding pathway and the flexibility needed to rapidly adapt services to our changing environment and escalating population need.

1.8 Critical success factors

The following areas represent the major factors that are critical to our success - where failure would significantly threaten the achievement of the strategies, goals and priorities outlined in this plan.

Managing demand

We have been successful in modifying the impact of acute demand growth on our services, and it is critical that we continue to manage this demand by predicting where demographics will drive an increase in need.

Our ability to increase elective delivery has been based on improving system efficiency, reducing acute demand and moving non-complex activity into a community-based setting. Post-quake, we have a sharper focus on more flexible responses that will get ahead of escalating issues, so care can be maintained in community settings.

Containing cost growth

It is critical that we continue to contain the cost of delivering services. If an increasing share of our funding has to be directed into meeting cost growth, our ability to invest in new technology and initiatives that allow us to respond to acute demand will be severely restricted.

We will continue to focus on the mechanisms that have contributed to our past success including: 'lean thinking' and 'releasing time for caring' initiatives, shared back-office functions, joint appointments and improved purchasing arrangements.

We will also continue to engage health professionals from across the system in prioritisation and service improvement. By shifting decision-making into the hands of those on the front line of service delivery, we have been able to improve health outcomes while introducing technical efficiencies that eliminate waste and duplication and significantly reduce cost pressures. It is critical that we continue to do so.

[9] *Results taken from the CDHB Staff Wellness Surveys conducted in March and October 2011.*

Rebalancing the system

It is also critical that we continue to reorient our health system to make the most effective use of available resources and increase capacity to match the demands of our population. We must continue to remove traditional barriers that restrict our ability to introduce more effective service delivery models.

Canterbury has created a permissive environment that allows innovators to move forward quickly and inspire others to make similar change. To support this momentum, we have changed the way we fund and contract services and made a step change in our approach to infrastructure to allow integration of activity and information, including shared patient records and management systems.

We will continue to realign service expenditure to focus on those populations that have the highest risk and the greatest ability to benefit. Working within the Canterbury Clinical Network District Alliance, we are exploring new funding models that will enable us to direct more resources towards those people with higher needs who require more coordinated or complex care.

Releasing workforce capacity

Releasing workforce capacity is another critical factor both in our transition to recovery and in meeting the future demand for services.

We have already adopted clinical governance and leadership models that engage our workforce in developing alternative models of care. We also support lean thinking processes that release clinical staff to provide more direct patient care. We will continue to invest in similar programmes, including technology and connected information systems, to support new ways of working and improve service quality (e.g. telemedicine, shared patient records and electronic referrals).

We will continue to unlock the potential of our workforce by supporting service delivery models that enable health professionals to work to the greatest extent of their scope. We will invest in training, professional education and leadership development programmes that support this direction and the development of 'new' health roles.

We also need to recognise that like the rest of the Canterbury population, our workforce is tired and stressed. We will continue to invest in good workplace practices that support our staff and focus on the positives about working in the Canterbury system to improve retention and recruitment rates.

With certainty and flexibility, the Canterbury health system could better manage the risks in our environment and provide a model that can be tested without setting precedents that could become difficult in the future.

As we move forward in a more constrained and uncertain environment, an associated risk is that people will become disengaged from leading and supporting the changes required to ensure longer-term sustainability. It is critical that we continue to emphasise 'whole of system' partnerships and clinical leadership to support ongoing engagement in the future vision.

Connecting the system

The earthquakes demonstrated a number of gaps and flaws in our current infrastructure, particularly the risk associated with disconnected patient information systems. In response, a number of base infrastructure tools are rapidly being developed, including an Electronic Shared Care Record View (ESCRV) and a Collaborative Care Management System (CCMS).

These will support the connecting infrastructure already in place, including HealthPathways and our Electronic Referral Management System (ERMS). Combined with the Canterbury Initiative approach and the Canterbury Clinical Network Alliance, these tools will enable us to clinically align care pathways, identify and target populations with the highest need and rapidly respond to changes in demand. Critically, these tools will also support us to better manage our vulnerable population in the event of another disaster.

Although well advanced, not all of these tools are completely implemented. It is critical that within the next 12 months we connect the Canterbury system electronically as well as organisationally.

Responding to the unknown

Finally, while our direction is predicated on reasonable assumptions and planning, there is no basis on which to predict activity and demand for health services after a natural disaster such as we have experienced, and no comparable situation to draw upon.

We will implement our transitional recovery plan to address urgent demand and restore and maintain capacity across our health system. We will work closely with primary and community providers, CERA and other organisations to accelerate initiatives to keep people well and healthy in their own homes. We will also closely monitor access and utilisation trends across the health system to identify where support is required to meet patient need and gauge how the system is functioning to manage our recovery.

Ultimately, however, we are dealing with a large element of the unknown. We can plan based on some key assumptions, but it is critical that we are prepared and enabled to respond quickly and flexibly to changing circumstances and need.

Any other major events, disruptions to the repair programme or a difficult winter season will put the goals of the DHB at risk. We will be closely monitoring all aspect of our system in order continue to maintain service delivery for our population and to meet the targets and expectations set in this document.

Setting Our Strategic Direction

What will a sustainable health system look like?

Although they may differ in size, structure and approach, DHBs have a common goal: to improve the health of their populations by delivering high quality and accessible health care. With increasing demand for services, workforce shortages and rising costs, this goal is increasingly challenging and our health system faces an unsustainable future. In response, significant changes are being made to the design and delivery of health services at all levels of the New Zealand health system.

2.1 National direction

The changes being driven across the New Zealand health system are in line with the wider strategic context outlined in the *New Zealand Health Strategy*, *the New Zealand Disability Strategy* and the *New Zealand Māori Health Strategy* (*He Korowai Oranga*).

These national strategies, together with the Minister of Health's annual letter of expectations and the *New Zealand Public Health and Disability Act,* provide guidance for policy and planning at regional and local levels. In particular, the *New Zealand Health Strategy* outlines objectives for the health of the New Zealand population and the role of DHBs in delivering the national vision: "*All New Zealanders lead longer, healthier and more independent lives*".[10]

Alongside these overarching strategies, the National Health Board has released *Trends in Service Design and New Models of Care*.[11] This document provides a high-level summary of emerging worldwide trends and international responses to the pressures and challenges facing the health sector.

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

Supported by clinical networks and multidisciplinary teams, the focus is shifting towards supporting people to better manage their own health and to stay well.

This emerging direction emphasises four major shifts in service delivery, based on the view that an aligned system-wide approach is required to improve health outcomes and reduce the unsustainable growth in demand for health services:

1. Greater support for early intervention, targeted prevention and self management, with a shift to more home-based care;
2. Greater support for a more connected system and integrated services, with a shift to the provision of more services in community settings;

> "We want our public health system to deliver better, sooner, more convenient care for all New Zealanders. We want reduced waiting times, better individual experiences for patients and their families, improved quality and performance and a more trusted and motivated health workforce."
>
> *John Key*
> *National Party Health Discussion Paper 2007*

3. Greater support for regional collaboration clusters and clinical networks, with a shift to more regional service provision; and
4. Managed specialisation, with a shift to consolidate the number of tertiary centres/hubs.

This reorientation is consistent with Government's commitment to *'better, sooner, more convenient'* health care and clear expectations to bring more health services closer to where patients live – accelerating the integration of primary and secondary services.

The development of Integrated Family Health Centres, Community Hubs and collaborative partnerships will further enhance primary and community services and free up hospital and specialist services to provide more intensive treatment and complex care.

Increased regional collaboration

Government also has clear expectations that alongside the blurring of traditional primary and secondary roles, the role of hospitals and the provision of specialised (tertiary) services will be critically reviewed and consolidated nationally and across DHB regions. Greater collaboration between DHBs is seen as a means to reduce duplication and waste, maximise clinical and financial resources and ensure the ongoing sustainability of health services.

A work programme to develop National Services and National Service Improvement programmes was introduced by the National Health Board in 2010, aimed at improving equity of access, quality, consistency and sustainability for vulnerable services. This was particularly aimed at high-cost/low-volume services including paediatrics and congenital cardiac services.

[10] *Refer to Appendix 2 for the legislative objectives of a DHB.*

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

Building on the DHB model, lead DHBs were selected to be responsible for the provision and development of national services. DHBs whose populations were recipients of these services were expected to work collaboratively with the national service provider – supporting outreach clinic arrangements to improve access for their populations.

National Service Improvement programmes require the commitment of clinicians and managers within DHBs across a designated service pathway to identify areas of opportunity and work together on interventions to improve equity of access, quality, consistency and sustainability nationwide.

2.2 Regional direction: 'best for the patient, best for the system'

Canterbury is part of the South Island region along with Nelson Marlborough, West Coast, South Canterbury and Southern DHBs. The South Island total population is 1,038,843 people, representing 24% percent of the total New Zealand population.

Each DHB is individually responsible for the provision of health and disability services for its own population and faces similar challenges in delivering high quality services, ensuring the future sustainability of those services and achieving Government priorities.

All of the South Island DHBs are changing the way they work within their local districts to meet these challenges and alleviate the pressures they face. However, individually we cannot make a large enough impact to ensure the future sustainability of South Island services, particularly more highly specialised and complex ones.

Implementing diverse but similar individual responses duplicates effort and investment and leads to service and access inequalities. Regional collaboration is an essential part of our future direction.

In agreeing a collaborative regional direction, the South Island DHBS have committed to a 'best for patient, best for system' approach. The South Island's Regional Health Services Plan articulates this regional direction and the key principles that will inform future regional service development, service configuration and infrastructure requirements.

The South Island Regional Health Services Plan has been approved by the regional Chief Executives and the Boards of all five South Island DHBs. It is available on the South Island Alliance's website: www.sialliance.health.nz.

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

Closely aligned to the national approach, the regional direction is based on the following concepts:

- More health care will be provided at home and in community and primary care settings;
- Secondary and tertiary services will be provided across DHB boundaries;
- Flexible models of care and new technologies will support service delivery in different environments from those traditionally recognised;
- Health professionals will work differently to coordinate a smooth transition for patients between services and providers; and
- Clinical networks and multidisciplinary alliances will support the delivery of quality health services across the health continuum.

These concepts emphasise the significant step change in the way we design and deliver services. Through regional service planning, traditional DHB boundaries and patient flows are being challenged to ensure that services are supported in a sustainable manner.

An alliance approach

Regional service planning in the South Island is implemented through service level alliances and work streams based around priority service areas.

Each service level alliance and work stream is clinically led and has active clinical input, with multidisciplinary representation from community and primary care as well as from hospital and specialist services.

Six service level alliances have been prioritised to respond to immediate challenges in the coming year: Cancer, Child Health, Health of Older People, Mental Health, Information Services and Support Services.

Alongside these service level alliances, collaborative activity is expanding through work streams aligned to a number of other priority areas: cardiac, elective, neurosurgery, ophthalmology, stroke, Māori health and HR services.

A generic model of care

Our success relies on improving patient flow across the South Island by aligning patient pathways, introducing more flexible workforce models and improving patient information systems to connect services across service levels, providers and regions.

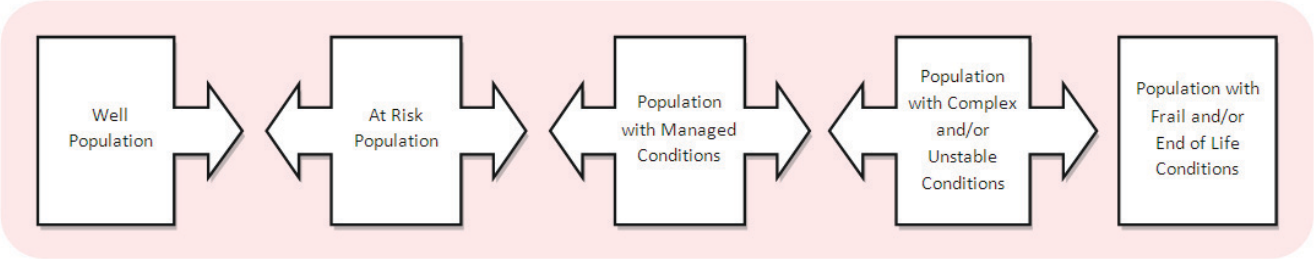
In support of this 'whole of system' approach, the South Island has adopted a generic model of care to ensure a consistent understanding of the range of health needs a person may have over their lifetime.

The model (Figure 3) focuses health planning on the patient's needs and the provision of the right service, at the right time and in the right place. It triggers a series of questions by asking what we need to do to:

- Keep people well in the community?
- Ensure early detection and intervention?

FIGURE 3: GENERIC (PATIENT-CENTRED) MODEL OF CARE

Our South Island model of care ensures a consistent approach to the full range of health needs over a person's lifetime.



- Support people to self-manage in community settings, avoid unnecessary hospital admissions and slow the deterioration of their condition?
- Ensure when people require complex interventions, they are available at the right time and at a high quality standard?
- Support people to regain their functional independence and avoid further complications?

This approach prompts the development of patient pathways that flow across the continuum of care and supports service redesign by questioning gaps and barriers. In this sense, the model supports quality clinical outcomes by identifying with the needs of the patient. It also encompasses a Whānau Ora approach by taking a holistic view of the person (or population) and the determinants of health that influence wellbeing.

Flexible and non-traditional workforce models are a central part of the future picture. The South Island Regional Training Hub is working to analyse workforce trends and future requirements and to develop plans for specific workforce groups and critical roles.

2.3 Local direction: transformation

The 'continuum of care' approach is not new in Canterbury. For five years we have been reorienting our health system and removing traditional boundaries and barriers to transform the way we work and improve outcomes for our population.

Developing the vision

Our vision is a Canterbury health system that keeps people healthy and well in their own homes – a system providing the right care and support, to the right person, at the right time and in the right place.

In 2007 over 1,000 stakeholders, providers, consumers and health professionals from across the system came together to find solutions to the challenges we faced.

We knew if we didn't actively transform services and service delivery, by 2020 Canterbury would need 2,000 more aged residential care beds, 20% more GPs and another Christchurch Hospital.

We began to reorient our system around the needs of patients rather than our needs as providers. In undertaking this transformation, we recognised it was not just about hospitals, but about a responsive and sustainable solution where all providers worked collaboratively to wrap care around the person.

Prior to the earthquakes, clinically led system-wide partnerships, service level alliances and work streams were making our vision a reality. While there is still a lot to do, real improvements are evident in the functioning of our system and the health of our population.

- *Our population is making healthier choices:* two-year-olds' immunisation rates reached 93% in Canterbury in Quarter 3 of 2011/12.
- *We deliver more in the community:* Our Acute Demand Management Service can now provide over 18,000 packages of care for acutely unwell people in the community rather than the hospital.
- *Access to diagnostics has improved:* 25,000 GP-referred diagnostics were delivered in 2010/11, with a broader range now available on GP referral.
- *Less activity in our hospital is acute:* At 0.78, Canterbury's acute medical discharge rate is the lowest of any large DHB in the country, and well below the national average (1.0).
- *Our system is better connected:* 470 clinically led patient pathways have been developed across primary/secondary care to streamline referrals processes and improve outcomes for patients.
- *People are waiting less:* Average waits for skin lesion removal dropped from 196 days in 2007 to just 53 days in 2011, and no one waits more than fours weeks for cancer radiation therapy.
- *Our older populations are better supported:* In its first year, our new CREST service has provided additional support to 987 older people.

With strong clinical leadership, we have developed integrated models of care that reconfigured traditional service delivery models into patient pathways that span the whole system and continuum of care.

The transformation we have achieved was invaluable immediately following the February earthquake and in the months since. Without the gains we had made, the Canterbury health system would not have averted crisis in the face of such destruction and could not have coped with the loss of bed capacity and infrastructure.

New horizons – balancing a fragile system

Canterbury faces the same challenges as other DHBs. The difference is the scale on which such challenges take place and the fragility of our infrastructure and population after the earthquakes. The Canterbury population exceeds half a million people across a very large geographic region. Our population is highly stressed and unsettled, and the infrastructure with which we deliver services is damaged and unstable.

None of the challenges we face are short-term pressures to which there is a 'quick fix' solution. Transformation of our whole health system remains the solution to coping with our future challenges. It is also the key to regaining our lost capacity and rebuilding the Canterbury health system better than it was before.

We are still focused on making the most of opportunities to develop tailored local solutions that allow us to do more (and see more people) with the resources available. At the same time, we are acutely aware of the fragility of our system, our workforce and our population and the need to quickly prioritise activity and redirect resources into areas of immediate need.

In order to achieve this, we will continue to engage everyone in Canterbury health system in activity that keeps people well and reduces the demand on hospital and aged residential care services where our capacity is most limited.

This means accelerating our transformation and recommitting to shifting activity and services to where they will have the greatest impact – moving the point of intervention to earlier in the path of illness by:

- Developing services that support people to stay well and take increased responsibility for their own health and wellbeing;
- Developing primary care and community services to provide a point of ongoing continuity in community-based settings and support people to stay well and remain in their own homes; and
- Freeing up hospital-based specialist resources to be more responsive to episodic events, cope with the increasing demand for more complex services and provide advice and support to primary care.

In recommitting to this direction, we will place additional expectations on primary and community resources and on the available capacity in this part of our system. Balancing what must be done with what can be done by our primary and community partners and our own hospital and specialist services will be an ongoing struggle in the coming year.

Our long-term priorities still focus on improving health outcomes for our population, but our more immediate priorities focus on:

- *Connecting the Canterbury health system* to release capacity by supporting timely, informed clinical decision-making at the point of care and by reducing duplication and waste across the system.
- *Maximising people's opportunity to stay at home* to support people in the right place – matching capacity to need and freeing up secondary care services to provide for those people with a more complex level of need.
- *Reducing the time people spend waiting* to slow the progression of illness and disease and to maximise people's opportunities to maintain or regain their functionality.

Improving Health Outcomes for our Population

What are we trying to achieve?

DHBs are responsible for supplying health and disability services to meet the needs of their populations; however, resources are limited. To cope with the increasing demand for services, we have designed pathways and models of care that influence the flow of people – shifting care to the most appropriate setting and reducing demand by supporting people to stay well and maximise their independence.

We work with stakeholders to effectively coordinate the way we care for our population and to influence demand. This will ultimately assist us to achieve our vision and people will receive the care and support they need, when they need it.

In line with the functions and responsibilities of a DHB, we will deliver on the priorities and expectations of Government. By achieving our local mission - "*To promote, enhance and facilitate the health and wellbeing of the people of Canterbury*" - we will deliver the Government's vision: "*All New Zealanders lead longer, healthier and more independent lives*".

At a regional level, the South Island DHBs are working collectively to deliver "*A clinically and fiscally sustainable South Island health system*." The regional focus on "*providing equitable and timely access to safe, effective, high quality services"* will not only contribute to ensuring health services are sustainable but, by keeping people well, it will also alleviate the increasing demand for services and improve health outcomes.

This section presents an overview of how we will demonstrate whether we are succeeding in improving the health and wellbeing of our population and that of the wider South Island. There is no single measure for the impact of the work we do, so we use population health indicators as proxies to demonstrate the outcome or impact being sought.

The South Island DHBs have identified three strategic outcomes and a core set of associated performance measures, which will demonstrate whether we are making a positive change in the health of our collective population. These are long-term outcome measures (5-10 years in the life of the health system) and as such, we are aiming for a measurable change in the health status of the South Island population over time, rather than a fixed target.

- *Outcome 1: People are healthier and take greater responsibility for their own health.*

  The development of services that better protect people from harm and support people to reduce risk factors, make healthier choices and maintain their own health and wellbeing.

- *Outcome 2: People stay well and maintain their functional independence.*

  The development of primary and community-based services that provide early diagnosis and treatment and support people to better manage enduring health conditions, reduce the complications of disease and injury and maintain functional independence in their own homes and communities.

- *Outcome 3: People recover from complex illness and/or maximise their quality of life.*

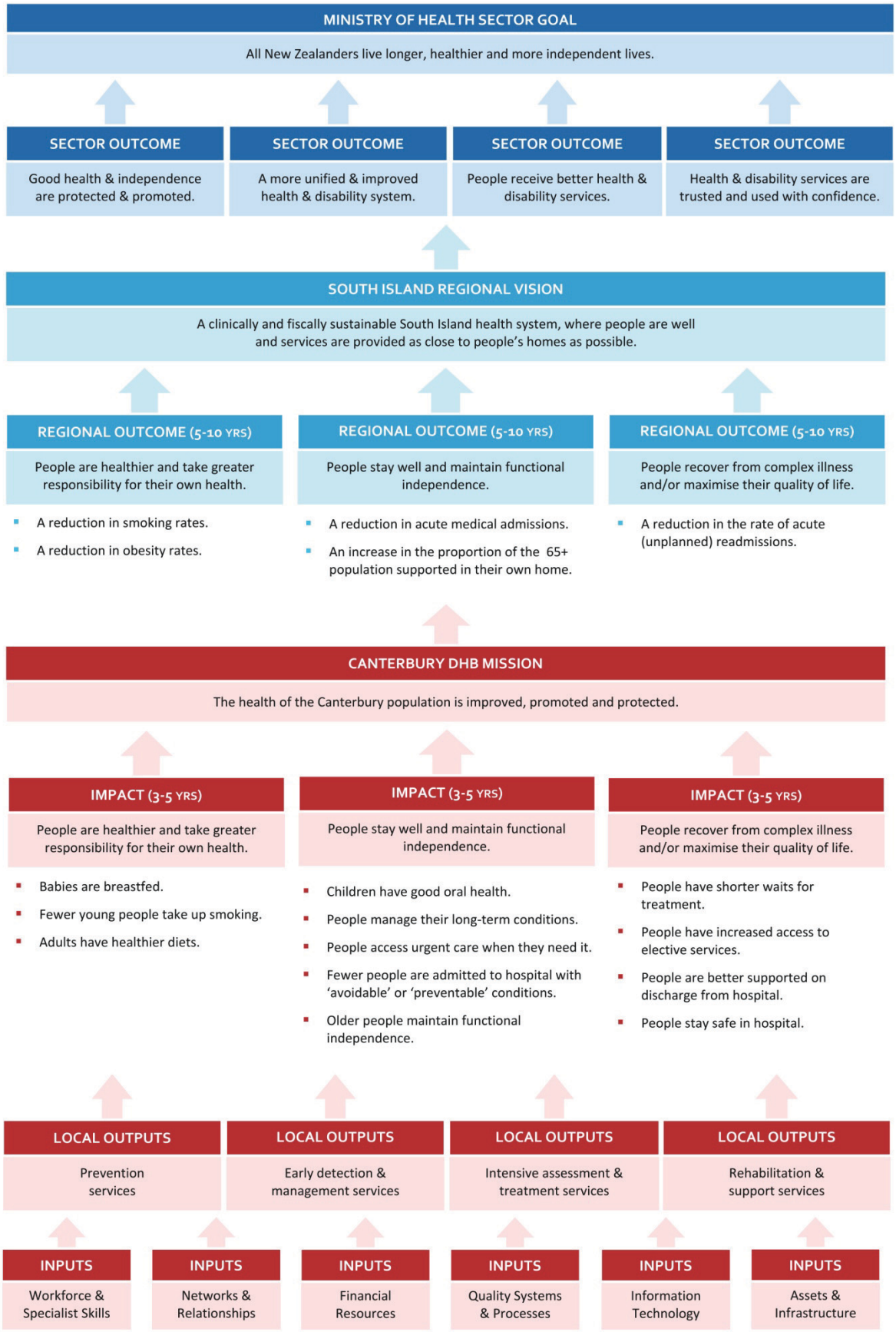
  The development of systems and models of care that free up secondary and specialist services to provide timely and appropriate complex care and advice to reduce the progression of illness, better support people's functional capacity and improve people's quality of life.

Against each of these desired regional outcomes, we have identified areas where individual DHB performance will have an impact on achievement and collectively agreed a core set of related medium-term (3-5 years) performance measures. Because change will be evident over a shorter period of time, these impact measures have been identified as the 'main measures', and each South Island DHB has set local targets to evaluate their performance over the next three years.

The following intervention logic diagram visually demonstrates the value chain: how the services that an individual DHB chooses to fund or provide (outputs) have an impact on the health of their population and result in the achievement of desired regional outcomes and the delivery of the expectations and priorities of Government.[12]

[12] *The DHB also has a Māori Health Action Plan which is a companion document to the Annual Plan that sets out key performance measures to support improvements in Māori health and reduce inequalities. The 2012/13 Māori Health Action Plan is available on the DHB's website.*

FIGURE 4: INTERVENTION LOGIC DIAGRAM



STRATEGIC GOAL

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

Expectation

Population health and prevention programmes ensure people are better protected from harm, more informed of the signs and symptoms of ill health and supported to reduce risk behaviours and modify lifestyles in order to maintain good health. These programmes create health-promoting physical and social environments which support people to take more responsibility for their own health and make healthier choices.

Why is this outcome a priority?

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

Tobacco smoking, inactivity, poor nutrition and rising obesity rates are major and common contributors to a number of the most prevalent long-term conditions. These are avoidable risk factors, preventable through a supportive environment, improved awareness and personal responsibility for health and wellbeing. Supporting people to make healthy choices will enable our population to attain a higher quality of life and to avoid, delay or reduce the impact of long-term conditions.

OUTCOMES MEASURES LONG TERM (5-10 YEARS)

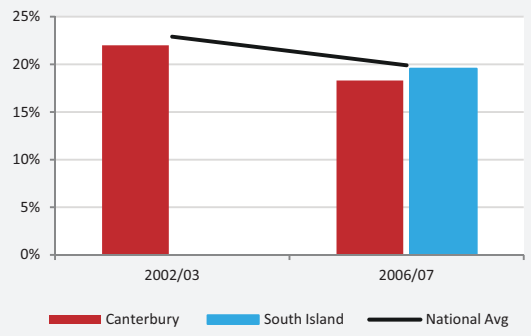
We will know we are succeeding when there is:

A reduction in smoking rates.

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

Data sourced from national NZ Health Survey via PHI Online.[13]

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

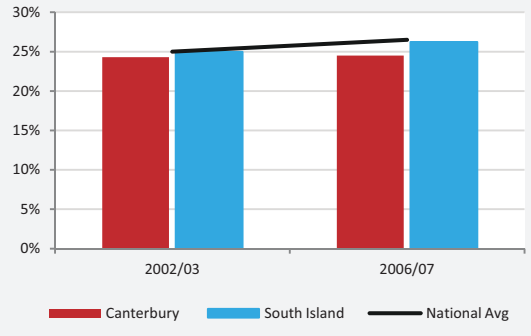


A reduction in obesity rates.

- *There has been a rise in obesity rates in NZ in recent decades, and the NZ Health Survey found that one in four adults (26.5%) and one in twelve children (8.3%) were 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.* [14]
- *Supporting our population to maintain healthier body weights through improved nutrition and increased physical activity levels is fundamental to improving their health and wellbeing and to preventing and better managing long-term conditions and disability at all ages.*

Data sourced from national NZ Health Survey via PHI Online.[13]

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



[13] *The NZ Health Survey was completed by the Ministry of Health in 2003/04 and 2006/07; the next survey results are expected in 2012.*

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

IMPACT MEASURES MEDIUM TERM (3-5 YRS)

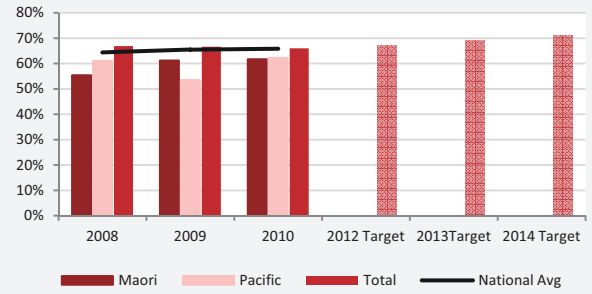
Over the next three years we seek to make a positive impact on the health and wellbeing of the Canterbury population and contribute to achieving the longer-term outcomes we seek. The effectiveness of the services the DHB funds and provides, and the contribution we make, will be evaluated using the following impact measures:

More babies are fully and exclusively breastfed.

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

Data sourced from Plunket via the Ministry of Health.

The percentage of Canterbury babies fully/exclusively breastfed at 6 weeks.	Actual 2010	Target 2012	Target 2013	Target 2014
	66%	67%	69%	71%

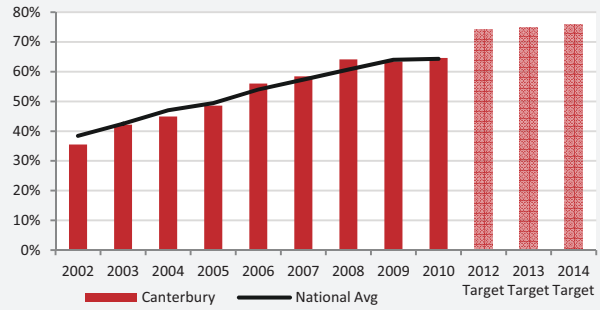


Fewer young people take up tobacco smoking.

- *Reducing smoking prevalence is largely dependant on preventing young people from taking up smoking.*
- *Over 90% of smokers have started smoking by 18 years of age, and the highest prevalence of smoking is amongst young people - approximately one in every four Canterbury teenagers (15-19) currently smokes.*
- *A reduction in the uptake of smoking is seen as a proxy measure of successful health promotion and engagement and a change in the social and environmental factors that influence risk behaviours and support healthier lifestyles.*

Data sourced from national Year 10 ASH Survey.[15]

The percentage of 'never smokers' among Year 10 Canterbury students.	Actual 2010	Target 2012	Target 2013	Target 2014
	65%	74%	75%	76%

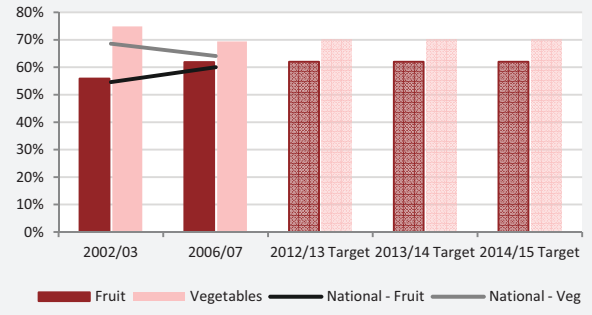


More adults have healthier diets.

- *Nutrition-related risk factors (such as high cholesterol, high blood pressure and obesity) jointly contribute to two out of every five deaths in NZ every year.*[16]
- *Appropriate fruit and vegetable consumption helps to protect our population against obesity, cardiovascular disease, diabetes and some common cancers and contributes to maintaining a healthy body weight.*
- *An increase in fruit and vegetable consumption is seen as a proxy measure of successful health promotion and engagement leading to a change in the social and environmental factors that influence people to make healthier choices.*

Data sourced from the national NZ Health Survey.[13]

The percentage of the population (15+) having the recommended servings of fruit and vegetables.		Actual 06/07	Target 12/13	Target 13/14	Target 14/15
	Fruit 2+	62%	>62%	>62%	>62%
	Veg 3+	69%	>70%	>70%	>70%



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

[16] *Niki Stefanogiannis: Nutrition and the burden of disease in NZ; 1997–2011, Public Health Intelligence, Ministry of Health, Wellington.*

STRATEGIC GOAL

2.5 People stay well and maintain their functional independence

Expectation

Primary and community services support people to stay well by providing earlier intervention, diagnostics and treatment and better managing their illness or long-term conditions. These services assist people to detect health conditions and risk factors earlier, making treatment and interventions easier and reducing the complications of injury and illness. They also support people to regain their functionality after illness and to remain healthy and independent.

Why is this outcome a priority?

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

Supporting primary care are a range of other health professionals including midwives, community nurses, social workers, aged residential care providers, personal health providers and pharmacists. These providers have prevention and early intervention perspectives that link people with other health and social services and support them to stay well. Studies show countries with strong primary and community care systems have lower rates of death from heart disease, cancer and stroke, and achieve better health outcomes for lower cost than countries with systems that focus on specialist level care.

With an ageing population, the South Island will require a strong base of primary care and community support, including residential care, respite and home-based support. If long-term conditions are managed effectively, crises and deterioration can be reduced and health outcomes improved. Even where returning to full health is not possible, access to responsive, needs-based services helps people to maximise function with the least restriction and dependence.

If people are well they need fewer hospital-level or long-stay interventions and, those who do, have a greater chance of returning to a state of good health or slowing the progression of disease. This is not only a better health outcome for our population, but it reduces the rate of acute and unplanned hospital admissions and frees up health resources.

OUTCOMES MEASURES LONG TERM (5-10 YEARS)

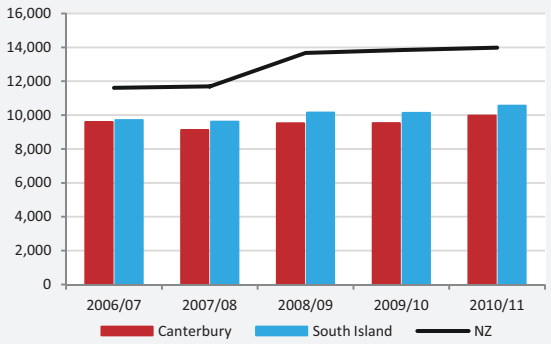
We will know we are succeeding when there is:

A reduction in the proportion of the population being admitted to hospital for an acute medical illness.

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

Data sourced from National Minimum Data Set.

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

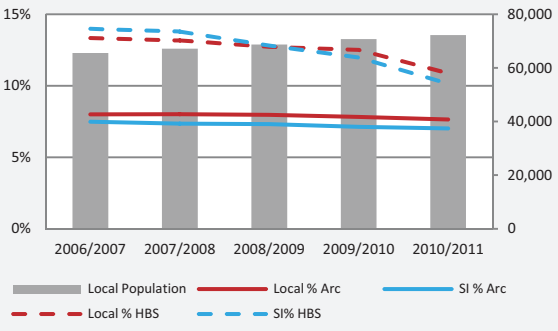


An increase in the proportion of the population (65+) supported to stay well in their own home.

- *While living in Aged Residential Care (ARC) is appropriate for a small proportion of our population when people receive adequate support for their needs, remaining in their own homes provides a 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 Home Based Support Service (HBSS) to people to stay well in their own homes.*

Data sourced from Client Claims Payments provided by SIAPO.

Outcome Measure: The percentage of the older population (65+) in ARC and those receiving HBSS.



IMPACT MEASURES MEDIUM TERM (3-5 YRS)

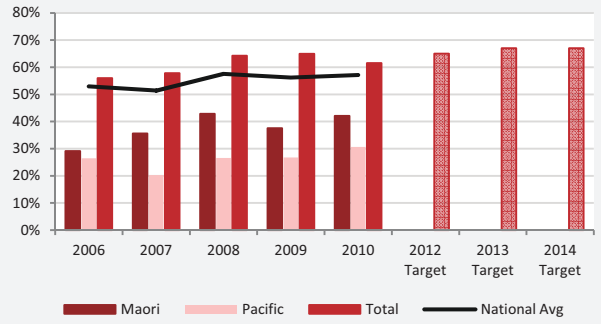
Over the next three years we seek to make a positive impact on the health and wellbeing of the Canterbury population and contribute to achieving the longer-term outcomes we seek. The effectiveness of the services the DHB funds and provides, and the contribution we make, will be evaluated using the following impact measures:

More children have good oral health.

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

Data sourced from Ministry of Health.

The percentage of Canterbury children caries free at age 5 (no holes or fillings).	Actual 2010	Target 2012	Target 2013	Target 2014
	62%	65%	67%	>67%



More people better manage their long-term conditions.

- *Diabetes is a significant cause of ill health and premature death, and diabetes prevalence is increasing at an estimated 4-5% a year.*
- *Improving the management of diabetes will reduce avoidable complications that require hospital-level intervention, such as amputation, kidney failure and blindness, and will improve people's quality of life.*
- *Diabetes is also strongly associated with cardiovascular diseases (heart attacks and stroke) and respiratory disease. As such, good diabetes management is seen as a proxy measure for good management of other long-term conditions as well.*

Data sourced from individual DHBs.[17]

The percentage of the Canterbury population identified with diabetes with HbA1c≤64mmol/mol.	Actual 10/11	Target 12/13	Target 13/14	Target 14/15

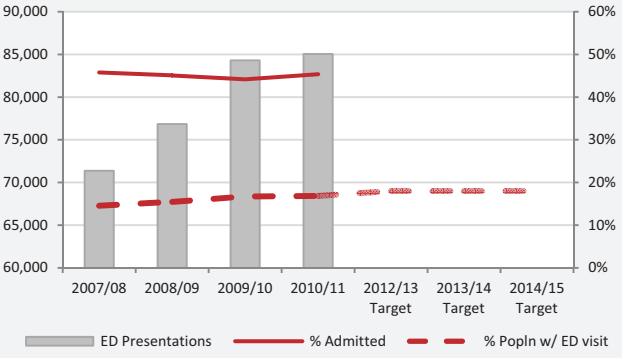
NOTE: The previous national diabetes programme is being replaced with local programmes across the country. Diabetes remains a priority area, and the intention is use GP identified diabetes data to set baselines against this measure in the coming year in line with the new Canterbury diabetes care improvement package.

People access care appropriate to their needs.

- *Supporting people to seek early intervention and providing alternative urgent care pathways will ensure people are able to access the right treatment and support when they need it, which is not necessarily in hospital Emergency Departments.*
- *Early and appropriate intervention will not only improve health outcomes for our population, but will also reduce unnecessary pressure on our hospitals.*
- *A reduction in the number of people presenting to the Emergency Department (ED) and an increase in the percentage of people presenting who are admitted are proxy measures of whether people are being more appropriately managed and supported elsewhere.*

Data sourced from individual DHBs.[18]

The percentage of the Canterbury population presenting at ED.	Actual 10/11	Target 12/13	Target 13/14	Target 14/15
	16.8%	≤18%	≤18%	≤18%



[17] *HbA1c≤64mmol/mol indicates satisfactory diabetes management.*

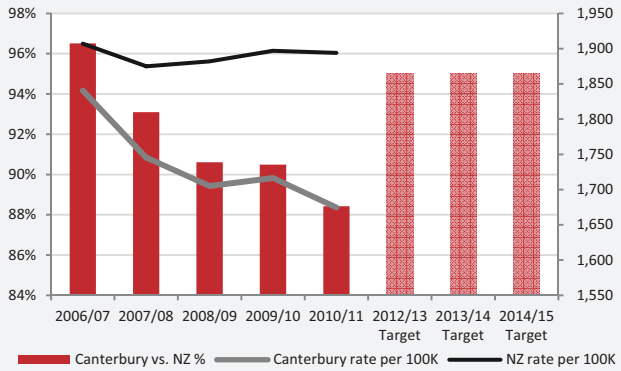
[18] *'Presenting' and 'Admitted' are defined by the Ministry of Health national ED health target.*

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

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

Data sourced from the Ministry of Health. [19]

The percentage of avoidable admissions for the Canterbury population compared to the NZ population (<75).	Actual 10/11	Target 12/13	Target 13/14	Target 14/15
	88%	≤95%	≤95%	≤95%

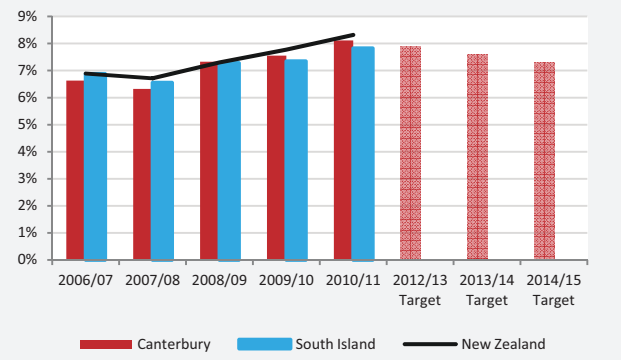


Older people maintain functional independence.

