CANTERBURY DISTRICT HEALTH BOARD

ANNUAL PLAN

Incorporating the 2019/20 Statement of Performance Expectations

2019/20

Statement of Joint Responsibility

The Canterbury District Health Board (DHB) is one of 20 DHBs established under the New Zealand Public Health and Disability Act in 2001. Each DHB is categorised as a Crown Agent under the Crown Entities Act, and is accountable to the Minister of Health for the funding and provision of public health and disability services for their resident populations.

This document is our Annual Plan which has been prepared to meet the requirements of the New Zealand Public Health and Disability Act, Crown Entities Act, Public Finance Act, and the expectations of the Minister of Health.

This document sets out our strategic goals and objectives and describes what we aim to achieve in terms of improving the health of our population and ensuring the sustainability of our health system. It also contains our Statement of Performance Expectations for the coming year and actions we will take in response to national priorities and expectations in 2019/20.

The Statement of Performance Expectation is presented to Parliament and used at the end of the year to compare planned and actual performance. Audited results are presented in the DHB's Annual Report.

The Canterbury DHB has made a strong commitment to 'whole of system' service planning. We work collaboratively and in partnership with other service providers, agencies and community organisations to meet the needs of our population and support a number of clinically-led Alliances as key vehicles for implementing system improvement and change.

Our alliance framework means we share a joint vision for the future of our health system with our alliance partners and agree to work together to improve health outcomes for our shared population. This includes our large-scale Canterbury Clinical Network (CCN) District Alliance, with twelve local provider partners, the South Island Regional Alliance with our four partner South Island DHBs and our transalpine partnership with the West Coast DHB.

The DHB recognises its role in actively addressing disparities in health outcomes for Māori and is committed to making a difference. We work closely with Manawhenua Ki Waitaha, both directly and through the CCN Alliance, to improve outcomes for Māori in a spirit of communication and co-design that encompasses the principles of Te Tiriti o Waitangi.

In signing this document, we are satisfied that it fairly represents our joint commitment and intentions for the coming year, and is in line with Government expectations for 2019/20.

Dr John Wood
CHAIR | CANTERBURY DHB

Ta Mark Solomon
DEPUTY CHAIR | CANTERBURY DHB

David Meates
CHIEF EXECUTIVE | CANTERBURY DHB

Honourable Dr David Clark
MINISTER OF HEALTH

Honourable Grant Robertson
MINISTER OF FINANCE

September 2019

Minister's Letter

Hon Dr David Clark

MP for Dunedin North
Minister of Health

10 June 2020

Sir John Hansen
Chair
Canterbury District Health Board

Dear Sir John

Canterbury District Health Board 2019/20 Annual Plan

This letter is to advise you that it is the decision of both the Minister of Health and the Minister of Finance that Canterbury District Health Board's (DHB's) 2019/20 Annual Plan, as submitted by the previous DHB governance, will not be approved.

I have made my expectations on improving financial performance very clear. I note that your DHB has planned the largest deficit among DHB's for the 2019/20 year. Current DHB financial performance is not sustainable, despite Government providing significant funding growth to DHBs in the past two Budgets.

I am aware that your DHB has set up several task forces to address the changes required to help drive operational and financial sustainability. This is a positive step with good work to date. There is more work to do and more could be done in 2019/20 and I support the plans for this work to progress. It is expected that as Chair, along with your Board you look at opportunities to significantly reduce your DHBs deficit. I look forward to receiving updates on the result of this work.

I also expect you will continually manage and monitor your cash position on a monthly basis with an ongoing year forecast.

I have already asked the Ministry to request further detail on the development of your savings plans for out-years, including a granular and phased focus on cost containment, productivity and efficiency, quality, safety and Māori health and equity.

It is critical that a strong and deliberate approach is taken to out-year financial plans including your operating revenue, expenditure budgets and specific sustainable savings plans.

I am aware you are planning a number of service reviews in the 2019/20 year. Please ensure that you advise the Ministry of Health (Ministry) as early as possible of any proposals for service change that may require Ministerial approval. Any capital business cases are also to be approved through the normal process. I am aware of the work that is being undertaken to progress the first stage Site Master Plan. I expect this process to continue to be managed throughout and I look forward to this being progressed promptly.

+64 4 817 8709 Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand d.clark@ministers.govt.nz beehive.govt.nz

I encourage you to continue to work with the Ministry to ensure Christchurch Hospital Hagley building (acute services) is completed as soon as possible with a safe transition.

It is very important that the health sector continues to deliver timely and effective services so that we can provide high quality and equitable outcomes for New Zealanders that will deliver on our Government's Wellbeing priorities.

I am looking forward to seeing continued support and progress in these priority areas and ask that you maintain a strong oversight of your team against the actions agreed by the Ministry in your Annual Plan.

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

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

Yours sincerely

Hon Dr David Clark
Minister of Health

Hon Grant Robertson
Minister of Finance

cc Mr David Meates, Chief Executive, Canterbury District Health Board

Dr Lester Levy, Crown Monitor, Canterbury District Health Board

Table of Contents

Foreword from the Chair and Chief Executive

Canterbury remains a very challenging environment. We continue to deal with the ongoing impacts and underlying stressors related to a range of significant events that have affected our community.