- *Around 25,000 New Zealanders (75+) are hospitalised annually as a result of injury due to falls. Compared to elderly people who do not fall, those who do experience prolonged hospital stay, loss of confidence and independence and an increased risk of institutional care.*
- *With an ageing population, a focus on reducing falls will help people to stay well and independent and will reduce the relative demand on acute and aged residential care services.*
- *The solution to reducing falls address various health issues and associated risk factors including: medications use, lack of physical activity, poor nutrition, osteoporosis, impaired vision and environmental hazards. A reduction in falls can therefore be seen as a proxy measure for improved health service provision for older people*

Data sourced from National Minimum Data Set.

The percentage of the Canterbury population (75+) admitted to hospital as a result of a fall.	Actual 10/11	Target 12/13	Target 13/14	Target 14/15
	8.1%	7.9%	7.6%	7.3%



[19] *This measure is based on the national DHB performance indicator SI1 and covers hospitalisations for 26 identified conditions including asthma, diabetes, angina, vaccine-preventable diseases, dental conditions and gastroenteritis. It is defined as the standardised rate per 100,000 for Canterbury divided by the standardised rate per 100,000 for NZ. A lower percentage is therefore better, as it indicates a lower rate of avoidable hospitalisation than the national average. Canterbury aims to remain under the national rate.*

STRATEGIC GOAL

2.6 People recover from complex illness and/or maximise their quality of life.

Expectation

Secondary-level hospital and specialist services meet people's complex health needs, are responsive to episodic events and support community-based care providers. By providing appropriate and timely access to high quality complex services, people's health outcomes and quality of life can be improved.

Why is this outcome a priority?

Clinicians, in collaboration with patients and their families, make decisions with regards to complex treatment and care. Not all decisions result in interventions to prolong life, but may focus on patient care such as pain management or palliative services to improve the quality of life. For those who do need a higher level of intervention, timely access to high quality complex care improves health outcomes by restoring functionality, slowing the progression of illness and disease and improving the quality of life.

The timeliness and availability of complex treatment and care is crucial in supporting people to recover from illness and/or maximise their quality of life. Shorter waiting lists and wait times are also indicative of a well functioning system that matches capacity with demand by managing the flow of patients through services and reducing demand by moving the point of intervention earlier in the path of illness.

As providers of hospital and specialist services, DHBs are operating under increasing demand and workforce pressures, and Government is concerned that patients wait too long for diagnostic tests, cancer treatment and elective surgery. The expectations around reducing waiting times, coupled with the current fiscal situation, mean DHBs need to develop innovative ways of treating more people and reducing waiting times with limited resources.

This goal reflects the importance of ensuring that hospital and specialist services are sustainable and that the South Island has the capacity to provide for the complex needs of its population now and into the future.

OUTCOMES MEASURES LONG TERM (5-10 YEARS)

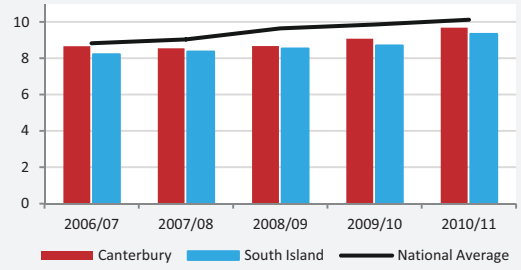
We will know we are succeeding when there is:

A reduction in the rate of acute (unplanned) readmissions to hospital and specialist services.

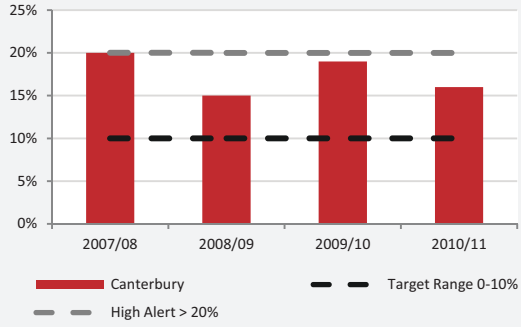
- *Readmission rates are a proxy measure of the quality of care, effectiveness of service provision and appropriateness of discharge from hospital and specialist services.*
- *They serve as a counter-measure to balance improvements in productivity and reduced lengths of stay, at the same time as our population is ageing and people are presenting with more complex conditions. They also provide an indication of the integration between services to appropriately support people on discharge from hospital.*
- *Improved patient safety, quality processes and clinically driven patient pathways will support patients to receive the most appropriate complex care and support whilst in our hospital and specialist services and reduce the likelihood of an adverse event requiring readmission.*
- *A reduction in acute (or unplanned) readmissions to hospital will demonstrate improved patient outcomes that enable people, their families and caregivers to maintain more stable lives and improve their quality of life.*

Data sourced from Ministry of Health and individual DHBs.

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



Outcome Measure: The rate of acute (unplanned) readmissions to mental health services within 28 days.[20]



[20] *This measure is based on the national Mental Health and Addictions KPI Framework measure which was introduced in 2007/08.*

IMPACT MEASURES MEDIUM TERM (3-5 YRS)

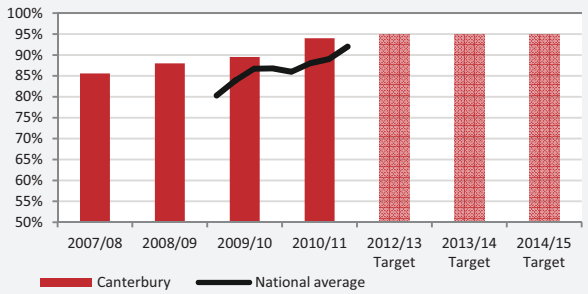
Over the next three years we seek to make a positive impact on the health and wellbeing of the Canterbury population and contribute to achieving the longer-term outcomes we seek. The effectiveness of the services the DHB funds and provides, and the contribution we make, will be evaluated using the following impact measures:

More people receive timely emergency care.

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

Data sourced from individual DHBs.[21]

	Actual 10/11	Target 12/13	Target 13/14	Target 14/15
The percentage of patients presenting at Canterbury EDs who are admitted, discharged or transferred within six hours.	94%	95%	95%	95%

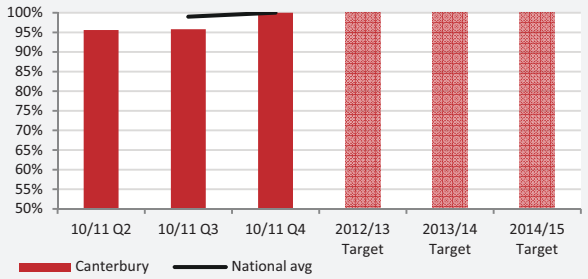


More people receive timely cancer services.

- *Cancer is the leading cause of death and a major cause of hospitalisation in NZ. Timely cancer treatment improves outcomes and the quality of people's lives.*
- *This measure, while targeting one part of a patient's journey, provides a good indicator of how well the whole system is responding to need.*
- *Māori and Pacific peoples have higher cancer incidence rates compared to other populations. Inequalities of access to screening, diagnosis and treatment contribute to poorer outcomes. Improving access and ensuring sufficient treatment capacity are both important factors to ensure Māori and Pacific people have the opportunity for equitable outcomes.*

Data sourced from individual DHBs.[22]

	Actual Q4 10/11	Target 12/13	Target 13/14	Target 14/15
The percentage of patients who receive radiation therapy treatment within four weeks of the decision to treat.	100%	100%	100%	100%

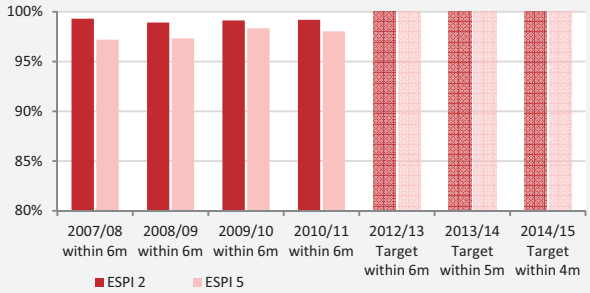


More people receive timely access to elective services.

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

Data sourced from Ministry of Health.[23]

	Actual 10/11	Target 12/13	Target 13/14	Target 14/15
The time people wait from referral to their First Specialist Assessment (ESPI 2).	≥ 6m	≤ 6m	≤ 5m	≤ 4m
The time people wait from the commitment to treat until treatment (ESPI 5).	≥ 6m	≤ 6m	≤ 5m	≤ 4m



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

[22] *This measure is based on the national DHB health target 'Shorter waits for cancer treatment' introduced in September 2010.*

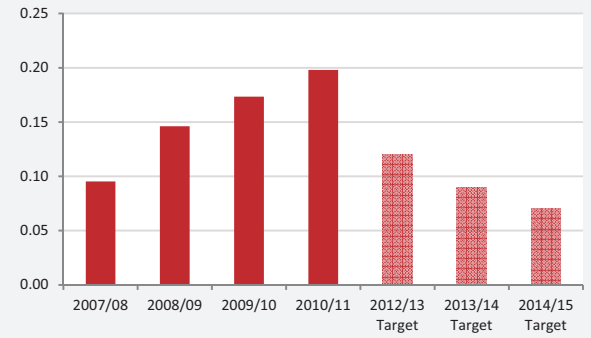
[23] *The Elective Services Patient Flow Indicators (ESPIs) have been established nationally to track system performance and DHBs receive summary reports from the Ministry of Health on a monthly basis. National average performance data is not made available and historical data is against a six month target. We aim to achieve 100% within 6 months by 30 June and 5 months by 31 December 2013.*

Fewer people experience adverse events that cause harm.

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

Data sourced from individual DHBs.[24]

The rate of SAC level 1 and 2 falls in Canterbury Hospitals for older people (65+).	Actual 10/11	Target 12/13	Target 13/14	Target 14/15
	0.20	0.12	0.09	0.07



More people receive timely post-discharge care.

- *Research indicates that mental health service users have increased vulnerability immediately following discharge, and those leaving hospital after an admission with a formal discharge plan that has linkages with community services are less likely to experience early readmission.*
- *Responsive intervention and community support post-discharge not only improves health outcomes, but also enables people, their families and caregivers to maintain more stable lives.*
- *This measure is therefore a proxy for access to services but also for continuity of services, demonstrating integration and coordination between services to improve the quality of people's lives.*

Data to be sourced from individual DHBs.

The percentage of people in Canterbury having a post-discharge contact within seven days of discharge from Specialist Services.	Actual 10/11	Target 12/13	Target 13/14	Target 14/15
	-	-	-	-

NOTE: The intention is to use the Key Performance Indicator (KPI) from the national Mental Health and Addictions KPI Framework. This Framework is currently being introduced through a staged process. The South Island DHBs will use this measure once data is established.

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

Government Expectations

2.7 Health targets - how will we contribute?

When planning investment and activity across the health system, DHBs must consider the role they play in the achievement of the vision and goals of Government – reflected in the annual expectations of the Minister of Health.

In setting expectations for 2012/13, Government has been clear that the public health system must deliver '*better, sooner, more convenient*' health care and achieve health goals from within current budgets. The Government has made commitments to New Zealanders to deliver even faster access to elective surgery, diagnostic tests, cancer services and youth drug and alcohol services and expects DHBs to meet these commitments.

The Minister of Health continues to advocate for strengthened clinical leadership and engagement, and expects to see improvements in productivity, patient safety and the quality of services.

The Minister also expects DHBs to focus strongly on service integration, particularly with primary care, including the development of integrated family health centres, direct-referral access to diagnostics and clinical pathways involving community and hospital clinicians.

The Minister's priorities for DHBs for 2012/13 are:

Integrated care: Developing integrated services to drive delivery and improve performance in three priority areas: unplanned and urgent care, long-term conditions and wrap-around services for older people. DHBs are also to work across their local networks to implement the Government's commitments to zero-fee after hours GP visits for children under 6, shorter waits for child and youth drug and alcohol treatment and further integration of child and maternity services.

Shorter waiting times: Improved access to services including: elective surgery, diagnostics tests, cancer treatments and child and youth drug and alcohol treatment.

Improving health services for older people: Developing integrated services for older people that support their continued safe, independent living at home, particularly after hospital discharge. DHBs will also work to implement the Government commitments related to dedicated stroke units and dementia pathways.

Regional integration: Accelerated collaboration between neighbouring DHBs to maximise clinical and financial resources and evidence of real gains. DHBs are also expected to make significant progress in implementing regional service plans and delivering on regional workforce, IT and capital objectives.

Efficiency and containing costs: Supporting the work of Health Benefits Ltd, Health Workforce NZ and the Health Quality and Safety Commission. Significant productivity gains are expected to be made across services and organisations.

Achievement of health targets: Joint planning with primary and community networks to deliver smoking, cardiovascular disease and immunisation targets.

The national health targets measure progress against key national priorities, with the anticipation that a unified, collaborative focus will drive performance improvement across the sector. Progress is monitored quarterly by the National Health Board.

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 the continuum, from prevention and early intervention services through to improved access to intensive assessment, treatment and support.

There is also alignment between regional and local priorities and the national health targets. In this sense, achievement of the national health targets is seen as a reflection of how well every level of the health system is working together to improve the health and wellbeing of our population.[25]

Canterbury is committed to making continued progress towards achieving the Minster's expectations and national health targets. Our contribution (in terms of local targets) is set out against the national health targets on the following page. The activity planned to achieve these health targets is outlined in the Service Performance section of this document.

[25] *Further information regarding the health targets can be found on the Ministry's website www.health.govt.nz.*

Shorter Stays in Emergency Departments

Government expectation

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

Canterbury contribution – see page 32

95% of people presenting at 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 at least 4,000 additional discharges nationally every year.[26]

Canterbury contribution – see page 34

16,110 elective surgical discharges will be delivered in 2012/13.

Shorter Waits for Cancer Treatment

Government expectation

Everyone needing cancer radiation or chemotherapy treatment will receive it within four weeks of the decision to treat.[27]

Canterbury contribution – see page 35

100% of people who need radiation or chemotherapy will receive it within four weeks.

Increased Immunisation

Government expectation

95% of all eight-month-olds are fully vaccinated against vaccine preventable diseases.

Canterbury contribution – see page 41

85% of all eight-month-olds will be fully vaccinated by 1 July 2013.

Better Help for Smokers to Quit

Government expectation

90% of smokers seen in primary care, 95% of those seen in public hospitals and 90% of women at confirmation of pregnancy with a Lead Maternity Carer (LMC) are offered brief advice and support to quit smoking.

Canterbury contribution – see page 49

90% of smokers seen in primary care and **95%** of those seen in public hospitals will receive advice and help to quit. Progress towards **90%** of pregnant smokers being offered advice and help to quit smoking.

More Heart and Diabetes Checks

Government expectation

90% of the eligible population have their cardiovascular risk assessed once every five years.

Canterbury contribution – see page 54

Progress towards **75%** of the eligible population having had their CVD risk assessed by 1 July 2013.

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

[27] *The national health target definition excludes Category D patients, whose treatment is scheduled with other treatments or part of a trial.*

Service Performance Priorities 2012-2013

INTEGRATING THE CANTERBURY HEALTH SYSTEM

Canterbury is tantalisingly close to delivering a fully integrated health system that provides a seamless flow of care rather than a series of isolated events. The answer to meeting the increasing demands on our system and rebuilding our lost capacity is not more of the same services, but more of the *right* services – delivered in the *right place* and at the *right time*.

Our ability to respond quickly and to flex the system around the needs of our population enabled us to cope when rapid replanning was required to maintain services following the earthquakes. Health professionals from all parts of the system worked together to create an integrated Canterbury Recovery Plan, the short-term elements of which have been delivered over the past 18 months.

Now that we have stabilised our health system and ensured its immediate recovery from the earthquakes, we are moving into a transition phase. Our system remains fragile and is at full capacity. In order to prepare our health system for the future, we need to make Vision 2020 a reality. Knowing the challenges of an ageing and growing population that lie ahead of us, Canterbury is seizing the opportunity to build our health system to be better than ever before.

During our recovery phase, our focus was by necessity on individual tasks and services. As we move forward into 2012/13, we have established the key priority areas for driving transformation, which are reflected throughout this document.

This work will be managed by the appropriate leadership groups from across both the Canterbury health system and the wider South Island region. All our activity is aligned to the shared vision that is evident throughout our system. Since the quakes, we have learnt to react, adapt and redesign services rapidly, but always with a clear sense of this direction.

While this direction of travel was part of the Canterbury solution to meeting and managing increasing demand before the earthquakes, the loss of capacity and significant damage to our health infrastructure makes accelerated delivery of our vision critical.

Where do we want to be?

To fully implement our vision, we will continue to improve the interface and connectivity between primary and secondary care. A significant number of the initiatives established across this interface in the past three years have been driven through the Canterbury Clinical Network (CCN) District Alliance's implementation of the *'Better, Sooner, More Convenient'* business case and through our unique Canterbury Initiative.

Our approach has been to bring together clinical representatives from general practice, hospital specialties and the community to identify and address challenges and design new models of care to support integrated service delivery and improve the patient journey. Over 470 clinically led patient pathways are now 'live' on Canterbury's HealthPathways website.

To the same end, three major IT projects are underway to better connect our system. The development of a Collaborative Care Management System (CCMS) will provide electronic access to care plans and clinical information for health professionals from across the system involved in the care of people with complex long-term conditions. The expansion of our Electronic Referral Management System (ERMS) will enable GPs to refer patients electronically to anywhere else in the system, including private providers. The extension of our Electronic Shared Care Record View (eSCRV) will provide a secure system for sharing basic patient information between health professionals involved in a person's care for faster, more informed treatment, shorter waiting times and better outcomes for patients.

Integrated Family Health Centres (IFHCs) and Community Hubs will also be developed across Canterbury in the coming year. This will help to rebuild damaged community health infrastructure in a way that supports greater integration between services. Hubs will be developed as a basis for the provision of community, secondary and specialist services in the community – closer to patients' homes.

Our priorities

The following sections highlight our immediate priorities for the coming year and the initiatives and activity we have planned to drive transformation and improvements in each priority area.

The Canterbury DHB has chosen its priorities based on population need, demand trends and the level of change needed to improve service delivery and health outcomes in our challenging environment. We have also aligned our priorities with the expectations of the Minister of Health and delivery of the national health targets.

Meeting the Minister's expectations

- 95% of all people presenting in ED will be admitted treated or discharged in under 6 hours.
- 75% of all children under six will have access to free GP services afterhours.
- 16,110 elective surgical discharges will be delivered in Canterbury, and no patient will wait more than 6 months for a first specialist assessment or treatment.
- 100% of people needing cancer radiation or chemotherapy treatment will receive treatment within 4 weeks of the decision to treat.
- Wait times for access to diagnostics will improve, particularly: Coronary Angiography, Colonoscopy, Magnetic Resonance Imaging (MRIs) and Computed Tomography (CT) scans.

In a constrained system with limited capacity, our approach to managing patient flow and reducing demand becomes critical. To continue to deliver quality care and meet our population's need, we need to ensure capacity is matched to demand and that the right care is delivered at the right time and in the right place.

This approach requires affordable access to effective care and treatment to support people to stay well. It requires a shift of appropriate hospital-based services into community-based settings to help to support people to better manage their long-term conditions, minimise waits for treatment and reduce unnecessary hospital visits. It also requires the introduction of alternative models of care for acute illness including urgent care options that support people in their own homes and communities rather than in ED.

Backing up this effective care and treatment is improved access to diagnostics and advice, improved patient flow in our hospital services and supported discharge services that improve recovery outcomes and reduce the risk of readmission.

By reducing demand on hospital capacity and using agreed pathways and referral guidelines, specialists' time will be freed up to invest in more complex patients. This will enable us to deliver more elective surgery and further reduce waiting times for complex care. New and virtual outpatient models, an increased focus on telemedicine and tight production planning will also help to improve access and take the 'wait' out of our system.

This complete picture will shift intervention to earlier in the patient journey and support our population while we recover the capacity we have lost.

The momentum that we have developed will be harnessed to support us through the immediate stresses and the disruption of repairs and aftershocks. At the same time, it will provide opportunities to build a truly integrated Canterbury system.

FIGURE 5: CANTERBURY – ONE HEALTH SYSTEM

Canterbury's vision is a holistic health system with people at the centre.

Adapted from the King's Fund UK: www.kingsfund.org.uk

3.1 Connecting the system

To deliver truly seamless care for our population, the whole Canterbury health system must be engaged in the vision and connected through system-wide pathways and information sharing.

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Engage the whole of the system in the vision and future direction. *To support our transformation and increase the responsiveness of the system.*	Continue to support the engagement of organisations and clinical groups in transformation activities across Canterbury. Ensure system-wide clinical and community participation is built into the future activity of the CCN District Alliance. Support the development and delivery of sector-wide communications about the work that is underway.	More signatories to the district alliance agreement. CCN communication plan in place including internet and public reporting by Q1.
Support the continued development of clinically led patient pathways. *To link clinicians across the health system and support true integration of services and maximise patient outcomes.*	Expand the use of HealthPathways across the Canterbury health system to support the delivery of the right care and support in the right place at the right time. Support the expansion of HealthPathways beyond Canterbury in order to improve the management of referrals and patient care across regions. Support the expansion of HealthInfo (the publicly available companion site to HealthPathways) to provide our population with the information they need to take more responsibility for managing their own health.	>470 HealthPathways available across the Canterbury system. Ongoing active review of current HealthPathways. Regional adoption of HealthPathways by all South Island DHBs by Q1.
Support the closer alignment of clinical information across the Canterbury health system. *To provide shared access to clinical information that enables timely clinical decision-making at the point of care and supports the integration of services.*	Complete the upgrade of the DHB Concerto System to support ongoing clinical systems development. Complete the implementation of GP e-referrals into the Concerto framework, enabling ERMS/Concerto integration.	ERMS/Concerto integration complete by Q3.
	Support increased use of the ERMS by general practitioners and improve the quality of referrals being sent to enable the system to plan and manage its capacity in a way that is responsive to the health needs of the population.	70% of all Canterbury GPs have access to ERMS by Q2.
	Continue to roll out the eSCRV to provide secure universal access to key health information in any health setting. Support pharmacists, Nurse Maude and general practice to contribute/access appropriate information.	Pharmacists and Nurse Maude have access to eSCRV by Q1.
	Take the next step in the rollout of Project Chain and expand Collaborative Care Management System (CCMS) and Collaborative Care Programme (CCP) capability to support care for individuals with complex health needs.	25% of all of 'frequently admitted' patients identified with complex/ long-term conditions enrolled in the CCP by Q4. [28]
	Continue to develop a real-time integrated Lightfoot data set and introduce related data sets, including acute demand management, to inform and engage clinical staff in new solutions to influence demand.	Live weekly update of Lightfoot data available by Q1.
	Expand our capacity to proactively manage bed allocation for planned and unplanned admissions within our hospitals and coordinate capacity planning activity with theatre and discharge planning.	16,110 elective surgical discharges delivered in Canterbury facilities by Q4.

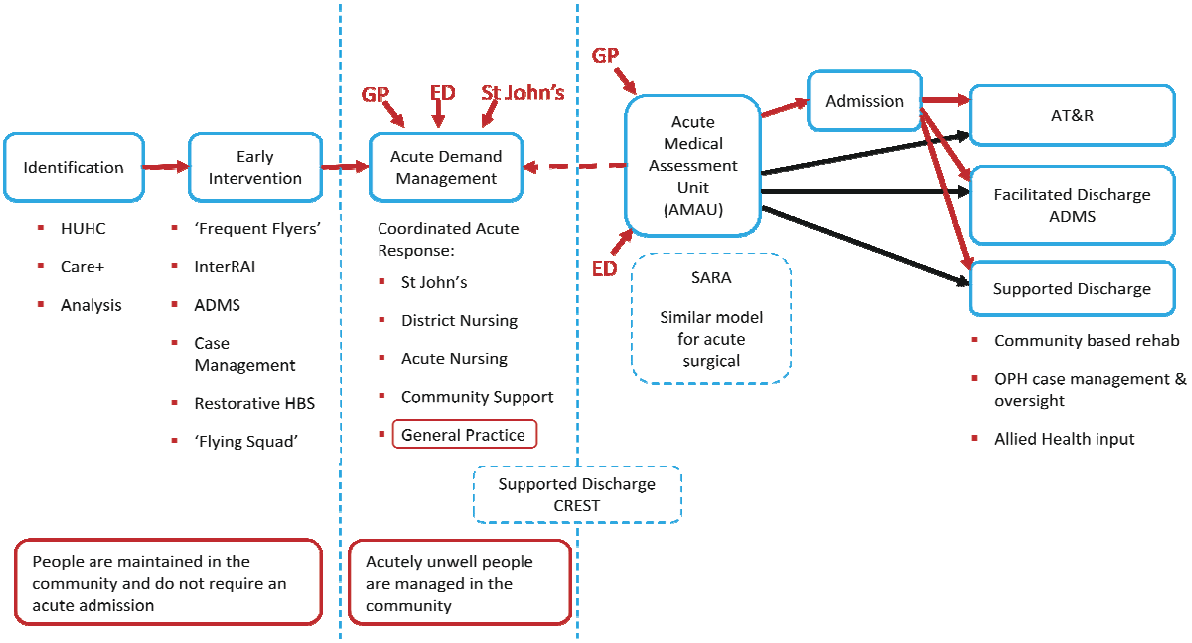
[28] *'Frequently admitted is defined as those people with a complex/long-term condition and 4+ visits to the ED within a year.*

3.2 Maximising people's opportunities to stay at home

Supporting people to stay well and providing access to timely and responsive care in people's own homes and communities will improve their quality of life and free up constrained hospital resources for those needing more complex care.

FIGURE 6: IMPROVED ACUTE PATIENT FLOW

Canterbury takes a 'whole of system' approach to maximising people's opportunities to stay at home.



OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Physically align primary and community care. *To further integrate the health system, improve access to services closer to people's homes and increase capacity by making better use of available resources.*	Support the development and implementation of eight Integrated Family Health Centres and networks in Christchurch by year-end.	6 urban IFHCs/networks under development by Q4.
	Support the Rural Health Workstream to develop rural IFHCs and scope the northern corridor to determine a framework that supports appropriate models of care for this population.	3 rural IFHCs under development by Q4.
	Support the development of Community Hubs to provide a range of outpatient and community specialist activity alongside extended primary care.	2 identified Community Hubs are scoped by Q4.
Improve the identification of people most at risk. *To target those most at risk and reduce acute demand pressures.*	Undertake predictive risk modelling (based on GAIHN) to identify people at risk of readmission and then extend this approach with primary and pharmacy data to predict initial admission risk. Continue to develop a real-time integrated Lightfoot data set and introduce related data sets, including acute demand, to inform and engage clinical staff in new solutions to influence demand.	Stage I model identifying people at risk of readmission validated by Q1. Stage II developed by Q2. Live weekly update of Lightfoot data available by Q1.
Support early intervention and the improved coordination of services across the system. *To support people to stay well and to reduce demand for hospital and ARC services.*	Support the insulation of the homes of people identified as having higher health needs. Use the new Collaborative Care Programme (CCP) to provide coordinated case management for people with unstable and complex health needs. Support the development of a new model for managing acute exacerbations of COPD. Complete the implementation of the Medication Management Service (MMS) to reduce harm and optimise medicines use.	100% of 'frequently admitted' respiratory and cardiology patients enrolled in CCP by Q1. Acute COPD model developed by Q1. 2,000 medication reviews provided for older people on multiple medications.

Acute demand services

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Support improved management of acutely unwell people and access to the most appropriate urgent care option at any given time. *To support more responsive services to minimise exacerbations of conditions that could have been better managed and reduce unnecessary ED and hospital presentations, especially among self and ambulance referrals (preload).*	Encourage GP practices to take up the current under-six-year-old payments and provide zero fees during hours. Engage with primary care to understand and eliminate barriers to offering zero fees to under-sixes after hours. Review afterhours use by children under six and agree protocols for free afterhours access in line with national timeframes. Work with the Child and Youth Health Workstream to monitor access to zero fees for children under six. Support general practices to provide a free afterhours nurse phone advice and triage service.	60% of the population under six have access to free afterhours care by Q1. 75% of the population under six have access to free afterhours care by Q4.
	Continue to refine acute demand services to target patients with the greatest capacity to benefit and to support those with a high level of need to access appropriate urgent care in the community rather than in hospitals. Identify and engage ARC facilities with high admission rates through provision of acute demand services to raise their capacity to manage acutely unwell patients. Engage St John Ambulance crews to use the Ambulance Referral Pathway and acute demand services to safely manage appropriate patients in the community. Enable proactive management of vulnerable patients in the community, including community observation and increased access to urgent diagnostics. Continue to promote calling general practice as the first point of (phone) contact 24/7.	18,000 acute care packages provided in the community. 250 patients utilise the ambulance referral pathway. Increased ED ratio of triage 1 to 3 versus 4 and 5. Proportion of the population presenting to ED maintained at ≤18%. Rate of acute medical admissions maintained at ≤11,000 per 100,000.
Deliver shorter stays in emergency departments. *To deliver ED services to patients in a timely manner that respects the patient's needs and values their time (contractility).*	Implement the DHB transitional recovery plan to support best use of bed capacity and maintain patient flow over the winter period and during invasive repairs. Implement Project RED as the comprehensive, prioritised approach to contractility, employing lean thinking and similar methodologies focusing on: ▪ Increasing the visibility of the key contributors to ED overcrowding i.e. length of stay, those waiting to be seen by inpatient doctors, frequent attendees and how busy each section of ED is, in order to develop targeted responses; and ▪ Supporting new dedicated acute demand nursing capacity to identifying patients that can be supported by community services as part of timely supported discharge.	95% of people presenting at ED are admitted, transferred or discharged within 6 hours. On-screen queues fully available, to support increased visibility and breech analysis, by Q1.
Improve facilitated discharge services. *To provide people with the care and support to return them to their own homes, reduce the time spent in ED and in the hospital and reduce the likelihood of readmission (afterload).*	Implement the DHB transitional recovery plan to support effective transfer processes at and between Christchurch and Princess Margaret Hospitals. Relaunch the integrated District Nursing and Restorative Home Support Services model to better support older people in their own homes.[29] Refocus acute demand resources using to support timely discharge for patients where appropriate. Expand CREST services to full capacity to enable proactive home-based rehabilitation to avoid hospital readmission and ARC admission. Ensure older people (65+) discharged after falls are referred to a Falls Prevention Programme.	Phased rollout of restorative model 75% complete by Q4. 1,100 older people (65+) supported by CREST services upon discharge or by direct GP referral. 800 older people (65+) access community-based falls prevention services.

[29] *The phased rollout of the restorative home support model was put on hold in 2011/12, due to earthquake priorities.*

3.3 Reducing the time people spend waiting

Health professionals across the Canterbury health system are working to deliver a system where the key measure of success, at every point, is reducing the time people spend waiting.

The Canterbury DHB is the major provider of hospital and specialist services in Canterbury and across the South Island. Recent experience has demonstrated that Canterbury is also a major player in New Zealand's health infrastructure at a national level.

It is crucial that we maintain our ability to deliver hospital and specialist services in order to ensure the whole New Zealand health system can meet demand. It is also crucial that our population maintains timely access to services in order to minimise the progression of illness, help people to stay well, support their functional capacity and improve their quality of life.

Where do we want to be?

To respond to our capacity constraints, we have adopted a 'whole of system' production planning approach and will significantly increase outsourcing to the private sector over the next two years. We expect to need private capacity in areas of elective surgical services such as Ophthalmology, Orthopaedics, Cardiac Surgery, General Surgery and Urology.

We will continue to invest in initiatives that have already helped us to increase capacity and delivery, such as elective production plans and clinically led allocation of theatre time to improve turnaround time for surgical patients and improve the efficiency of our system.

Local and regional standardised care pathways and protocols will help to improve equity of access and reduce waiting times. Our Oncology, Haematology and Palliative Care departments have come together to form the Canterbury Region Cancer and Blood Service to better integrate cancer services and reduce waiting times. We will also integrate palliative care services to improve access and responsiveness across the system.

We will also look to our primary and community partners to support people to stay well and reduce acute demand. To balance the system we will also work to provide direct access and shorter waiting times for diagnostics to reduce the time people spend waiting for treatment and minimise the demand for acute services that can arise from a delay in intervention.

Referred services

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Align primary and community service and delivery models with integrated clinical pathways. *To support the transformation of our health system, improve service quality and reduce waiting times by increasing capacity earlier in the continuum of care.*	Continue the rollout of radiology e-referrals to provide GPs with direct access to diagnostics. Continue to clinically review Community Referred Radiology (CRR) referrals to ensure sustainable access to the most valuable tests. Provide feedback to CRR referrers on their referral patterns in comparison with peers, and provide GP education and updates to HealthPathways on referral guidelines and best practice. Integrate 'electronic order entry' for all radiology referrals from hospital-based services, followed by electronic approval of reports. Maintain a 'just in time' imaging approach that meets referral request times, including developing MRI capacity at CRR. Work toward a fully integrated radiology service for Canterbury, integrating community and secondary care imaging requirements.	CRR fully operational for MRI by Q1. Radiology results included in the Testsafe South repository by Q2. 40% of CRR referrals are submitted electronically. 90% of CRR referrals are accepted on first referral. 100% of imaging is completed according to referral request by Q4.
	Implement new dispensing arrangements for community pharmacy services that support better use of subsidised medicines by providing expert medicines advice to prescribers and patients. Support the establishment and evaluation of demonstration sites with pharmacy and general practice working under the revised multidisciplinary model.	5 demonstration sites operating by Q1. 12 demonstration sites participating by Q4.
	Apply an overarching clinical leadership/governance model to laboratory services in a way that recognises the integrated nature of the health system. Review and implementation a plan for access to sample collection that improves rural access to laboratory testing. Support the use of testing information and utilisation data in a way that optimises effective clinical practice.	New laboratory service contracted and operating under shared governance model by Q1. Common test naming standards implemented by Q3.

Elective services

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Increase production capability for the delivery of elective surgery. *To meet national expectations around the delivery of elective surgical discharges and ensure continued access to services for the Canterbury and South Island populations.*	Engage services in production planning and development of 'whole of DHB' production plans that provide a clear operational basis for delivery (including private capacity). Support weekly production planning to deliver to capacity and respond to changes in demand. Maintain a pool of low complexity 'list fillers' who can come for surgery at short notice. Deliver clinically appropriate elective procedures in acute settings where outcomes are more beneficial for patients. Regularly monitor and report against Elective Surgery Patient flow Indicators (ESPIs) to ensure continued compliance. Formalise agreements with private providers for the outsourcing of elective surgery and also agree arrangements for out-placing of DHB staff in private facilities in order to increase capacity and reduce risk. Redirect appropriate IDF inflows to increase the capacity available to Canterbury residents in Canterbury facilities. Utilise other DHBs' facilities and staff resources to deliver care to Canterbury residents where possible and appropriate. Increase uptake of the Electronic Referral Management System (ERMS) to ensure the right patients are referred for surgery. Engage clinical services teams in planning earthquake repair work that will impact services to minimise disruption to service delivery.	Additional theatre space secured by Q3. 16,110 elective surgical discharges delivered in Canterbury facilities by Q4. 70% of GP referrals sent electronically by Q4. Elective theatre session utilisation maintained at ≥85%. Population access (per 10,000) not significantly below agreed rates by Q4: Major joints: 21 Cataracts: 27
Continually improve service capacity within our hospital and specialist services. *To improve service quality, reduce waiting times support increased flexibility in times of higher need (i.e. winter) and meet the increasing needs of our population.*	Continue to implement lean thinking processes, including production planning, to identify and remove the bottlenecks in current capacity, improve patient flow and reduce waiting times. Support the treatment of patients in order of assigned priority and the increased use of national Clinical Priority Access Criteria tools to improve consistency in prioritisation and decisions on treatment. Implement the key projects from the transitional recovery plan that will release and create bed capacity. Support surgical teams to revise patient flow plans for first specialist assessments (FSAs) and commitment to treatment. Support GP Liaison roles at key points across the system to assist in improving referrals processes and supporting triage of referrals. Support surgical teams to review performance benchmarks to improve start times and patient turnaround and increase available theatre time for additional elective procedures. Review and refine acute theatre models to reduce the impact of acute demand variation on the delivery of elective surgery. Support a culture that ensures, where clinically appropriate, day surgery/day of surgery admissions are normal practice. Continue to enable direct GP access to diagnostics to improve patient flow and reduce waiting times. Closely monitor the DHB's repair programme in order to minimise the impact on service delivery and the risk of under delivery.	Temporary outpatients department opened to support increased capacity by Q1. 82% of elective and arranged surgeries are day of surgery admissions. 85% of people receive their elective coronary angiogram procedure within 3 months (90 days). 75% of people receive their CT and MRI scans within 6 weeks (42 days). 50% of people received their diagnostic colonoscopy procedure within 6 weeks (42 days). All patients waiting less than 6 months for FSA and treatment by 30 June and 5 months by 31 December 2013.
Align strategic activity across the South Island. *To make the most effective use of resources and ensure equity of access for our populations.*	Participate in the South Island Electives Workstream and support delivery of the regional work plan. Work with other South Island DHBs to agree a regional production plan to identify available regional capacity and forecast 'hot spots'. Collectively agree and ensure equitable access to elective services across the South Island.	Regional approach to address identified 'hot spots' in place by Q2. Agreed regional volume for bariatric services met by Q4.