- *4 September, 2010, Mag 7.1 earthquake*
- *22 February, 2011, Mag 6.3 earthquake*
- *13 June 2011, Mag 6.4 earthquake*
- *23 December 2011, Mag 6.0 earthquake*
- *2013 and 2014, Several Serious Floods*
- *14 February 2016, Mag 5.7 earthquake*
- *14 November 2016, Mag 7.8 earthquake*
- *13 February 2017, Port Hills Fire*

In March 2019, our community was exposed to another extreme and devastating event, when two Christchurch Mosques were the target of a terrorist attack that took the lives of 51 people and sent our city into lockdown.

We are proud to be part of a health system that stepped up in such a remarkable way to respond to the needs of the victims and their families. We want to thank our primary and community partners who collaborated to provide community support, and our Mana Ake teams who reached into school communities. We particularly want to thank our staff who worked tirelessly in the days and weeks following the attack to provide care in the most traumatic of circumstances.

We know from experience that the ongoing impact for the victims, families, Muslim community and some of our wider population will be a complex process and it will take time. The future wellbeing of our population is reliant on a responsive and flexible approach, informed by local need and supported by central government. As we move forward, we are working closely with other agencies and organisations to provide a locally-led and integrated wellbeing response, to ensure people get the help they need when they need it. Included in this work is the development of an online Resilience Hub, a central point for health and wellbeing support.

Committing to a sustainable future

In acknowledging our unique environment and challenges, we remain committed to an approach which recognises our strengths and continues to build a more integrated and resilient system. Our vision is simple, an integrated health system that keeps people healthy and well, in their own homes and communities. We are a connected health system, centred around people, and a strong platform exists for the next phase of our journey.

In moving forward, we are committed to working alongside the Ministry of Health to navigate the challenges our health system faces. The recent appointment of a Crown Monitor will help facilitate this, and represents an opportunity to ensure that the Government and the DHB are well aligned and to support the development of a sustainable operational pathway for the future.

The commissioning of our new facilities remains an essential element in our sustainability. We need to rebuild our lost capacity and enable investment in the infrastructure needed to meet the increasing demand for services as our population continues to grow.

The completion of the Hagley Building on Christchurch Hospital's campus will allow us to regain some of the capacity lost following the earthquakes, bring theatres back into operation, upgrade our intensive care and emergency departments, create much needed space for services and enable more integrated service delivery.

Before we can realise the efficiencies completion of this building will allow, we need to undertake the significant migration of existing services into the new building and the repatriation of outsourced services. New Zealand's largest ever hospital migration, it will be a sizable and incredibly complex piece of work for our teams in the coming year. Almost 3,000 staff and up to 300 patients will need to migrate into the new building over a two-week period.

Approval for the construction of the new mental health facility on the Hillmorton campus will allow us to relocate services stranded on The Princess Margaret Hospital site and make significant improvements in the experience of mental health consumers, their families and our staff. The planning and design phases have commenced and the new facility is expected to be complete by 2023.

Collaborating for better outcomes

In the coming year we will focus on service efficiency and improving the flow of patients across our system to reduce the pressure on specialist services. We will work with our primary care partners to implement the Government's direction for primary mental health care and continue our commitment to cross-sector collaboration, including the Mana Ake initiative in schools to improve the wellbeing of our young people and ACC partnerships to reduce harm and enhance recovery. We will also be looking to build community capacity to further support the integration and delivery of services such as: palliative care, mental health and addiction services, maternity services, rural health services, community nursing, restorative care and rehabilitation.

As the largest health service provider in the South Island, we will continue to work with our regional counterparts, particularly the West Coast DHB as part of our shared transalpine model, to support the delivery of services and progress regional priorities outlined in the South Island Regional Health Services Plan. We will also continue to support the roll-out of regional information systems and solutions, including the South Island Patient Information Care System (PICS). When fully implemented, this single shared electronic system will help to simplify access to patient information and support improved clinical decision making, no matter where in the South Island a person is treated.

Addressing equity

In the coming year, we will build on our partnerships with our Māori and Pacific providers and Whānau Ora agencies, to provide communities with access to the services they need earlier, and improve the health and wellbeing of our Māori and Pacific populations. Working together we are strengthening our focus on actions that eliminate inequity. These actions are outlined in our Annual Plan and System Level Measures Improvement Plan. To support this work, we are also deliberately investing in strategies to build a workforce that better reflects the diversity of our community.

Supporting our people

In supporting our community's recovery, we need to ensure that we have strong teams in place. We will progress the implementation of our People Strategy to create an environment where our people can thrive. In supporting the health and wellbeing of our staff, we will also look to address growing sick leave rates to contribute to a more sustainable future.

As always, we remain focused on continuing to deliver high quality care to our community. We know that we could not achieve what we do without the ongoing support of our people, both those who work for and those who work with us. We look forward to working alongside you in the coming year to make it better for the people of Canterbury.

David Meates
Chief Executive

John Wood
Chair, Canterbury DHB

September 2019

OVERVIEW

Who are we and what do we do?

Introducing the Canterbury DHB

1.1 Who are we

The Canterbury District Health Board (DHB) is one of twenty DHBs in New Zealand, charged by the Crown with improving, promoting and protecting the health and independence of our resident populations.