Cancer services

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Increase production capability for the delivery of cancer treatment and integrate cancer information and referrals systems with the wider health system. *To improve access to timely treatment for cancer patients, meet clinical guidelines, improve service quality and improve treatment outcomes for our population.*	Work with the Southern Cancer Network (SCN) to review potential models for identifying people with a high suspicion of cancer and implement the most appropriate model to enable the system-wide tracking of patients from referral to treatment across all specialities. Continue to implement lean thinking and HealthPathway processes to identify and remove the bottlenecks in current capacity, improve patient flow and reduce waiting times. Implement Mosaiq Oncology Information System to streamline the workflow from first diagnosis/staging to treatment/follow-up. Make arrangements with St George's Cancer Centre and the Southern Blood and Cancer Service to ensure the Canterbury system has the capacity to maintain 4 week wait times. Maintain close monitoring of waiting lists for Canterbury patients and support the South Island DHB with regular performance data. Support more interactive recruitment strategies for Radiation Therapists as a key workforce: i.e. branding, facebook, alumni.	Plan to enable tracking of people with high suspicion of cancer underway by Q1. Medical oncology and haematology patients in the Mosaiq System by Q1. Baselines for 62, 14 and 31 day indicators established by Q3. 100% of patients receive radiation or chemotherapy treatment within 4 weeks of the decision to treat.
	Work with the SCN on the Specialist Multidisciplinary Meeting (MDM) Project to enhance the functionality of MDMs, integrate information and data systems with the wider health system and improve patient care and management. Agree a preferred provider for audiovisual/ videoconferencing services to expand the coverage of Multidisciplinary Meetings (MDMs) across the South Island and nationally. Support SCN to recommend a MDM Co-ordination Model for the approval of the South Island Alliance. Taking into account existing information systems such as ERMS, implement the agreed model in Canterbury in a way that supports integration of the whole of the system including: ▪ Extending MDM coverage to include all tumour types; ▪ Improving the structure of MDMs including membership, use of technology and administrative support for documentation; ▪ Standardising information system and electronic processes to better support the administration and coordination of MDMs including electronic referrals, agendas, forms and data collection; ▪ Reviewing the clinical decision-making and governance processes around MDMs; and ▪ Considering the appointment of MDM support and coordination roles and professional development and training to support the implementation of the new MDM Model.	Feasibility study for the audiovisual/ videoconferencing service completed by Q2. New audiovisual/ videoconferencing service rolled out regionally by Q4. SCN recommendations for MDM Coordination Model delivered by Q1. Agreed MDM Coordination Model adopted and in place by Q3.
Align and integrate palliative care services. *To increase access to care that meets patients' needs.*	Integrate the specialist and community palliative care services to form one Canterbury palliative service that provides care across the whole Canterbury health system. Establish a joint Clinical Director position for the Integrated Palliative Care Service. Continue the rollout of the Liverpool Care pathway in community and hospital settings.	Integrated Palliative Care Service established by Q1. 40 ARC facilities are using the Liverpool Care Pathway by Q4.
Align strategic activity across the South Island. *To make the most effective use of resources and ensure equity of access.*	Support the SCN to implement the South Island Blood and Cancer Service Plan recommendations. Participate in the South Island review of non-surgical DHB services to establish a baseline for regional planning. Complete the CDHB oncology outreach review to identify opportunities to improve the integration of outreach services.	CDHB outreach review completed by Q2.

3.4 Older persons' health services

Canterbury's population is ageing. Older people experience more illness and disability than other population groups, so this is driving an increasing demand for health and disability services and aged residential care services. We estimate that approximately half our health resources are used to support and provide health services for people over 65.

The February earthquake has had a considerable impact on inpatient and aged residential care (ARC) capacity. Canterbury has lost 640 ARC beds, with eight facilities evacuated and one other deemed vulnerable. The transformation already taking place in Canterbury, including our lower acute medical admission rates and the fast-tracked implementation of supported discharge and restorative care models, gave us enough spare capacity to absorb the initial loss of bed capacity.

However, the next few winters will be particularly difficult, as damaged housing and increased stress take their toll and exacerbate health conditions.

To address immediate capacity needs, a number of aged-related strategies and smarter support services for older people have been prioritised to reduce our reliance on ARC and help address demand pressures across our health system.

Where do we want to be?

The DHB will redirect its population based share of the national savings from the reduced pharmaceutical budget ($5.5m) into supporting smarter support services and improving dementia services including: expanding CREST, Acute Demand and Falls Prevention services and supporting the development and implementation of dementia pathways.

The direction is aligned to our vision of a system that delivers the right care and support, to the right person, at the right time, in the right place where system-wide strategies enable better management of long-term conditions and a reduction in acute and unnecessary hospital admissions. The emphasis is on flexible, responsive, needs-based care, provided in the community to support older people to stay well and in their own homes.

This work will be largely driven through the Aged Care Work Stream of the CCN as part of Canterbury's *Better, Sooner, More Convenient* business case.

To ensure the strategies we are implementing are better supporting older people we will monitor a number of programme level outcome indicators and also compare admission and readmissions for people 65+ and 75+ and well as for the total population.

Ageing in place

Living in ARC is appropriate for a small proportion of our population, but it can also be associated with a more rapid functional decline than 'ageing in place'. With appropriate support older people often remain healthier for longer by staying active and positively connected to their families and communities.

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Provide timely and coordinated community care and rehabilitation services for older people who require additional support. *To enable older people to live well at home and to support restored functioning and independence - reducing acute demand on hospital and ARC services and supporting the system to cope with reduced bed capacity.*	Complete the implementation of the Medication Management Service (MMS) to reduce harm from adverse reactions and optimise medicines use.	2,000 medication reviews provided for older people on multiple medications.
	Support implementation of the primary/secondary Cognitive Impairment Pathway (via HealthPathways). Support a primary /secondary design group to review referral patterns to ensure the pathways are improving care for people with early dementia and memory loss. Provide 'Walking in Others' Shoes' dementia education training for Dementia and Hospital Level ARC providers. Develop and provide 'Walking in Others' Shoes' dementia education training for community service providers. Consider the extension of 'Walking in Others' Shoes' dementia education training into all ARC facilities.	Cognitive Impairment Pathway implemented by Q1. Tailored dementia training programme for community service providers running by Q1. Programme for extension of dementia training across ARC presented by Q1. Cognitive Impairment Pathway referrals reviewed by Q4.

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Continued from previous page… Provide timely and coordinated community care and rehabilitation services for older people who require additional support. *To enable older people to live well at home and to support restored functioning and independence - reducing acute demand on hospital and ARC services and supporting the system to cope with reduced bed capacity.*	Support the CCN to champion and monitor CREST with regular reporting on utilisation, milestones and outcomes. Expand the CREST service to include older people referred directly by their GP to better support people with deteriorating health by Q2. Revise the CREST equipment pathway to optimise the availability and use of equipment. Communicate the CREST approach widely to ensure providers are aware of and utilise CREST services. Maintain CREST as an integral component in aged care focused education sessions.	CREST streamlined equipment process in place Q3. 900 older people (65+) supported by CREST upon hospital discharge. 200 older people (65+) supported by CREST upon direct GP referral. 20% reduction in acute admissions for people supported by CREST services. 10% reduction in acute readmissions for CREST clients.
	Continue to support our comprehensive stroke service to ensure provision of services for the Canterbury population. Engage clinical leads in aligning the continuum of care for stroke across the whole of the Canterbury health system. Continue to support increased referral of people to stroke rehabilitation services after acute events. Explore combined rehabilitation programmes for people with long-term conditions under the CCN work stream.	Stroke rehabilitation baselines re-established by Q1. ≥70% of people experiencing an acute stroke event access stroke rehabilitation by Q4.
Implement a 'whole of system' approach to falls prevention for older people (65+).[30] *To reduce harm, hospitalisation or early entry into ARC as a result of falls and support older people to live safely in their own homes and maintain functional independence.*	Support the CDHB Clinical Board and CCN to champion and monitor falls prevention activity with regular monitoring of falls rates, milestones and outcomes. Implement clinically led and complementary falls prevention strategies that improve the integration of falls prevention activities across the whole system. Communicate the falls prevention approach widely to ensure providers are aware of and utilise evidence-informed strategies and programmes. Introduce falls prevention as an integral component in aged care focused education sessions. Promote 'Zero harm from falls' in aged residential care settings and provide a complementary ARC-based Vitamin D Supplementation Programme. Complete the Quality and Safety Commission study on establishing the value of InteRAI in falls prevention.	Integrated community-based falls prevention programmes in place by Q1. 800 older people (65+) access community-based falls prevention services. 75% of ARC residents receive Vitamin D supplements. 10% reduction in the proportion of the older population (75+) presenting at ED as a result of a fall. 10% reduction in the proportion of the older population (75+) admitted to hospital as a result of a fall.
Implement the restorative home support services model across Canterbury services.[31] *To provide more responsive and targeted services that better meet the needs of older people and enable them to maintain and regain independence.*	Support the CCN Aged Care Workstream to relaunch this programme (put on hold due to earthquakes) and to oversee the transition of home-based support services (HBSS) to a restorative service model. Initiate an Alliance Agreement with Canterbury HBSS providers that will see all new clients enter the revised model by Q1. Provide specialist training and educational support to community providers to support the implementation of the restorative model. Implement a comparative and peer review based quality improvement process with support from specialist services.	InterRAI training provided to HBSS providers by Q1. Quality improvement process operational by Q2. Phased rollout of restorative model 75% complete by Q4.

[30] *The implementation of a 'whole of system' approach to falls prevention was delayed in 2011/12, due to earthquake priorities.*

[31] *The phased rollout of the restorative home support model was put on hold in 2011/12, due to earthquakes priorities.*

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Enable system-wide, multidisciplinary models for working with older people in Canterbury. *To ensure equity of access and support informed clinical decision-making at the point of care.*	Expand the InterRAI suite by ensuring restorative HBSS providers have training/access to the InterRAI contact assessment for non-complex clients. Support the expansion of the InterRAI suite to include Aged Residential Care (ARC) modules. Provide training for Canterbury ARC providers and GPs who have opted into the process and information sessions for key stakeholders. Provide OPHSS Gerontology Nurse Specialists with the tools to help them support ARC providers using InterRAI. Ensure progress with provision of read-only access to InterRAI for GPs, ARC and HBSS providers.	2 ARC InterRAI information sessions organised in 2012/13. More Canterbury ARC facilities are using InterRAI – base 11 facilities. 85% of people receiving long-term HBSS have had a comprehensive clinical assessment. 90% of people entering ARC care have had a clinical assessment of need using InterRAI.
Implement the ARC Residential Recovery and Improvement Plan. *To restore capacity post-quake, reduce demand on acute hospital services and enable a more strategic approach to meeting future demand for ARC.*	Closely monitor ARC utilisation and engage providers in capacity management and quality improvement. Work with CERA to ensure ARC capacity and special purpose low income housing for older people is an integral part of core planning. Monitor ARC workforce requirements and through OPHSS Clinical Nurse Specialist Team and Gerontology Nurse Specialists proactively support skill development and provide nursing and education support to improve clinical capability and patient safety. Identify opportunities to develop innovative models of care including: supported housing, restorative, respite and sub-acute care and electronic booking systems.	Clinical education support session provided to the ARC workforce every quarter. Opportunities for sub-acute care for older people presented to Aged Care Workstream by Q3.
Align strategic activity across the South Island. *To make the most effective use of resources and workforce and ensure equity of access for our populations.*	Participate in the South Island Regional Alliance for Older Persons' Health, support the Regional Work Plan and engage in the next steps of the ARC review. Support the South Island Stroke Work Stream to implement the regional stroke services plan and regionally agreed clinical pathways. Coordinate and support the rollout of InterRAI across the South Island to reduce variation of assessments and service access/provision. Implement SI Dementia Initiatives including 'Walking in Others' Shoes' to improve the skill sets of those working with older people who have dementia. Implement the South Island Advance Care Planning (ACP) initiative to enable people to consider and complete their own ACP.	Regional clinical stroke groups and work plan developed by Q1. InterRAI incorporated into assessment processes of all 5 South Island DHBs by Q4. First iterations of 'Walking in Others' Shoes' fully implemented in Canterbury by Q2. ACP strategy and training requirements agreed by Q2. Consistent ACP recording and terminology across Canterbury and SI by Q4.

3.5 Child, youth health and maternity services

A focus on child and youth health is an investment in the future of our population. Poor health in childhood can lead to poorer health outcomes into adulthood. Risk and protective factors and social patterns established in childhood and adolescence have a significant impact on health long-term.

Meeting the Minister's expectations

- The immunisation health target has shifted focus from two-year-olds to eight-months-olds, and Canterbury aims to meet national expectations and achieve the 85% target by the end of the coming year.
- There is a clear expectation to provide zero fee after hours GP visits for children under six, which we are working with local primary care networks to implement.

International literature on disaster recovery indicates that those who were vulnerable prior to a disaster have an increased risk of poor health afterwards.[32] We are addressing this by placing additional focus on interventions that identify vulnerable children and young people and help them to access services that will improve their health in the immediate and longer term.

In the coming year, we will establish a Child and Youth Health Workstream under the CCN District Alliance to support the development of a 'whole of system' approach to child and youth health services in Canterbury. We will also continue to participate in the Regional Child Health Services Alliance, particularly in the development of regional referral pathways.

This type of integrated, 'whole of system' approach is particularly critical in light of the quake-related capacity pressures we face and the additional stress on children, families, expectant mothers and high-need populations.

Immunisation Services

Immunisation is an important component in keeping people well and out of hospital, particularly over winter while Canterbury's capacity is severely stretched and when our population is especially vulnerable.

Canterbury's Immunisation Service Level Alliance (ISLA) was established in 2010, and has already developed an integrated service model for immunisation. This model identifies the actions required to improve service delivery for all immunisation events, including childhood, HPV and seasonal influenza programmes. These actions reduce fragmentation amongst our immunisation service providers, which is particularly critical in light of the negative impact the earthquakes have had on pre-planning and recalls for immunisations.

We are committed to achieving the national target and ensuring 85% percent of all eight-month-olds are fully vaccinated. We will also provide free flu vaccinations to children and young people under 18 to protect our whole population over winter.

Maternity Services

A positive maternity journey provides children with the best possible start in life. This means taking an integrated approach to all the issues and determinants that impact on the health of mothers and babies.

Canterbury's multidisciplinary Maternity Development Group has produced a *Maternity Journey Action Plan* based on opportunities identified at a participatory workshop in February 2011. Over 120 consumers and health providers from across the system attended and helped to identify what works well, where there are gaps and the key areas for improvement.

In the coming year the DHB will also implement the national Maternity Quality and Safety Programme.

Where do we want to be?

Integrated delivery models for child, youth and maternity services will streamline the coordination of similar services, reduce duplication and fragmentation and improve the identification of vulnerable children to better target service delivery.

Although we aim to make improvements in the health of our whole population and have set a number of goals, our capacity for delivering additional services is very limited. The ongoing disruption and relocation of people's homes and support networks makes tracking and contacting people a challenging process.

Initiatives that create capacity or reduce demand will be higher priority in the coming year. We will prioritise children with the highest need and focus on strengthening the relationships between these families and their general practice teams to support them to stay well. We will also foster a collaborative approach to reconnecting people with their general practice as their key point of contact and responding quickly to people's immediate needs.

This work will be largely driven through the establishment of a Child and Youth Health Workstream under the CCN with a work plan being established in the first quarter of the coming year.

[32] *Bidwell, S (2011), 'Long term planning for recovery after disasters: ensuring health in all policies – a literature review', CDHB-Community and Public Health*

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Implement an integrated, 'whole of system' approach to services for children and young people in Canterbury. *To support continuity of care, equity of access and improved clinical decision-making at the point of care – reducing fragmentation and improving health outcomes for children and young people.*	Enhance collaboration around protection, prevention and early intervention strategies: ▪ Support the provision of housing insulation to reduce respiratory illness and avoidable hospital admission. ▪ Identify initiatives to reduce smoking in pregnancy as part of a wider strategy for reducing Sudden Unexplained Death in Infants (SUDI). ▪ Ensure a child perspective is presented to local authorities in planning Christchurch's rebuild.	Progress towards 90% of women who identify as smokers at the time of confirmation of pregnancy being offered advice and support to quit. 75% of the population under six have access to free afterhours care by Q4. Fewer children (aged 0-4) admitted to hospital with avoidable conditions – base 97% of national rate.
	Facilitate integration of services across the health system and between health and other social sectors: ▪ Support zero-fee GP visits for children under six. ▪ Scope a community paediatric service. ▪ Support enrolment at birth with general practice, WellChild/Tamariki Ora and oral health providers.	
Identify and support vulnerable children and young people with high health needs. *To enable early intervention and more responsive and targeted service delivery to reduce health issues that negatively affect children's wellbeing and development and improve longer-term health outcomes.*	Support the B4 School Check (B4SC) Clinical Advisory Group to closely monitor access, referral patterns, and the growth and development of the service. Streamline processes and release clinical capacity by using the Central Coordination Team to issue 'first' B4SC invites. Implement PHO Level monitoring/forecasting reports (focused on high needs children) to support B4SC delivery. Use PHO mobile engagement teams to improve B4SC uptake amongst Māori, Pacific and Quintile 5 children.	80% of children in deprivation Quintile 5 receive a B4SC. 80% of children in deprivation Quintiles 0-4 receive a B4SC.
	Develop a multidisciplinary assessment service for vulnerable children and young people that incorporates Gateway Assessments and other complementary services. Establish a health, education and social services advisory group to monitor access to assessments, referrals patterns and development of the service.	Gateway Assessment processes established and running by Q1. 100% of children referred by CYF are receiving Gateway Assessments by Q2.
	Support a tiered approach to the delivery of mental health and AOD services to ensure early intervention and increased access to treatment and support for young people.	Refer to mental health section page 43.
	Support the provision of the CDHB Child and Family Safety Services and implement recommendations from the annual audit of the programme.	Combined audit of child and partner abuse components of the VIP >140/200.
Integrate and improve the delivery of oral health services across the whole system. *To identify those children most at risk of tooth decay, implement effective treatment and preventive care that reduces risk factors and has lasting benefits in terms of improved nutrition and healthier body weights.*	Collaborate with Well Child/Tamariki Ora (WCTO) providers and general practice to identify children most at risk of tooth decay and support their families to maintain good oral health and access preventive care. Identify efficiencies in the Community Dental Service to reduce the number of children not being seen on time for routine dental checkups (including 'releasing time to care' project to streamline service provision). Investigate and implement alternatives to the current service model for adolescents to engage more young people – particularly those at low decile schools. Work with Partnership Health and the University of Otago to pilot a nationally-funded project to improve tooth brushing by young adults. Lead the national project to standardise all DHBs on a centralised electronic oral health record.	66% of children (0-4 years old) are enrolled in DHB-funded oral healthcare services. 90% of children enrolled in school and community dental services are examined according to planned recall. 75% of all eligible adolescents access DHB-funded dental care.

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Align strategic activity across the South Island and increase regional collaboration. *To make the most effective use of resources and workforce and ensure equity of access for our populations.*	Participate in the Regional Child Health Alliance and support the implementation of a programme of integrated care across SI DHBs and associated services. Assist in the mapping of SI community-based child development programmes and the development of SI child and youth health quality indicators. Support the implementation of referral pathways for vulnerable children and those with chronic conditions. Encourage the utilisation of telemedicine facilities to improve acute care and follow-up for children and young people both regionally and rurally.	Regional programme of care for implemented by Q4. General surgery and gastroenterology regional pathways implemented by Q4. Child development services quality improvement initiative implemented by Q4. Maternal depression pathway and chronic conditions referral pathway implemented by Q4.

Immunisation

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Further integrate and improve the delivery of immunisation services across the whole system. *To improve immunisation coverage and timeliness and reduce illness and hospital admissions due to vaccine-preventable disease.*	Refine the Immunisation Reporting Programme to enable NIR Administrators to provide more direct support to general practice, improve the accuracy of reporting and better locate unvaccinated children. Expand Reporting to include PHO-level Coverage Reports to help identify and address any gaps in service delivery. Refocus the missed events coordinator to support the timely vaccination of 8 month old children. Identify and implement opportunities to improve recall systems for HPV and to share NIR processes.	Regular NIR reports generated for GP practices to facilitate timely 8-month immunisations by Q1. Automation of key elements of the NIR Reporting Programme achieved by Q1. PHO-level monitoring enabled by Q1.
	Support the ISLA to lead improvements in the quality of immunisation services, monitor performance and ensure a 'whole of system' approach to immunisation. Invest in a coordinated promotion programme for all immunisation events to raise public awareness, increase coverage and reduce decline rates. Improve linkages and referral processes between LMCs, WCTO providers and general practice to increase enrolment and coverage rates with ISLA working collaboratively with the Maternity Strategy and Child and Youth Health Streams. Use outreach services to locate and vaccinate hard-to-reach children and those displaced by the quakes. Use the secondary care immunisation programme to vaccinate and promote immunisation for unvaccinated children who present at hospital. Continue to invest in systems that support children to be fully vaccinated by aged two – including missing events coordination, outreach and opportunistic vaccinations. Invest in free flu vaccinations for those under 18, as well as for older people (65+), to reduce winter demand on the Canterbury health system. Identify and implement opportunities to link HPV immunisation with other vaccination programmes and improve promotion, delivery and coverage rates.	Immunisation promotion course for non-vaccinators delivered by Q2. 90% of all newborn babies have an identified GP or WCTO provider by 2 weeks of age. 85% of all 8-month-olds are fully vaccinated by Q4. 40% of young people (<18) have a seasonal flu vaccination. 75% of older people (65+) have a seasonal flu vaccination. More young women receive HPV Dose 1 –base 46%

Maternity services

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Implement an integrated 'whole of system' approach to maternity services in Canterbury. *To provide women with access to maternity care that meets their needs and expectations and enhance continuums of care across the maternity journey that reduce fragmentation and improve health outcomes.*	Establish standardised Canterbury-wide maternity information for women on pre-pregnancy health, childbirth, maternity services and care of newborns. Support increased access to contraception for women who identify at high risk of unplanned pregnancy.	Standardised information available to Canterbury women via HealthPathways and HealthInfo by Q3.
	Support the development of an electronic 'Find a Midwife' system to enable women to identify a Lead Maternity Carer (LMC) who best meets their needs. Fund referrals from LMCs to general practice for women in need of additional support for medical, mental health or social concerns. Scope the development of an integrated model that enables additional support for women with high non-obstetric and psychosocial needs. Work collaboratively with pregnancy and parenting education providers to review the courses provided in order to better meet the needs of a wider range of women. Plan for the implementation of new national service specifications for pregnancy and parenting education.[33] Work with general practise and LMCs to identify pregnant women who smoke and ensure they are offered advice and support to quit.	Progress towards 30% of pregnant women accessing DHB funded pregnancy and parenting education courses. Progress towards 90% of women who identify as smokers at the time of confirmation of pregnancy being offered advice and support to quit.
	Analyse data to understand motivations and issues that influence women's choice of where to birth. Consider the most appropriate structure and location for primary birthing facilities in Canterbury as part of the IFHC and Community Hub development and our transitional recovery and facilities plans. Work on the development of evidence-based guidelines that support women to confidently choose the most appropriate birthing facility. Raise awareness of birthing options and use of primary units to free up specialist services to provide care and support for women with more complex birthing needs.	Survey of women's motivation for birthing choice by Q1. Proposal regarding future birthing units is made by Q2. More women are birthing in community primary birthing facilities - base 12%.
	Identify actions to improve linkages and referral processes between LMCs, WCTO providers and general practice to support earlier intervention. Support the Canterbury Breastfeeding Group to review education and breastfeeding services and identify opportunities to better support new mothers to develop confidence in breastfeeding.	90% of all babies have an identified GP or WCTO provider by 2 weeks of age. 67% of all infants are fully or exclusively breastfed at 6 weeks of age and 28% at 6 months.
	Implement the national Maternity Quality and Safety Programme and embed a monitoring and reporting framework across Canterbury services. Enhance Maternity Governance structures to incorporate consumer and primary care voices and engage them in the development and implementation of the Programme. Establish a Coordinator and LMC Liaison to support the implementation and enhance links across the system. Support a joint (Canterbury/West Coast) approach to ensure alignment and improve quality outcomes.	Canterbury Quality and Safety Strategic Plan approved by Q1. Key structure and roles established by Q2. First Maternity Quality and Safety Report delivered by Q4.

[33] *The Ministry of Health is currently reviewing content and service specifications for pregnancy and parenting education).*

3.6 Mental health services

It is estimated that at any one time, 20% of the population have a mental illness or addiction and 3% are severely affected by mental illness. As a result of the recent traumatic events and ongoing stresses on our population, certain groups will need additional support over the next few years.

The February earthquake and ongoing aftershocks will have a significant ongoing psychological impact on the Canterbury population. Addressing this impact is a key component of our planning and a four-tiered response that spans public health, primary, community and secondary services has already been implemented. This response incorporates dedicated individual and group programmes for children and youth, adults and older people. Capacity will be further expanded as community need becomes more apparent.

With an ageing population, there is also increasing demand for mental health services from people over 65. The likelihood of mental illness (predominantly dementia) increases with age, and older people have different patterns of mental illness, often accompanied by loneliness and physical frailty or illness. Older people need responsive support appropriate to their life stage.

Where do we want to be?

Our system of mental health is based on a recovery approach. We are continuing to develop community-based options, which provide services closer to people's own homes, and an increased commitment to integration of services across the sector is evident in the willingness of all parties to work closely together.

Integrating pathways and improving access to specialist clinical resources are a major focus. We have established single points of entry for child and youth services and for adult services, which receive referrals and enable GPs and NGOs to telephone a consultant psychiatrist for treatment advice for people who do not require case management within specialist services.

This provides the benefit of timely specialist advice without the need for a specialist appointment or disruption of the primary/community care relationship.

Integration within our own specialist mental health services has been improved with a closer working relationship between community and inpatient services. A planned realignment of these services will increase community-based service options, ensuring people with complex and non-complex mental health needs are well supported by flexible clinical and support services. Implementation will be progressed by reconfiguring current resources from across the mental health system.

Implementation of our Alcohol and Other Drug (AOD) Plan is streamlining our AOD services and supporting increased collaboration. The plan sits within the wider scope of best practice and focuses on local solutions using the extensive experience of consumers, families, clinicians and other stakeholders. The transformation so far has enabled earlier access to assessments, increased the numbers of people accessing AOD services, and led to numerous service improvements within AOD organisations across Canterbury.

In the coming year we will work to implement the national Youth Mental Health Project recently announced by Government.

We will also continue to examine the range of mental health services in Canterbury and critically evaluate whether they meet the needs of service users. This work will include a regional focus on alignment and integration and on implementation of the Regional Mental Health Plan, which can be found in the Regional Health Services Plan at www. sialliance.health.nz.

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Maintain earthquake-related mental health services. *To support people post-quake and meet expected increased demand.*	Continue to support primary and secondary services with increased resources to deliver trauma cognitive behavioural therapy based programmes for all age groups. Provide clinical support and expertise to non-health community providers that contribute to the four-tiered mental health earthquake response.	≥2,000 people suffering anxiety and trauma as a result of the earthquake access EQ related mental health services across primary and secondary care.[34]
Improve the interface between Disability and Mental Health Services. *To improve service responsiveness and better support people at risk.*	Engage the Ministry of Health's Disability Support Service (DSS) in Canterbury's recovery process. Establish a DSS/DHB working group to address areas of concern and to improve relationships. Develop and pilot new models of care to more appropriately support people with disabilities.	DSS/DHB working group established by Q1. A reduction in the number of people with disabilities that are discharge ready but 'stuck' in inpatient services.

[34] *This includes assessments, individual sessions and extended consultations in primary or secondary care with an EQ code.*

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Expand and enhance youth mental health services. *To improve access and service responsiveness for young people, reduce acute admissions and readmissions to specialist mental health services and support young people and their families to maintain more stable lives.*	Implement the national youth mental health project to support child and adolescent mental health services and improve access for young people. Explore opportunities created through the national project to increase High Dependency Unit capacity in Youth Inpatient Services for young people that require secure care (locally/regionally). Expand community-based youth mental health and AOD services to improve access across the system through the development of partnerships between community-based services and Child and Adolescent Mental Health Specialist Services to improve responsiveness to young people. Introduce the 'Choice and Partnership Approach' (CAPA) across all Specialist Mental Health Child and Youth Mental Health Services to reduce waiting times for services.	70% of young people (0-19) referred for non-urgent mental health or addiction services are seen in three weeks. 75% of young people (0-19) referred for non-urgent mental health or addiction services are seen in eight weeks. ≥95% of all long-term clients (0-19) have current relapse prevention plans in place. ≥3% of young people (0-19) access complex mental health services.
Transform the mental health system to reflect current needs. *To improve access and service responsiveness for people with mental illness, reduce acute readmissions to specialist mental health services and enable the DHB to meet future needs within available resources.*	Participate in and support cross-sector community initiatives that support recovery and wellbeing. Implement the new model of care for Community and Inpatient Adult Specialist Mental Health Services to deliver a shared care response. Expand the range of community services available closer to home, supported through reconfiguration of resources as outlined in the Adult Services Plan. Enhance the responsiveness of the Adult Single Point of Entry Service to primary and community services to support a shared care response. Develop a single treatment plan to be used across Specialist Mental Health Services (SMHS) services. Increase the capacity of community acute services through SMHS and NGO respite care partnerships. Continue to refine access pathways to ensure a tailored response for individuals and best use of system resources. Implement the Co-Existing Problems Plan. Ensure all long-term clients have relapse prevention plans to support a shared care approach and self management.	≥4,000 Brief Intervention Counselling (BIC) sessions are provided in primary care (includes EQ services. 70% of people (20-64) referred for non-urgent mental health services are seen in three weeks. 75% of people (20-64) referred for non-urgent mental health services are seen in eight weeks. ≥95% of all long-term clients have current relapse prevention plans in place. An increased proportion of the population access complex mental health services: ≥3.0% of people aged 0-19. ≥2.5% of people aged 20-64.
Transform the Alcohol and Drug (AOD) system to reflect current needs. *To improve access and service responsiveness for people with addictions and AOD needs and enable the DHB to meet future needs within available resources.*	Appoint a system-wide Alcohol Harm Reduction Coordinator to ensure a consistent approach to implementing public health alcohol-related harm interventions in Canterbury. Implement the Canterbury integrated AOD Withdrawal Management and Respite Pathway. Expand the range of community AOD support options to enable more people to access services in the community and closer to their own homes. Continue to refine access pathways for AOD services to ensure tailored responses and make best use of resources across the system. Implement the national Co-Existing Problems Plan to increase capabilities around AOD. Implement a joint project with Police to follow-up people apprehended for alcohol and drug related issues and proactively engage them in services. Work with corrections and courts to increase access to addiction assessment and treatment. Explore targeted alcohol screening in primary care to proactively engage people in services	Alcohol Coordinator in place by Q1. 70% of people referred for non-urgent AOD services are seen in three weeks. 75% of people referred for non-urgent AOD services are seen in eight weeks.

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Implement the Suicide Prevention Initiative. *To improve service quality and better support people at risk.*	Continued to implement consistent assessment and management processes for suicide risk across primary and secondary settings and in ED services. Implement a consistent response to post-attempt care with a pilot in the Christchurch Hospital ED.	Use the evidence base collected over the 24 month pilot period to undertake an evaluation and determine next steps in the implementation - 2014.
Align strategic activity across the South Island. *To make the most effective use of resources and workforce and ensure equity of access for our populations.*	Participate in the South Island Regional Alliance and support the implementation of the Regional Mental Health Plan. Participate in a regional DSS working group to improve cross-sector pathways/responsiveness. Participate in a regional CAMHS working group to maintain a continuous quality improvement cycle. As regional provider, take the lead in developing standards of care protocols, screening tools and admissions criteria to ensure consistency and quality of care regionally. As regional provider, identify workforce, education and supervision opportunities to build capacity and capability across South Island services and support the continuum of care for patients, particularly when they are transferring between regional and district provider services.	Regional working group for Inpatient CAMHS established by Q1. South Island approach to baby boarders agreed for regional Mothers and Babies Service by Q2. Regional admission criteria for Medical Detoxification Services agreed by Q2. Regional Forensics Services aligned with new National Development Service Plan.

3.7 Whānau ora services

The Canterbury population generally has better access to health services and better health status than the average New Zealander. This is true for all ethnicities living in Canterbury, but nonetheless, there are still real disparities between Māori and Pacific populations and the rest of the Canterbury population in relation to health outcomes and life expectancy.

Canterbury's Māori and Pacific populations while each having their own unique needs and health issues, have some similar characteristics. Both have higher rates of diabetes, respiratory disease and cardiovascular disease and are over-represented in terms of risk factors, particularly smoking. Two in every five Māori are daily smokers (41%) and three in every ten Pacific people (29%), compared to 19% of the total population.

We have particular concerns with regard to the health of our Māori and Pacific populations after the earthquakes as a higher proportion of these populations were residents in the worst-affected areas. These populations face colder homes, increased stress and overcrowding in homes and schools - all factors which increase their vulnerability to both physical and mental illness.

Many families and whānau have shifted from their homes and are effectively disconnected from their usual primary care networks. Those who have stayed in their homes face different challenges that have interrupted their usual routines and health-seeking behaviours. Loss of personal income and interruption of transport links will present further barriers in accessing health care.

Where do we want to be?

Working collaboratively has helped us respond to the changing needs of our population (particularly in response to the earthquakes), and keeping the patient at the centre is a critical factor in achieving positive outcomes for Māori and Pacific populations.

We are committed to working with Manawhenua Ki Waitaha (representing the seven Ngāi Tahu Rūnanga), the Whānau Ora Collectives and local stakeholder and provider networks to enhance participation in decision-making. This includes participation in the development of strategies to identify and address the determinants of health and build healthy, vibrant communities.

Our collaborative approach and the prioritisation of wrap-around services for vulnerable population groups will be supported by the implementation of the national Whānau Ora initiative over the next few years.

The DHB is working closely with the two Whānau Ora collectives (Te Waipounamu & Pacific Trust Canterbury) on the development of their Plans of Action which will support a new way of working and improve long-term health outcomes for both Māori and Pacific populations.

The prioritisation of services for vulnerable children will also assist in improving Māori and Pacific health, including immunisations, B4 School Checks and the introduction of gateway assessments. They will also benefit from the prioritisation of targeted acute demand and long-term condition programmes and the provision of services in the community and closer to home.

In the last 18 months, a local Māori and Pacific Provider Leadership Forum has evolved to support improved service delivery and build the capability and capacity of Māori and Pacific service providers. This Provider Forum has been particularly active in considering key determinants of health and agreeing two priority areas of focus for service improvement at a hui in late 2011. This direction will be a part of wider planning as we take opportunities to reorient services over the coming year.

In line with the activity and initiatives planned for the coming year, the DHB has also refreshed its Māori Health Action Plan, which brings together a snapshot of the activity and action occurring across our health system to improve health outcomes for Māori. The DHB publicly monitors performance against the Action Plan as a means of increasing the focus on Māori health.

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Work together to support a reorientation of health services to better reflect the needs of our Māori and Pacific populations. *To identify opportunities to reduce inequalities of access, support participation in service development and enable the DHB to meet future needs within available resources.*	Progress the reorientation of Māori and Pacific services to improve service delivery and utilisation. Support the Māori and Pacific Provider Forum to raise awareness amongst mainstream providers of the capacity and capability of Māori and Pacific health providers. Support internal reorientation of NGO service delivery approaches to reflect Whānua Ora models. Share information about Whānau Ora across the system to support closer alignment and collective approaches. Reorient planning and funding models to align with solutions and future direction of services. Review patient pathways to improve access and outcomes.	Reorientation of Māori and Pacific services underway by Q1. Māori Health Plan progress reported six-monthly. Improved long-term health outcomes for Māori and Pacific populations.

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Work together to support the implementation of the national Te Puni Kokiri led Whānau Ora initiative. *To ensure health and social services empower whānau and offer wrap-around services tailored to their needs.*	Take a lead in the assessment of the regional Te Waipounamu and local Pacific Trust Canterbury Business Cases and Plans of Action (Phase 1 of the national initiative). Participate in the Whānau Ora Regional Leadership Group. Support the Whānau Ora collectives to move into Phase 2 of the national programme and develop Whānau Ora models. Work with other government agencies to actively support the implementation of Whānau Ora, improve cross-sector collaboration and ensure a holistic approach. Identify opportunities for the introduction of Integrated Contracts across government agencies to support the implementation of the Whānau Ora models.	Each collective has an approved Plan of Action by Q1. Each collective has Whānau Ora models developed by Q4. Improved long-term health outcomes for Māori and Pacific populations.
Work together to build healthy, connected and vibrant communities. *To create environments that support Māori and Pacific populations to take more responsibility for their own health and wellbeing and address the determinants that negatively affect health outcomes.*	Support a stronger prevention focus including the provision of housing insulation to reduce respiratory disease. Collaborate with WellChild/Tamariki Ora providers to identify strategies to support mothers to breastfeed, including peer support and lactation services. Use outreach services to locate and vaccinate hard-to-reach Māori and Pacific children and those displaced from their general practice as a result of the earthquakes. Identify Māori and Pacific children most at risk of tooth decay and support their families to maintain good oral health and access preventative care. Support ABC Smoking Cessation Programmes in hospital and primary care settings to provide advice and support for people wanting to stop smoking and implement processes to support Māori and Pacific smokers into targeted community-based cessation support. Facilitate community action that enables Māori and Pacific populations to achieve healthy nutrition and activity goals and improve their cooking and nutrition skills. Target the Health Promoting Schools programme at schools with a high proportion of Māori and Pacific children. Take particular account of new Resource Management Act applications that may affect drinking water quality and maintain water quality targets.	67% of Māori and Pacific infants are fully or exclusively breastfed at 6 weeks and 28% at 6 months. 85% of all 8-month-olds are fully vaccinated by Q4. 66% of all 0-4 year olds are enrolled in DHB-funded oral health services. 95% of all hospitalised smokers and 90% of all enrolled smokers seen in general practice are provided with advice and help to quit. ≥200 people enrol with the Aukati Kaipaipa smoking cessation programme. A regular programme of Healthy Christchurch hui is developed and 3 hui held.
Work together to identify and wrap services around vulnerable children and young people with high health needs. *To enable early intervention and more responsive and targeted service delivery to reduce health issues that negatively affect children and young people's wellbeing and development and improve longer-term health outcomes.*	Support WellChild/Tamariki Ora (WCTO) providers to implement Early Additional Contacts to improve health outcomes for the most vulnerable children (0-122 days old). Use PHO mobile engagement teams to improve B4SC uptake amongst Māori, Pacific and Quintile 5 children. Support the implementation of zero-fee GP visits for children under six. Develop a service for vulnerable children and young people incorporating Gateway Assessments. Support investment in a tiered (wrap-around) approach to the delivery of mental health, alcohol and other drug services to ensure early intervention and increased access to treatment and support for Māori and Pacific youth. Support the provision of the CDHB Child and Family Safety Services and implement annual audit recommendations.	90% of all newborn babies have an identified GP or WCTO provider by 2 weeks of age. 80% of children in deprivation Quintile 5 receive a B4 School Check. 100% of children referred by CYF are receiving Gateway Assessments by Q2. 75% of the population under six have access to free afterhours care by Q4. ≥3% of young people (0-19) access complex mental health services.

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Work together to wrap services around Māori and Pacific people with complex and long-term conditions. *To support people to stay well in their own homes and communities and reduce the demand for complex care and hospital and specialist services.*	Invest in the development of responsive programmes to better meet the needs of Māori and Pacific people through the CCN Māori Health, Pacific Health and Long-term Conditions work streams. Support Māori mobile nursing services to link with CCN to better support Māori with long-term conditions. Engage GPs in the delivery of Cardiovascular Disease (CVD) Risk Assessments for Māori and Pacific people. Collaborate with Māori and Pacific service providers to increase access to diagnostics, programmes and rehabilitation for people with respiratory disease. Support the development of a new diabetes care improvement package that will promote better diabetes management, improve referrals pathways and provide education for people newly diagnosed with diabetes.	More Māori have a CVD risk assessment every five years, with progress towards the national health target by Q4 – base 12.8%. More Pacific people have a CVD risk assessment every five years, with progress towards the national health target by Q4 – base 8.9%.[35] Avoidable hospitalisation rates maintained at ≤95% of the national rate.
Support Māori and Pacific workforce development. *To increase the number of Māori and Pacific people working in health fields and improve the cultural responsiveness of mainstream services.*	Support the Māori and Pacific Provider Forum's clinical leadership team as a collaborative services partnership to build capacity across the system. Support Whānau Ora collectives to build the capacity and capability to implement their Whānau Ora initiatives. Support study scholarships to engage Māori and Pacific people in primary healthcare fields. Lead the regional delivery of the national Kia Ora Hauora Māori Workforce Development Service (Te Waipounamu) to increase the number of Māori working in the health sector.	5 Pacific primary care study scholarships awarded locally. 10 Māori primary care study scholarships awarded locally. 250 Māori enrolled and studying towards careers in health regionally.