In 2019/20, we will receive approximately $1.945 billion dollars from Government with which to meet the needs of our population. In accordance with legislation and consistent with Government objectives, we use that funding to:

Plan the future direction of our health system and, in collaboration with clinical leads and alliance partners, develop demand strategies and determine the services required to meet the needs of our population.

Fund the health services required to meet the needs of our population and, through our collaborative partnerships and ongoing performance monitoring, ensure these services are safe, equitable and effective.

Provide the health services to our population, through our hospital and specialist services, general practices, and community and home-based support services.

Promote and Protect our population's health and wellbeing through investment in health protection, promotion and education services and the delivery of evidence-based public health initiatives.

1.2 What makes us different?

The Canterbury DHB has the second largest population of any DHB in the country. In 2019/20 we will be responsible for 578,340 people, 11.6% of the total New Zealand population.

We own and operate six major facilities: Christchurch, Christchurch Women's, Hillmorton, Burwood, Princess Margaret and Ashburton Hospitals, and many smaller urban and rural facilities, and cover the second largest geographical area of any DHB - 26,881 square kilometres and six Territorial Local Authorities.

We are the largest trauma centre in New Zealand and the fifth largest in Australasia. We deliver the second largest number of elective (planned) surgeries in the country and deliver half of all the elective surgery provided in the South Island.

We employ more than 10,700 people across our service divisions and facilities, making us the largest employer in the South Island. We also hold and monitor over 1,000 service contracts and agreements with other organisations, agencies and individuals who provide health and disability services for our population. This includes: general practice; pharmacy; laboratory; maternity; child health; personal health; mental health; dental; residential and aged care service providers; private hospitals; and the three Primary Health Organisations in Canterbury.

1.3 Our regional role

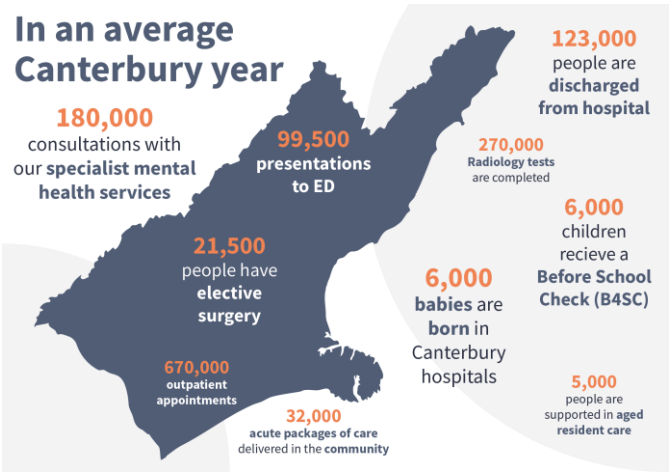
As the second-largest tertiary service provider and the largest trauma centre in the country, Canterbury provides an extensive range of highly specialised services to people from other DHBs where the service or treatment is not available.

This regional demand is complex in nature and growing steadily. In the five years to June 2017, there was a 9.5% increase in hospital admissions and a 15.5% increase in outpatient appointments for people referred by other DHBs. In 2017/18, almost 7,000 people from outside of Canterbury were discharged from one of our hospitals and we provided over 61,155 outpatient appointments to people from other DHBs.

The services we provide on a regional basis include: brain injury rehabilitation, child and youth inpatient mental health, eating disorder, neonatal, cardiothoracic, neurosurgery, endocrinology and forensic services. We are one of only two DHBs in the country providing paediatric oncology, acute spinal cord impairment surgery, hyperbaric oxygen therapy and specialist burns treatment. Our laboratory service is also one of only two tertiary level laboratories in the country and in a typical year delivers over four million diagnostic tests, informing 60-70% of the clinical decisions made across our health system.

A formal transalpine service partnership established with the West Coast DHB, means our specialists provide regular outpatient clinics and surgical lists on the West Coast. This arrangement enables more equitable access to highly specialised services for the population of the Coast and supports improved workforce planning between both DHBs. The West Coast and Canterbury DHBs have shared operational resources since 2010. This includes a joint chief executive, executive directors, clinical leads and corporate service teams.

Since 2015, we have also been responsible for the Chatham Islands (840 kms east of Christchurch) with a population of just over 600 people.



1.4 Our population profile

The Canterbury region has undergone rapid population changes post-quake. Despite an initial dip and a redistribution of our population, we are now experiencing a greater growth rate than was predicted prior to the earthquakes.

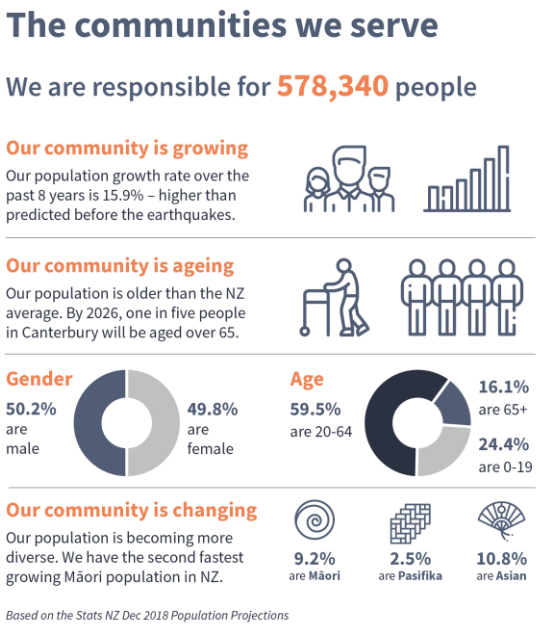
There has been a 15.9% increase in our population over the past eight years. We had not anticipated reaching current population levels until 2025/26.

Our population is older than NZ as a whole and Canterbury has the largest number of people aged over 65 in the country. The latest population figures show 16.1% of our population are aged over 65, a total of 93,150 people. By 2026 one in every five people in Canterbury will be over 65.

Many long-term conditions become more common with age, including heart disease, stroke, cancer and dementia. As people age they develop more complex health needs and are more likely to need specialist services. Our ageing population will put significant pressure on our workforce and infrastructure.

We also know that some population groups have less opportunity and are more vulnerable to poor health outcomes than others. Ethnicity, like age and deprivation, is a strong predictor of need for health services. Canterbury has the sixth largest and second fastest growing Māori population in the country. There are 53,300 Māori living in Canterbury and by 2026 Māori will represent 10% of our population.

Our Māori and Pacific populations have much younger age structures, with 11% of our Māori and Pacific populations aged under five, compared to 5.9% of the total population. There is a growing body of evidence that children's experiences during the first 1,000 days of life have far-reaching impacts on their health, educational and social outcomes. In supporting our population to thrive, it will be important to focus on our younger Māori and Pacific populations.



1.5 Our population's health

Canterbury's population has very similar life expectancy (81.5 years) to the New Zealand average (81.4 years). Differences continue to exist for Māori compared to non- Māori. Māori have poorer overall health and a lower life expectancy (79.1). However, the equity gap for life expectancy in Canterbury is reducing at a faster rate and at 2.4 years is considerably smaller than the national gap where Māori life expectancy (75.1) is almost 6.3 years lower than the total population.

The increasing prevalence of long-term physical and mental health conditions is one of the major drivers of demand for health services and the main cause of health loss amongst adults. This is also true for Canterbury where an increasing number of people are living with long-term conditions such as cancer, heart disease, respiratory disease, diabetes and depression.

A reduction in known risk factors such as smoking, poor diet, lack of physical activity and hazardous drinking could dramatically reduce pressure on our health system and greatly improve health outcomes for our population. All four major risk factors have strong socio-economic gradients, so population health interventions that reduce these risk factors will also contribute to reducing health inequities between population groups.

The most recent combined results from the 2014-2017 New Zealand Health Survey found that:

- 28% of our adult population are classified as obese and rates amongst our Māori (46%) and Pacific (59%) populations are significantly higher.
- 20% of our adult population (one in five). identified as likely to drink in a hazardous manner
- 15% of our total population are current smokers with smoking rates for our Māori (40%) and Pacific (37%) populations significantly higher.
- 11% of our total population identified as inactive (having little or no physical activity). Māori (12%) and Pacific (15%) rates are slightly higher.

EARTHQUAKE AND MOSQUE ATTACK IMPACTS

While new research indicates some sections of our population are coping with the psychological impact of the earthquakes and thriving in their lives, there is increasing divergence in our community with a marked increase in demand for mental health support. The NZ Health Survey reported that 23% of our population have been diagnosed with a mood or anxiety disorder, compared to 19% of the population nationally.

This has been further exacerbated by the March 2019 mosque attacks, when our community was exposed to another extreme and traumatic event. The immediate response of our health services was exemplary, acute operating theatres at Christchurch Hospital running non-stop for 24 hours and staff working overtime to treat and support the victims and their families. General practice and primary mental health teams collaborated to provide free and streamlined support,

and our Mana Ake programme provided a platform to reach into school communities to distribute information and to provide immediate guidance, determine need, and respond accordingly.

We know from experience that recovery from disasters and emergencies is complex and takes time. The ongoing impact for the victims, families, Muslim community and some groups of our wider population will be longer-term. The health impacts for children are particularly worrying and supporting their wellbeing is a major focus for our health system.

1.6 Our unique operating challenges

Like health systems world-wide, the shared challenges DHBs are facing are well understood. Populations are ageing, service demand is growing, and meeting increasing treatment and infrastructure costs and heightened expectations around wage and salary increases, are an ongoing challenge.

While Canterbury has made real inroads in achieving a truly integrated health system, meeting the health needs of a large population is complex. Progress is hampered by the unique operational challenges we continue to face following the earthquakes.

POPULATION PRESSURES

Following the earthquakes, our population growth has been rapid, with a 15.9% increase over the past eight years. While this population growth is positive for our economic recovery and confidence in the region, it is a major challenge for our health system. Our population has also spread out across the region with Selwyn, Waimakariri and Ashburton being three of the fastest growing districts in the country. We are working hard to find a balance between the increasing needs of our growing population, and the workforce, infrastructure, and funding resources at our disposal.