[35] *The National Heart and Diabetes Health Target for is for 90% of the eligible population to have had their cardiovascular risk assessed at least once in every five years. The Canterbury target is to achieve 75% by 1 July 2013.*

3.8 Disease prevention services

International literature on disaster recovery indicates that an increase in risk behaviours such as tobacco smoking, alcohol consumption, poor nutrition and reduced physical activity is typical in response to stressful events, and those who were vulnerable prior to the disaster have an increased risk of poor health.

Meeting the Minister's expectations

- 90% of smokers seen in primary care and 95% of those identified in a public hospital are provided with brief advice and support to quit smoking.
- Progress towards ensuring 90% of women who identify as smokers at confirmation of pregnancy are offered quit advice and support.

The earthquakes have had a considerable impact on Canterbury residents, with many families shifting from their homes and becoming disconnected from their usual community and support networks, especially in the hardest hit areas. An increase in risk behaviours is typical in times of stress and has been evident following the Canterbury earthquakes.

The continued provision of community-based prevention, education and support services and the facilitation of community action projects are central to rebuilding our communities and promoting positive lifestyle behaviours. Without a deliberate focus, inappropriate lifestyle behaviours may become ingrained for the longer term.

Common preventable environmental factors and lifestyle choices, such as smoking, poor nutrition, lack of physical activity, excessive alcohol, poor housing, inadequate heating and poor air quality are major causes of long-term conditions and consequently avoidable death, hospitalisation and reduced quality of life. Addressing these factors will help to mitigate the increasing incidence and impact of long-term conditions in our community.

Where do we want to be?

Our disease prevention plans and health promotion programmes are particularly focused on reducing risk factors and supporting positive change amongst identified high-risk groups who are more likely to be negatively affected by the events of the past year. With reduced capacity across Canterbury, there will be additional emphasis on sharing resources, reducing duplication and waste and supporting community groups to develop sustainable long-term projects.

Meeting the Minister's expectations

Canterbury is also focused on achieving the national health target to support people to quit smoking, including pregnant women who identify as smokers.

We have embedded the 'Ask, Brief advice, Cessation support' (ABC) programme across our health system - with training available in a range of settings and ABC now part of routine care. Strong smokefree clinical leadership is evident in our hospital and specialist services and in primary care. In the coming year, we will look to encourage and facilitate the inclusion of pharmacists and LMCs in the ABC programme.

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Improve breastfeeding confidence and support mothers to care for themselves and their babies. *To contribute positively to infant health and wellbeing and lay the foundations for a healthy life.*	Support the Canterbury Breastfeeding Steering Group to take a lead in strengthening stakeholder alliances, joint planning, promotion of available services and monitoring of outcomes. Work alongside the Maternity Development Group to identify opportunities to better engage women in breastfeeding strategies and improve integration between maternity providers. Promote supportive environments and expand the variety and location of breastfeeding courses to engage with more women. Invest in supplementary services to support breastfeeding, including peer support and lactation services that are accessible and appropriate for high-needs and at-risk women. Support increased LMC and Tamariki Ora input into educating, encouraging and supporting women to breastfeed. Establish a breastfeeding referral pathway that helps providers to refer mothers to the most appropriate level of support.	50 volunteer mothers are engaged in Mum 4 Mum peer support training. 580 mothers referred to lactation consultants. ≥85% of all mothers have established breastfeeding on hospital discharge. 67% of all infants are fully or exclusively breastfed at 6 weeks of age and 28% at 6 months.

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Empower people and communities to take positive action to improve health and wellbeing. *To support healthy eating, physical activity and healthy body weights and reduce the risk factors of long-term conditions.*	Facilitate community action that enables Māori and Pacific people to continue to achieve healthy nutrition and activity goals, increase capability and rebuild communities post-quake. Provide targeted community-based programmes that help people to improve their cooking skills, nutrition knowledge and physical activity levels, focusing on: 'Healthy Eating, Healthy Ageing', 'Appetite for Life' and Green Prescription (Be Active) Programmes. Invest in the implementation of Canterbury's newly developed community-based falls prevention programme, with its 'whole of system' focus on restorative care, rehabilitation and prevention. Engage in shared planning/implementation through the Canterbury Intersectoral Physical Activity and Nutrition Group (CIPANG) and jointly identify and address any issues, gaps and barriers.	90 Appetite for Life courses are delivered. 1,500 people access additional physical activity support via their GP. 800 older people (65+) access community-based falls prevention programmes.
Implement smoking cessation programmes. *To reduce the major risk factor of long-term conditions and reduce inequalities in health outcomes, particularly for Māori and Pacific people, who have disproportionately higher smoking rates.*	Provide and promote smokefree environments to support cessation attempts and reduce exposure to second-hand smoke. Undertake controlled purchase operations (CPOs) to ensure tobacco retailers comply with existing and new smokefree legislation. Continue to improve the implementation of ABC in our hospitals: ▪ Further enhance ABC documentation, data collection and systems to streamline and reduce the burden of reporting; ▪ Provide ongoing ABC training for staff (formal and informal), including 'train the trainer' approaches and the e-learning module, to support clinicians to change behaviours; ▪ Support clinical leadership including clinical smokefree leader, Directors of Nursing (DONs) and smokefree ward champions; ▪ Explore ways to support Māori smokers to transition from hospital into a community-based cessation programme; and ▪ Continue to support monitoring and feedback processes, including weekly dashboards, weekly monitoring by DONS and charge nurses, coding department feedback and ward audits. Support the implementation of ABC in primary care and systems to provide and record the provision of smoking cessation advice: ▪ Work with PHOs to develop resources and provide training for GP teams on documentation of smoking status and the provision and documentation of cessation advice and support; ▪ Establish smokefree leaders and champions in each PHO; ▪ Explore the use of dashboards tools for PHOs and the DHB to monitor and provide feedback on activity; ▪ Provide training to support pharmacists to provide brief advice, NRT and referrals to cessation support; and ▪ Provide targeted community-based cessation support to Māori and whānau through the Aukati Kaipaipa cessation programme. Work with general practice and LMCs to ensure processes are in place to provide pregnant women with ABC, supported by the DHB's Maternity Journey Programme. Promote the use of NRT and other medications to support effective cessation in a variety of settings and ensure people badly affected by the earthquakes have easy access to cessation support and NRT. Enhance referral pathways to ensure smooth transitions between hospital/primary/community cessation supports (including Quitline). Support other organisations, especially those dealing with at-risk clients, to establish routine processes for addressing smoking issues.	≥90% of tobacco retailers identified from controlled purchase operations are compliant with legislation. 95% of hospitalised smokers are provided with advice and help to quit. 90% of enrolled smokers seen in general practise are provided with advice and help to quit. ≥200 people enrol with the Aukati Kaipaipa smoking cessation programme. ≥7,000 Canterbury residents seek additional cessation support from 'Quitline' services. 4 large group ABC training sessions are delivered in primary care. 60% of community pharmacy staff complete ABC e-learning. Progress is made towards providing 90% of women who identify as smokers at the time of confirmation of pregnancy advice and support to quit.

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Implement programmes that reduce the harm caused by alcohol. *To reduce a major risk factor of harm and long-term conditions.*	Appoint a system-wide Alcohol Harm Reduction Coordinator to ensure a consistent approach to implementing public health alcohol-related harm interventions across Canterbury. Deliver host responsibility training to improve the skills of Duty Managers in reducing alcohol-related harm. Monitor On- and Club-Licensed premises assessed to be of high or medium risk of creating alcohol-related harm. Assist Police with alcohol controlled purchase operations (CPOs) to reduce the supply of liquor to minors. Investigate and report on requests from District Licensing Agencies for new licences and licence renewals within 15 days of request.	Alcohol coordinator role in place Q1. 50 host training sessions delivered. > 6 monitoring visits per year for high-risk premises and >3 per year for medium-risk premises.
Ensure health and wellbeing are considerations in earthquake recovery. *To positively influence the determinants of health and improve lifelong health and wellbeing.*	Continue to lead the intersectoral work of Healthy Christchurch. Continue to update the issues papers for the City Health and Wellbeing Profile to inform recovery and non-recovery work across health and other sectors. Engage with CERA and CCC rebuild and recovery planning, including participation in the Community Wellbeing Planners Group and Community Wellbeing Index Project. Partner with ECAN to ensure health is a central consideration in the Canterbury Water Management Strategy. Take particular account of new Resource Management Act applications that may affect drinking water quality. Continue to contribute to the work of the CERA-initiated Sustainable Homes Working Party in the areas of Legislative Change and Enabling Sustainable Home Improvements. Continue to work alongside Community Energy Action to encourage health professionals to refer vulnerable people to the Warm Families Project. Continue to support the Healthy Homes Project (under the DHB's Acute Demand Management Programme) to subsidise home heating and insulation for those with higher health needs.	A regular programme of Healthy Christchurch hui is developed and 3 hui held. CDHB contribution is evident in group/project outputs. Drinking water supply compliance targets (set by the Ministry of Health) continue to be met.

3.9 Managing long-term conditions

Long-term conditions are the leading cause of death and a major cause of avoidable hospitalisation in New Zealand. The World Health Organisation estimates that over 70% of healthcare funds are currently spent on long-term conditions and that with an ageing population, this will increase.

Respiratory disease

Respiratory disease is a major long-term condition associated with the ongoing legacy of tobacco use, obesity and an ageing population. Up to 100,000 people in Canterbury may be affected by respiratory issues, including chronic obstructive pulmonary disease (COPD), asthma and sleep disorders. Respiratory disease also disproportionately affects our Māori population.

Uniting health professionals from across the system, Canterbury's clinically led Integrated Respiratory Service has worked to develop a more whole-of-system approach to managing respiratory disease.

This collaborative approach has enabled services that were previously only available in hospital to be delivered in the community for earlier diagnosis and treatment. Over 1,800 people were seen in the community for spirometry, sleep assessment or pulmonary rehabilitation last year, with no need for a hospital visit.

Diabetes

Diabetes is estimated to cause around 1,200 deaths per year in New Zealand and can lead to blindness, amputation, heart disease and kidney failure. Its impact in terms of both illness and cost to the health sector is significant, and diabetes prevalence is increasing at an estimated 4-5% each year. Māori and Pacific people are particularly affected, with diabetes rates about three times higher than other New Zealanders.

Building on the success of our Integrated Respiratory Service, we have created a clinically led Integrated Diabetes Service (IDS) to develop a single, whole-of-system approach for diabetes care. This approach has already begun to provide more services for people with diabetes, with the assistance of diabetes health pathways for those newly diagnosed or starting insulin, a new Community Dietician and a team of Clinical Diabetes Nurse Specialists who support general practices to ensure systematic identification and management.

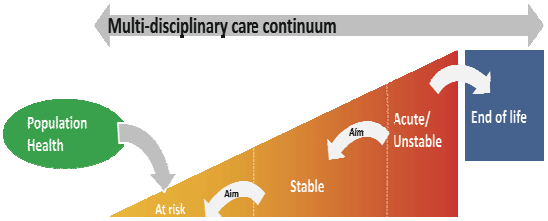
Cardiovascular disease (CVD)

CVD includes coronary heart disease, circulation, stroke and other diseases of the heart and is a leading cause of death and hospitalisation. Older people, Māori and Pacific people have higher rates of CVD, which will increase as our population ages.

Addressing CVD is reliant on systematic identification and management of people who have or are at risk of CVD. Increasing the number of CVD risk assessments delivered in primary care is a national priority. We are working closely with our primary care partners to stratify the Canterbury population and ensure those with the highest needs are receiving CVD risk assessments as we work towards achieving the national health target.

Seamlessly aligned care

In Canterbury, we are aligning the funding, functions and model of care across the whole health system to reduce the impact of long-term conditions on people's lives, reduce acute and avoidable admissions to hospital and improve mortality rates by facilitating early intervention and appropriate treatment.



Where do we want to be?

Good management requires systematic processes to be in place for identifying and regularly monitoring patients. The ongoing disruption and relocation of people's homes and support networks makes this tracking and recall of patients a challenge, and this is therefore an important area of focus for the next year.

Because of the strain on our system, we cannot achieve everything we would like and have to prioritise those with the most immediate and highest health needs.

Over the coming year, we will continue to develop integrated pathways and partnerships to support systematic care for people with long-term conditions. In particular, we will focus on collaborative approaches to COPD management, the development of an integrated diabetes package of care and the provision of CVD risk assessments.

This work will be supported by clinically designed and aligned health pathways, health professional education and greater access to diagnostics and other services in the community.

Respiratory disease

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Improve the identification of people at risk of respiratory disease. *To improve access to respiratory interventions that prevent admissions and ensure people have a structured programme or care plan.*	Consolidate and refine the identification of people with Chronic Obstructive Pulmonary Disease (COPD) and Obstructive Sleep Apnoea (OSA) by promoting case finding alongside other long-term conditions. Formalise, maintain and audit the hip and knee pathway to support case finding for OSA (with a BMI > 35) and COPD in primary care. Collaborate with Māori health providers and deliver improved access to diagnostics and tailored respiratory programmes for Māori.	People with OSA identified by the hip and knee pathway by Q2. ≥1,000 people access spirometry tests in the community. ≥650 people access sleep assessments in the community.
Ensure people receive the right care and support at the right time and in the right setting. *To support people to stay well, modify lifestyles, better manage their condition and reduce the progression or impact of their illness.*	Enhance linkages with public health programmes to support those at risk of respiratory disease. Support seamless patient care and improved access to respiratory services for patients in rural communities. Explore the Continuous Positive Airways Pressure (CPAP) model of care that promotes and supports an annual patient review in the community. Develop an integrated, multidisciplinary approach to the management of acute and sub-acute COPD. Continue to support community-based respiratory nurses and invest in enhancing people's skills and competence to better manage respiratory conditions. Expand CCMS/CCP capability to facilitate coordination between providers for complex respiratory patients who are frequent attendees at ED and hospital.	Acute COPD model developed by Q1. 100% of 'frequently admitted' respiratory patients enrolled in CCP by Q4. 10% reduction in COPD admissions and readmissions for people supported by CCP.
	Enhance secondary care activity for complex respiratory diseases, including lung cancer, cystic fibrosis, tuberculosis and respiratory failure. Implement a transparent single gateway and triage of specialist referrals to ensure equity of access. Streamline inpatient management for diagnosis of lung cancer and pleural disease and establish a diagnostic and therapeutic outpatient-focused service. Establish a community-based model for acute Cystic Fibrosis and Bronchiectasis patients.	Medical Thoracoscopy Service consolidated by Q4. No one waits longer than 6 months for a first specialist assessment or treatment by 30 June and 5 months by 31 December 2013.
Support rehabilitation programmes. *To reduce the likelihood of an exacerbation or readmission and to improve the quality of life.*	Expand access to community pulmonary rehabilitation programmes via referral from other conditions and rehabilitation programmes (such as CREST). Work with Māori and Pacific service providers to increase access to rehabilitation for Māori and Pacific people with respiratory disease.	More people access pulmonary rehabilitation programmes in the community – base 108.

Diabetes

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Realign and integrate diabetes services in Canterbury. *To develop and integrated approach to diabetes that is best for patient, best for system.*	Support the Integrated Diabetes Services Development and Operational Groups (IDSDG and IDSOG) and the Diabetes Consumer Group to develop an integrated local approach for people with diabetes in Canterbury to replace the current national Diabetes Annual Reviews. Support the IDSDG to continue to develop service responses in identified priority areas: practice nurse education, retinal screening, podiatry, coding and community dietetics.	New Diabetes Care Package developed, agreed and implemented by Q1.
Improve the identification of people 'at risk' of diabetes. *To identify focus areas of improvement and ensure access to appropriate monitoring, management and support to improve diabetes management.*	Work with primary care to identify all those people in their enrolled population who have diabetes. Support the IDSDG and primary care clinical governance groups to actively promote consistent coding for diabetes. Support the development of initiatives to 'case-find' and engage high-need groups with diabetes. Provide education and training to improve the systematic monitoring of diabetes where additional support is needed.	General Practices identify all patients with Diabetes from practice management data by Q2. Review of the identified priority areas of focus against population data is complete by Q4.
Ensure people receive the right care in the right setting. *To support people to stay well, modify their lifestyles, better manage their conditions and reduce the progression of illness.*	Support the IDSDG, Diabetes Consumer Group and primary care clinical governance groups to: ▪ Identify baseline minimum care for the population and for high-risk / high-needs groups. ▪ Agreed a set of indicative outcomes indicators to be collected from the population identified with diabetes (retinal screening, podiatry, blood pressure, BMI, HbA1c, cholesterol, creatinine, electrolytes, urine). ▪ Develop a communication plan in support of the new Diabetes Care Improvement Package. ▪ Monitor and review the implementation and performance of the new Diabetes Care Improvement Package and recommend improvements. Realign the current Diabetes Annual Review funding with the provision of the new Diabetes Care Improvement Package and further support this with the investment of additional funding to meet the needs of the population.	Baseline minimum package of care agreed by Q1. Indicators for new Diabetes Care Package agreed by Q1. Collection of indicator data commenced by Q2. More people with diabetes (identified by general practice) are supported to manage their diabetes – base: 49%. More high-needs people with diabetes (identified by general practice) are supported to manage their diabetes – base: 56%.
	Aligned with the development and implementation of the Diabetes Care Improvement Packages:	
	Continue to invest in programmes to support people newly diagnosed with Type 2 diabetes and people with diabetes who are starting insulin treatment. Support the development and delivery of tools and patient education for improving self management of diabetes. Provide support and training to general practice teams to enable them to better identify people with diabetes and provide good quality diabetes care. Enhance collaboration between primary, community and secondary service providers via the use of integrated patient pathways and the HealthPathways website	More people newly diagnosed with Type 2 diabetes access support in the community – base 163. More people starting insulin treatment access support in the community – base 69. ≥79% of the population identified with diabetes have good diabetes management: HbA1c ≤64mmol/mol.
	Invest in enhancing community access to specialist services (i.e. community diabetes nurses and dieticians) in line with the new package. Invest in enhancing community access to specialist treatment in identified focus areas (i.e. retinal screening) in line with the new package of care.	

Cardiovascular disease

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Improve the identification of people at risk of CVD. *To improve access to appropriate intervention and support improved self management of CVD.*	Support Partnership PHO to establish a baseline population who have had a CVD risk assessment in the last five years. Support general practice to accurately record CVD risk assessment provision through 1:1 coding education. Engage with primary care clinical governance groups to agree appropriate measures to identify patients most at risk of CVD and apply stratified risk assessments.	Establish CVD Risk Assessment baselines by Q1. Agree a stratified risk assessment approach by Q2. Progress towards achievement of the national health target by Q4 – base 13.7% [36]
Ensure people receive the right care in the right setting. *To support people to stay well, modify lifestyles, better manage their condition and reduce the progression of illness.*	Maintain direct referral to exercise tolerance testing to support clinical CVD risk assessment. Review cardiology patient pathways between primary and secondary to support integrated CVD management to support improved service delivery and patient outcomes. Expand CCMS/CCP capability to facilitate coordination between providers for complex CVD patients. Maintain GP access to specialist support to assist in managing people with CVD.	CVD and cardiology HealthPathways reviewed by Q2 100% of 'frequently admitted' cardiology patients enrolled in CCP by Q4.
	Implement agreed protocols, processes and systems to ensure prompt local risk stratification of suspected Acute Coronary Syndrome (ACS) Agree and implement clinical pathways from primary to tertiary care for patients with suspected ACS. Improve direct access to diagnostics to facilitate treatment. Provide training for staff in the risk assessment of patients with suspected ACS according to national guidelines. Ensure systems and processes for patients with suspected ACS meet the needs of high-risk groups. Communicate and monitor national cardiac surgery targets to improve performance and equity of access. Implement opportunities from the Vector Consulting Report to improve patient flow within the Cardiology Department.	85% of people receive their elective coronary angiograms within 3 months (90 days). No one waits longer than 6 months for a first specialist assessment or treatment by 30 June and 5 months by 31 December 2013. Population access (per 10,000) will not be significantly below agreed rates by Q4: Coronary angiography: 32.3. Percutaneous revascularisation: 12. Cardiac surgery: 6.2 - 6.5.
Support rehabilitation programmes. *To reduce the likelihood of a subsequent CVD event and support people to optimise recovery.*	Continue to support increased referral of people to cardiac rehabilitation after acute events. Support primary care education to improve the management of cardiology patients in the community. Explore combined rehabilitation programmes for people with long-term conditions under the CCN work stream.	CVD education session developed and delivered to general practice by Q3. ≥30% people access cardiac rehabilitation after an acute event.
Align strategic activity across the South Island. *To make the most effective use of resources and workforce and ensure equity of access for our population.*	Support the South Island Cardiac Work Streams to implement the regional cardiac services plans and regional clinical pathways for ACS patients. Support the monitoring of intervention rates and the implementation of regionally protocols and pathways. Identify opportunities for increased cardiology nursing training via the regional training hubs.	Regional service plan for cardiac service developed by Q3. Two regional cardiac HealthPathways agreed by Q4.

[36] *The National Heart and Diabetes Health Target for is for 90% of the eligible population to have had their cardiovascular risk assessed at least once in every five years. The Canterbury target is to achieve 75% by 1 July 2013. Partnership, Canterbury's largest PHO, has been participating in the CVD risk assessment programme for less than 2 years. Work is underway to establish alternative means of identifying people whose risk was assessed within the last 5 years prior to Partnership beginning to collect risk assessment data.*

Supporting our Transformation

Organisational strengths – expanding our capability

Organisational strength or capability is defined as 'what an organisation needs in terms of culture, leadership, relationships, people, processes, technology, physical assets and structures to efficiently deliver the outputs required to achieve its goals'.

Having already identified the challenges we face, the outcomes we seek and our critical success factors, this section highlights the capability we have within the Canterbury health system and the capability we will need to develop in the coming year to support our transformation and deliver on our goals.

4.1 Canterbury culture

In order to meet the needs of our population and fully achieve our vision, we need a strong and inclusive organisational culture and an engaged workforce - committed to doing the best for their patients and for the health system.

We recognise that our vision is wider than just the DHB, and in this sense we seek to engage and inspire not only our own workforce, but all the people who work in the Canterbury health system.

To enable this, we have adopted a decision-making approach that recognises that our relationships with the organisations we fund need to be more than contractual. In order to respond to the changing needs of our population and the current pressures we face, Canterbury needs to be able to make flexible, responsive and immediate decisions.

Our approach is to view the Canterbury health system as one system with one health budget. At the core is a decision-making and prioritisation framework that makes clear which decisions remain the role of the DHB, and which decisions should be devolved to clinicians, health professionals and providers on the front line of service delivery (at the clinician/patient interface).

Creating a shared vision

In 2007 we began our journey to engage the entire health system in the 2020 challenge by encouraging people to 'make it better' for patients and clients. Over 2,000 people participated in our six week Vision 2020 showcase, with this base group taking the message out to the wider health workforce.

At the same time, we invested in leadership programmes that promote 'lean thinking' approaches to service and system design such as '*XcelR8*', *'CollaboR8'*, '*Improving the Patient Journey*' and the '*Canterbury Initiative*' and '*HealthPathways*' development.

These unique leadership programmes empower participants to positively improve the effectiveness and efficiency of the health system. By the end of the year over 500 health professionals are expected to have participated in the XcelR8 and Particip8 programmes and over 470 clinically led patient HealthPathways will have been developed through the Canterbury Initiative.

We also engage and encourage our health workforce through our Quality and Innovation Awards, which recognise excellence in quality improvement. Since the programme began in 2003, it has recognised 140 projects from across both hospital and community services. Many have gone on to experience success in national and international awards programmes.

By investing in a patient-focused culture of partnership, participation, innovation and continuous quality improvement; we have built up considerable momentum and support for transformation in Canterbury. Our health system culture is an important element in our success, and we will continue to support leadership and change programmes that engage our workforce and improve service delivery for our population.

Our challenge

Planning, funding and delivering health services is a complex business, and in Canterbury involves an annual spend of more than $1.4 billion dollars. To be effective, we must have capable leadership, a healthy organisational culture, sound relationships, an engaged workforce, robust and rigorous systems and the right infrastructure and assets.

In the aftermath of the earthquakes, we also need to be able to do things differently. Our resources are stretched and our circumstances exceptional. Doing things differently will mean making some allowances, but it will also mean making the most of opportunities. The strengths of the Canterbury system will support us to make the necessary decisions over the coming year to continue to meet our population's needs with limited capacity.

Prioritisation principles

- *Effectiveness:* Services should produce more of the outcomes desired, such as a reduction in pain, greater independence and improved quality of life.
- *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 from public spending.
- *Whānau ora:* Services should have a positive impact on the holistic health and wellbeing of the person and their family/whānau.
- *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:* Implementation of the service is carefully considered, including the impact on the whole system, workforce considerations and any risk and change management requirements.

4.2 Good governance

To support good governance across our system, we have a clear accountability framework that empowers our governors and leaders to provide direction and monitor performance. This is underpinned by a well articulated strategic vision and clear decision-making frameworks.

We are fortunate to have a well functioning Board whose members contribute a wide range of expertise to their governance role. Governance capability is maintained through regular forums and supported by a mix of experts, professionals and consumers on the Board's advisory committees. Several of Canterbury's Board and advisory members are also members for the West Coast DHB, supporting an understanding of transalpine priorities and a more regionalised approach.

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

Clinical leadership

Shared clinical/management decision-making is vital in our current environment, when decisions must be made quickly to meet the immediate needs of our population. Clinical input into decision-making is embedded in the DHB's shared clinical/management model. This model is replicated across the whole of Canterbury's health system, with a framework of primary/secondary clinical leadership helping to drive transformation through the Canterbury Clinical Network (CCN) District Alliance.

The Canterbury DHB's Clinical Board is a multidisciplinary clinical forum that oversees the DHB's clinical activity. The Board advises the Chief Executive on clinical issues and takes an active role in setting clinical standards and encouraging best practice and innovation. Members support and influence the DHB's vision and play an important clinical leadership role, leading by example to raise the standard of patient care.

Clinical governance is further facilitated by the DHB's Chief Medical Officer and Executive Directors of Nursing and Allied Health, who provide clinical leadership and input into DHB decision-making at the executive level.

Māori participation in decision-making

We continue to encourage greater participation of Māori in the development of plans and strategies to improve health outcomes and reduce health inequalities. The DHB has a formal Memorandum of Understanding with Manawhenua Ki Waitaha (representing the seven Ngāi Tahu Rūnanga) and engages informally at many levels with Māori providers and community groups to enhance participation in decision-making.

In the last 18 months, a Māori and Pacific Provider Leadership Forum has evolved to improve the planning and delivery of services and provide advice and insight that supports improved decision-making.

The DHB also has a Māori Health Action Plan, which brings together a snapshot of the activity occurring across the system to improve health outcomes. The DHB publicly monitors performance against the Action Plan as a means of increasing the focus on Māori health.

In addition, the DHB's Executive Director of Māori and Pacific Health provides cultural leadership and input into decision-making at the executive level of the DHB.

Consumer and community input

The advice of consumer and community reference and advisory groups also assists in improving the planning and delivery of services.

The DHB's Consumer Council provides input into decision-making as a permanent advisory group for the Chief Executive and supports a partnership model that ensures a strong and viable voice for consumers in health service planning and delivery. The Council consists of 16 representatives nominated by consumers and consumer advocacy groups. Networks support each representative in their role and facilitate wider communication across the Canterbury community.

Clear prioritisation and decision-making principles

The input and insight of these groups supports good decision-making, but the environment in which we operate still requires the DHB to make some hard decisions about which competing services or interventions to fund with limited resources available.

There is a need to protect vital services that are meeting an immediate health need or contributing to population health gain and to maintain key relationships and provider capacity. At the same time, we must be aware that any poor short-term prioritisation decisions may shift demand for health services towards the more acute end of the continuum or place unsustainable demand on other providers, including other DHBs.

The DHB has an established prioritisation framework and a set of prioritisation principles - based on best practice and consistent with our strategic direction. These principles assist us in making the final decisions on whether to develop or implement new services. They are also applied when we review existing investments and support the reallocation of funding, on the basis of evidence, to services that are more effective in improving health outcomes and reducing inequalities.

Monitoring our performance

In our role as funder of services, we hold over 1,000 contracts and service agreements with the organisations and individuals who provide the health services required to meet the needs of our population. We make decisions on these contracts based on our shared decision-making approach and prioritisation framework and monitor these agreements through regular performance reports and data analysis. We also monitor and assess the quality of services provided through reporting of adverse incidents, routine quality audits, service reviews and issues-based audits.

In our role as provider of services, we have annual volume and performance expectations which are monitored and publicly reported alongside an agreed set of productivity and quality performance indicators. We also report quarterly to the Ministry of Health against a set of ownership indicators and regularly feed into health benchmark and quality indicator reporting to compare our performance with other providers.

The DHB supports the Minister of Health's expectation that the public should receive better information on performance by publishing on our website and in local newspapers our quarterly performance against the national health targets.

4.3 Quality and patient safety

Our patient-focused culture supports two of our health system's greatest strengths: continuous quality improvement and a commitment to patient safety. In supporting clinical leadership across the system, we are engaging our workforce in initiatives that encourage innovation, participation and partnership.

We are committed to the national quality improvement projects including: Medication Safety, Quality Accounts, Mortality Review, Incident Management/Reportable Events, Infection Prevention and Control and the Surgical Checklist.

In the coming year, in line with the regional direction our local Quality Strategic Plan, our Clinical Board will champion quality projects focused on: Pressure Injuries, Seclusion Reduction, Patient Stories, Reducing Alcohol Harm and improving our emergency response through the Canterbury/West Coast Emergency Care Coordination Team. In addition, Canterbury will focus on the following major projects.

A 'whole of system' approach to falls prevention

Canterbury has a vision of moving towards 'zero harm' from falls, and we are working as an integrated system to establish research and evidence-based practice in falls prevention. This is a key component in our strategy for improving the health of older people in Canterbury and reducing acute demand on services.

Two Canterbury studies into the factors relating to falls recently received funding from the Health Quality and Safety Commission, and their findings will help to inform strategies to reduce the falls rate for people in our health system. The first study was a real-time review of patient fall events in the hospital setting, and the second evaluated InterRAI Home Care assessment data as a predictor of falls causing injury and health events.

Our goal requires the engagement and support of clinical leaders in a 'whole of system' approach to falls prevention, and we have recently begun to implement an integrated community-based falls prevention strategy with the establishment of Community Falls Champions and a volunteer-led programme. More than 800 people will access falls prevention services in the next year.

Patient safety walk rounds

The Clinical Board's Patient Safety Walk Rounds provide frontline staff with the opportunity to converse directly with Clinical Board members about their ideas for improvement and to share their successes and concerns regarding patient safety. They also improve the visibility of our clinical leaders and provide an opportunity to champion patient safety at grassroots level. This is an ongoing programme, which includes both hospital and specialist services and community providers.

Canterbury's health innovation hub

In 2011 we received the green light to establish the local branch of the National Health Innovation Hub (HIH). The Canterbury HIH aims to facilitate the development of leading-edge ideas and improvements across the health system specialising in the evaluation, management and commercialisation of intellectual property.

Supported by the Canterbury Development Corporation, universities and tertiary education providers, the innovations supported through the Hub will improve both patient outcomes and the productivity of our system through the accelerated adoption of proven service improvements. By providing opportunities for clinicians to be at the front end of health development, the Hub will also help to attract and retain valuable clinical staff in Canterbury. The launch of the Canterbury HIH is planned for June 2012.

Greater collaboration

Increased collaboration between DHBs and across the wider health sector will also help us to identify opportunities to improve quality and patient safety.

Canterbury will participate in the Health Quality and Safety Commission's Central Line Associated Bacteraemia Programme. This will enable DHBs to learn from each other in a collaborative environment, share experiences and trial improvements that identify best practices. The initial phase will focus on intensive care units and the development of a collaborative approach, understanding the unique environment of each DHB, and sharing best practice from around New Zealand.

Our ongoing participation in the Adverse Drug Event Collaborative with Counties Manukau and Capital and Coast DHBs will help us identify opportunities to improve medication safety. Canterbury is also participating in some of the Australasian Health Round Table initiatives: Long Stay Patients, Trigger Tool Methodology and Standardised Hospital Mortality Ratio. These projects will help us to further improve the quality of the care we provide.

4.4 Our people

Global competition for skilled people, the expectations of younger generations of employees and the impact of rapidly changing demographics are ongoing challenges for the whole of the New Zealand health system. We are faced with an ageing population and increasing demand for health services. It is imperative that we build and retain a workforce capable of meeting the needs of our population and create a workplace environment that attracts and retains that workforce.

As a good employer, we promote equity, fairness and a safe and healthy workplace. We uphold high standards of governance and ethical business conduct through a clear set of organisational values, including an integrated code of conduct and a commitment to continuous quality improvement and patient safety.

However, in Canterbury's current context, it is not sufficient just to be a good employer. With increasing financial and workforce constraints, we must transform the way we deliver health services to our population in order to meet future demand for services. We simply do not have the workforce numbers to continue to provide services as we have in the past, and we cannot afford to compete financially for scarce workers.

Strategic direction

Canterbury has spent the past several years transforming the way we work. We have focused on engaging people from right across our system in the development of alternative models of care and on training and education to expand people's capabilities to ensure we can meet the future needs of our population.

The development of more integrated models of care has fostered strong cross-system partnerships and improved the continuity of care for patients. Not only is this approach increasing system capacity and improving patient outcomes, but it also helps to attract and retain people by engaging them in determining the future direction of services. More than 470 clinically led patient pathways will be in place across the Canterbury health system by the end of this year, and an increasing number of advanced nursing, allied health and medial positions are being developed to support changing workforce and delivery models.

Telemedicine, outreach clinics and connected electronic patient information and referral systems have allowed us to further expand capacity. Health Professionals are now better able to provide services, supervision and advice to colleagues in other parts system or the country without a significant increase in workforce numbers. Videoconferencing and telemedicine smooth the transfer of patients being treated for medical detoxification between tertiary and secondary services, enable remote supervision of dieticians on the West Coast and support the provision of specialist advice. Christchurch paediatric specialists can now carry our 'virtual ward rounds' at Grey Base Hospital.

Training and education programmes are supporting expanded roles and enabling health professionals to work to the greatest extent of their scope. The Professional Development Recognition Programme (PDRP) and allied health assistants are enabling the establishment of new roles and expanded practice scopes across the Canterbury health system. Clinical Pharmacists now join wards rounds, physiotherapists are completing specialised assessments and new advanced Gerontology Nurse Specialist roles will soon be supported regionally.

Investment in primary care education has allowed over 900 GPs, practice nurses and pharmacists to attend peer-led, evidence-based education sessions promoting clinical best practice. Aligned to the transformational change underway across Canterbury, these sessions promote the use of integrated pathways and increase the capability of our whole system. Over 90% of Canterbury GPs and 85% of practice nurses will have access to the primary care education programme by Q4.

CANTERBURY DHB WORKFORCE 2011

Female Headcount	*Male Headcount*	*DHB Total Headcount*
7,254	1,661	8,915
81% part time		12% of NZ total
Average Age	*Largest Ethnic Group*	*Avg. Length of Service*
46.3 years	NZ European 58%	9.7 years
Largest Workforce	*Youngest Workforce*	*Oldest Workforce*
Nursing 4,308	Technical and Scientific	Care and Support
48% of DHB workforce	Avg. Age 44.5 years	Avg. Age 51.6 years

With the introduction of dedicated education units, we have increased the number of clinical placements for nursing students in our hospitals. We now employ over 100 new graduate nurses each year through the national Nursing Entry to Practice Programme (NETP) and the mental health specialty stream NESP. Our NETP programmes support nurses in both primary and secondary settings, and we are now considering opportunities to extend the programme across other disciplines and into aged residential care settings.

We are supporting the development of an appropriately skilled Māori health workforce by taking the South Island lead for Kia Ora Hauora, a national initiative aimed at increasing the number of Māori studying towards health careers and working in health fields. The initiative will support more than 250 Māori regionally.

We are supporting the development of our rural clinical workforce both in Canterbury and on the West Coast with recent investment in Rural Training Centres in Ashburton and Greymouth. This includes new split-site roles that enable graduates to work in both hospital and community settings, such as the split-site pharmacy roles on the West Coast. These roles help improve collaboration across the system and reduce isolation factors, encouraging people to work in rural locations.

We have also stepped up our participation in the Health Workforce NZ (HWNZ)-sponsored Regional Training Hubs. These Hubs will become centres of excellence for postgraduate clinical training and education, career planning, role development and administration of activities such as bonding schemes. A review of the training delivered to Post Graduate (PG) Students PG Year 1 and PG Year2 and current career planning pathways for HWNZ-funded staff will be completed this year in order to align training and career planning.

Operational direction

Unfortunately, all of this activity has been overshadowed by the significant disruption to our health system over the last 18 months. Canterbury DHB retention rates, previously higher than the national average, have (not unexpectedly) dropped by 2%.

The need for us to take an integrated approach to workforce planning is now more imperative than ever. As our system copes with increasing demand and reduced bed capacity, we are relying on our primary and community partners to support people to stay well and out of hospital. It is crucial that we support the whole of Canterbury's health workforce and not just our own.

Our objective is to develop workforce plans for critical workforce groups that will guide recruitment and employee development now and into the longer term. This work will factor in projected demand growth, changing demographics, future service models and workforce needs and gaps, alongside the need to align planning with the transformational direction of the Canterbury health system. This will be supported through the Regional Training Hub and the South Island Tertiary Alliance. Data analysis for the South Island health workforce and action plans by priority work streams will be completed in the first half of the year.

In collaboration with the Canterbury and Otago Universities and the South Island Polytechnic Network, we have also developed a South Island Tertiary Alliance to deliver a single management and leadership curriculum for all health employees in the South Island. This will promote career enhancement, maximise people's potential and help us to retain valuable employees. HWNZ is now an active member.

Our internal strategy continues to support progressive reform of HR practices. During the coming year, we expect to digitise processes and further integrate Canterbury and West Coast HR systems. This is a significant piece of work that will bring improved efficiencies and support managers to better manage their staff through greater information access. We will also align recruitment processes, performance management and succession planning approaches across the DHB, as well as commencing work on culture and employee engagement projects.

This includes developing innovative recruitment and employee resiliency strategies and re-branding the Canterbury system – accentuating the positives to improve recruitment and retention. Targeted strategies will be developed for allied health, technical and scientific roles, including radiation therapists and experienced physiotherapists.

An action plan with key deliverables for 2012/13 is attached as Appendix 8. The DHB also has a Workforce Plan, which is a companion document to this Plan and is available on our website.