DEMAND PRESSURES

Service demand patterns have changed. Prolonged levels of stress and anxiety are exacerbating chronic illness and negatively impacting on the health and wellbeing of our population. Increased demand is evident across our system, particularly in mental health services. We have implemented a number of intervention strategies to reduce this growing demand, but it remains a significant issue. Our health system is at full capacity and resources are stretched.

As a major tertiary provider, we are also dealing with an increasing level of demand for highly complex and resource-intensive services from neighbouring DHBs, with a 9.5% increase in hospital admissions for people from other DHBs over the last five year. Our theatres, intensive care, radiology and oncology services are under particular pressure. These factors also place additional pressure on our workforce.

FACILITIES PRESSURES

The earthquake damage to our infrastructure was extensive and repair strategies are not simple. We lost more than 44 buildings and are having to cope with fewer hospital beds and a shortage of theatres. Ongoing delays with major redevelopment projects have added to the pressure and Christchurch Hospital's Hagley Building (Acute Services) is still not complete. We are hiring private theatres for our staff to work in and outsourcing more and more surgeries, to meet service demand, the increased service costs are significant. Construction delays and disruptions place considerable pressure on staff and budgets.

Our growing population, changing service demand and increasing regional service expectations are compounding this pressure. The Hagley Building alone will not provide sufficient capacity to meet our population's needs and further investment will be required. A number of facilities are also damaged and need repair, but are reaching the end of their functional life. We are working hard to ensure the safety of our patients and staff, but the future of all of our facilities needs to be firmly determined.

WORKFORCE PRESSURES

Our Staff and Family Wellbeing Survey results show that people are engaged and believe they are making a difference, but they are weary and staff commitment is being tested. Sick leave rates have risen rapidly and are now among the highest in the country. This view is reiterated by providers from across our health system, equally concerned about the wellbeing and resilience of their workforce.

The DHB is working hard to maintain a safe environment and ensure the wellbeing of our staff, particularly as we shift people, patients, and services to repair and redevelop facilities. We have implemented a number of initiatives to mitigate disruptions, however construction noise, service relocation and parking issues are causing increasing stress for staff and patients alike.

FISCAL PRESSURES

Our fiscal pressures are also compounded by the extraordinary impacts of the earthquakes. Increased earthquake-related operational costs are evident in a number of areas including treatment costs related to increased health need, outsourcing costs to cover lost theatre and bed capacity and multi-year construction delays. The DHB is also meeting substantial depreciation and capital-related charges associated with the repair of damaged buildings.

While a careful programme of repair is underway, it is apparent that a considerable portion of our earthquake repair work will not be covered by our insurance proceeds. The DHB's normal capital expenditure and maintenance budgets will not be enough to cover repair costs and to address capacity constraints as our population continues to grow.

Our Strategic Direction

1.7 The Canterbury vision

Eleven years ago, health professionals, clinical leaders, consumers and key stakeholders came together to rethink the future of the Canterbury health system.

We knew we needed to do things differently and we needed to work together to address our collective challenges. Together, we committed to a vision that recognised our future was not just about hospitals, but about everyone working together as one team to do the right thing for both the patient and the system.

Our vision is an integrated health system that keeps people healthy and well in their own homes and communities. A connected health system, centred around people, that aims not to waste their time.

Our vision is underpinned by three strategic objectives:

- The development of services that support people to stay well and enable them to take greater responsibility for their own health and wellbeing.
- The development of primary and community-based services that support people in the community and provide a point of ongoing continuity, which for most will be general practice.
- The freeing-up of hospital-based specialist resources to be responsive to episodic events, provide timely access to more complex care and specialist advice to primary care.

OUR PERFORMANCE STORY SO FAR

In working to deliver on our vision, we are doing things differently. We re-evaluated our relationships with health providers, and with the people we care for. We've become more integrated, more connected and we've reduced waste and duplication.

By enabling clinically-led service design, integrating service delivery models and expanding the role of primary and community providers, we have been able to moderate the growth rate in acute demand for hospital services. We have also been able to significantly reduce the proportion of people living in aged residential care and reduce their length of stay, creating savings which have been used to better support people in their own homes and communities.

Like some of the more innovative health systems around the world, a cornerstone of our success has been the redesign of shared clinical pathways and service delivery models, to address service gaps and improve access to the right services at the right time. Connecting information systems and sharing data has also been a key enabler of change. Access to real-time information, at the point of care, is helping us to improve the quality and safety of the care we provide and is reducing the time people waste waiting.

Engagement with health services is positive. At the end of 2017/18, 93% of our population were enrolled with primary care, 95% of eight months olds were fully immunised and we have the lowest acute medical admissions in the country. Despite capacity constraints, we delivered 21,402 elective surgeries, 72 more than our national target, 96% of people waited less than four months for treatment and 94% of people received their surgery on the day of admission.

1.8 Nationally consistent

Our vison is closely aligned to the Government's long-term vision for New Zealand and for the health sector, as articulated through the NZ Health Strategy with its central theme 'live well, stay well, get well'.

It particularly reflects alignment with the Government theme 'Improving the well-being of New Zealanders and their families' and the priority outcomes: Support healthier, safer, more connected communities; Make New Zealand the best place in the world to be a child; and Ensure everyone who is able to, is earning, learning, caring or volunteering.