Engagement and commitment

In 2010 (prior to the earthquakes) the DHB undertook a staff survey to measure the engagement of our workforce. The results told us that 68% of our overall workforce is engaged, with only 4% disengaged. International research suggests that highly engaged people put forth 57% more effort and are 87% less likely to leave an organisation.

Obviously the past 18 months have been extremely difficult for everyone working in the Canterbury health system. However, recent staff survey results indicate that our staff continue to feel supported and want to be here.

In December we intend to repeat the engagement survey to determine the effect that the past year's earthquakes have had on our staff and to identify further opportunities for improvement.

Expanding our capacity

Canterbury is fortunate to have considerable clinical and professional capability across the system. However, significant opportunities have yet to be realised that will help deliver a fully interconnected and responsive health system. Information systems, assets, infrastructure, and alliance partnerships are all critical enablers to delivering our strategic goals and improving outcomes for our population.

4.5 Investment in information systems

Information management is a national priority, and DHBs are taking a collective approach to implementing the Government's *National Health Information Technology Plan* (NHITP). The South Island DHBs have collectively determined the strategic actions to deliver on NHITP, and we are committed to this approach.

One of our joint priorities is to enable seamless and transparent access to clinical patient information. This will benefit patients by enabling more effective clinical decision-making, improving standards of care and reducing the risk of missing important information.

This is particularly relevant in Canterbury, where the earthquakes have displaced many people from their health providers and clinical records, and have highlighted weaknesses in the responsiveness and resilience of our clinical information systems.

It is critical that we accelerate implementation of a more effective, structured and integrated health information system. While the longer-term system architecture is yet to be defined, we have identified a number of short-term actions to deliver immediate improvements.

Our information solutions involve working closely with clinicians and stakeholders across Canterbury to ensure that the right clinical information is available to the right people, at the right time and in the right place. This includes significant investment in the development of HealthPathways, which now provides assessment, management, and referral information for over 470 clinical conditions. HealthInfo is a recently developed patient version for the clinical conditions covered by HealthPathways. Initial testing demonstrates high support from both clinicians and patients, and HealthInfo will be developed through 2012/13.

Major 2012/13 Information Services initiatives include the following initiatives (an action plan with key deliverables for 2012/13 is attached as Appendix 9).

The Concerto Clinical Information System (CIS): The CIS is a portal that brings all a patient's clinical information into one view, and allows the entry of new data in an organised and clinically effective way. Canterbury is taking the lead in the rollout of the CIS across the South Island. Whilst this project is ambitious, a single integrated regional portal will greatly improve clinical decision-making and provide timely information at the point of care. The CIS includes a focus on e-Discharges, which allow discharge summaries to be sent electronically to GPs, significantly assisting a 'whole of system' approach to patient care. A single Concerto record will be shared across Canterbury, West Coast and South Canterbury DHBs by Q3.

Our Electronic Referral Management System (ERMS): The next step in the rollout of CIS is supporting e-Referrals. Previously all GP referrals were sent by fax to our hospitals and to private providers. ERMS automates this process so that GPs can refer patients using their desktop Patient Management System. Most of Canterbury's GPs now use ERMS, which carries 3,000 to 5,000 referrals every month. Referrals arrive at the hospital department in an electronic 'inbox' and can be easily monitored and managed. In the coming year, we will assist the West Coast to adopt ERMS by Q3, and we will lead and support the rollout of ERMS across the whole of the South Island over the next two years.

Our Emergency Shared Care Record View (eSCRV): The eSCRV is a secure system for sharing key patient information between all of the health professionals involved in a person's care. The system stores people's key health information (such as allergies, prescribed medications and test results) and will lead to faster, more informed treatment, shorter waiting times and better outcomes for patients. The project has evolved out of lessons learnt during the earthquakes and has been made possible through a partnership between the DHB, Pegasus Health and software experts Orion Health. We expect eSCRV to be widely available by Q1 and fully functional across the Canterbury health system by Q2.

Our Collaborative Care Management System (CCMS): This system integrates clinical information and shared planning to support primary and community providers to better manage individuals with complex needs and long-term conditions. The implementation project, known as 'Project Chain', is delivered under the CCN and involves the DHB, Pegasus Health, software experts HSA Global and many community-based providers. CCMS is being implemented in the first instance to support Canterbury's CREST programme and to introduce systemised planning and collaborative care for people with complex long-term conditions who frequently attend ED or are admitted to hospital. We aim to have 25% of all patients identified with complex/long-term conditions enrolled in the Programme by Q4.

A Single Patient Administration System: Canterbury currently supports three different systems across our hospital services. One of these (HOMER), used in acute settings, is approaching 'end of life'. We will move to a single system, in alignment with the South Island's regional direction. This is a significant undertaking and will take several years to complete. Implementation will focus on best practice processes and will enhance data quality locally, regionally and for national collection. A regional business case will be delivered by Q2 this year, and Canterbury will prepare to implement a single regional patient administration system by Q1 2014.

An Integrated Data Set: We are working with St John and Lightfoot Solutions to integrate ambulance, Emergency Department and secondary care data. This 'real time' data set allows us to monitor service utilisation and patient journeys to identify system-wide opportunities to influence and respond to demand. This data has huge potential in terms of understanding the drivers within the Canterbury health system and helping to plan our transition from earthquake recovery. Live weekly data will be available from Q1 of this year.

4.6 Repair and redesign of facilities

It is imperative that our transformation is underpinned by a hospital system that is responsive and supports flexibility of service provision.

Our facilities had already been identified as an impediment to the continued transformation of our health system. Their physical geometry offers no further opportunity for co-location of services and hampers the introduction of service delivery models that would improve the quality of care. Our patient pathways highlighted the operational inefficiency of facilities that fragmented services across multiple sites.

The earthquakes have radically escalated these physical capacity constraints. Only the dedication of our maintenance and engineering team has kept our major sites going in the face of extensive damage. Almost all of our 200 buildings have been affected, and some have had to be closed and demolished. Many of our services have been relocated or are in inadequate temporary accommodation and some staff are working from their own homes.

73 medical beds from Christchurch Hospital have been relocated to the Princess Margaret Hospital, further fragmenting services across sites.

Significantly, due to the damage sustained, our facilities can no longer be relied upon to continue to function in the event of another large disaster.

In recognition of the long-identified capacity problems and subsequent damage, the Government has given Canterbury the go-ahead to develop a business case for rebuilding Christchurch Hospital, including a new acute wing, and for building a specialist centre for older people's services at Burwood Hospital. This will enable us to rebuild our lost capacity and 'future-proof' Canterbury's health infrastructure.

Fortunately, the land that our main sites are built on has been cleared as stable and suitable for building. This is particularly important with regard to the Christchurch Hospital site, where most of the rebuild is focused, and the continuation of the main hospital on its central city site has been identified by the City Council as core to the recovery of Christchurch.

While our original facilities strategy still holds, there are new challenges around finances and timing. Our original business case was clearly affordable for the DHB, but other capital commitments post-quake will see us moving to a deficit situation as we recover. This is a process that will be worked through alongside consideration of public/private partnerships that might support the funding of the rebuild.

It is the timing of the rebuild that has become the most critical factor. We have over 9,000 damaged rooms in need of repair. We must make decisions about short-term capital investments to fix existing infrastructure in the context of the longer-term direction, or health dollars will be wasted. This risk is heightened by changes in building codes, which increase the extent and cost of upgrades and repairs to our existing buildings to meet more stringent earthquake standards.

In order to avoid costly and wasteful investment in short-term fixes, preparing and submitting the business case for Canterbury's rebuild is a priority. Canterbury submitted the indicative business case to the Capital Investment Committee in June. We hope to receive clear direction from Cabinet by August.

In the meantime, the Board has approved a specific decision-making framework for the repair and rebuild of DHB infrastructure damaged in the earthquakes. This involves consideration of various factors and competing tensions, including:

- Protecting our patients from risk;
- Protecting our staff from risk and supporting the recruitment and retention of our workforce;
- Maintaining service delivery;
- Coordinating with the repair and rebuild of community-owned health infrastructure;
- Meeting the costs of new post-quake standards for built infrastructure, not all of which is covered by insurance, and the impact on our ability to fund new infrastructure; and
- Not wasting millions on repairing buildings that have already been identified as not clinically fit.

Balancing these competing tensions is complex, and the new framework supports consistency of decision-making. (Refer to Appendix 7 for the framework.)

While we are presented with difficult decisions, we are also presented with opportunities. The increased levels of trust between health stakeholders post-quake have provided an opportunity to collectively work together not only on new models of care but on new infrastructure to support them.

The former Christchurch Women's site on Colombo Street has been identified as a possible location for future health services and a means to support lost community capacity. A business case is being developed in conjunction with a number of partner organisations for the site to become a Community Hub with extended services, including 24/7 acute primary care.

4.7 System partnerships and alliances

Working collaboratively has enabled us to respond to the changing needs of our population (particularly in response to the earthquakes), and is a critical factor in achieving the objectives set out in this plan.

The DHB is committed to sharing resources and knowledge to boost capacity in the health sector. We are also committed to working with external agencies and providers in other sectors to influence the social determinants that strongly contribute to improving longer-term health outcomes for our population.

Health in all policies

The concept of 'Health in All Policies' (HiAP) describes an integrated and systematic method of including health in all policy assessment and decision-making. The concept involves working in partnership with other agencies and (non-health) sectors and seeking common outcomes. The premise for this approach is that health is greatly influenced by our lifestyles and the environment in which we work, live and play.

The DHB provides leadership for the Canterbury HiAP partnership along with the Christchurch City Council (CCC), Regional Council and Partnership Health PHO. This partnership uses health impact assessment and relevant methodologies to assess policies and initiatives for their potential impact on health outcomes and brings in a 'health' focus early in the policy-making cycle.

A working example of the HiAP partnership is the Integrated Recovery Planning Guide developed by the DHB and CCC, which is being used in the master-planning for Sydenham and Lyttelton Recovery.[37]

Canterbury Earthquake Recovery Authority (CERA)

The Canterbury DHB has a close working relationship with the CERA. This involves participating at many levels, including the Government Leaders Group and a number of relevant working groups. We have been able to support CERA's activity through the provision of staff, information and expertise as requested. This relationship has worked well for the people of Canterbury, ensuring coherent planning for communities. The DHB is committed to an ongoing role and partnership as the Canterbury recovery gathers momentum.

Canterbury Clinical Network (CCN) District Alliance

The CCN was formed in response to opportunities presented by Government to transform and integrate systems. It was established with the explicit inclusion of the DHB as a key partner to enable collaborative planning across the whole of our health system.

The CCN's work focuses on delivery of Canterbury's *'Better, Sooner, More Convenient'* Business Case (now in year 3 of implementation), including the establishment of Integrated Family Health Centres and Community Hubs and the strengthening of clinical leadership as a fundamental driver of improved patient care.

Together we have established a significant array of local alliances and workstreams to support the development of clinically led patient pathways and ensure the right people get the right care and support, at the right time and in the right place. Over 470 HealthPathways will sit across the interface between primary and secondary care and help to improve the quality of care, reduce the time people spend waiting and support the delivery of more services closer to people's own homes.

Regional collaboration

The five South Island DHBs have adopted a modified Alliance Framework to support accelerated regional planning and service delivery.

The Chief Executives form the Alliance Leadership Team and take responsibility for coordination of regional health service planning under the Alliance Governance Board (the DHB Chairs). This step up to a regional alliance better supports collective decision-making and enables the South Island DHBs to provide clear long-term signals around regional service planning and capital investment – improving the use of shared resources.

South Island regional planning is implemented through service level alliances and work streams. Canterbury is well represented across the regional planning streams, and our commitment to specific regionally planned actions has been reflected throughout this document. The full regional work plan can be found in the South Island Regional Health Services Plan at www.sialliance.health.nz.

National collaboration

At a national level, we work with the education, social development and justice sectors to improve outcomes for our population through health promotion, nutrition, physical activity, alcohol and drug and mental health initiatives – integrating services to meet shared goals.

We are committed to implementing a number of national programmes to improve health outcomes, including B4 School Checks, Immunisation Programmes, Gateway Assessments, the Youth Mental Health Project recently announced by Government and the rollout of the InterRAI assessment tool for which Canterbury is taking a lead in the South Island.

Canterbury will continue to participate in the national work streams led by the National Health Board, National Health IT Board, Health Quality and Safety Commission and Health Workforce New Zealand.

[37] *The Integrated Planning Recovery Guide, Version 2.0. Christchurch 2011: CCC and CDHB. http://www.cph.co.nz.*

4.8 Subsidiary companies

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

Brackenridge Estate Limited was incorporated in 1998 and provides residential care, respite services and day programmes for people with intellectual disability and high dependency needs. Brackenridge operates a range of houses on its site and in the community. Funding for Brackenridge comes from two sources: a contract directly with the Ministry of Health and contracts with the Ministry of Social Development. Brackenridge is working through a strategic planning process, including consideration of its future ownership, with the view to, at some stage, transition to non-DHB ownership.

Canterbury Laundry Service Limited was incorporated as a company in February 1993. The Canterbury DHB owns all shares, as well as 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 the major fixed assets of the company, which pays a rental to the DHB for the use of the land and buildings. The company provides laundry services to DHB hospitals and a range of external clients.

Canterbury is also a joint shareholder in the *South Island Shared Services Agency Limited* (SISSAL), which is wholly owned by the five South Island DHBs. The company remains in existence; however, following the move to a regional alliance framework, the staff will now operate as a service to South Island DHBs from within the employment and ownership of the Canterbury DHB, as the ***South Island Alliance Programme Office*** (SIAPO).

Legal transfer of the employees has taken place, and transfer of the assets is being progressed. The company will be retained as a shell, pending dissolution. SIAPO is funded jointly by the South Island DHBs to provide services such as contract and provider management, audit, analysis, service development and project management with an annual budget of around $3.4m.

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

4.9 Accountability to the Minister

As a Crown entity, the DHB must have regard for Government legislation and policy as directed by the Minister of Health. As appropriate, and required by legislation, we will engage the Minister in discussion and seek prior approval before making any significant service change. The DHB will also inform the Minister of any proposals for significant capital investment or the disposal of Crown land. We will also comply with requirements in relation to any specific consultation expectations that the Minister communicates to us.

The Crown Entities Act requires the DHB to report annually to Parliament on our performance, as judged against our Statement of Intent, and to publish this account as our Annual Report.

In addition, we will comply with reporting requirements and obligations in the Crown Entities Act and Operational Policy Framework and with specific expectations that the Minister communicates to us. This includes ad-hoc information reports, service agreement reporting and the following regular formal reporting provided to the National Health Board:

- Annual Reports and Audited Financial Statements;
- Quarterly non-financial performance reports;
- Quarterly health target reports;
- Quarterly reports on service delivery against plan;
- Bi-annual risk reports;
- Monthly financial reports; and
- Monthly wait time and ESPI compliance reporting.

The DHB also meets requirements with respect to national data collection including: ethnicity reporting, national health index (NHI), national minimum dataset (NMDS), national booking reporting system (NBRS), national immunisation register (NIR) and national non-admitted patient collection (NNPAC).

Service Configuration

5.1 A flexible and responsive health system

As we move ahead with our transformation and respond to the after-effects of the Canterbury earthquakes, it is also critical that we are able to reorient and rebalance our system to make the most effective use of the limited resources available to enable us to do more for our population.

Flexibility in our approach over the past 18 months has enabled us to continue to deliver core health services in the face of significant disruption and constraint. Unfortunately sometimes traditional policy and service change processes can delay decision-making and take it away from the front line of service provision.

To enable our recovery, we will seek support from the Ministry to be more flexible in the way we fund, contract and deliver health services in order to act responsively and decisively to support the immediate needs of our population. We will also seek support for contracting outside of national processes in areas such as pharmacy, laboratories, primary care and aged care services to allow for further innovation and management of capacity constraints.

Service coverage

The service coverage schedule between the DHB and the Ministry is the translation of Government policy into the required minimum level and standard of service to be made available to the public.

In our current extraordinary circumstances, it is likely that the way in which some services are delivered will have to be adjusted to allow for providers' short-term capacity constraints and the movement of services as we undertake the extensive and invasive facility repairs.

However, whilst we may have to deliver services differently and from different locations, we do not seek any immediate exceptions to the Service Coverage Schedule for the coming year.

Ongoing review and development of local and regional patient pathways will identify any service coverage issues and gaps. We will also monitor service risks through analysis of demand trends, risk reporting and formal audit and compliance mechanisms. We will keep the Ministry informed of any service coverage gaps that become apparent over the next year.

Service change

We anticipate that new models of care and delivery will continue to emerge as we respond to the immediate needs of our population and rebuild our capacity.

In line with Canterbury's shared decision-making approach, decisions regarding how a service should be delivered are made collectively and as close to the front line of service delivery as possible. Therefore, while we can anticipate change and articulate the outcomes we seek, we cannot pre-empt the extent or detail of any service change.

The DHB is required to notify the Minister of Health before making any significant service change, and we will continue to keep the Minister and Ministry informed of any service changes.

Significant service changes anticipated over the coming year fit into five categories and are aligned to previously approved plans and direction:

Service shifts or reconfiguration to support the repair of infrastructure or the provision of services with reduced capacity - in line with our transitional recovery plan.

The redesign of service models across hospital and specialist services to improve patient safety, clinical quality and productivity - in line with Vision 2020, our 'Improving the Patient Journey' Programme and our Quality Strategic Plan.

The redesign of service models across the whole system to build capacity to responsively meet both immediate needs and future demand and to improve health outcomes in line with Vision 2020 and the CCN '*Better, Sooner, More Convenient*' Business Case.

Regional service shifts or reconfiguration of service models to support regional consistency and equity of access, ensure the sustainability of vulnerable services and improve health outcomes for the South Island population in line with the Regional South Island Health Services Plan.

National service redesign or change to policy to align processes with national policy, implement Government strategies and meet the expectations of our Minister.

Canterbury has a policy of ongoing participatory engagement, and we will keep a steady stream of information flowing across the sector on the planned transformation of any services. Any service changes will also be carefully considered so as not to destabilise or negatively affect our neighbouring DHBs.

Service risks and opportunities

Our greatest service risk going into the next 12 months is simply dealing with the unknown. There is no basis upon which to predict activity and demand after the earthquakes and no comparable situation to draw upon.

We will continue our open dialogue with the Ministry in regards to our recovery and any service coverage issues or risks that become apparent.

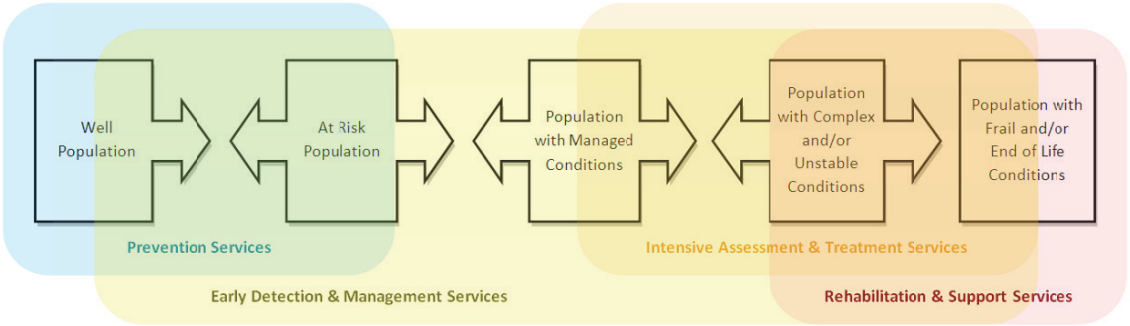
Forecast of Service Performance

Measuring our performance

As the major funder and provider of health and disability services in Canterbury, we aim to make positive changes in the health status of our population. The decisions we make about which services will be funded and delivered will have a significant impact on the health of our population and will improve the effectiveness of the whole Canterbury health system.

FIGURE 7: SCOPE OF DHB OPERATIONS – OUTPUT CLASSES AGAINST THE CONTINUUM OF CARE

Our outputs cover the full continuum of care for our population.



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

One of the functions of this document is to demonstrate how we will evaluate the effectiveness of the decisions we make. Over the longer-term we do this by measuring our performance against a set of desired outcomes (outlined in the strategic direction section of this document on page 17).

In the more immediate term, we evaluate our performance by providing a forecast of our planned performance (what services or 'outputs' we will deliver in the coming year). We then report actual performance against this forecast in our end-of-year Annual Report.[38]

Choosing measures of performance

In order to present a representative picture of performance, our outputs have been grouped into four '*output classes*' that are a logical fit with the stages of the continuum care and are applicable to all DHBs:

- Prevention Services;
- Early Detection and Management Services;
- Intensive Assessment and Treatment Services; and
- Rehabilitation and Support Services.

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

In order to best demonstrate this, we have chosen to present our forecast of service performance using a mix of output measures. These measure Timeliness, Coverage, Volume and Quality - all of which help us to evaluate different aspects of our performance and against which we have set targets to demonstrate the standard expected.

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

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

[38] *DHB Annual Reports can be found at www.cdhb.govt.nz.*

In some cases the DHB will measure the number of people 'trained' in a particular programme or method, to give further assurance of quality provision and of the capacity of the system to deliver these services.

Setting standards

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

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

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

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

Measures that relate to new services have no baseline data. A number of the output measures also relate to Canterbury-specific services for which there is no national comparison or national average available. These instances have been noted.

It is also important to note a significant proportion of the services funded/provided by the DHB are driven by demand – such as laboratories tests, emergency care, maternity services, mental health services, aged residential care and palliative care. Estimated service volumes have been provided to give the reader context in terms of the use of resource and capacity across the Canterbury system. However these estimated volumes are not seen as targets and are not set as such – they are provided for information to give context to the picture of performance.

Additional Notes:

Some data is provided to the DHB by external parties and is provided by calendar and not financial years; other data can be affected by a lag in invoicing and is subject to change by late claims. Rather than footnote every instance, symbols are used to indicate where this is the case: † indicates data provided on calendar not financial year. Δ indicates data that could be affected by a lag in invoicing and is subject to change; data for such measures in this document was run on or before 19 June 2012.

Where does the money go?

The table below presents a summary of the 2012/13 budgeted financial expectations by output class.

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

REVENUE	TOTAL
Prevention	$29,314,765
Early detection and management	$357,447,134
Intensive assessment & treatment	$843,396,477
Support & rehabilitation	$220,719,624
Grand Total	**$1,450,878,000**

EXPENDITURE	TOTAL
Prevention	$33,293,879
Early detection and management	$358,638,644
Intensive assessment & treatment	$876,072,200
Support & rehabilitation	$222,879,277
Grand Total	**$1,490,884,000**
Deficit	**($40,006,000)**

OUTPUT CLASS

6.1 Prevention services

Output class description

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

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

Why is this output class significant for the DHB?

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

Successful provision of these services will reduce risk factors such as smoking and improve positive behaviours such as breastfeeding, healthier diets and regular exercise – which will improve the overall health and wellbeing of our population.

OUTPUTS SHORT-TERM PERFORMANCE MEASURES (2012/13)

Health Promotion and Education Services *These services inform people about risks and support them to be healthy. Success begins with awareness and engagement, reinforced by programmes and legislation that support people to maintain wellness and make healthier choices.*	Notes	Actual 2010/11	Target 2012/13	Current National Average
Volunteer mothers are engaged in Mum 4 Mum peer support training	V [39]	22	50	-
The proportion of new mothers establishing breastfeeding on hospital discharge.	Q [40]	86%	≥85%	-
Smokers identified in hospital receive smoking cessation advice and support.	C	74%	95%	85%
Smokers identified in primary care receive smoking cessation advice and support.	C	14%	90%	26%
Smokers participate in the Aukati Kaipaipa smoking cessation programme.	V	279	≥200	-
The proportion of tobacco retailers compliant with current legislation.	Q [41]	90%	≥90%	-
Priority schools are supported by the Health Promoting Schools framework.	C [42]	57%	70%	-
'Appetite for Life' courses are provided in the community.	V [43]	81	90	-
Green Prescriptions are provided to people needing physical activity support.	V [44]	1,621	≥1,500	-

[39] *Mum4Mum training supports social change by allowing the DHB to significantly increase its capacity to deliver key messages through informal contact facilitated by appropriately trained volunteer mothers. The measure is the number of mothers trained.*

[40] *The proportion of women breastfeeding is seen as a measure of service quality, demonstrating the effectiveness of consistent, collective health promotion messages delivered during the antenatal, birthing and early postnatal period.*

[41] *The proportion of compliant retailers is seen as a measure of service quality, demonstrating the effectiveness of the information, training, support and advice provided to retailers.*

[42] *The Health Promoting Schools Framework is used to address health issues with an approach based on activities within the school setting that can impact on health. 'Priority' schools are low decile, rurally isolated and/or have a high proportion of Māori and/or Pacific children.*

[43] *AFL is a healthy lifestyle programme that helps participants make positive changes to the habits that have led to their weight gain.*

[44] *A Green Prescription is a health professional's written advice to a patient to be physically active, as part of their health management.*

Population Based Screening Services *These services are mostly funded and provided through the National Screening Unit and help to identify people at risk of illness and pick up conditions earlier. They include breast and cervical cancer screening and antenatal HIV screening. The DHB's role is to encourage uptake, as indicated by high coverage rates.*	Notes	Actual 2010/11	Target 2012/13	Current National Average
Children (aged 4) are provided with B4 School Health Checks.	C [45]	71%	80%	-
Children referred by CYF are provided with Gateway Assessments.	C	new	100%	new
Eligible women (20-69) have a cervical cancer screen every three years.	C [46]	72%	75%	72%
Eligible women (45-69) have a breast screen examination every two years.	C [46]	83%	≥70%	68.7%

Immunisation Services *These services reduce the transmission and impact of vaccine-preventable diseases. The DHB works with primary care and allied health professionals to improve the provision of immunisations both routinely and in response to specific risk. A high coverage rate is indicative of a well-coordinated, successful service.*	Notes	Actual 2010/11	Target 2012/13	Current National Average
Children are fully immunised at eight months of age.	C	new	85%	new
The proportion of the children (aged 2) 'reached' by immunisation services.	Q	97%	≥95%	95%
Eligible young women (12-18) are engaged in the HPV vaccination programme.	C [47]	46%	≥46%	53%
Young people (<18) receive a free influenza ('flu') vaccination.	C	21%	40%	-
Older people (65+) receive a free influenza ('flu') vaccination.	C †	74%	75%	65%
The total number of older people (65+) receiving a free influenza vaccination.	V [48] †	50,025	≥53,000	-

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

[46] These national screening programmes screen women for signs of breast and cervical cancer to enable early treatment to reduce the rate of associated mortality. Standards are based on national targets; Canterbury aims to deliver at a level above these national targets. Breast screening results are for the two years to May 2011, while the national average is for the two years to June 2010.

[47] The measure is based on young women 12-18 who have been provided with Dose 1. The national average is based on the 'major' six DHBs. Like childhood immunisation rates, HPV immunisation rates will be negatively affected by displacement in Christchurch. The lower target reflects the work that will need to be done to reconnect people with their general practice and re-establish immunisation rates.

[48] The volume target is based on the number of vaccinations required to achieve 75% coverage and assumes an enrolled population of 70,752 (Jan 2012). The volume is important, as significant population growth for this age group means an increased volume must be delivered year on year to maintain the same percentage coverage across the population.

OUTPUT CLASS

6.2 Early detection and management services

Output class description

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

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

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

Why is this output class significant for the DHB?

New Zealand is experiencing an increasing prevalence of long-term conditions, so called because once diagnosed people usually have them for the rest of their lives. Some population groups suffer from these conditions more than others, and prevalence also increases with age. The associated increase in demand for services includes an increasing demand for acute and urgent care services that, in Canterbury, is growing at a faster rate than our population.

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

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

OUTPUTS SHORT-TERM PERFORMANCE MEASURES (2012/13)

Primary Health Care (GP) Services *These services are offered in local community settings by teams of general practitioners (GPs), registered nurses, nurse practitioners and other primary healthcare professionals, aimed at improving, maintaining or restoring people's health. High levels of enrolment with general practice are indicative of engagement, accessibility and responsiveness of primary care services.*	Notes	Actual 2010/11	Target 2012/13	Current National Average
Newborn babies (<2 weeks) are enrolled with a GP or WellChild provider.	C	new	90%	new
The Canterbury population is enrolled with a Primary Health Organisation.	C	97%	≥95%	96%
Integrated patient pathways are established across primary/secondary care.	V [49]	363	>470	-
People are provided Brief Intervention Counselling (BIC) in primary care settings.	V [50] Δ	4,873	≥4,000	-
Avoidable hospitalisation rates for children (0-4) remain below the national rate.	Q [51]	97%	≤95%	100%

[49] *These clinically designed pathways inform new patient-centred models of care. The HealthPathways website helps general practice navigate the pathways, with information on referrals, specialist advice, diagnostic tools, GP procedure subsidies and patient handouts. The measure includes clinical, resource and referral pathways.*

[50] *The Brief Intervention Coordination Service provides people with mild to moderate mental health concerns up to 5 sessions of free 'early' psychological intervention from their general practice teams, with the possibility of onward referral to a related community agency if appropriate. The aim is to provide early intervention and help people to reduce the likelihood of developing enduring conditions.*

[51] *Some admissions to hospital are seen as preventable through appropriate early intervention. These admissions provide an indication of the access and effectiveness of primary care and an improved interface between primary and secondary services. The measure is the national DHB performance indicator SI1, defined as the standardised rate per 100,000 for Canterbury divided by the standardised rate per 100,000 for NZ. A lower percentage is better, indicating a lower avoidable hospitalisation rate than the national average of 100%.*

Oral Health Services *These services are provided by registered oral health professionals to help people maintain healthy teeth and gums. High enrolment indicates engagement, while timely examination and treatment indicates a well-functioning, efficient service.*	Notes	Actual 2010/11	Target 2012/13	Current National Average
Children (<5) are enrolled in oral health services.	C †	66%	66%	60%
Enrolled children (0-12) are examined according to planned recall.	T †	85%	90%	89%
Adolescents (13-17) access DHB-funded oral health services.	C †	67%	75%	68%

Long-term Conditions Programmes *These services are targeted at people with high health need due to long-term conditions and aim to reduce deterioration, crises and complications. Success is demonstrated through identification of need, regular monitoring and outcomes that demonstrate good conditions management. A focus on early intervention strategies and additional services available in the community will help to reduce the negative impact of long-term conditions and the need for hospital admission.*	Notes	Actual 2010/11	Target 2012/13	Current National Average
People with diabetes are supported to manage their condition by their GP.	C [52]	49%	52%	68%
People with CVD risk have a CVD Risk Assessment once every 5 years.	C [53]	14%	75%	39%
Skin lesions (skin growths, including cancer) are removed in primary care.	V Δ	2,059	≥2,000	-
Spirometry tests are provided in community rather than hospital settings.	V [54] Δ	1,118	≥1,000	-

Pharmacy Services *These services include dispensing of medicines and are demand-driven. As long-term conditions become more prevalent, demand for pharmaceuticals will likely increase. To improve service quality, we will introduce medication management for those on multiple medications to reduce potential negative interactive effects.*	Notes	Actual 2010/11	Target 2012/13	Current National Average
Total number of pharmaceutical items dispensed in the community.	V Δ	8.4M	est. <9M	-
Medication reviews are provided for older people on multiple medications.	V	new	2,000	-

Referred Services *These are services to which a health professional may refer a person to help diagnose a health condition, or as part of treatment. They are provided by personnel such as laboratory technicians, medical radiation technologists and nurses. To improve performance, we will target improved primary care access to diagnostics to improve clinical referral processes and decision-making.*	Notes	Actual 2010/11	Target 2012/13	Current National Average
Total number of laboratory tests completed.	V Δ	2.3M	est. <2.6M	-
Total number of GP referred Community Referred Radiology tests completed.	V	29,399	est.>30,000	-
The proportion of Community Referred Radiology tests accepted.	Q [55]	88%	90%	-
People receive their elective coronary angiogram procedure within 3 months.	T	new	85%	new
People receive their Computed Tomography (CT) scans within 6 weeks.	T	new	75%	new
People receive their Magnetic Resonance Imaging (MRI) scans within 6 weeks.	T	new	75%	new

[52] This measure differs from the former diabetes annual review Health Target, which has been discontinued nationally. Data is currently being sourced from the PHO Performance Programme.

[53] This refers to CVD risk assessments undertaken in primary care in line with the expectations of the PHO Performance Programme and the new 'More heart and diabetes checks' health target. Partnership, Canterbury's largest PHO, has been participating in the CVD risk assessment programme for less than 2 years compared to some PHOs who have been participating for over 4 years. Work is underway to establish alternative means of identifying people whose risk was assessed within the last 5 years prior to Partnership joining.

[54] Spirometry is a tool for measuring lung function, assisting in the assessment of a range of respiratory conditions and providing this service in the community means people do not need to wait for a hospital appointment. Community spirometry volumes include those delivered by both GPs and mobile community respiratory providers.

[55] The acceptance rate of community referred radiology tests is seen as a measure of service quality, by demonstrating the appropriateness of the referrals being received and therefore the quality of the education, information and support being provided to referrers.

OUTPUT CLASS

6.3 Intensive assessment and treatment services

Output class description

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

The Canterbury DHB provides an extensive range of intensive treatment and complex specialist services to its population – and to the populations of other DHBs that do not provide the most complex services in their own regions. The DHB also funds some intensive assessment and treatment services for its population that are provided by other DHBs, private hospitals or private providers. A proportion of these services are driven by demand which the DHB must meet, such as acute and maternity services. However, others are planned services for which provision and access are determined by capacity, clinical triage, national service coverage agreements and treatment thresholds.

Why is this output class significant for the DHB?

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

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

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

OUTPUTS SHORT-TERM PERFORMANCE MEASURES (2012/13)

Specialist Mental Health Services *These are services for those most severely affected by mental illness or addictions. They include assessment, diagnosis, treatment, rehabilitation and crisis response when needed. Utilisation and wait times are monitored to ensure service levels are maintained and to demonstrate responsiveness to need.*	Notes	Actual 2010/11	Target 2012/13	Current National Average
Young people (0-19) have access to specialist mental health services.	C [56] Δ	2.4%	≥3%	2.8%
Adults (20-64) have access to specialist mental health services (SMHS).	C [56] Δ	2.9%	≥2.5%	3.4%
People referred for non-urgent MH and AOD services are seen within 3 weeks.	T	74%	≥75%	65%
People referred for non-urgent MH and AOD services are seen within 8 weeks.	T	86%	≥70%	77%
The proportion of long-term clients (0 -19) with current relapse prevention plans.	Q [57]	78%	≥95%	80%
The proportion of long-term clients (20-64) with current relapse prevention plans.	Q [57]	94%	≥95%	86%

[56] *The national expectation is that around 3% of the total population will need to access specialist mental health service. This measure includes specialised services provided by the DHB and NGOs (who submit NHI level reporting). The national average is to September 2011.*

[57] *Relapse prevention/resiliency planning helps to minimise the impact of mental illness, improving outcomes for clients. Clients with enduring serious mental illness are expected to have an up-to-date plan identifying early warning signs and what actions to take.*

Acute/Urgent Services *These are medical or surgical services for illnesses that have an abrupt onset or progress rapidly. While the need for care is urgent it does not always require a hospital admission. There are a number of acute and urgent community-based approaches, unique to Canterbury, that have been established to reduce acute demand on hospital services in light of lost capacity post-quake. For more complex acute conditions, hospital-based services include emergency services, short-stay acute assessment, acute medical and surgical services and intensive care services.*	Notes	Actual 2010/11	Target 2012/13	Current National Average
Children under six have access to free primary care after hours.	C	new	75%	new
General Practices provide access to telephone triage outside business hours.	C	81%	95%	-
Acute Demand Packages of Care are provided in community settings.	V [58]	16,510	18,000	-
Total number of people presenting at hospital emergency departments.	V	85,056	est.<92,000	-
People receive chemotherapy within 4 weeks of the decision to treat.	T	100%	100%	-
Reporting rates for medication, IV & blood incidents increase.	Q [59]	1.65	≥2.3	-
Staph Aureus HABSIs infection rates decrease.	Q [60]	new	≤0.04	-

Elective/Arranged Services *These are services for people who do not need immediate hospital treatment and are 'booked' or 'arranged' services. This includes elective surgery, but also non-surgical interventions (such as coronary angioplasty) and specialist assessments (either first assessments, follow-ups or preadmission assessments).*	Notes	Actual 2010/11	Target 2012/13	Current National Average
Total number of surgical First Specialist Assessments (FSAs) provided.	V	35,006	est.>38,000	-
The proportion of surgical FSAs that are non-contact (virtual).	Q [61]	3.5%	4.5%	-
Total number of elective surgical discharges (surgeries provided).	V [62]	14,974	16,110	-
Proportion of elective/arranged surgeries provided as day cases.	Q [63]	55%	57.8%	56%
Proportion of people who receive their surgery on the day of admission.	Q[63]	79%	82%	81%
Elective/Arranged inpatient length of stay (days) is maintained.	Q [63]	3.8	≤4.0	-
Total number of outpatient attendances.	V	578,196	est.>600,000	-
Outpatient 'Did not Attend' rates are reduced.	Q	5.5%	≤5%	-

[58] *Acute demand or acute admission avoidable packages of care allow people who would otherwise require a hospital admission to be treated in their own homes or community through Canterbury's Acute Demand Management Service (ADMS).*

[59] *Targets for medication, IV and blood incidents are set to increase the rate of reported incidents, in line with our policy of open disclosure of events. Achievement reflects transparency and willingness of staff to learn from events and prevent them from reoccurring. This measure is per 1,000 inpatient bed days.*

[60] *Staphylococcus aureus is often found in the nose or on the skin of healthy people, causing them no harm. However, Staph aureus can cause infection, and hospitalised patients are at greater risk because they are unwell and have lowered resistance to infection. It is transmitted via contact with people already carrying the bacteria, or through improperly washed hands, surfaces or equipment; therefore, rates of Staph aureus in hospital can reflect the effectiveness of infection control procedures. This measure is per 1,000 inpatient bed days and is now using the Australian Council of Healthcare Standards (ACHS) and Centres for Disease and Control (CDC) HABSI definition.*

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

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

[63] *When elective surgery is delivered as a day case or on the day of admission, it makes surgery less disruptive for patients who can spend the night before in their own homes and frees up hospital beds where capacity in tight due to the earthquake. Day case, day of admission rates and average length of stay are balanced against readmissions rates to ensure service quality is appropriate. These measures are based on the OS6 and OS7 national performance measures set for DHBs.*

Maternity Services *These services are provided to women and their families through pre-conception, pregnancy, childbirth and for the first months of a baby's life. These services are provided in home, community and hospital settings by a range of health professionals, including midwives, GPs and obstetricians and include: specialist obstetric, lactation, anaesthetic, paediatric and radiology services. We will monitor volumes in this area to determine access and responsiveness of services.*	Notes	Actual 2010/11	Target 2012/13	Current National Average
Total number of maternity deliveries in Canterbury DHB facilities.	V	6,175	est.>6,000	-
Baby friendly hospital accreditation is maintained.	Q[64]	yes	yes	-
The proportion of total deliveries, made in Primary Birthing Units.	V [65]	12%	≥13%	-

Assessment, Treatment and Rehabilitation Services (AT&R) *These are services provided to restore functional ability and enable people to live as independently as possible. Services are delivered in specialist inpatient units, outpatient clinics and also in home and work environments. An increase in the rate of people discharged home with support, rather than to residential care or hospital environments, (where appropriate) is indicative of the responsiveness of services.*	Notes	Actual 2010/11	Target 2012/13	Current National Average
Total number of admissions for older people (65+) into inpatient AT&R services.	V	3,188	est.>3,000	-
The proportion of admissions into AT&R (PMH) made by direct community referral	Q	20%	≥20%	-
The proportion of AT&R inpatients discharged to their own home rather than ARC.	Q[66]Δ	72%	≥70%	-

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

[65] *The DHB aims to increase people acceptance and confidence in using primary birthing units rather than having women birth in secondary or tertiary facilities when it is not needed, in order to make better use of resources and to ensure limited secondary services are more appropriately available for those women who need more complex or specialist intervention.*

[66] *While living in Aged Residential Care (ARC) is appropriate for a small proportion of our population, when people receive adequate support for their needs, remaining in their own homes provides a higher quality of life as a result of staying active and positively connected to their communities. Therefore, a discharge from AT&R to home (rather than ARC) reflects the quality of AT&R and community support services in terms of assisting that person to regain their functional independence so that, with appropriate community supports, the person is able to safely 'age in place'.*

OUTPUT CLASS

6.4 Rehabilitation and support services

Output class description

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

Support services also include palliative care services for people who have end-stage conditions. It is important that they and their families are appropriately supported, so that the person is able to live comfortably, have their needs met in a holistic and respectful way and die without undue pain and suffering. Delivery of these services is likely to include coordination with many other organisations and agencies and may include public, private and part-funding arrangements.

Why is this output class significant for the DHB?

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

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

While living in Aged Residential Care (ARC) is appropriate for a small proportion of our population, Canterbury rates are above national averages. Living in ARC has also been associated with a more rapid functional decline than 'ageing in place' and is a more expensive option. Resources could be better spent providing appropriate levels of support to people to help them stay in their own homes and to moderate the need for residential care and hospital level services.

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

OUTPUTS SHORT-TERM PERFORMANCE MEASURES (2012/13)

Needs Assessment and Services Coordination Services *These are services that determine a person's eligibility and need for publicly funded support and the best mix of supports based on the person's strengths, resources and goals. The supports are delivered by an integrated team in the person's own home or community. The delivery of assessments and the use of evidence-based tools indicate quality, equity of access and responsiveness.*	Notes	Actual 2010/11	Target 2012/13	Current National Average
Total number of older people (65+) provided with a clinical assessment of need.	V Δ	7,551	est.>8,000	-
People 65+ receiving long-term HBSS have a comprehensive clinical assessment.	Q [67] Δ	77%	85%	-
People entering ARC have a clinical assessment of need using the InterRAI tool.	Q [68] Δ	new	90%	-

[67] *Comprehensive clinical assessment ensures that service decisions are based on a robust, internationally verified assessment tool so that the level of support provided matches a person's level of need and people receive equitable access to support.*

[68] *InterRAI is an evidence-based geriatric assessment tool. Using InterRAI ensures assessments are high quality and consistent so that people receive equitable access to support and care. InterRAI also supports improved integration by providing health professionals with a common language of assessment and an electronic means of transferring information. This measure includes all people entering ARC.*

Palliative Care Services *These are services that improve the quality of life of patients and their families facing life-threatening illness, through the prevention and relief of suffering by means of early intervention, assessment, treatment of pain and other supports.*	Notes	Actual 2010/11	Target 2012/13	Current National Average
Total number of people supported by hospice or home-based palliative services.	V Δ	3,160	est.>2,000	-
Total number of ARC facilities trained to provide the Liverpool Care Pathway.	V [69]	23	40	-

Rehabilitation Services *These services restore or maximise people's health or functional ability following a health-related event. They include mental health community support, physical or occupation therapy, treatment of pain or inflammation and retraining to compensate for specific lost functions. Success is measured through increased referral of the right people to these services.*	Notes	Actual 2010/11	Target 2012/13	Current National Average
People are referred to stroke rehabilitation services after an acute event.	C [70]	71%	≥70%	-
People are referred to cardiac rehabilitation services after an acute event.	C	27%	≥30%	-
People have access to community-based pulmonary rehabilitation courses.	V	108	≥108	-
Older people have access to community-based falls prevention programmes.	V [71]	new	800	new

Home-Based Support Services *These are services designed to support people to continue living in their own homes and to restore functional independence. They may be short or longer-term in nature. An increase in the number of people being supported is indicative of increased capacity in the system, and success is measured against decreased or delayed entry into residential or hospital services.*	Notes	Actual 2010/11	Target 2012/13	Current National Average
Total number of people supported by home based support services.	V Δ	8,420	est.>8,400	-
Total number of people supported by district nursing services.	V Δ	6,008	est.>6000	-
Older people have access to CREST services on hospital discharge or GP referral.	V [72]	166	1,100	-
The proportion of people accessing CREST acutely readmitted to hospital.	Q[73]	3% reduction	10% reduction	-

Respite and Day Services *These services provide people with a break from a routine or regimented programme so that crisis can be averted or so that a specific health need can be addressed. Services are provided by specialised organisations and are usually short-term or temporary in nature. They may also include support and respite for families, caregivers and others affected. Services are expected to increase over time, as more people are supported to remain in their own homes.*	Notes	Actual 2010/11	Target 2012/13	Current National Average
Total number of older people supported by day services.	V Δ	671	est.>550	-
Total number of individuals accessing mental health planned and crisis respite.	C Δ	798	Est.>800	-
Occupancy rate of mental health planned and crisis respite beds.	C [74] Δ	77%	≥85%	-

[69] *The Liverpool Care Pathway is an international programme adopted nationally and reflects best-practice care. It begins with training of staff with the eventual aim of increasing the number of people supported by the pathway.*

[70] *The 2010/11 baseline is for quarters 1-3 only, as data capture was compromised following the February earthquake.*

[71] *This measure refers to Canterbury's Integrated Falls Prevention Service which launched in February 2012. The service seeks to support older people to maintain their independence and live safely in their own homes and communities, reducing harm as a result of falls.*

[72] *The CREST service began in April 2011 and facilitates early discharge from hospital to appropriate home-based rehabilitation.*

[73] *This target is measured against the readmission rates for the 65+ population not receiving CREST services.*

[74] *Occupancy rates provide an indication of a service's 'capacity'. The aim is to maintain enough beds to meet demand requirements (with some space to flex) but not too many to imply that resources are underutilised and could be better directly to other areas.*

Residential Care Services *These services are provided to meet the needs of a person who has been assessed as requiring long-term residential care in a hospital or rest home indefinitely. With an ageing population, a decrease in the number of subsidised bed days is seen as indicative of more people being successfully supported to continue living in their own homes and is balanced against the level of home-based support.*	Notes	Actual 2010/11	Target 2012/13	Current National Average
Total number of (subsidised) ARC rest home beds provided (days).	V [75] Δ	666,342	est.<676,000	-
Total number of (subsidised) ARC hospital beds provided (days).	V [75] Δ	495,442	est.<507,000	-
Total number of (subsidised) ARC dementia beds provided (days).	V [75] Δ	212,445	est.>212,000	-
Total number of (subsidised) ARC psycho-geriatric beds provided (days).	V [75] Δ	62,430	est.>62,000	-
ARC residents receive vitamin D supplements.	C	new	75%	new
Rate of acute admissions into hospital services from ARC facilities is maintained.	Q[76] Δ	3.9%	≤4.0%	-

[75] *These measures are based on estimates made prior to the earthquakes and loss of ARC capacity; it is likely that they will drop against an increase in home-based support, district nursing and CREST services as people are supported in their own homes.*

[76] *The denominator for this measure is the total number of acute admissions into hospital.*

Financial Performance 2012-2015

Fiscal sustainability

While health continues to receive a large share of national funding, clear signals have been given that Government is looking to the whole of the health sector to rethink how we will meet the needs of our populations with a more moderate growth platform. The Minister of Health expects DHBs to operate within existing resources and approved budgets and to work collaboratively to ensure service delivery is clinically and financially sustainable.

7.1 Meeting our financial challenges

Like all DHBs, Canterbury faces significant fiscal pressures: the costs of meeting wage and salary increases; demand for diagnostics and residential care; rising prices and treatment-related costs; and increased public expectations - particularly around the availability of new and more technologically advanced treatments.

Despite these pressures, prior to the earthquakes Canterbury was on track to deliver a break-even financial performance. The earthquakes and ongoing aftershocks have resulted in unplanned net expenditure and costs of over $26m to date. These cost impacts are expected to continue to influence our financial results over a number of years. This has been evidenced in various types of expenditure, from the securing of external capacity to support our service delivery, through to emergency repairs and maintenance.

As a direct result of the earthquakes, Canterbury's raw 2011/12 financial result was estimated to be a $10m deficit. The Ministry of Health has provided a further $10m of revenue to eliminate this deficit.

The total cost of the earthquakes is still an unknown factor. We are unable to predict the final interplay between the costs of repairs and insurance recovery and the impact of new Building Codes on repair costs. However, we do know that a significant proportion of remedial work to buildings will not be covered by insurance proceeds, particularly where repairs are to attain moderate compliance with the updated building codes. We are also unable to predict the likely increase in demand for services from a vulnerable population under stress for more than 18 months. This uncertainty creates an unprecedented level of financial volatility, particularly in regards to the long-term outlook.

There is no 'quick-fix' solution. To ensure our health system is clinically and financially sustainable, we have focused on making decisions that are 'best for patient and best for system'. Canterbury was already investing in this direction pre-quake to meet the challenges we faced, and we will have to redouble our efforts to cope with the added pressures of our earthquake recovery.

Constraining cost growth is critical to our success. If an increasing share of our funding continues to be directed into meeting the cost of providing services, our ability to maintain current levels of service will be at risk. We will also be severely restricted in terms of our ability to invest in new equipment, technology and initiatives that will allow us to meet future demand. This would be further exacerbated by revenue volatility driven by population fluctuations.

It is also critical that we continue to rebalance our health system. By integrating and improving the quality of the care we provide, we can reduce rework (readmissions) and duplication, avoid unnecessary expenditure and do more (and see more people) within our current resources.

Canterbury's future is not about doing more of the same, but doing more with the same.

7.2 Financial outlook

Revenue from the Government (via the Ministry of Health) is the main source of DHB funding. This is supplemented by additional funding from side agreements with organisations such as the Accident Compensation Corporation and payments from other DHBs for services provided to their populations.

For 2012/13 we are forecasting that Canterbury's funding, excluding non-Government-related revenue, will increase by approximately $8m (2011/12 $38m). This has been significantly affected by the recent changes in population trends; however, we are not seeing a corresponding decline in demand for services.

With capacity still restricted across Canterbury after the earthquakes, it is vital that we focus our investment on restorative models of care and services that support people to stay well and reduce hospital admissions and demand for Aged Residential Care (ARC) beds.

We are continuing to apply additional expenditure to primary and community services (including district nursing and home-based support) in order to support our recovery, manage predicted increases in demand, and support people in their own homes and communities rather than in hospital and ARC.

Out-years scenario

The current reality facing Canterbury is that there is a high level of uncertainty and variability related to both revenue and expenditure in out-years, dependant on a variety of assumptions. These assumptions relate to a wide variety of interrelated factors, and include: revenue volatility based on population shifts; changing health demands in the post-earthquake environment; population deprivation changes; earthquake repair cost variability; decisions and timing around facilities redevelopment plans; costs of building repairs not covered by insurance; and the timing and extent of insurance proceeds.

Given the sheer level of unpredictability, we do not feel it is prudent to provide one likely out-year scenario. Instead, in the interests of transparency, three potential scenarios have been provided, each based on a number of assumptions and variables, to provide stakeholders with a sense of how these volatile external factors may influence our financial results.

However, it is important to note that these scenarios do not represent the limit of extremes, merely the modelling of significant shifts in population assumptions (and the downstream impacts on funding that this has). We have not performed significant modelling of repair cost variables, nor major shifts in service trends. Any change in the complex mix of contributory factors will drive results that will differ significantly from those shown here.

Living within our means

In order to meet the expectations of the Minister of Health the Canterbury DHB will continue to focus on strategies to constrain cost growth and rebalance our health system. These strategies are reflected throughout this document.

- Reducing variation, duplication and waste.
- Doing the basics well and understanding our core business – best for patient, best for system.
- Investing in clinical leadership and clinical input into operational processes and decision-making.
- Developing workforce capacity and supporting integrated, less traditional workforce models.
- Realigning service expenditure to better manage the pressure of demand growth and support a system with reduced bed capacity.
- Supporting unified systems to share resources and enable clinical decision-making at the point of care to reduce delays and improve the quality of care.

The DHB will actively support South Island Support Service Level Alliance and the identified work streams under this Alliance to implement tighter cost controls and make purchasing and productivity improvements to limit the rate of cost pressure growth.

The South Island Support Services Alliance has a clinical lead alongside the CEO sponsor and a clear goal of involving clinicians in the rationalisation and standardisation of products and services to reduce clinical risk and increase engagement in the programme and hence increase purchasing power. Clinicians and health professionals are best placed to identify technical efficiencies that will reduce duplication and waste.

The Canterbury DHB is taking a lead in a number of these work streams including the Procurement and Supply Chain work stream and will contribute to South Island savings of $15m predicated in the next year (using Health Benefits Limited methodology). Work streams focused on food, laundry, maintenance and engineering and clinical engineering services will be re-engaged (after being put on hold after the earthquakes) and regional work and saving plans identified by Q2.

Through the Alliance the DHB will also maintain and strengthen the relationship with Health Benefits Limited to assist them in their signalled intention of implementing an operation model in partnership with DHB to achieve mutual benefits and cost savings. The key actions to align Support Services activity with HBL work programmes are identified in the South Island Regional Health Services Plan available at www.sialliance.health.nz.

7.3 Assumptions

We have made the assumption that Canterbury will run a deficit for the 2012/13 financial year as a continued result of covering the cost of the earthquake.

We are aware that the costs around building and infrastructure repairs, insurance payments, and the additional costs of compliance with new Building Codes will be significant. However, like wider system impacts from the earthquakes and continuing aftershocks, these costs are not yet fully known - and where uncertain, have not been assumed in our forecasts.

We are also aware that there will be increased demand from a vulnerable population that has been under stress for more than 18 months. However there is no comparative situation we can use to make assumptions about the level of this demand and while we have made conservative predictions, this creates a level of uncertainty for the coming year.

In preparing our forecasts, we have made the following assumptions.

- Revenue and expenditure have been budgeted on current Government policy settings and known health service initiatives.
- Population based funding in 2012/13 will remain at the level indicated in December 2011.
- We will receive fair prices for services provided on behalf of other DHBs and the Crown, including paediatric Oncology services.
- The DHB will retain early payment arrangements.
- Costs of compliance with any new national expectations yet to be identified will be cost neutral or fully funded. Any future legislative

changes, sector reorganisation or service devolvement (during the term of this Plan) will be cost neutral or fully funded.

- The Ministry of Health will continue to fairly fund Canterbury for expenditure in relation to the recent series of earthquakes.
- There will be fluctuations between actual results and budget depending on both the costs and applicable accounting treatment of repairs to buildings, infrastructure, and equipment not covered by insurance recoveries. Due to the continuing emergent nature of current insurance claims, insurance proceeds as included in these financial forecasts have been limited to recognition of that which is virtually certain only, in line with current NZ accounting standards.
- There will be fluctuations between actual results and budget where repairs are covered by insurance and expenditure but recoveries cannot be recognised within the same financial year.
- There may potentially be further impairment on our land, buildings and infrastructure as a result of the earthquakes. However, the estimated impact has not yet been quantified; therefore, we have assumed there will be minimal financial impact.
- Work will continue on the Facilities Redevelopment Plan (for Christchurch Hospital and Older Persons' Health Specialist Services) in conjunction with decisions relating to earthquake repairs; however, no major facilities development or capital expenditure associated with the redevelopment will take place during the term of this Plan, unless specific prior approval has been given by the Minister of Health.
- Borrowings required to fund both our Facilities Redevelopment Plan and our seismic repair programme costs (those which are unfunded by insurance proceeds) will be available from an external source.
- Employee cost increases for expired wage agreements will be settled on fiscally sustainable terms, inclusive of step increases and the impact of accumulated leave revaluation.
- External provider increases will be made within available funding levels.
- Transformation and earthquake recovery strategies and programmes will not be delayed due to sector or legislative changes, and investment to meet increased demand will be prioritised and approved in line with our Board's strategy.
- Revenue and expenditure have been budgeted on current and expected operations with no assumption for costs or disruptions associated with further natural disasters, or with any pandemic.

7.4 Asset planning and investment

Business cases

In 2010 the DHB supported the Canterbury Clinical Network's submission of the business case for 'Better, Sooner, More Convenient' health care in Canterbury. This was approved by the Minister of Health, and 2012/13 will be year 3 of the implementation of this transformational plan. The initiatives and programmes planned for year 3 are outlined in Appendix 6 of this document, and will be funded within current allocations.

In 2010 the DHB also submitted a business case seeking approval for the redevelopment of Christchurch Hospital and Older Persons' Health Specialist Services. The Minister of Health has given approval to proceed with the development of the business case, including the investigation of suitability for a public/private partnership, and we will continue to progress this in the coming year.

Timeframes for the approval of this redevelopment/ rebuild are now particularly critical to avoid the substantial unnecessary costs of short-term structural upgrades that will not improve clinical suitability of facilities that are already unfit for service needs. Subject to approval, the required timelines for the redevelopment are: Burwood (Older Persons' Health Services) site by 2014 and Christchurch site by 2016.

These timeframes will need to be reconfirmed after consideration from a holistic perspective, particularly after recent direction from the Ministers Health and Treasury to explore the suitability of public/private partnerships, and the quantum of the earthquake-related repairs and required seismic compliance.

In the coming year the DHB will prepare a business case for the redevelopment of the Kaikoura Hospital site as an Integrated Family Health Centre, and the former Christchurch Women's Hospital site as a Community Hub. These business cases are expected to be delivered before the end of 2012/13.

Capital expenditure

Canterbury's capital expenditure budget totals $134m for the 2012/13 year, subject to appropriate approvals. In addition to normal clinical and other operational capital requirements, this includes the following significant capital projects:

- Kaikoura Hospital detailed design, to support the preparation of the business case;
- Children's Haematology Oncology Centre (deferred from 2011/12 due to earthquake disruption);
- Strategic IT developments, including our Patient Management System, Electronic Shared Care Record View, Collaborative Care Management System and Electronic Referral Management System;
- Intensive Care Unit, and Surgical Services expansions; and

- Phase 1 of the facilities redevelopment programme (This is subject to cabinet approval. Although currently included within outyears' capital plans, subsequent phases may be funded via public/private partnership, thereby altering the expected capital requirements).

Other significant capital expenditure already committed, where expenditure will be incurred in the 2012/13 financial year, has been included (such as the Christchurch Hospital campus boiler replacement).

Capital expenditure associated with immediate projects required as a result of damage to our infrastructure, and the infrastructure of providers we fund, has been included within our capital plans. However, this has been done on the basis of a timely approval of our overall facilities development plan. Should this not occur, or be significantly delayed, a revision of the capital expenditure budget will need to be performed to continue to allow provision of services in the interim. As the overall cost of seismic repairs is intrinsically linked to the approval of our facilities development plan, the overall impact of lengthy delays or non-approval would be a significant increase in capital expenditure.

It is assumed that the capital required for these building developments will be approved and/or funded via the National Health Board Capital Investment Committee, and decisions would be made in conjunction with overall building and service needs in the medium term.

7.5 Debt and equity

The Canterbury DHB currently has a $129.650m total loan facility with the Crown Health Funding Agency, which is fully drawn down. The DHB's estimated total term debt is expected to be $144.650m as at June 2013; this reflects additional borrowing of $15m during the 2013 year. The DHB is also repaying $1.861m of equity annually 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.

7.6 Additional information

Disposal of land

As part of the preparation required for the anticipated Christchurch Hospital redevelopment, a land exchange is planned between the Christchurch City Council and the Canterbury DHB. This was part of a significant public consultation in 2010, which received Christchurch City Council and widespread community support. The Christchurch City Council is pursuing the land transfer.

Disposal of surplus assets over the next three years may include a house property in Amuri Avenue, Hamner Springs. This property was previously approved for disposal by the former Minister of Health but not purchased by the Crown as part of a larger holding.

Due process will be undertaken with regard to any sale of DHB land. 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.

The development of the CBD plan and the CERA Recovery Strategy may have an impact on decisions that can be taken in regard to land and facilities.

Activities for which compensation is sought

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

Acquisition of shares

Before we or any of our associates or subsidiaries subscribe for, purchase, or otherwise acquire shares in any company or other organisation, our Board will consult the responsible Minister(s) and obtain their approval. This includes seeking approval for establishing the legal entities required to formally establish the 'Innovation Hub' in Canterbury.

Accounting policies

The accounting policies adopted are consistent with those in the prior year. For a full statement of accounting policies, refer to Appendix 10.

Forecast of Financial Performance

Current Year Base

7.7 Group statement of comprehensive income

	2010/11 Actual $'000	2011/12 Forecast $'000	2012/13 Forecast $'000
Income			
Ministry of Health revenue	1,333,681	1,371,634	1,379,624
Patient related revenue	40,550	33,962	33,140
Other operating income	25,254	56,663	32,091
Interest income	6,207	6,319	6,023
Total Income	1,405,692	1,468,578	1,450,878
Operating expenses			
Employee benefit costs	563,628	585,565	610,010
Treatment related costs	125,645	132,908	128,767
External service providers	570,452	597,127	601,001
Depreciation & amortisation	46,866	44,510	49,625
Interest expenses on loans	4,668	4,571	4,708
Other expenses	79,684	86,803	79,273
Total operating expenses	1,390,943	1,451,484	1,473,384
Operating surplus before capital charge	14,749	17,094	(22,506)
Capital charge expense	14,854	17,127	17,500
Surplus / (deficit)	(105)	(33)	(40,006)
Other comprehensive income			
Impairment of property, plant, & equipment	**33,845**	**-**	**-**
Total Comprehensive Income	**(33,950)**	**(33)**	**(40,006)**

7.8 Group statement of financial position

Crown equity	30/06/11 Actual $'000	30/06/12 Forecast $'000	30/06/13 Forecast $'000
General funds	130,304	143,923	172,062
Revaluation reserve	145,701	145,701	145,701
Retained earnings / (losses)	(77,190)	(77,223)	(117,229)
TOTAL EQUITY	**198,815**	**212,401**	**200,534**
REPRESENTED BY:			
CURRENT ASSETS			
Cash & cash equivalents	87,803	142,567	61,446
Trade & other receivables	61,727	45,872	45,872
Inventories	8,916	9,641	9,641
Investments	18,132	-	-
TOTAL CURRENT ASSETS	176,578	198,080	116,959
CURRENT LIABILITIES			
Trade & other payables	120,294	95,300	95,300
Capital charge payable	4,355	4,275	4,500
Employee benefits	141,039	153,321	153,321
Borrowings	30,000	-	-
TOTAL CURRENT LIABILITIES	295,688	252,896	253,121
NET WORKING CAPITAL	(119,110)	(54,816)	(136,162)
NON CURRENT ASSETS			
Investments	1,927	54,650	54,650
Property, plant, & equipment	368,284	349,636	429,431
Intangible assets	698	581	5,265
Restricted assets	13,686	13,686	13,686
TOTAL NON CURRENT ASSETS	384,595	418,553	503,032
NON CURRENT LIABILITIES			
Employee benefits	7,984	8,000	8,000
Restricted funds	13,686	13,686	13,686
Borrowings	45,000	129,650	144,650
TOTAL NON CURRENT LIABILITIES	66,670	151,336	166,336
NET ASSETS	**198,815**	**212,401**	**200,534**

7.9 Group statement of movements in equity

	30/06/11 Forecast $'000	30/06/12 Forecast $'000	30/06/13 Forecast $'000
Total Equity at Beginning of the Period	229,352	198,815	212,401
Total Comprehensive Income	(33,950)	(33)	(40,006)
	(33,950)	(33)	(40,006)
Other Movements			
Contribution back to Crown	(1,861)	(1,861)	(1,861)
Contribution from Crown - Earthquake operational support			-
Contribution from Crown - Seismic Capital	5,274	15,480	30,000
Total equity at end of the period	**198,815**	**212,401**	**200,534**

7.10 Group statement of cashflow

	2010/11 Actual $'000	2011/12 Forecast $'000	2012/13 Forecast $'000
CASH FLOW FROM OPERATING ACTIVITIES			
Cash provided from:			
Receipts from Ministry of Health	1,308,321	1,367,489	1,379,624
Other receipts	64,172	80,625	65,231
Interest received	6,207	6,319	6,023
	1,378,700	1,454,433	1,450,878
Cash was applied to:			
Payments to employees	549,164	573,267	610,010
Payments to suppliers	750,155	812,557	809,041
Interest paid	4,663	4,571	4,708
Capital charge	15,428	17,207	17,275
GST - net	(1,544)	-	-
	1,317,866	1,407,602	1,441,034
NET CASH INFLOW / (OUTFLOW) FROM OPERATING ACTIVITIES	**60,834**	**46,831**	**9,844**
CASH FLOW FROM INVESTING ACTIVITIES			
Cash was provided from:			
Sale of property, plant, & equipment	53	-	-
Receipt from sale of investments	-	(52,723)	-
	53	(52,723)	-
Cash was applied to:			
Purchase of investments & restricted assets	9,613	(18,132)	-
Purchase of property, plant, & equipment	35,960	25,745	134,104
	45,573	7,613	134,104
Net Cashflow from Investing Activities	**(45,520)**	**(60,336)**	**(134,104)**
Cashflows from Financing Activities			
Cash provide from:			
Equity Injection	5,274	15,480	30,000
Loans Raised		54,650	15,000
	5,274	70,130	45,000
Cash applied to:			
Loan Repayment			
Equity Repayment re FRS-3	1,861	1,861	1,861
	1,861	1,861	1,861
Net Cashflow from Financing Activities	**3,413**	**68,269**	**43,139**
Overall Increase/(Decrease) in Cash Held	18,727	54,764	(81,121)
Add Opening Cash Balance	69,076	87,803	142,567
Closing Cash Balance	**87,803**	**142,567**	**61,446**

7.11 Summary of revenue and expenses by arm

	2010/11 $'000 Actual	2011/12 $'000 Forecast	2012/13 $'000 Forecast	2013/14 $'000 Forecast	2014/15 $'000 Forecast
Funding Arm					
Revenue					
MoH revenue	1,288,618	1,324,797	1,329,927	1,386,503	1,446,664
Total Revenue	1,288,618	1,324,797	1,329,927	1,386,503	1,446,664
Expenditure					
Other - Personal Health	936,287	952,879	983,154	1,020,083	1,060,982
Other - Mental Health	130,665	138,626	139,294	143,753	150,082
Other - Disability Support	218,358	230,019	219,587	228,365	232,934
Other - Public Health	1,398	1,933	2,069	2,133	2,214
Other - Maori Health	1,682	1,826	1,689	1,741	1,807
Total Expenditure	1,288,390	1,325,283	1,345,793	1,396,075	1,448,019
Net Surplus/(Deficit)	**228**	**(486)**	**(15,866)**	**(9,572)**	**(1,355)**
Other Comprehensive Income	-	-	-		
Total Comprehensive Income	**228**	**(486)**	**(15,866)**	**(9,572)**	**(1,355)**
Governance & Funder Admin					
Revenue					
Other	784	40	1,966	1,966	1,966
Total Revenue	784	40	1,966	1,966	1,966
Expenditure					
Personnel	3,225	4,416	5,646	5,811	5,985
Depreciation	13	-	-		
Internal allocation from Provider Arm	(4,580)	(6,127)	(5,360)	(5,558)	(5,766)
Other	2,126	1,751	1,680	1,713	1,747
Total Expenditure	784	40	1,966	1,966	1,966
Net Surplus/(Deficit)	-	-	-	-	-
Other Comprehensive Income	-	-	-	-	-
Total Comprehensive Income	-	-	-	-	-
Provider Arm					
Revenue					
MoH revenue	763,001	774,992	794,490	830,986	876,909
Patient Related Revenue	29,797	33,922	32,590	30,861	33,170
Other	41,430	62,982	36,698	34,255	34,416
Total Revenue	834,228	871,896	863,778	896,102	944,495
Expenditure					
Personnel	560,099	581,149	604,364	618,619	651,207
Depreciation	46,866	44,510	49,625	54,434	58,516
Interest & Capital charge	19,519	21,698	22,208	24,788	26,408
Other	208,077	224,086	211,721	212,956	219,673
Total Expenditure	834,561	871,443	887,918	910,797	955,804
Net Surplus/(Deficit)	**(333)**	**453**	**(24,140)**	**(14,695)**	**(11,309)**
Impairment of Property, Plant, & Equipment	**33,845**	-	-	-	-
Total Comprehensive Income	**(34,178)**	**453**	**(24,140)**	**(14,695)**	**(11,309)**
In House Elimination					
Revenue					
MoH revenue	(717,938)	(728,155)	(744,793)	(779,799)	(824,187)
Total Revenue	(717,938)	(728,155)	(744,793)	(779,799)	(824,187)
Expenditure					
Other	(717,938)	(728,155)	(744,793)	(779,799)	(824,187)
Total Expenditure	(717,938)	(728,155)	(744,793)	(779,799)	(824,187)
Net Surplus/(Deficit)	-	-	-	-	-
Other Comprehensive Income	-	-	-		
Total Comprehensive Income	-	-	-	-	-
Consolidated					
Revenue					
MoH revenue	1,333,681	1,371,634	1,379,624	1,437,690	1,499,386
Patient Related Revenue	29,797	33,922	32,590	30,861	33,170
Other	42,214	63,022	38,664	36,221	36,382
Total Revenue	1,405,692	1,468,578	1,450,878	1,504,772	1,568,938
Expenditure					
Personnel	563,324	585,565	610,010	624,430	657,192
Depreciation	46,879	44,510	49,625	54,434	58,516
Interest & Capital charge	19,519	21,698	22,208	24,788	26,408
Other	776,075	816,838	809,041	825,387	839,486
Total Expenditure	1,405,797	1,468,611	1,490,884	1,529,039	1,581,602
Net Surplus/(Deficit)	**(105)**	**(33)**	**(40,006)**	**(24,267)**	**(12,664)**
Property Revaluation	33,845	-	-	-	-
Total Comprehensive Income	**(33,950)**	**(33)**	**(40,006)**	**(24,267)**	**(12,664)**

Out-Year Scenarios

7.12 Group statement of comprehensive income

	Scenario 1		Scenario 2		Scenario 3	
	2013/14 Forecast $'000	2014/15 Forecast $'000	2013/14 Forecast $'000	2014/15 Forecast $'000	2013/14 Forecast $'000	014/15 Forecast $'000
Income						
Ministry of Health revenue	1,422,181	1,479,429	1,437,691	1,499,387	1,489,451	1,553,477
Patient related revenue	40,280	41,780	40,280	41,780	40,280	41,780
Other operating income	21,153	22,010	21,153	22,010	21,153	22,010
Interest income	5,649	5,791	5,649	5,791	5,649	5,791
Total Income	1,489,263	1,549,010	1,504,773	1,568,968	1,556,533	1,623,058
Operating expenses						
Employee benefit costs	625,930	654,887	624,430	657,192	639,260	679,920
Treatment related costs	128,914	133,900	128,914	133,599	131,461	137,251
External service providers	616,276	615,996	616,276	623,861	627,763	635,098
Depreciation & amortisation	54,434	58,516	54,434	58,516	54,434	58,516
Interest expenses on loans	7,514	10,334	6,614	8,234	5,714	11,534
Other expenses	81,198	83,656	80,198	82,057	81,595	85,127
Total operating expenses	1,514,266	1,557,290	1,510,866	1,563,458	1,540,227	1,607,446
Operating surplus before capital charge	(25,003)	(8,280)	(6,093)	5,510	16,306	15,612
Capital charge expense	18,174	18,174	18,174	18,174	18,174	18,174
Surplus / (deficit)	(43,177)	(26,454)	(24,267)	(12,664)	(1,868)	(2,562)
Other comprehensive income						
Impairment of property, plant, & equipment	-	-	-	-	-	-
Total Comprehensive Income	**(43,177)**	**(26,454)**	**(24,267)**	**(12,664)**	**(1,868)**	**(2,562)**

7.13 Group statement of financial position

	Scenario 1		Scenario 2		Scenario 3	
	30/06/14 Forecast $'000	30/06/15 Forecast $'000	30/06/14 Forecast $'000	30/06/15 Forecast $'000	30/06/14 Forecast $'000	30/06/15 Forecast $'000
Crown equity						
General funds	235,201	276,517	235,201	257,607	235,201	235,208
Revaluation reserve	145,701	145,701	145,701	145,701	145,701	145,701
Retained earnings / (losses)	(160,406)	(186,860)	(141,496)	(154,160)	(119,097)	(121,659)
TOTAL EQUITY	**220,496**	**235,358**	**239,406**	**249,148**	**261,805**	**259,250**
REPRESENTED BY:						
CURRENT ASSETS						
Cash & cash equivalents	72,262	55,670	76,172	54,460	88,571	74,562
Trade & other receivables	45,872	45,872	45,872	45,872	45,872	45,872
Inventories	9,641	9,641	9,641	9,641	9,641	9,641
Investments	-	-	-	-	-	-
TOTAL CURRENT ASSETS	127,775	111,183	131,685	109,973	144,084	130,075
CURRENT LIABILITIES						
Trade & other payables	95,300	95,300	95,300	95,300	115,300	115,300
Capital charge payable	4,500	4,500	4,500	4,500	4,500	4,500
Employee benefits	153,321	153,321	153,321	153,321	153,321	153,321
Borrowings	-	-	-	-	-	-
TOTAL CURRENT LIABILITIES	253,121	253,121	253,121	253,121	273,121	273,121
NET WORKING CAPITAL	(125,346)	(141,938)	(121,436)	(143,148)	(129,037)	(143,046)
NON CURRENT ASSETS						
Investments	-	-	-	-	-	-
Property, plant, & equipment	538,227	624,681	538,227	624,681	538,227	624,681
Intangible assets	5,265	5,265	5,265	5,265	5,265	5,265
Restricted assets	13,686	13,686	13,686	13,686	13,686	13,686
TOTAL NON CURRENT ASSETS	557,178	643,632	557,178	643,632	557,178	643,632
NON CURRENT LIABILITIES						
Employee benefits	8,000	8,000	8,000	8,000	8,000	8,000
Restricted funds	13,686	13,686	13,686	13,686	13,686	13,686
Borrowings	189,650	244,650	174,650	229,650	144,650	219,650
TOTAL NON CURRENT LIABILITIES	211,336	266,336	196,336	251,336	166,336	241,336
NET ASSETS	**220,496**	**235,358**	**239,406**	**249,148**	**261,805**	**259,250**

7.14 Group statement of movements in equity

	Scenario 1		Scenario 2		Scenario 3	
	30/06/14 Forecast $'000	30/06/15 Forecast $'000	30/06/14 Forecast $'000	30/06/15 Forecast $'000	30/06/14 Forecast $'000	30/06/15 Forecast $'000
Total Equity at Beginning of the Period	200,534	220,496	200,534	239,406	200,534	261,805
Total Comprehensive Income	(43,177)	(26,454)	(24,267)	(12,664)	(1,868)	(2,562)
	(43,177)	(26,454)	(24,267)	(12,664)	(1,868)	(2,562)
Other Movements						
Contribution back to Crown	(1,861)	(1,861)	(1,861)	(1,861)	(1,861)	(1,861)
Contribution from Crown - Earthquake operational support	50,000	43,177	50,000	24,267	50,000	1,868
Contribution from Crown - Seismic Capital	15,000	-	15,000	-	15,000	-
Total equity at end of the period	**220,496**	**235,358**	**239,406**	**249,148**	**261,805**	**259,250**

7.15 Group statement of cashflow

	Scenario 1		Scenario 2		Scenario 3	
	2013/14 Forecast $'000	2014/15 Forecast $'000	2013/14 Forecast $'000	2014/15 Forecast $'000	2013/14 Forecast $'000	2014/15 Forecast $'000
CASH FLOW FROM OPERATING ACTIVITIES						
Cash provided from:						
Receipts from Ministry of Health	1,422,181	1,479,429	1,437,691	1,499,387	1,489,451	1,553,477
Other receipts	61,433	63,790	61,433	63,790	61,433	63,790
Interest received	5,649	5,791	5,649	5,791	5,649	5,791
	1,489,263	1,549,010	1,504,773	1,568,968	1,556,533	1,623,058
Cash was applied to:						
Payments to employees	625,930	654,887	624,430	657,192	639,260	679,920
Payments to suppliers	826,388	833,553	825,388	839,516	820,819	857,476
Interest paid	7,514	10,334	6,614	8,234	5,714	11,534
Capital charge	18,174	18,174	18,174	18,174	18,174	18,174
GST - net	-	-	-	-	-	-
	1,478,006	1,516,948	1,474,606	1,523,116	1,483,967	1,567,104
NET CASH INFLOW / (OUTFLOW) FROM OPERATING ACTIVITIES	**11,257**	**32,062**	**30,167**	**45,852**	**72,566**	**55,954**
CASH FLOW FROM INVESTING ACTIVITIES						
Cash was provided from:						
Sale of property, plant, & equipment	-	-	-	-	-	-
Receipt from sale of investments	54,650	-	54,650	-	54,650	-
	54,650	-	54,650	-	54,650	-
Cash was applied to:						
Purchase of investments & restricted assets	-	-	-	-	-	-
Purchase of property, plant, & equipment	163,230	144,970	163,230	144,970	163,230	144,970
	163,230	144,970	163,230	144,970	163,230	144,970
Net Cashflow from Investing Activities	**(108,580)**	**(144,970)**	**(108,580)**	**(144,970)**	**(108,580)**	**(144,970)**
Cashflows from Financing Activities						
Cash provide from:						
Equity Injection	65,000	43,177	65,000	24,267	65,000	1,868
Loans Raised	45,000	55,000	30,000	55,000	-	75,000
	110,000	98,177	95,000	79,267	65,000	76,868
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	1,861	1,861
Net Cashflow from Financing Activities	**108,139**	**96,316**	**93,139**	**77,406**	**63,139**	**75,007**
Overall Increase/(Decrease) in Cash Held	10,816	(16,592)	14,726	(21,712)	27,125	(14,009)
Add Opening Cash Balance	61,446	72,262	61,446	76,172	61,446	88,571
Closing Cash Balance	**72,262**	**55,670**	**76,172**	**54,460**	**88,571**	**74,562**

Appendices

Further information for the reader

Appendix 8.1 – Glossary of terms

Appendix 8.2 – Objectives of DHB

Appendix 8.3 – Organisational chart

Appendix 8.4 – Overview of hospital and specialist services

Appendix 8.5 – DHB performance monitoring framework

Appendix 8.6 – BSMC year 3 implementation plan

Appendix 8.7 – Decision-making framework for CDHB built infrastructure

Appendix 8.8 – Investment in our people 2012/13

Appendix 8.9 – Investment in information systems 2012/13

Appendix 8.10 – Statement of accounting policies

Appendix 8.11 – Minister of Health's letter of approval

References

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

All Ministry of Health or National Health Board documents referenced in this document are available either on the Ministry's website (www.health.govt.nz) or the National Health Board's website (www.nationalhealthboard.govt.nz).