The Minister of Health's annual Letter of Expectations also signals priorities and expectations for DHBs. The expectations for the coming year signal a strong focus on equity in health and wellness.

The priorities emphasised for 2019/20 are:

- Improving child wellbeing;
- Improving mental wellbeing;
- Improving wellbeing through prevention;
- Better population health outcomes, supported by a strong and equitable public health and disability system;
- Better population health outcomes, supported by primary health care;
- Strong fiscal management.

This Plan outlines how we will deliver on the Minister's expectations in the coming year. The Minister's Letters of Expectation for 2019/20 are attached as Appendix 2.

It is also important that all twenty DHBs are working collaboratively to capture service improvements, share

innovations and allocate resources effectively to meet the needs of the population of New Zealand in a fair and equitable way. The DHB Chief Executives are looking to identify and capture opportunities as part of a Collective Improvement Programme and the Canterbury DHB is committed to contributing to this programme of work as it is developed.

1.9 Regionally responsive

There are five DHBs in the South Island (Nelson Marlborough, Canterbury, West Coast, South Canterbury and Southern) and together we provide services for over one million people, almost a quarter (23%) of the total NZ population.

While each DHB is individually responsible for the provision of services to its own population, we work regionally through the South Island Regional Alliance to address our shared challenges and develop more responsive and effective health services.

Our jointly developed South Island Health Services Plan outlines our regional direction, priorities and agreed work programme for 2019-2022. There are six regional priority focus areas: Data and Information; First 1,000 Days; Mental Health; Acute Demand Management; Social Determinants of Health; and Advance Care Plans.

Canterbury DHB has made a strong regional commitment and is engaged in a number of work streams including: cardiac, child health, older person's health, major trauma, mental health, cancer, stroke, telehealth, public health, oral health, and workforce.

Canterbury also takes the lead for Information Services regionally, including development of HealthPathways, HealthOne and the rollout of the South Island Patient Information Care System (PICS). These shared electronic systems help to simplify access to patient information and support improved clinical decision making, no matter where a person is treated.

The Regional Health Services Plan can be found on the Alliance website: www.sialliance.health.nz.

1.10 Committed to achieving equity

Not everyone living in Canterbury experiences the same health outcomes, and some people experience advantages and opportunities that others do not.

Social determinants such as education, employment, housing and geographical location can impact on opportunity as can aspects of a person's identity including age, gender, ethnicity, social class, sexual orientation, ability or religion. Equity is about fairness and we are committed to achieving equity in health outcomes particularly for Māori and Pacific people who currently experience poorer health outcomes.

Acknowledging and taking steps to address inequities in our system can be confronting and challenging, but is necessary if we are to progress towards equity. By making this commitment we acknowledge that we will need to evolve our workforce, build health literacy and cultural capabilities and redesign service delivery models, to better meet the diverse needs of all the people in our community.

The DHB's planning is guided by a range of national strategies, including: He Korowai Oranga (the Māori Health Strategy), Ala Mo'ui (Pathways to Pacific Health and Wellbeing), the Healthy Ageing Strategy and the NZ Disability Strategy. We are also supported by tools such as the Health Equity Assessment Tool (HEAT) to assess, identify and address disparities.

Actions to deliver health equity are identified in the National Priorities section of this Plan, identified with the code EOA, Equity Outcome Action.

Our Immediate Focus

While we have achieved significant momentum, progress has been hampered by the unique operational and population health challenges we have faced following the earthquakes. Population growth across all population groups is also driving associated service demand across our system.

Our planning forecasts show our health system is at full capacity. Sustaining current service levels and meeting demand through the coming winter will be a significant challenge; we do not have enough acute hospital beds to meet forecasted demand.

To keep our system operating, and meet immediate service demand within current resources, we need to manage our business well, keep people connected and identify opportunities to reduce duplication and waste.

Because resources are increasingly limited, we also need to continue to work collaboratively, across both health and social services and between DHBs, to ensure our investment is directed into activity and services that will provide the greatest impact.

Three Strategic Themes highlight the factors seen as critical to our immediate and long-term success.

KEEPING OUR HEALTH SYSTEM OPERATING:

- Maintaining our whole of system approach
- Improving the flow of patients across the system
- Supporting the commissioning of new facilities

SETTING THE DHB UP FOR FUTURE SUCCESS:

- Creating a sustainable pathway forward
- Investing in an effective People Strategy
- Delivering on our Digital and ICT Transformation
- Completing a masterplan for Christchurch Hospital

CONTRIBUTING REGIONALLY & NATIONALLY:

- Supporting industrial negotiations
- Delivering on new service expectations and policies
- Responding to vulnerable service challenges

This focus was reiterated in strategic discussions held with the Ministry of Health as part of the DHB's annual planning in May 2019, where key challenges and the DHB's future focus were discussed.

In the coming year the DHB will continue to focus on service efficiency and improving the flow of patients across the system to reduce the pressure on our hospital services, which are at full capacity. This will include an emphasis on acute admissions, radiology services, long-stay patients (particularly older patients and patients needing rehabilitation and support on discharge) and hospital acquired conditions that extend people's length of stay and have a negative impact on health outcomes.