The Crown Entities Act 2004 and the Public Finance Act 1989, both referenced in this document are available on the Treasury website (www.treasury.govt.nz).

8.1 Glossary of terms

ACC	Accident Compensation Corporation	Crown Entity set up to provide comprehensive no-fault personal accident cover for New Zealanders.
	Acute Care	Management of conditions with sudden onset and rapid progression.
ARC	Aged Residential Care	Residential care for older people, including rest home, hospital, dementia and psycho-geriatric level care.
CCN	Canterbury Clinical Network District Alliance	An alliance of Canterbury health professionals whose initial focus is the implementation of the 'Better, Sooner, More Convenient' business case, which began in 2009.
	Capability	What an organisation needs (in terms of access to people, resources, systems, structures, culture and relationships), to efficiently deliver outputs.
CVD	Cardiovascular Disease	Diseases affecting the heart and circulatory system, including: ischaemic heart disease, rheumatic heart disease, cerebrovascular disease and other forms of vascular and heart disease.
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.
	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.
	Crown agent	A Crown entity that must give effect to government policy when directed by the responsible Minister.
	Crown Entity	A generic term for a diverse range of entities referred to in the Crown Entities Act 2004. Crown Entities are legally separate from the Crown and operate at arm's length from the responsible or shareholding Minister, but are included in the annual financial statements of the Government.
CFA	Crown Funding Agreement	An agreement by the Crown to provide funding in return for the provision of, or arranging the provision of, specified services.
	Determinants of Health	The range of personal, social, economic and environmental factors that determine the health status of individuals or populations.
	Effectiveness	The extent to which objectives are being achieved. Effectiveness indicators relate outputs to impacts and to outcomes. They can measure the steps along the way to achieving an overall objective or an Outcome and test whether outputs have the characteristics required for achieving a desired objective or government outcome.
ESPIs	Elective Services Patient flow Indicators	A set of indicators developed by the Ministry to monitor how patients are managed while waiting for elective (non-urgent) services.
FSA	First Specialist Assessment	(Outpatients only) The 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	Also known as glycated haemoglobin, HbA1c reflects the average blood glucose level over the past 3 months.
	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. Impact measures should be attributed to DHB outputs in a credible way and represent near-terms results expected from the outputs delivered.
IPJ	Improving the Patient Journey	A programme established by the DHB to encourage frontline health professionals to improve patient outcomes by reducing unnecessary delays within the patient continuum of care and embedding innovation tools and techniques into services
	Input	The resources (e.g. labour, materials, money, people, technology) an organisation uses to produce outputs.
IDFs	Inter District Flows	Services (outputs) provided by a DHB to a patient whose place of residence is in another DHB's region. 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.
InterRAI	International Resident Assessment Instrument	A comprehensive geriatric assessment tool.
	Intervention	An action or activity intended to enhance outcomes or otherwise benefit an agency or group.
	Intervention logic model	A framework for describing the relationships between resources, activities and results, which provides a common approach for planning, implementation and evaluation. Intervention logic focuses on being accountable for what matters: impacts and outcomes.

	Morbidity	Illness, sickness.
	Mortality	Death.
NHI	National Health Index	An NHI number is a unique identifier assigned to every person who uses health and disability services in NZ. A person's NHI number is stored on the NHI along with their demographic details. The NHI is used to help with the planning, coordination and provision of health and disability services across NZ.
NGO	Non-Government Organisations	In the context of the relationship between 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.
OPF	Operational Policy Framework	An annual document endorsed by the Minister of Health that sets out 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, including a change in that state or condition. Outcomes are the impacts on the community of the outputs or activities of Government (e.g. a change in the health status of a population).
	Output Class	An aggregation of outputs of a similar nature.
	Outputs	Final goods and services delivered to a third party outside of the DHB. Not to be confused with goods and services 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	Professional health care received in the community, usually from a general practice, covering a broad range of health and preventative services. The first level of contact with the health system.
PHO	Primary Health Organisation	PHOs encompass the range of primary care practitioners and are funded by DHBs to provide of a set of essential primary healthcare services to the people enrolled with that PHO.
	Public Health	The science and art of preventing disease, prolonging life and promoting health and efficiency through organised community effort.
	Purchase agreement	A documented arrangement between a Minister and a department or other organisation for the supply of outputs.
	Regional collaboration	Refers to DHBs across geographical 'regions' planning and delivering services (clinical and non-clinical) together. Four regions exist: Northern, Midland, Central and Southern. The Southern region includes all five South Island DHBs (Canterbury, Nelson Marlborough, South Canterbury, Southern and West Coast DHBs). Regional collaboration sometimes involves multiple regions, or may be 'sub-regional collaboration' (DHBs working together in a smaller grouping of two or three DHBs, e.g. Canterbury and West Coast).
	Secondary Care	Specialist care that is typically provided in a hospital setting.
SSP	Statement of Service Performance	Government departments, and Crown entities from which the Government purchases a significant quantity of goods and services, are required to include audited statements of service performance with their financial statements. These statements report whether the organisation has met its service objectives for the year.
	Tertiary Care	Very specialised care often only provided in a smaller number of locations
	Vision 2020	Canterbury's vision for our future health system, developed through system-wide engagement in 2007 to find solutions to the challenges our health system faced: if we didn't actively transform our system, by 2020 Canterbury would need 2,000 more ARC beds, 20% more GPs and another Christchurch Hospital.

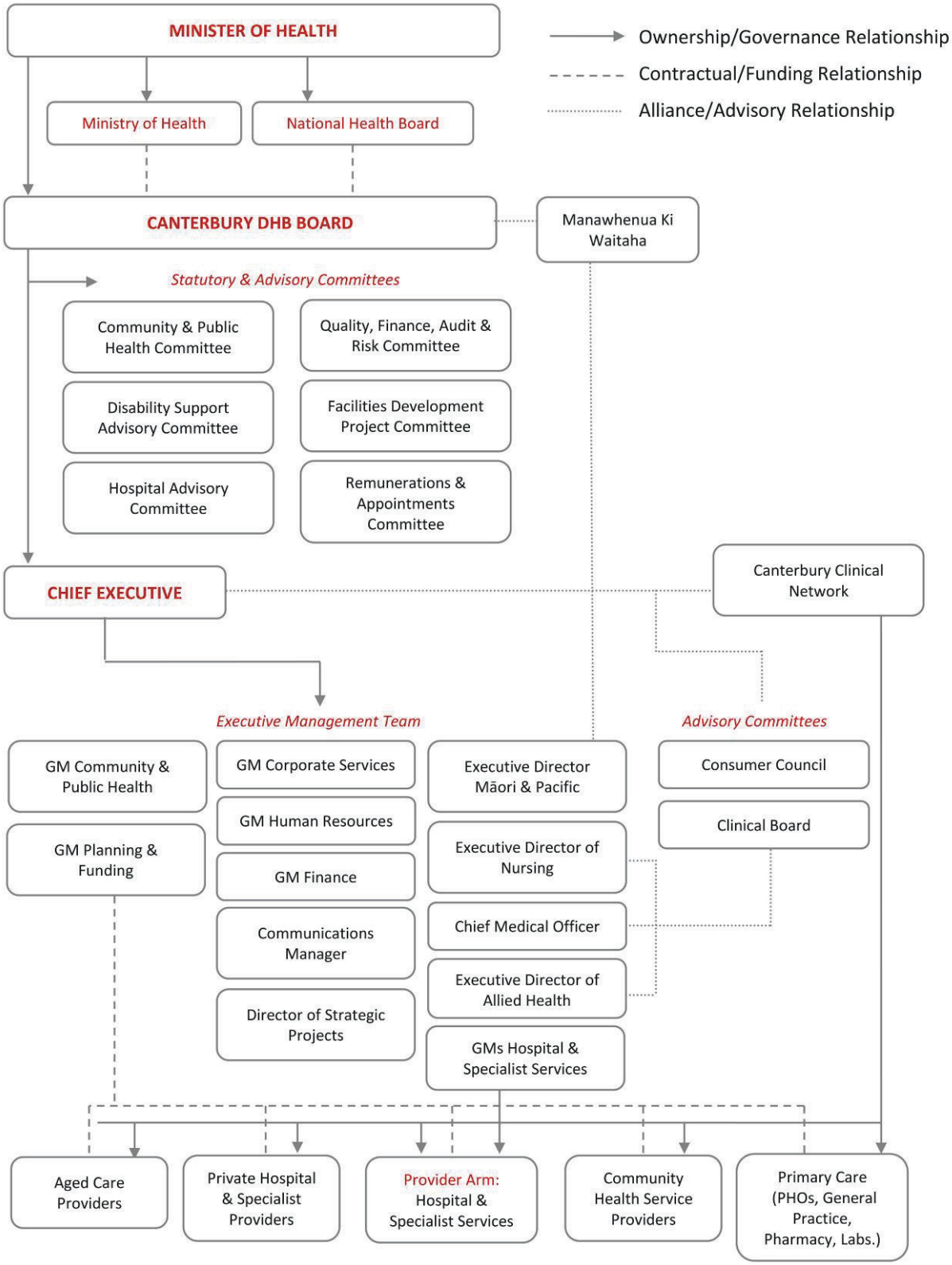
8.2 Objectives of a DHB – New Zealand Public Health and Disability Act (2000)

Part 3: Section 22:

The New Zealand Public Health and Disability Act outlines the following objectives for DHBs:

- 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.

8.3 Canterbury DHB organisational chart



8.4 Overview of hospital and specialist services

HOSPITAL SUPPORT AND LABORATORY SERVICES

Cover support services such as: medical illustrations, specialist equipment maintenance, sterile supply, 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 offer 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

Cover medical services: general medicine, cardiology/lipid disorders, endocrinology/diabetes, respiratory, rheumatology/immunology, infectious diseases, oncology, gastroenterology, clinical haematology, neurology, renal, palliative, hyperbaric medicine, dermatology, dental and sexual health. They also cover 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 84,000 patients per annum.

SPECIALIST MENTAL HEALTH SERVICES

Cover specialist mental health services: adult community; adult acute; rehabilitation; child, adolescent and family (CAF); forensic; alcohol and drug; intellectually disabled persons' health; and other Specialty services. Services (including alcohol and drug services) are provided by a number of outpatient, inpatient, community-based and mobile services throughout Canterbury. Regional inpatient beds and consultation liaison are provided by the Forensic, Eating Disorders, Alcohol and Drug, and CAF Services. Rural Adult Community and CAF Services are provided to Kaikoura and Ashburton through outreach clinics.

OLDER PERSONS' SPECIALIST HEALTH AND REHABILITATION SERVICES

Cover assessment, treatment, rehabilitation and psychiatric services for the elderly in inpatient, outpatient, day services and community settings; specialist osteoporosis and memory clinics; inpatient and community stroke rehabilitation services and specialist under 65 assessment and treatment services for disability-funded clients. The DHB's School and Community Child and Adolescent Dental Service is also managed through this service area. Rehabilitation services (provided at Burwood Hospital) include spinal, brain injury, orthopaedic, chronic pain management services and a range of outpatient services. The majority of DHB elective orthopaedic surgery is undertaken at Burwood Hospital, as well as some general Plastics lists. The Burwood Procedure Unit also provides a 'see and treat' service for skin lesions in conjunction with primary care.

ASHBURTON AND RURAL HEALTH SERVICES

Cover 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 and 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

Cover 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 is 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.

8.5 DHB performance monitoring framework

Policy Priorities Dimension

Performance Measure and description			2012/13 Target	National Target	Frequency
PP1 Clinical leadership self assessment					
Provide a qualitative report identifying progress achieved in fostering clinical leadership and the DHB engagement with it across their region.			NA	NA	Annual
PP2 Implementation of Better, Sooner, More Convenient primary health care					
1. BSMC alliance deliverables – submit a jointly agreed Year 3 Implementation Plan, and provide quarterly reports on progress against the plan and on the operation and expenditure of the Flexible Funding Pool. **2. Report against the following:** • Description of how all necessary clinicians and managers will be involved in the ongoing process of development, delivery and review • Activities to integrate community pharmacy • Activities to expand and integrate nursing services • Evidence of health needs analysis of population by localities • Identification of targeted areas/patient groups for improved outcomes as a result of enhanced primary/community service delivery (focus on long-term conditions) including: a. Target for the number of people expected to be appropriately managed in primary/community setting rather than in secondary care. b. Target for growth reduction in Ed attendance, acute inpatient admissions and bed days. c. Target for prevention of readmission for the 75+ population. d. Identification of new service activity quantified in patient terms. • Activities (with timeline) to ensure infrastructure and revenue streams appropriate to support the identified change in activities and service delivery model • Progress against the above infrastructure and revenue stream milestones • Activities to ensure free afterhours services to children under six years of age. **3. Additional deliverable for Quarter 4** – provide a report with: • each PHO's working capital requirements, total cash balance and total income in advance at the end of the financial year. • the PHOs that the DHB has required to provide forecast expenditure plans for both cash balances and income in advance, including quarterly targets for reductions in cash balances. • a copy of the relevant PHOs' forecast expenditure plans.			a: ADMS = 18,000 POC b: % of population presenting at ED ≤18% b: rate of acute medical admissions ≤ 11,000 per 100,000 b: LOS ≤4.00 days c: 75+ Readmission Rate: ≤14.02 d: CREST = 1,100 clients	NA	Quarterly
PP6 Improving the health status of people with severe mental illness					
The average number of people domiciled in the DHB region, seen per year rolling every three months (the period is lagged by three months) for: child and youth aged 0-19; adults aged 20-64; and older people aged 65+, each specified for each of the three categories Māori, Other, and in total.	**Age 0-19**	Total	3%	NA	Six-Monthly
		Māori	3%		
	Age 20-64	Total	2.5%		
		Māori	3.6%		
	Age 65+	Total	NA		
PP7 Improving mental health services using relapse prevention planning					
1. Report the number of adults (20+) with enduring serious mental illness who have been in treatment for 2+ years since the first contact with any mental health service. Report the subset of alcohol and other drug clients only for the 20+ age group. 2. Report the number of children and youth (≤19) who have been in secondary care treatment for one or more years who have a treatment plan. 3. Report the number and percentage of long-term clients with up to date relapse prevention/treatment plans. 4. Describe the methodology used to ensure adult long-term clients have up-to-date relapse prevention plans and that appropriate services are provided.	**Adult (20+)**	Total	95%	**95%**	Six-Monthly
		Māori	95%	**95%**	
	Child & Youth	Total	95%	**95%**	
		Māori	95%	**95%**	

Performance Measure and description			2012/13 Target	National Target	Frequency
PP8 Shorter waits for non-urgent mental health and addiction services					
Provide a narrative that identifies what processes have been put in place to reduce waiting times and explains variances of more than 10% vs. target. (Rolling annual waiting time data will be provided by the Ministry sourced from PRIMHD.)	**Mental Health Provider Arm**				
	People referred for non-urgent mental health services seen **within 3 weeks**	0-19	70%	**80%**	Six-Monthly
		20-64	70%		
		65+	70%		
		Total	70%		
	People referred for non-urgent mental health services seen **within 8 weeks**	0-19	75%	**95%**	Six-Monthly
		20-64	75%		
		65+	75%		
		Total	75%		
	Addictions (Provider Arm and NGO)				
	People referred for non-urgent addiction services seen **within 3 weeks**	0-19	70%	**80%**	Six-Monthly
		20-64	70%		
		65+	70%		
		Total	70%		
	People referred for non-urgent addiction services seen **within 8 weeks**	0-19	75%	**95%**	Six-Monthly
		20-64	75%		
		65+	75%		
		Total	75%		
PP10 Oral Health DMFT Score at year 8					
Upon the commencement of dental care, at the last dental examination before the child leaves the DHB's Community Oral Health Service, the total number of: (i) permanent teeth of children in school Year 8 (12/13-year olds) that are – Decayed (D), Missing (due to caries, M), and Filled (F); and (ii) children who are caries-free (decay-free).	**DMFT Score**	Total	2012: 0.82 2013: 0.77	NA	Annual
		Māori	2012: 0.82 2013: 0.77		
		Pacific	2012: 0.82 2013: 0.77		
PP11 Children caries-free at 5 years of age					
At the first examination after the child has turned five years, but before their sixth birthday, the total number of: (i) children who are caries-free (decay-free); and (ii) primary teeth of children that are Decayed (d), Missing (due to caries, m), and Filled (f).	**Caries-free**	Total	2012: 65% 2013: 67%	NA	Annual
		Māori	2012: 65% 2013: 67%		
		Pacific	2012: 65% 2013: 67%		
PP12 Utilisation of DHB funded dental services by adolescents					
Report the total number of adolescents accessing DHB-funded adolescent oral health services.		Total	2012: 75% 2013: 85%	**85%**	Annual
PP13 Improving the number of children enrolled in DHB funded dental services					
Measure 1 - Report the total number of children aged 0 to 4 years of age inclusive, who are enrolled with DHB-funded oral health services. **Measure 2** - Report: (i) the number of pre-school children and primary school children who have not been examined according to their planned recall; and(ii) the greatest length of time children have been waiting for their scheduled examination, and the number of children waiting for that period.		Children enrolled **0-4 years**	2012: 66% 2013: 68%	NA	Annual
		Children not examined **0-12 years**	2012: 10% 2013: 7%		
PP16 Workforce - Career Planning					
Provide quantitative data on progress achieved for career planning for DHB staff.			NA	NA	Annual
PP18 Improving community support to maintain the independence of older people					
The percentage of people aged 65+ receiving long-term home-support services in the last 3 months who have had a Comprehensive Clinical Assessment and a completed care plan.			85%	≥95%	Quarterly

Performance Measure and description			2012/13 Target	National Target	Frequency
PP20 Improved management for long term conditions (CVD, diabetes and Stroke)					
Part 1, Focus area 1: Cardiovascular disease Supply a quarterly narrative report on data supplied by the Ministry, and DHB performance relating to the number of people diagnosed with ischemic heart disease and on lipid lowering medications.			NA	NA	Quarterly
Part 1, Focus area 2: Stroke services Provide a quarterly narrative report on stroke services delivered, including plans and actions to improve services.					
Part 1, Focus area 3: Maintain or Improve access to Diabetes Annual Reviews The percentage of people enrolled in a PHO and expected to have diagnosed diabetes who have a record of a Diabetes Annual Review during the reporting period.			52%		
Part 2, Focus area 1. Progress in delivery of Diabetes care improvements Provide a quarterly progress report on delivery of actions and volumes agreed for each improvement area identified in the Annual Plan.			NA		
Part 2, Focus area 2 Local Diabetes Team Service (or an equivalent service) Provide the annual report from the local diabetes team or equivalent to the Ministry.					Annual
Part 2, Focus area 3. Diabetes Management The percentage of people with type I or type II diabetes receiving a free annual check during the reporting period who had an HbA1c of ≤ 64mmol/mol.		Total	79%		Quarterly
		Māori	79%		
		Pacific	79%		
PP21 Immunisation Coverage					
The percentage of eligible children fully immunised at 24 months of age.		Total	95%	95%	Annual
		Māori	95%		
		Pacific	95%		
System Integration Dimension					
SI1 Ambulatory sensitive (avoidable) hospital admissions					
Provide a commentary on the latest 12 month ASH data available via the nationwide service library. This commentary may include additional district level data not captured in the national data collection and also information about local initiatives that are intended to reduce ASH admissions. Provide information about how health inequalities are being addressed with respect to this health target, with a particular focus on ASH admissions for Pacific and Māori 45-64 year olds.	**Age 0-74**	Total	≤95%	NA	Six-Monthly
		Māori	≤95%		
		Pacific	≤95%		
	Age 0-4	Total	≤95%		
		Māori	≤95%		
		Pacific	≤95%		
	Age 45-64	Total	≤95%		
		Māori	≤95%		
		Pacific	≤95%		
SI2 Regional service planning					
A single progress report on behalf of the region, agreed by all regional DHBs, focusing on the actions agreed by the region and detailed in their regional plan.			NA	NA	Quarterly
SI3 Ensuing delivery of Service coverage					
Report progress achieved during the quarter towards resolution of exceptions to service coverage identified in the Annual Plan, and not approved as long term exceptions, and any other gaps in service coverage identified by the DHB or Ministry.			NA	NA	Six-Monthly

Performance Measure and description				2012/13 Target	National Target	Frequency
SI4 Elective services standardised intervention rates						
Report for any procedure where the standardised intervention rate is significantly below the target: 1.what analysis the DHB has done to review the appropriateness of its rate; and 2.whether the DHB considers the rate to be appropriate for its population OR 3. a description of the reasons for its relative under-delivery of that procedure; and 4.the actions being undertaken in the current year (2012/13) that will ensure the target rate is achieved		**Major joint replacement procedures**		21 per 10,000	21.0 per 10,000	Annual
		Cataract Procedures		27 per 10,000	27.0 per 10,000	
	Cardiac Procedures	**Cardiac surgery**		6.2 per 10,000	6.2-6.5 per 10,000	Quarterly
		Percutaneous revascularisation		≥11.9 per 10,000	≥11.9 per 10,000	
		Coronary angiography services		≥32.3 per 10,000	≥32.3 per 10,000	
SI5 Delivery of Whānau Ora						
Provide a qualitative report identifying progress within the year showing the DHB's active engagement with existing and emerging Whānau Ora Provider Collectives, steps towards improving service delivery within these providers and supporting the building of mature providers.				NA	NA	Annual
SI7 Improving breast-feeding rates						
Set DHB-specific breastfeeding targets with a focus on Māori, Pacific and the total population respectively to incrementally improve district breastfeeding rates to meet or exceed the National Indicator. Maintain and report on appropriate planning and implementation activity to improve the rates of breastfeeding in the district. This includes activity targeting Māori and Pacific communities. Provide local data from non-Plunket Well Child providers. (The Ministry will provide breastfeeding data sourced from Plunket.)		**6 weeks**	Total	67%	**74%**	Annual
			Māori	67%		
			Pacific	67%		
		3 Months	Total	57%	**57%**	
			Māori	57%		
			Pacific	57%		
		6 Months	Total	28%	**27%**	
			Māori	28%		
			Pacific	28%		
Ownership Dimension						
OS3 Inpatient length of stay						
The standardised average length of stay for inpatients (excluding day patients).				≤4.00 Days	NA	Quarterly
OS5 Theatre Utilisation						
Submit the following data elements, represented as a total of all theatres in each Provider Arm facility: Actual theatre utilisation, resourced theatre minutes, actual minutes used as a percentage of resourced utilisation.				85%	85%	Quarterly
OS6 Elective and arranged day surgery						
The standardised day surgery rate.				57.8%	59.6%	Quarterly
OS7 Elective and arranged day of surgery admissions						
The day of surgery admission rate.				82%	NA	Quarterly
OS8 Acute readmissions to hospital						
The standardised acute readmission rate (unplanned acute readmissions to hospital within 28 days).			Total	≤9.36	NA	Quarterly
			Age 75+	≤14.02	NA	
OS10 Improving the quality of data provided to national collection systems						
Measure 1: National Health Index (NHI) duplications				≤6%	3-6%	Quarterly
Measure 2: Ethnicity set to 'Not stated' or 'Response Unidentifiable' in the NHI				≤2%	0.5-2%	
Measure 3: Standard versus specific diagnosis code descriptors in NMDS				≥55%	55-65% specific	
Measure 4: Timeliness of NMDS data				≤5%	2-5% late	
Measure 5: NNPAC Emergency Department admitted events have a matched NMDS event				≥97%	97-99.5%	
Measure 6: PRIMHD File Success Rate				≥98%	98-99.5%	

Performance Measure and description	2012/13 Target	National Target	Frequency
Output Dimension			
OP1 Output Delivery Against Plan			
Part A: Hospital production. Output delivery vs. plan for the following groups of personal health services: Casemix included medical, surgical and maternity services; non-casemix medical and surgical services; and ED non-admitted events.	Within 3% of plan	Within 3% of plan	Quarterly
Part B: Monitoring the delivery of personal health services and mental health services Mental health volume delivery vs. plan.	Within 5% of plan	Within 5% of plan	
Developmental: Establishment of baseline (no target/performance expectation is set)			
DV1: Improving cancer treatment			
To be defined – faster cancer treatment will be measured by: (i) patients referred urgently with a high suspicion of cancer have their first specialist assessment within 14 days. (ii) patients with a confirmed diagnosis of cancer receive their first cancer treatment (or other management) within 31 days of decision to treat. (iii) patients referred urgently with a high suspicion of cancer receive their first cancer treatment (or other management) within 62 days.	Provide data to establish baseline.		Quarterly
DV2: Improving waiting times for diagnostic services			
To be defined – deliverables will involve four modalities: Elective coronary angiogram to be reported to the National Booking Reporting System (NBRS) in accordance with NBRS data dictionary reporting requirements. Colonoscopy (excluding surveillance), Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) reporting templates to be submitted to the National Health Board within 20 days of the end of the previous month. The reporting template will be located on the NSFL website with other Performance Measure Documents.	Provide data to establish baseline.		Monthly

8.6 BMSC – year 3 implementation plan

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
1. Accelerate the urgent care workstream's progress. *To provide the most appropriate urgent care options to meet patient need at any given time, and ensure that only people who need hospital services present at ED and that others receive timely care in the community.*	1.1. Review afterhours utilisation by children under six and agree protocols for free afterhours access in line with national timeframes. Support GP practices to provide a free afterhours nurse phone advice and triage service.	60% of the population under six have access to free afterhours care by Q1. 75% of the population under six have access to free afterhours care by Q4.
	1.2. Continue to develop and refine acute demand services to target patients with the greatest capacity to benefit and support those with a high level of need to access appropriate urgent care in the community rather than in hospitals.	≥18,000 urgent care packages provided in the community.
	1.3. Engage St John Ambulance crews to use the Ambulance Referral Pathway and acute demand services to safely manage appropriate patients in the community.	≥250 patients utilise the ambulance referral pathway by Q4.
	1.4. Enable proactive management of vulnerable patients in the community, including community observation and increased access to urgent diagnostics. Continue to promote calling general practice as first point of contact (phone) 24/7.	The proportion of the population presenting to ED will remain below 18%. Reduction in the growth rate of medical admissions.
2. Continue the aged care workstream's progress. *To enable older people to live well at home and in their community.* *This will reduce demand on acute hospital and aged residential care services.*	Age adjusted rates of acute hospital admissions and residential care admissions for elderly will be monitored and reported.	
	2.1. Improve early intervention to support people with deteriorating health. CREST (Community Rehabilitation and Enablement Support Team) will be rolled out to maximum capacity by December 2012.	≥1,100 people (65+) supported by CREST on discharge or direct GP referral by Q4. 200 people (65+) supported by CREST upon direct GP referral by Q4. 20% reduction in acute hospital admissions for people supported by CREST services. 10% reduction in acute readmissions for people supported by CREST.
	2.2. Implement the HealthPathways Cognitive Impairment Pathway to improve the community care of people with early dementia and memory loss.	Pathway implemented by Q1.
	2.3. Provide 'Walking in Others' Shoes' dementia education training for community service providers.	Tailored dementia training programmes running by Q1. Regular monitoring of referrals and service provision by Q2.
	2.4. Reduce harm from adverse medication reactions and optimize medicines use. Fully implement the Medication Management Service (MMS).	2,000 MMS services completed by Q4. MMS service reports on outcomes.
	2.5. Reduce harm from falls amongst people aged over 65. Implement the Community Falls Prevention Service with Falls Champions. Integrate falls prevention strategies across the sector. Train primary care teams.	≥800 people (65+) access community-based falls prevention services by Q4. 10% reduction in the proportion of the population (75+) presenting at ED as a result of a fall. 10% reduction in the proportion of the older population (75+) admitted to hospital as a result of a fall.
	2.6. Promote "zero harm from falls" in inpatient settings including Aged Residential Care (ARC).	75% of ARC residents are receiving Vitamin D supplements by Q4.
	2.7. The phased rollout in Christchurch of the restorative home support model was put on hold in 2011/12 due to post-earthquake changes in priority. This is to be continued in 2012/13.	Rollout to be 75% complete by June 2013.
	2.8. Ensure the progressive rollout of access to InterRAI to Canterbury clinicians by working on the rollout of InterRAI assessment by Residential Care providers.	InterRAI training provided to Home Based Support Service providers by the end of Q1.
	2.9. Ensure access to InterRAI reports is available to key stakeholders within the health system. For example	Two ARC InterRAI information sessions organised in 2012/13.

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
	primary care, community care providers and aged residential care. Provide evidence that nominated groups have read-only access and information/training has occurred on interpretation of reports as required.	More Canterbury ARC facilities use InterRAI – base 11 facilities.
	2.10. Optimise the availability of equipment to CREST patients through the revision of the CREST equipment pathway; the implementation of an appropriate system for equipment sourcing, retrieval and storage.	Equipment sourcing, storage and retrieval processes in place by Q3.
		CREST equipment pathway revised to reflect improved processes by Q3.
		Regular meetings between CREST OTs and Planning and Funding established to make ongoing quality improvements by Q3.
	2.11. Advance Care Planning improved and recorded in the same way consistently across Canterbury.	Agree on strategy and training requirements by Q2.
3. Implement the Child and Young People's workstream	3.1. Establish the CCN Child and Youth Health Workstream and develop two key 2012/13 work programmes.	Child and Youth work programmes established by Q1.
	3.2. Enhance collaboration around protection, prevention and early intervention strategies: Identify initiatives to reduce smoking in pregnancy as part of the development of a wider strategy for reducing Sudden Unexplained Death in Infants (SUDI).	Progress towards 90% of women who identify as smokers at the time of confirmation of pregnancy being offered advice and support to quit.
	3.3. Support the implementation of zero-fee after hours GP visits for children under six.	75% of the population under six have access to free afterhours care by Q4.
	3.4. Support children being enrolled at birth with general practice, WellChild/Tamariki Ora and oral health providers.	90% of all new babies will have an identified WellChild/Tamariki Ora provider or GP by 2 weeks of age.
	3.5. Support the B4 School Check (B4SC) Clinical Advisory Group to closely monitor access to Checks, referral patterns, and the growth and development of the service. Identify population patterns and track the movement of high-need families around Canterbury. Use PHO mobile engagement teams to improve B4SC uptake amongst Māori, Pacific and Quintile 5 children.	80% of children in deprivation Quintile 5 receive a B4SC.
		80% of children in Quintiles 0-4 receive a B4SC.
	3.6. Develop a service for vulnerable children and young people that incorporates Gateway Assessments and other aligned and complementary services.	Gateway Assessment processes established and running by Q1.
		100% of children referred by CYF are receiving Gateway Assessments by Q2.
	3.7. Involve Well Child/Tamariki Ora providers and general practice in identifying children most at risk of tooth decay and support their families to maintain good oral health and access preventive care.	≥66% of 0-4 year olds are enrolled in DHB-funded oral healthcare services.
		≥90% of children enrolled in school and community dental services are examined according to planned recall.
		≥65% of five year olds are caries free (no holes or fillings).
	3.8. Investigate and implement alternatives to the current solely private practice-based service model for adolescents to engage more young people in the service – particularly those at low decile schools.	≥75% of all eligible adolescents use DHB-funded dental care.
4. Continue to improve the integration between Primary and Secondary Services. *To support the provision of the right care in the right place at the right time by the right provider.*	4.1. Continue to link clinicians across the health system to build trust and ways of working together that maximise patient outcomes. Expand the range of clinical pathways between primary and secondary care to ensure patients receive the right care at the right time from the right provider, support the reduction in waiting times and maximise the value provided by clinicians right across the health sector.	470 HealthPathways available across the Canterbury system by Q4.
		Ongoing active review of current HealthPathways.
5. Implement the urban Integrated Family Health and Social Service Network System. *To support health and social service providers coming together to work in a*	5.1. Develop and support the implementation of eight Integrated Family Health Centres (IFHCs) and networks within Christchurch.	6 urban IFHC/networks under development by Q4.
	5.2. Support the development of two Community Hubs across Canterbury to provide a range of outpatient and community specialist activity alongside extended primary	Identified community hubs are scoped by Q4.

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
defined community to operate as an integrated team.	care.	
6. Implement the Rural Health Workstream. *To ensure health services in the rural parts of Canterbury deliver comprehensive, integrated family health services equitably, efficiently and sustainably.*	6.1. The Rural Health Workstream will develop integrated family health services including the development of IFHCs in rural Canterbury.	Advice is developed for Integrated Family Health Services within the Ashburton TLA. Framework recommendations will be provided by March 2012 and further developed during 2012/13 financial year.
		Rural Workstream meetings continue throughout the 2012 calendar year at approximately 6 weekly intervals.
		Rural Workstream networks with other Service Level Alliances and Workstreams are developed ensuring sound communication channels.
		Construction of Darfield IFHC underway by Q1.
		Construction of Kaikoura IFHC completed by Q4.
		Business Case for Akaroa IFHC underway by Q2.
	6.2. Undertake the scoping of the northern corridor to understand utilisation and determine a framework that supports appropriate models of care for this population.	Integrated Family Health Services advised on for the Northern Corridor. Framework recommendations will be provided by June 2012 and further developed during 2012/13 financial year.
7. Continue improvements for patients with long term conditions. To reduce the growth in the number of people with, and improve the outcomes of those who have, long term conditions, including diabetes, cardiovascular disease and respiratory disease.		
Improve the identification of people at risk of respiratory disease. *To improve access to appropriate respiratory interventions that prevent admissions and to ensure that people with respiratory disease are managed under a structured programme or care plan.*	7.1. Support the implementation of ABC in primary care with systems to provide and record the provision of smoking cessation advice:	90% of enrolled smokers seen in general practice are provided with advice and help to quit.
		≥200 people enrol with the Aukati Kaipaipa smoking cessation programme.
		≥7,000 Canterbury residents seek additional cessation support from 'Quitline' services.
		4 large group ABC training sessions are delivered in primary care.
		60% of community pharmacy staff complete ABC e-learning.
	7.2. Undertake predictive risk modelling to identify people at risk of readmission.	Stage I model focused on identifying people at risk of readmission validated by Q1.
		Stage II model focused on first admission developed by Q2.
	7.3. Continue to develop a real-time integrated Lightfoot data set and introduce related data sets, including acute demand management, to inform and engage clinical staff in new solutions to influence demand.	Live weekly update of Lightfoot data available by Q1.
	7.4. Consolidate and refine the case finding of people with Chronic Obstructive Pulmonary Disease (COPD) and Obstructive Sleep Apnoea (OSA). Collaborate with Māori health providers and deliver improved access to diagnostics and tailored respiratory programmes for Māori.	More people access spirometry tests in the community (for COPD) – base 1,118.
		More people access sleep assessments in the community (for OSA) – base 690.
Ensure people receive the right care and support at the right time and in the right setting. *To support people to stay well, modify lifestyles, better manage their condition and reduce the progression or impact of their illness.*	7.5. Enhance linkages with public health programmes for warmer homes and smoking cessation to support those at risk of respiratory disease. Support seamless patient care and improved access to respiratory services for patients in rural communities. Explore the Continuous Positive Airways Pressure (CPAP) model of care that promotes and supports an annual patient review in the community.	Equitable access to respiratory services across urban and rural communities.
		Primary and secondary care access to nursing services in a collaborative approach with general practice.
		Establish multidisciplinary home-based care for lung disease.
		100% of 'frequently admitted' respiratory

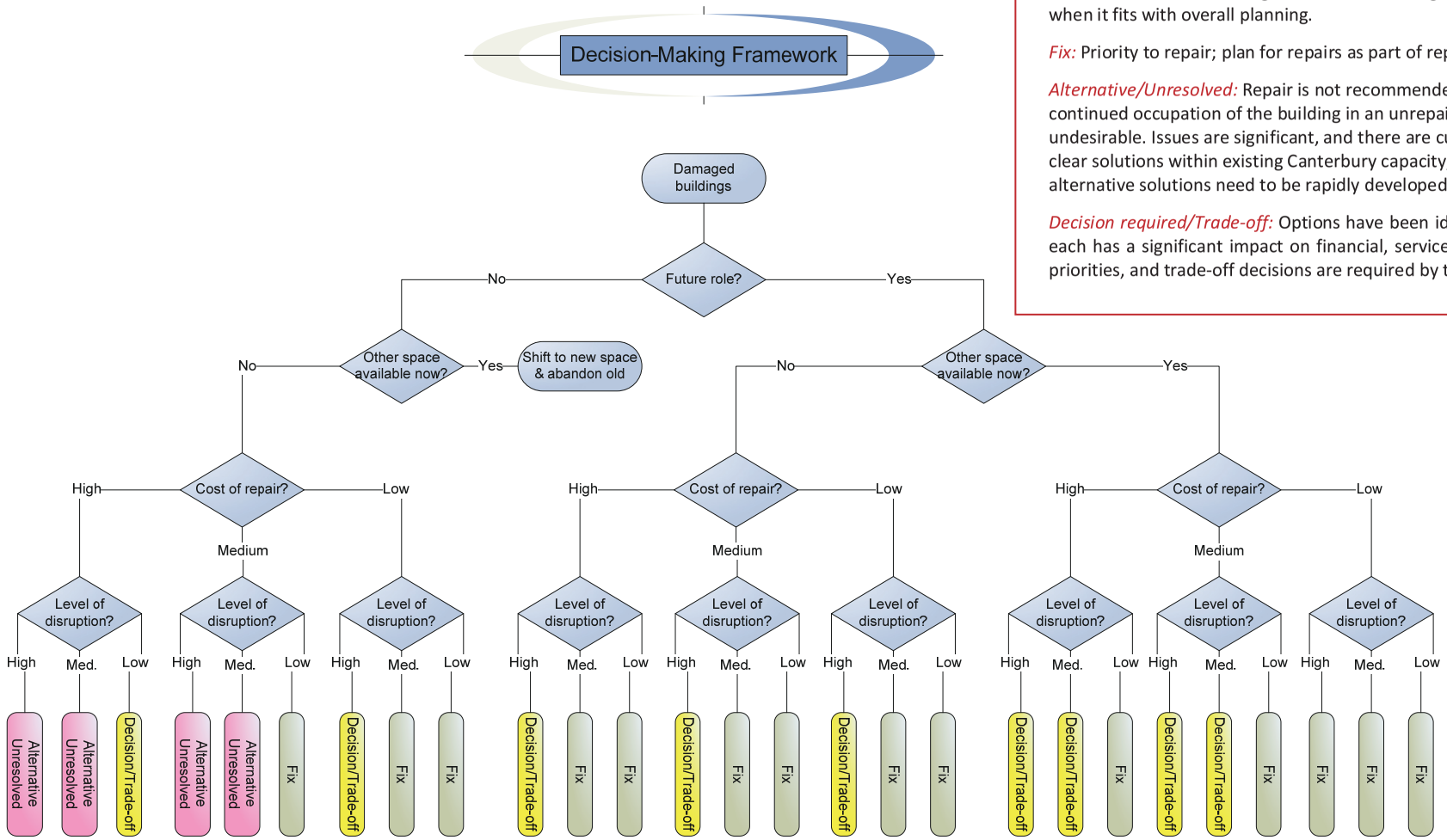
OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
	Work towards an integrated, multidisciplinary approach to the management of acute and sub-acute COPD at multiple points of intervention through the system including: primary care, acute demand, ambulance, ED and hospital discharge. Continue to support community-based respiratory nurses and Allied Health professionals across the system to reduce hospital admissions. Continue to invest in enhancing skills and competence in managing respiratory conditions. Expand Collaborative Care Management System (CCMS) capability to facilitate coordination between primary and secondary care providers for complex patients with long-term conditions. Focus on cardiology and respiratory patients who are frequent attendees at ED and hospital.	patients enrolled in CCMS by Q4. 10% reduction in COPD admissions and readmissions
	7.6. Support continued investment in rehabilitation programmes. To reduce the likelihood of an exacerbation or readmission and to support people to improve the quality of their lives.	More people access pulmonary rehabilitation programmes in the community – base 108.
Improve the identification of people at risk of diabetes. *To improve access to appropriate interventions that prevent admissions and to ensure that people with diabetes are managed under a structured programme or care plan.*	7.7. The Integrated Diabetes Service (IDS) Development and Operational groups and the Diabetes Consumer Group will develop an integrated approach for people with diabetes in Canterbury that is 'best for patient, best for system'. Implement a Diabetes Care Improvement Package which enhances the provision of diabetes care across the enrolled population with a particular emphasis on high-risk / high-needs groups.	Target high needs group defined by Q1. New Diabetes Care Improvement Package agreed by Q1. Strategy for newly diagnosed in place by Q2. More people with diabetes (identified by general practice) are supported to manage their diabetes.
Ensure people receive the right care in the right setting. *To support people to stay well, modify their lifestyles, better manage their conditions and reduce the progression of illness.*	7.8. Continue to invest in programmes that support lifestyle and behavioural modification to support people most at risk of Diabetes and CVD.	90 Appetite for Life courses delivered in the community.
	7.9. Continue to invest in programmes to manage people newly diagnosed with Type 2 diabetes and people with diabetes who are first starting insulin treatment. Design and implement clinical/patient education and tools for improving and supporting self management of diabetes. Provide support and training to general practice teams to enable them to provide good quality diabetes care in their local communities.	More people newly diagnosed with Type 2 diabetes access support in the community – base 163. More people starting insulin treatment access support in the community – base 69.
	7.10. Enhance collaboration between primary, community and secondary service providers. Expand access to specialist support (i.e. community diabetes nurses and dieticians) to increase capacity to support the management of people with diabetes.	79%of the proportion of the population identified with diabetes have HbA1c ≤64mmol/mol. 79%of the proportion of the Maori population identified with diabetes have HbA1c ≤64mmol/mol.
	7.11. Enhance access to specialist treatment in focus areas (i.e. retinal screening) to support the management of people with diabetes in line with the Diabetes Care Improvement Package.	More people with diabetes access retinal screening services
Improve the identification of people at risk of Cardiovascular Disease (CVD) *To improve access to appropriate intervention and support improved self management of CVD.*	7.12. Work with the PHO Performance Programme (PPP) and Partnership PHO to establish a baseline population who have had a CVD risk assessment in the last five years. Support general practice to accurately record CVD risk assessment provision through 1:1 coding education. Support national improvements to the available electronic tools that will enable efficient recording of CVD risk assessment data.	More eligible Maori people have had a CVD risk assessment in the past five years – base 12.8%. Progress towards achievement of the national health target by Q4 – base 13.7%
Ensure people receive the right care in the right setting. *To support people to stay well, modify lifestyles, better manage their condition and reduce the progression of illness.*	7.13. Review the cardiology patient pathways agreed between general practice and hospital specialists to support integrated CVD management.	CVD and cardiology HealthPathways reviewed by Q2.
	7.14. Maintain direct referral to exercise tolerance testing to support clinical CVD risk assessment.	