The commissioning of new facilities remains an essential element in our immediate and long-term sustainability. On completion of the Christchurch Hospital Hagley Building (ASB) in 2019, the DHB will undertake the significant migration of existing services into the new building and repatriation of outsourced services back into DHB facilities. This will be a sizable piece of work for our teams in 2019/20.

We also need to agree solutions to enable investment in the infrastructure needed to meet the growing and future demand for services. This will include a focus on completion of a number of master-plans and business cases over the coming year, such as the masterplan for the Christchurch Hospital campus.

In setting the DHB up for future success and creating a sustainable pathway forward, a population health and wellbeing approach is a critical factor in our strategy. This focus presents an opportunity for our community to work collaboratively to improve health outcomes. Cross-sector investment will be a key focus for the DHB in the coming year with a continued commitment to the Mana Ake initiative in schools and ACC partnerships to reduce harm and enhance recovery.

We will also continue to work closely with our primary care partners to support people closer to home and enable access to earlier intervention to improve health outcomes. This will include support for the rollout of new national primary mental health initiatives.

Equity is a key focus for our system and we will build on our partnerships with Māori and Pacific Whānau Ora agencies, to empower people to take the lead in their own health journey and provide people with access to the services they need earlier and closer to home. We plan to capture the lessons learnt in areas where equity gaps are closing in Canterbury and replicate this work across other areas.

We will progress the implementation of our People Strategy to support the health and wellbeing of our staff and create an environment where our people can thrive. Sick leave rates have been growing across the DHB highlighting the pressures on our workforce and the need for an increased focus on this work.

Continued implementation of our digital and IT transformation is also a critical success factor with value added technology supporting more efficient ways of working, reducing duplication and waste and improving decision making and planning with access to real-time serviced data.

The DHB is also committed to working closely with the Ministry of Health to agree a sustainable operating pathway and to understand and balance population need with fiscal responsibilities. Key fiscal challenges are not insignificant and a deliberate operational focus on service efficiency and effectiveness will help to support a sustainable future for our health system. Anticipated service changes are highlighted in section 3.12 of this Plan.

THE YEAR AHEAD

What can you expect from us?

2

Delivering on National Priorities and Targets

The following section highlights the activity the DHB will undertake to deliver on national priorities and expectations in 2019/20. This activity, and the associated actions and targets, is reflected in the work plans of our local and regional alliances and the project and work plans of our operational and corporate services teams.[1]

Over the last several years, we have made some positive inroads into improving health outcomes for Māori and Pacific people living in Canterbury, with strong engagement in childhood immunisation and Well Child programmes and reductions in avoidable hospitals admissions. We are determined to make further progress. Throughout this section, actions aimed at improving Māori and Pacific health outcomes are indicated by the Equity Outcome Action code (EOA).

Alignment to Health System and Government Priority Outcomes have also been indicated throughout the Plan with the following symbols.

System Outcome	Government Priority Outcome
E We have health Equity for Māori and other groups	W Make New Zealand the best place in the world to be a child
L We live longer in good health	E Ensure everyone who is able to, is earning, learning, caring, or volunteering
Q We have improved quality of life	G Transition to a Clean, Green, and Carbon Neutral New Zealand
	C Support healthier, safer and more connected communities

2.1 Improving Child wellbeing

Government Theme: Improving the well-being of New Zealanders and their families

Planning Priority: Immunisation	E L W
Expectations: ▪ Establish innovative solutions to improve and maintain high immunisation rates at all childhood milestones from infancy to age 5. ▪ Outline actions to further strengthen your school-based immunisation programme to better meet the needs of Māori and Pacific youth.	
Actions to Improve Performance	**Milestones**
Focus on increasing the uptake of vaccinations during pregnancy, as an opportunity to build relationships with mothers and provide early protection for babies.	Q2: Survey of new parents undertaken, to understand the reasons for declines and improve messaging. Q2: Education Programme developed, to support vaccination conversations with pregnant women. Q3: Opportunity to provide additional pregnancy vaccinations through community pharmacy investigated nationally.
Continue to monitor and evaluate immunisation coverage to identify opportunities to maintain high immunisation coverage across all ages, with a particular focus on improved coverage at age five and equity across population groups. (EOA)	Ongoing: Provision of Immunisation Register (NIR), Missed Event and Outreach Service support to general practice teams to reduce declines for childhood vaccinations. Quarterly: Evaluation of vaccination coverage rates by the Immunisation SLA to identify opportunities to further improve coverage and respond to emerging issues.
Further strengthen the school-based Human Papillomaviruses (HPV) immunisation programme and identify innovative solutions to reduce the equity gaps in coverage rates for young Māori and Pacific students. (EOA)	Ongoing: Provision of support to general practice to enable the co-delivery of HPV and TdaP immunisations at age 11, including development of resources.[2] Q2: Undertake analysis on coverage data to identify opportunities to target high need populations. Q2: Consult with Māori groups to better understand barriers to adolescent vaccinations. Q2: Trial of an online consenting process for the school-based HPV programme launched.