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
	7.15. Expand Collaborative Care Management System (CCMS) capability to facilitate coordination between primary and secondary care providers for complex patients with long-term conditions.	100% of 'frequently admitted' cardiology patients enrolled in CCMS by Q4.
Support rehabilitation programmes. *To reduce the likelihood of a subsequent CVD event or readmission and to support people to optimise recovery and improve the quality of their lives.*	7.16. Continue to support increased referral of people to cardiac and stroke rehabilitation after acute events. 7.17. Provide GP education to improve the management of cardiology patients in the community. 7.18. Explore combined rehabilitation programmes for people with long-term conditions under the CCN long-term conditions work stream.	More people access cardiac rehabilitation after an acute event – base 27%. More people access stroke rehabilitation after an acute event – base 71%.
8. Implement the Māori Health Workstream. *To promote Whānau Ora as the core 'future mindset' that allows us to change the way we think, plan and deliver our health services into the future.*	8.1. Support primary healthcare teams to provide competent care to Māori whānau in a manner that is consistent with the emerging direction on whānau ora.	Workshops covering the stage two, i.e. cultural competency material, will be delivered.
	8.2. Provide input to Māori Community Events which support whānau to live healthy lives within the community.	Five events will be supported during 2012/13.
	8.3. Work with He Oranga Pounamu and its Canterbury Provider Network to progress the Kura Pounamu implementation of Whānau Ora.	Evidence is provided to show that the health sector in Canterbury is working with He Oranga Pounamu to maximise the impact of both programmes.
9. Implement the Pacific Health Workstream. *To increase awareness and educate health professionals in best practice models of engagement with Pacific People.*	9.1. Implement the Pacific Health Action Plan to support Pacific peoples' access to primary health services and ensure that Pacific people experience good health outcomes.	Provide cultural competency training to general practice teams and pharmacy teams. One large group session and five small group rounds will be delivered before the end of September 2012. Participation in four Pacific Career guidance activities to promote health as a career option completed by 30th September 2012 Annual review and update of the Pacific Primary Health care report completed by July 30th 2012. Evidence for the development of a Pacific diabetes project will be gathered and reported on by December 2012.
	9.2. Pacific Scholarships offered to health students from Canterbury area.	5 Pacific scholarships are offered and awarded before 30th September 2012.
Enable the transformation activities across Canterbury and support the implementation of Business Case workstream initiatives.		
10. Provide clear communication with stakeholders about work that is underway	10.1. Develop and deliver sector-wide communications about the work that is underway, including internet and public reporting.	CCN communication plan is in place by Q1.
11. Continue to implement improvements in Information Technology.	11.1. Expand the use of e-Discharges, allowing summaries to be sent electronically to GPs, and the use of Éclair laboratory results reporting and electronic lab test sign-off.	E-referral process at CDHB safe and efficient by Q1.
	11.2. Complete the implementation of GP e-referrals into the Concerto framework, enabling Electronic Referral Management System (ERMS) /Concerto integration.	ERMS/Concerto integration complete by Q3.
	11.3. Support increased use of ERMS by general practitioners and improve the quality of referrals being sent.	70% of all Canterbury GPs have access to ERMS by Q2.
	11.4. Continue the rollout of ERMS to all hospital departments and to other South Island DHBs – beginning with the West Coast. Expand the referral management capability of the e-Referrals (Orion Phase 2) to improve the efficiency and allocation of resources and provide better health outcomes to patients.	Concerto e-Referrals in use in 8 of the highest referral volume departments by Q3. 70% of all GP referrals sent electronically by Q4.
	11.5. Take the next step in implementing eSCRV to provide secure universal access to key health information in any health setting. Complete the rollout to pharmacists, Nurse Maude and general practice and support them to contribute/access	100% of pharmacists and Nurse Maude have access to eSCRV by Q1. 90% of all community health professionals have access to eSCRV by Q2.

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
	appropriate information.	
	11.6. Expand Collaborative Care Management System (CCMS) capability to facilitate coordination between primary and secondary care providers for complex patients with long-term conditions. Monitor and report on patient outcomes for those enrolled in the Collaborative Care Programme (CCP) to evaluate success and encourage adoption of the programme across the system.	100% of respiratory and cardiology 'frequent attendees' in CCP by Q4. 25% of all patients identified with complex/long-term conditions in CCP by Q4 All GP and hospital interfaces completed Q4.
	11.7. Continue to develop a real-time integrated Lightfoot data set and introduce related data sets, including acute demand management, to inform and engage clinical staff in new solutions to influence demand.	Live weekly update of data available by Q1. Regional opportunities identified by Q3.
12. Broaden the range of partners within the Alliance Framework.	12.1. Continue to support the engagement of a range of organisations and clinical groups in transformation activities across Canterbury. Ensure system-wide clinical and community participation is built into the future activity of the CCN District Alliance.	More signatories to the district alliance agreement – base 4.
13. Continue to improve access to diagnostic services.	13.1. Continue the rollout of radiology e-referrals to provide GPs with direct access to diagnostics. Provide feedback to CRR referrers on their referral patterns in comparison with peers, and provide GP education and updates to HealthPathways on referral guidelines and best practice. Maintain a 'just in time' imaging approach that meets referral request times, including developing MRI capacity at CRR.	≥40% of CRR referrals are submitted electronically. ≥90% of CRR referrals are accepted on first referral. CRR fully operational for MRI by Q1. 100% of imaging is completed according to referral request time by the end of Q4.
	Complete the Testsafe/Radiology project to include CRR reports in the Testsafe South repository.	Radiology results are included in the Testsafe South repository by Q2.
	13.2. Work toward a fully integrated radiology service for Canterbury, integrating community and secondary care imaging requirements.	An alliance framework is developed in this area.
14. Implement new models for community pharmacy services.	14.1. Implement new dispensing arrangements for community pharmacy services that support better use of subsidised medicines by providing expert medicines advice to prescribers and patients.	Five demonstration sites operating by Q1. 12 demonstration sites participating by Q4.
15. Implement the new laboratory system	15.1. Ensure that an overarching clinical leadership model is applied to the laboratory service in a way that recognises the integrated nature of the health system.	New laboratory service contracted and operating under shared governance model by Q1.
	15.2. Review and implementation a plan for access to sample collection that improves rural access to laboratory testing.	Action plan developed by the end of Q2.
	15.3. Ensure that information is used in a way that optimises effective clinical practice.	Common test naming standards implemented by Q3. Increased access to Testsafe South by clinical referrers via the rollout of eSCRV. Involve laboratory based medical and scientific staff in supporting the development of HealthPathways
16. Continue to develop and implement the recommendations of the Flexible Funding Pool SLA.	16.1. Changes to the service and funding models used within primary care will be developed to improve primary care's ability to respond appropriately to its population.	Proposed changes will be put in place for at least some demonstration sites before the end of December 2012.
17. Immunisation	17.1. Refine the Immunisation Reporting Programme to enable NIR Administrators to provide more direct support to general practice, improve the accuracy of reporting and better locate unvaccinated children.	Regular NIR reports generated for GP practices to facilitate timely immunisation for 8-month-olds by Q1.
	17.2. Expand the Reporting Programme to include PHO-level Coverage Reports to help identify and address any gaps in service delivery.	PHO-level monitoring enabled by Q1.

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
	17.3. ISLA will lead improvements in the quality of immunisation services, monitor performance and ensure a 'whole of system' approach to immunisation. Raise public awareness of immunisation and increase coverage. Improve linkages and referral processes between LMCs, WellChild/Tamariki Ora providers and general practice to increase enrolment and coverage rates. Use outreach services to locate and vaccinate hard-to-reach children and those displaced by the quakes.	Immunisation promotion course provided for non-vaccinators delivered by Q2.
		90% of all new babies will have an identified WellChild/Tamariki Ora provider or GP by 2 weeks of age
		85% of all 8-month-olds fully vaccinated by Q4.
	17.4. Invest in free flu vaccinations for those under 18, as well as for older people (65+), to reduce winter demand on the Canterbury health system.	≥40% of young people (<18) have a seasonal flu vaccination.
		≥75% of the population (65+) have a seasonal flu vaccination.
	17.5. Identify and implement opportunities to link HPV immunisation with other vaccination programmes and improve promotion, delivery and coverage rates.	More young women will receive HPV Dose 1 – base 46%.

8.7 Decision-making framework for CDHB built infrastructure



Definitions of algorithm outputs

Abandon: If a critical structural weakness is identified, cease using the building as soon as practical. If no critical structural weakness exists but no longer useful, cease using the building when it fits with overall planning.

Fix: Priority to repair; plan for repairs as part of repair strategy.

Alternative/Unresolved: Repair is not recommended, but continued occupation of the building in an unrepaired state is undesirable. Issues are significant, and there are currently no clear solutions within existing Canterbury capacity, so alternative solutions need to be rapidly developed.

Decision required/Trade-off: Options have been identified, but each has a significant impact on financial, service or strategic priorities, and trade-off decisions are required by the Board.

8.8 Investment in our people

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Promote and support the desired culture of the CDHB. *To foster positive behaviours that support our transformation, improve employee engagement and ensure we are able to deliver on our strategic goals.*	Promote the desired culture via channels valued by the organisation including: Quality and Innovation Awards, Clinical Board 'Walk Rounds' and Mid-Winter Dialogues. Invest in programmes and initiatives that reiterate the desired behaviours and culture, including *'XcelR8', 'Particip8' and 'Releasing Time to Care'*. Introduce a diagnostic tool to assess current and ideal culture values and identify opportunities for change. Align systems for goal-setting, performance reporting, and communications to reinforce cultural messages.	Cultural diagnostic tool introduced by Q3. 2 service divisions running culture pilot project by Q3. 500 people particulate in XcelR8 and Particip8 programmes.
	Act on opportunities identified in the 2010 Staff Engagement Survey to improve engagement levels across the organisation (Career Development, Performance Management Incident Reporting). Use the data from the new attachment and exit technology to identify further opportunities for improvement. Re-run the Staff Engagement Survey in Q2 to evaluate progress and engagement levels since the initial survey.	1% overall improvement in employee engagement results. ≥80% of staff leaving would consider returning. ≥80% of staff recommend CDHB as an employer.
Implement change leadership and development programmes. *To engage our health workforce in the transformation of the system and ensure that change is accepted, long-term and sustainable.*	Establish clinical champions across the Canterbury health system to promote best practice and lead change. Support CCN Service Level Alliances and Workstreams to engage health professionals across the system in transformational change based on a 'best for patient, best for system' approach. Drive change through the development of clinically led patient pathways that support evidence-informed practice and improve health outcomes for patients. Deliver sector-wide communications about the work that is underway to support momentum, including online and public reporting.	CCN communication plan in place by Q1. CDHB Quality Accounts developed by Q2. >470 HealthPathways available across the Canterbury system by Q4.
	Introduce talent identification programmes and a core curriculum that support leadership development. Implement succession planning for critical leadership roles.	CDHB/WCDHB core curriculum in place by Q4.
Expand our workforce capacity through improved workforce planning, recruitment and retention. *To ensure we have the workforce we need to meet the future demand for services and that our workforce reflects the community it serves.*	Research and redefine Canterbury's brand and employee value profile as Christchurch City rebuilds. Invest in market mapping, profiling of candidates and alternative channels to engage prospective employees. Continue to support the NETP and NESP programmes and encourage our community partners to increase their intake. Expand access to the NETP website to allow community partners to access the site externally and improve communications. Develop an Allied Health, Technical and Scientific recruitment website to promote the varied roles and the contribution they make to the Canterbury and West Coast health systems. Lead the regional delivery of the Kia Ora Hauora Māori Workforce Development Service to encourage more Māori to work in health. Support scholarships to engage Māori and Pacific people in primary health fields. Introduce a Canterbury Alumni and Employee Referral Programme to keep people connected to Canterbury. Implement an Employee Resiliency Strategy to support our current workforce in stressful environment including workforce support and counselling programmes and wellness days.	1% overall improvement in CDHB retention rates. >100 nurses enrol in the NETP programmes. Allied Health, Technical and Scientific recruitment site running by Q2. CDHB Alumni established. 5 Pacific primary care scholarships awarded. 10 Māori primary care scholarships awarded. >250 Māori studying in health regionally.

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Continued… Expand our workforce capacity through improved workforce planning, recruitment and retention.	Share resources and develop a wider talent pool by leveraging off the use of shared recruitment and retention technology (Phoenix). Digitise all HR administration processes to streamline process and further integrate Canterbury and West Coast HR systems. Explore an integrated HRIS platform across the whole Canterbury health system to further expand the talent pool.	All WCDHB recruitment undertaken by CDHB by Q1. Hiring Managers recruitment time halved – base >4 days per annum.
Expand our workforce capability through improved training, education, learning and career development. *To support changes in technical skills, competencies that will enable people to expand their roles and support changes in behaviours that will improve performance levels and the quality of service provision to meet future demand for services.*	Work with undergraduate professions and training agencies to establish future capability requirements and ensure appropriate training spaces are available. Address barriers that currently limit staff from working to the full extent of their education, skills and experience. Support nurses to engage in PDRP to expand their scope of practice and identify advanced nursing opportunities in priority areas (BSMC, Aged Cared, Mental Health and Rehabilitation). Support allied health role development for: allied health assistants; pharmacy technicians; and advanced roles. Develop and implement peer support/mentoring programmes for practitioners working in isolation. Invest in education that aligns with the direction of the DHB to support general practice to develop competencies that support our transformation. Support ongoing skills development, building on CDHB learning and development plans and South Island Alliance workforce activities.	Credentialing process developed using the Nursing PDRP framework for expanded nursing practice. 10 people have completed Level 3 NZQA allied health assistant qualifications. 90% of Canterbury GPs have access to the primary care education programme. 85% of Canterbury Practice Nurses have access to the primary care education programme.
	Embed desired capabilities into recruitment processes, position descriptions, development plans and succession planning. Provide training in Sonar 6 performance management to ensure a consistent approach to setting expectations. Introduce online technology to allow more time for quality conversations on performance expectations. Introduce performance measures covering a combination of what (technical) and how (behavioural) to increase engagement in performance management and change.	Moodle technology learning and management systems and training portals established by Q4. 1,000 people complete Sonar 6 training. 70% of DHB employees use the online performance system by Q4.
Align workforce activity across the South Island. *To make the most effective use of our current workforce and ensure we have the workforce we need to meet the future demand for services across the South Island.*	Support the Regional Training Hub to analyse workforce trends and future requirements and identify appropriate responses to identified workforce gaps. Support the regional coordination of clinical placements to specialist training programmes. Identify opportunities to deliver or connect education to professional groups under the South Island Alliance workstreams. Develop a regional programme of peer support/mentoring, education and training that encourages post graduate studies. Review and standardise the career pathways and training opportunities for PGY1 and PGY2 students. Review and standardise career planning for HWNZ funded trainees. Implement a minimum of three innovative new clinical placements/new roles of practice. Review and support improvements to regional education sessions, forums, peer support and mentoring using innovative approaches including e-learning and video conferencing. Strengthen the training network within Te Waipounamu and facilitate the coordination and delivery of post-graduate training and education to all workforce groups.	Data analysis for South Island health workforce complete by Q1. Annual Plans by priority workstream agreed by Q2. Peer support/mentoring programme agreed by Q2. Regional programme to promote post graduate studies agreed by Q3. Review on PGY1 and PGY2 training complete by Q3. 100% of HWNZ-funded staff have career plans in place by Q4. 3 new placements/roles implemented by Q4. South Island health workforce plan developed by Q4.
	Support the development of a common set of regional workforce planning tools, core HR policies and HR metrics. Establish common DHB individual employment agreement contracts and common HR guidelines for joint appointments.	5 core HR policies adopted by all SI DHBs by Q4.

8.9 Investment in information systems

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Support the closer alignment of clinical information across the Canterbury health system. *To provide shared access to clinical information that enables timely clinical decision-making at the point of care and supports the integration of services.*	Expand the use of HealthPathways across the Canterbury health system to support the delivery of right care and support in the right place at the right time. Support the expansion of HealthInfo (the publicly available companion site to HealthPathways) to provide our population with the information they need to take more responsibility for managing their own health.	>470 HealthPathways available across the Canterbury system. Ongoing active review of current HealthPathways.
	Expand the use of e-Discharges, allowing summaries to be sent electronically to GPs, and the use of Éclair laboratory results reporting and electronic lab test sign-off. Complete the implementation of GP e-referrals into the Concerto framework, enabling ERMS/Concerto integration.	E-referral process at CDHB safe and efficient by Q1. ERMS/Concerto integration complete by Q3.
	Support increased use of ERMS by general practitioners and improve the quality of referrals being sent. Continue the rollout of ERMS to all hospital departments and to other South Island DHBs – beginning with the West Coast. Expand the management capability for referrals received by DHB hospitals (Orion Phase 2) to improve the efficiency and allocation of resources and provide better health outcomes to patients.	70% of all Canterbury GPs have access to ERMS by Q2. Concerto e-Referrals in use in 8 of the highest referral volume departments by Q3. 70% of all GP referrals sent electronically by Q4.
	Take the next step in implementing eSCRV to provide secure universal access to health information in any health setting and complete the rollout to pharmacists, Nurse Maude and GPs.	Pharmacists and Nurse Maude have access to eSCRV by Q1.
	Expand CCMS capability to facilitate coordination between primary and secondary care providers for complex patients with long-term conditions. Engage primary, secondary and pharmacy providers in managing their complex patients via the CCMS. Monitor and report on patient outcomes for those enrolled in the Collaborative Care Programme (CCP) to evaluate success and encourage adoption of the programme across the system.	100% of respiratory and cardiology 'frequent attendees' in CCP by Q4.77 25% of all patients identified with complex/long-term conditions in CCP by Q4 All GP and hospital interfaces completed Q4.
	Continue to develop the real-time integrated Lightfoot data set, including acute demand management, to inform and engage clinical staff in new solutions to influence demand.	Live weekly update of data available by Q1.
Support the closer alignment of clinical information across the South Island. *To improve regional networking and enable continuums of care that sit across regions but still allow timely informed clinical decision-making at the point of care.*	Support the expansion of HealthPathways beyond Canterbury in order to improve the management of referrals and patient care across regions.	All South Island DHB have adopted HealthPathways Q1.
	Support the implementation of a unified SI approach to the Concerto Clinical Information System by taking the lead in the implementation on the West Coast DHB by end of Q1. Coordinate the rollout and use of ERMS across the South Island beginning with West Coast but including all by Q1 2013/14.	Single Concerto record across CDHB/SCDHB/WCDHB by Q3. Phase I ERMS on the WC by Q3. Phase I ERMS in all South Island DHBs by Q1 2013/14.
	Support the migration of West Coast DHB laboratory information to the Regional Solution (TestSafe South) as the next step in creating a single laboratory/pharmacy repository.	Single laboratory and pharmacy repository across CDHB/WCDHB by Q3.

[77] *'Frequent attendees' are defined as those with complex/long-term conditions and 4+ visits to ED within a year.*

OUR PERFORMANCE STORY 2012/13		
OBJECTIVE	**ACTION**	**EVIDENCE**
Continued… Support the closer alignment of clinical information across the South Island.	Support the SI Information Services Service Level Alliance to achieve a single SI Patient Administration System (PAS). Prepare to implement single SI PAS in Canterbury by Q1 2014.	Business case for regional approach to PAS submitted for approval Q2.
	Coordinate and support the implementation of the South Island Clinical Cancer Information System (SICCIS) and align Canterbury and Southern DHB endoscopy software.	SICCIS in place by Q2. Endoscopy in place by Q3.
	Coordinate and support the ongoing expansion of InterRAI and consolidate the use of the InterRAI suite to improve the quality and clinical applicability of the platform. Expand InterRAI to accommodate ARC and HBSS modules. Provide regular and consistent data extractions to the SI HOP Service Managers and Planning and Funding Manager.	InterRAI incorporated into assessment processes of all 5 South Island DHBs by Q4. All long-term ARC and HBSS clients assessed using InterRAI prior to entry.
Improve the quality of data collection and storage. *To support clinical quality and efficiencies, and better inform service planning and development.*	Coordinate and support the SI Health Telecommunications Network and support the Network to carry increased traffic and connect regional healthcare agencies together. Move data centre facilities to tier 3 facilities which will further support regional initiatives, reliability and disaster recovery. Identify and implement initiatives that improve the quality of data collection and provide training that emphasises the need for National Health Index (NHI) and ethnicity data recording.	Selection and shift to new data centre complete by Q2. NHI duplications are $\leq$6%. Ethnicities set to 'Not stated' or 'Response Unidentifiable' in the NHI are $\leq$2%.
Support the implementation of National IT Solutions. *To optimise the use of national health resources and improve quality across the health system.*	Support the National Health IT Board to implement the national Medication Safety Programme. Establish a regional medicines management group. Implement 'Medchart' across inpatient settings and align with the NZ Universal List of Medicines. Support the IT Health Board's e-Prescribing service once national timelines are finalised.	Statement of Intent on regional alignment agreed by Q1. Regional e-Pharmacy available by Q2. First inpatient wards using Medchart by Q4.

8.10 Statement of accounting policies

The prospective financial statements in this Statement of Intent for the year ended 30 June 2013 are prepared in accordance with Section 38 of the Public Finance Act 1989 and they comply with NZ IFRS, 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 8 of the Statement of Intent.

REPORTING ENTITY AND STATUTORY BASE

Canterbury DHB ("Canterbury DHB") is a Health Board established by the New Zealand Public Health and Disability Act 2000. Canterbury DHB is a Crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand. Canterbury DHB 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.

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

Canterbury DHB'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 Canterbury DHB consist of Canterbury DHB, 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). From 1 December 2011, the operation and staff of South Island Shared Service Agency Ltd (SISSAL) were transferred over to Canterbury DHB and managed under the South Island Alliance Programme Office.

The Canterbury DHB 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 New Zealand Public Health and Disability Act 2000 and Section 154 of the Crown Entity Act 2004, which includes the requirement to comply with New Zealand Generally Accepted Accounting Practice (NZ GAAP). In accordance with NZ GAAP, the consolidated financial statements comply with New Zealand equivalents to International Financial Reporting Standards (NZ IFRS), 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 Canterbury DHB 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 that are not yet effective and have not been early adopted

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.
- NZ IAS 24 *Related Party Disclosure (Revised 2009)* replaces NZ IAS 24 *Related Party Disclosures (Issued 2004)* and will be applied for the first time in the DHB and group's 30 June 2012 financial statements. Changes to disclosure requirements include: more information is required to be disclosed about transactions between the DHB and entities controlled, jointly controlled, or significantly influenced by the Crown; clarifies that related party transactions include commitments with related parties and information is required to be disclosed about any related parties with Ministers of the Crown.
- FRS-44 New Zealand Additional Disclosures and Amendments to NZ IFRS to harmonise with IFRS and Australian Accounting Standards (Harmonisation Amendments) – These were issued in May 2011 with the purpose of harmonising Australia and New Zealand's accounting standards with source IFRS and to eliminate many of the differences between the accounting standards in each jurisdiction. The amendments must first be adopted for the year ended 30 June 2012. Canterbury DHB has not yet assessed the effects of FRS-44 and the Harmonisation Amendments.

As the External Reporting Board is to decide on a new accounting standards framework for public benefit entities, it is expected that all new NZ IFRS and amendments to existing NZ IFRS with a

mandatory effective date for annual reporting periods commencing on or after 1 January 2012 will not be applicable to public benefits entities. This means that the financial reporting requirements for public entities are expected to be effectively frozen in the short-term. Accordingly, no disclosure has been made about new or amended NZ IFRS that exclude public benefit entities from their scope.

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.

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

Subsidiaries

Subsidiaries are entities controlled by Canterbury DHB. Control exists when Canterbury DHB 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.

Canterbury DHB 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 Canterbury DHB has significant influence, but not control, over the financial and operating policies.

The consolidated financial statements include Canterbury DHB'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 Canterbury DHB's share of losses exceeds its interest in an associate, Canterbury DHB's carrying amount is reduced to nil and recognition of further losses is discontinued except to the extent that Canterbury DHB has incurred legal or constructive obligations or made payments on behalf of an associate.

Canterbury DHB's investments in associates are carried at cost in Canterbury DHB'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 Canterbury DHB'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 comprehensive income.

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 Canterbury DHB in its Annual Plan and included in the Statement of Intent tabled in parliament. The budget figures have been prepared in accordance with NZ IFRS, using accounting policies that are consistent with those adopted by Canterbury DHB 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 fitout 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 comprehensive income. Any decreases in value relating to 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 other comprehensive income. 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 New Zealand Public Health and Disability Act 2000, the assets and liabilities of Canterbury Health Ltd were vested in Canterbury DHB on 1 January 2001. Accordingly, assets were transferred to Canterbury DHB at their net book values as recorded in the books of Canterbury Health Ltd. In effecting this transfer, the DHB 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 Canterbury DHB 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 Canterbury DHB. All other costs are recognised in the surplus or deficit when incurred.

Disposal of Property, Plant and Equipment

Where an item of plant and equipment is disposed of, the gain or loss is recognised in the surplus or deficit. It 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 surplus or deficit 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 & Fit Out	10 – 50	2 - 10%
Leasehold Building	3 – 20	5 - 33%
Plant, Equipment & 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 Canterbury DHB 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 surplus or deficit when 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 surplus or deficit 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 other comprehensive income.

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 surplus or deficit. Where these investments are interest-bearing, interest calculated using the effective interest method is recognised in the surplus or deficit.

Financial assets classified as held for trading or available-for-sale are recognised/derecognised on the date Canterbury DHB 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 Canterbury DHB'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 surplus or deficit.

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 surplus or deficit.

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 other comprehensive income even though the financial asset has not been derecognised. The amount of the cumulative loss that is recognised in other comprehensive income is the difference between the acquisition cost and current fair value, less any

impairment loss on that financial asset previously recognised in other comprehensive income.

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 the asset's ability to generate net cash inflows and where Canterbury DHB 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 other comprehensive income, a reversal of the impairment loss is also recognised in other comprehensive income.

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 liabilities 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 surplus or deficit 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 surplus or deficit as incurred.

Defined benefit plans

Canterbury DHB 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 or 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

Canterbury DHB'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 New Zealand government bonds at the year end date. Canterbury DHB accrues the obligation for paid absences when the obligation both relates to employees' past services and it accumulates. The sick leave amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date to the extent Canterbury DHB 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 Canterbury DHB 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

Canterbury DHB belongs to the ACC Partnership Programme whereby the DHB accepts the management and financial responsibility for employee work related illnesses and accidents. Under the programme the DHB 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 DHB 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

Canterbury DHB 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. Canterbury DHB 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 surplus or deficit.

Income tax

Canterbury DHB is a crown entity under the New Zealand 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

Canterbury DHB 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 Canterbury DHB, 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 Canterbury DHB and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by Canterbury DHB.

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 surplus or deficit on a straight-line basis over the term of the lease. Lease incentives received are recognised in the surplus or deficit 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 surplus or deficit.

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 Canterbury DHB's accounting policies

The preparation of financial statements in conformity with NZ IFRS 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 Canterbury DHB 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 Canterbury DHB to consider a number of factors such as the physical condition of the asset, expected period of use of the asset by Canterbury DHB, 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 surplus or deficit, and carrying amount of the asset in the statement of financial position. Canterbury DHB minimises the risk of this estimation uncertainty by:

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

In light of the Canterbury earthquakes, Canterbury DHB has reviewed the carrying value of land and buildings, resulting in an impairment of land and buildings. Other than this review, Canterbury DHB has not made any other significant changes to past assumptions concerning useful lives and residual values.

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 Canterbury DHB.

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.

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

Non-government grants

Canterbury DHB 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.

8.11 Minister of Health's letter of approval

Office of Hon Tony Ryall

Minister of Health
Minister for State Owned Enterprises

RECEIVED
2 8 MAR 2013
BY:

11 March 2013

Mr Bruce Matheson
Chair
Canterbury District Health Board
PO Box 1600
Christchurch 8140

Dear Mr Matheson

Canterbury District Health Board 2012/13 Annual Plan

This letter advises that together with the Minister of Finance, I have approved and signed Canterbury District Health Board's (DHB) 2012/13 Annual Plan for one year.

I appreciate the significant work that goes in to preparing such a thorough annual planning document especially considering the difficulties you have faced during the earthquake recovery process. I understand the uncertainty the earthquakes created in forecasting your likely financial performance. The delay in finalising the Annual Plan allowed more certainty and a revision of your forecast financial performance to a $40M deficit. I look forward to seeing your progress as I monitor your achievements over the remaining course of the year.

While recognising these are tight economic times, the Government is dedicated to improving the health of New Zealanders and continues to invest in key health services. In Budget 2012, Vote Health received the largest increase in government spending, demonstrating the Government's on-going commitment to safeguarding and growing our public health services.

Health targets

Government Health Targets are selected to drive on-going improvements in specific priority areas in order to meet the public's growing expectations of accessing quality health care.

I appreciate your DHB's efforts to deliver on the Health Targets and your progress in achieving these. Your plan acknowledges the changes in focus with regard to the cancer, immunisation and tobacco targets and identifies actions to support their achievement. I am satisfied the activities you have identified in your Annual Plan will deliver on these new targets, while building on current achievements for emergency departments and electives, as well as cardiovascular disease and diabetes.

Shorter waiting times

The Government has made commitments to New Zealanders to deliver even faster access in a number of key areas including elective surgery, diagnostic tests, chemotherapy treatment and youth drug and alcohol services. Thank you for your work to support these commitments in particular the commitment to ensure no one waiting more than six months for a first specialist assessment (FSA) or treatment by 30 June 2013 and a reduction of waiting times to the Government's goal of five months by 31 December 2013. I look forward to seeing your planned results in these priority areas.

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

Regional Integration

Greater integration between regional DHBs supports more effective use of clinical and financial resources. I expect DHBs to make significant progress in implementing their Regional Service Plans, including actions for identified Government priorities and your agreed regional clinical priorities.

Included in these priorities are the achievements of regional workforce, IT and capital objectives that have been set, as well as your on-going support for the work of Health Benefits Limited, the National Health Committee and the Health Quality and Safety Commission.

I understand that the National Health Board (NHB) will be hosting a meeting of all South Island DHBs regarding electives delivery and how to appropriately use the available capacity within the region. I encourage and look forward to seeing tangible benefits provided to patients as a result of this important regional initiative being implemented.

It is evident from your Annual Plan that your DHB is working to realise the benefits of regional and sub-regional collaboration, and that this influences your local service planning. I look forward to seeing delivery on your agreed Regional Service Plan actions as detailed in your Annual Plan.

Integrated care

I expect all DHBs to increase their focus on service integration, particularly with respect to primary care, ensuring the scope of activity is broadened and the pace significantly stepped up. I look forward to seeing your DHB continuing its integrated care approach driving delivery and improved performance, particularly with respect to unplanned and urgent care, long term conditions and wrap around services for older people.

I am pleased to see an enhanced commitment to achieving this priority area in your Annual Plan and movement towards more tangible actions to show how you will achieve real progress towards providing a better range of services in the community. I expect you to be active in advancing these improvements to the way primary and community services are delivered closer to home. The Ministry of Health (the Ministry) and NHB will be working closely with DHBs to support the implementation of integration work programmes.

Living within our means

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

Approval of your Annual Plan is conditional upon your Board fully supporting the investment required in Health Benefits Limited's Finance, Procurement & Supply Chain detailed business case.

I understand the uncertainty for your DHB regarding population and health needs over the three year period as the area continues to recover from the impact of the earthquakes. For this reason I have only provided approval for a single year. I am prepared to accept a deficit of up to $40M for this year and I will be watching with keen interest your progress against these planned results. I am also prepared to provide up to $40M of Earthquake deficit funding for this year provided that your DHB demonstrates its need to the Ministry. It is important that your Board works hard to reduce the deficit track in the coming years and also maintain the expected service performance.

Savings from the community pharmaceutical budget

Earlier in the year, I directed DHBs to put the $30M savings from the community pharmaceutical budget for 2012/13 towards the following initiatives:

- extending zero fees for primary care for children under six to afterhours;
- providing support for child and adolescent mental health services;
- implementing the faster cancer treatment initiative;
- supporting smart investment home care for older people;
- providing an increase in aged care residential subsidy for bed day price, and for further improvements in dementia services.

I am interested to follow your progress in implementing these initiatives.

Health of older people

Our aging population poses many challenges to the health system and addressing these challenges is a Government priority. DHBs are expected to develop wrap around services for older people and continue to invest in home and community support services, including post hospital discharge support to reduce acute admissions.

I am pleased to see detail in your Annual Plan on how you are planning to deliver health services for older people. I am particularly interested to follow your progress in relation to the provision of organised stroke services, services to reduce acute admissions, improvements in respite care and the development of dementia care pathways.

Whānau Ora

Whānau Ora is an inclusive interagency approach to providing health and social services in which DHBs play a key role. I expect your DHB's planned actions to deliver on Whānau Ora to reflect the strategic change, confirmed support to selected Whānau Ora collectives greater involvement of DHB leaders and activities to improve performance and build mature providers.

Prime Minister's Youth Mental Health Project

The Prime Minister's Youth Mental Health Project's cross-agency initiatives aim to prevent youth mental health problems developing and improve access to specialised treatment for those who need it. I would like to thank you for your demonstrated commitment to this Government priority, including through your planned actions to build capacity and capability of specialist child and youth mental health and addition services, in order to improve service responsiveness.

Cardiac Services

The focus on improving access to cardiac surgery has resulted in very positive outcomes for patients over recent years. I am pleased to see your commitment to continuing progress in this area, through reducing waiting times and ensuring an appropriate level of access during 2012/13, not only for surgery, but across a wider suite of cardiac services.

The link between regional networks and cardiac providers is very important in this area, and I expect your local contribution to align with regional planning, and for regional collaboration to be strengthened to support delivery, waiting list management, and improved patient pathways.

Diabetes Care

This year each DHB has been asked to develop a Diabetes Care Improvement Package in consultation with primary care partners, to better support prompt access to services and increasingly more effective management of people with diabetes.

These packages should enable innovation in service delivery, more focused activity to improve patient care where it is most needed and are to be built with strong evidence based best practice in mind. They should build on the good practice already provided through general practice to enhance and optimise outcomes for patients. I look forward to following the progress of these packages with your primary care partners.

Community Pharmacy Services Agreement

DHBs have undertaken to provide a well executed transition to the new Community Pharmacy Service Agreement. I know you will want to ensure your management confirms this happens locally.

Annual Plan Approval

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

The Government is actively considering the business case for capital investment in redeveloping Christchurch's hospitals. A decision by the Government will be made in the near future and will rely upon your DHB providing a sound financial and clinical platform to base the investments upon.

I would like to thank you, your Board and management for your valuable contribution and continued commitment to delivering quality health care to your population in the most difficult circumstances in which the earthquakes left. The DHB's response to the earthquakes and the recovery from the damage is a tribute to all staff of your organisation and to all of Canterbury's health system. I wish you every success in the remaining part of the year. The challenges you are facing will continue including the need to manage the financial position of the DHB. To assist you at a governance level the National Health Board will contact you regarding the appointment of an advisor to assist with liaison with Wellington.

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

Yours sincerely

Hon Tony Ryall
Minister of Health


our health system