Measures of Success
60% of pregnant women vaccinated against Pertussis (whooping cough). Childhood vaccination decline rates are reduced. 95% of 8-month olds fully immunised. 95% of 2-year olds fully immunised. 95% of 5-year olds fully immunised. 75% of boys and girls (year 8) complete the HPV vaccination programme.

[1] Our System Level Measures (SLM) Improvement Plan is developed in collaboration with our Canterbury Clinical Network Alliance partners and is attached is an appendix to this Annual Plan, providing a broader picture of the activity planned across the Canterbury health system.

[2] TDaP - adult diphtheria and tetanus vaccine and adult acellular pertussis vaccine.

Planning Priority: School-Based Health Services	L W

Expectations:

- Commit to providing quantitative reports in Q2 and Q4 on the implementation of school-based health services (SBHS) in decile 1 to 4 secondary schools (and decile 5 if applicable), teen parent units and alternative education facilities.
- Outline current activity to implement Youth Health Care in Secondary Schools: A framework for continuous quality improvement in each school (or group of schools) with SBHS.
- Outline the current activity to improve the responsiveness of primary care to youth.
- Commit to providing quarterly narrative reports on the actions of the Youth Health Service Level Alliance (SLA) to improve health of the DHB's youth population.
- Outline actions to ensure high performance of the Youth Health SLA (or equivalent).

Actions to Improve Performance	Milestones	Measures of Success
Continue to support the delivery of SBHS in all decile one to four secondary schools, teen parent units and alternative education facilities across Canterbury.	Quarterly: Provision of quantitative reports on the delivery of SBHS to the Ministry. Q1: Rollout to decile 5 schools confirmed with the Ministry of Health.	95% of year nine children in decile 1-4 schools receive a HEEADSSS (Home, Education, Eating, Activities, Drugs and Alcohol, Suicide and Depression, Sexuality and Safety) Assessment.
Continue to promote the use of the Youth Health Care in Secondary Schools Framework tool, to support continuous quality improvement across SBHS schools.	Q2: Framework promoted at the Health & Education Steering Group, to raise awareness across providers. Q3: Best practise examples shared, to increase engagement and use of the Framework tool.	
Maintain an integrated approach to responding to the needs of young people in Canterbury, with active oversight from the cross-sector Child & Youth Health Alliance Work Stream (Canterbury's SLAT equivalent). (EOA) *Strong Māori and Pacific representation on the Child & Youth Work Stream ensures actions and programmes are targeting inequities for high need populations.*	Quarterly: Provision of qualitative reports on delivery against the Youth Health work plan. Q2: Development of a Gender Affirming Care pathway, to address barriers to support for young people, scoped. Q2: Development of a pathway to support young people with complex health care needs, transition between child and adult services scoped.	

Planning Priority: Planning Priority: Midwifery Workforce	E L E

Expectations:

- Develop, implement, and evaluate a midwifery workforce plan to support: undergraduate training, including clinical placements; recruitment and retention of midwives; changes to models of care that use the full range of the midwifery workforce within DHBs; and service delivery mechanisms that make best use of other health workforces to support both midwives in their roles and pregnant women.
- Detail the actions that you will take towards implementing Care Capacity Demand Management (CCDM) for midwifery by June 2021 and outline the most significant actions the DHB will undertake in 2019/20 to progress implementation of CCDM for midwifery.

Actions to Improve Performance	Milestones	Measures of Success
Identify key stakeholders to support the development of a Regional Maternity Workforce Plan to support improved undergraduate training and future workforce planning.	Q1: Regional Workshop Held. Q4: Regional Maternity Workforce Plan drafted.	80% of women are registered with an LMC by 12 weeks of pregnancy. >13% of babies in Canterbury are delivered in Primary Birthing Units. Baseline established for proportion of midwives identifying as Māori and Pacific. CCDM implemented for midwifery June 2021.
Establish regular meetings with ARA and Otago Polytechnic Schools of Midwifery to further develop the graduate workforce pipeline, with a particular focus on increased enrolment of Māori and Pacific midwifery students. (EOA)	Quarterly: Joint meetings with Ara and Otago. Q3: Ten new graduate midwives appointed.	
Stocktake planned retirements across the maternity workforce, to identify opportunities to phase retirements, minimise system impacts and plan for recruitment.	Q2: Stocktake of planned retirements complete.	
Work with Māori and Pacific leads to identify initiatives to support and retain Māori and Pacific midwives and improve the cultural awareness of our maternity team, to enhance the service experience for Māori and Pacific women. (EOA)	Q2: Maternity Hui held to build awareness and support within and across the team.	
Progress implementation of a proposal for change for antenatal assessment, to support the development of a sustainable service delivery model that meets the future needs of our population and better supports our clinical workforce. (EOA)	Q2: Maternity Assessment Unit established, to improve service delivery, patient flow and support for clinical teams and LMCs. Q3: Rural-based Antenatal Outpatient Clinic Hubs established, to support care closer to home.	

Support the implementation of Care Capacity Demand Management (CCDM) for midwifery by June 2021, working with other DHBs to ensure a consistent approach to implementation of CCDM for maternity services. *Refer to the CCDM action table for further detail and timeframes for implementation of CCDM.*	Q1: Director of Midwifery engaged as a member of the CCDM Council to support implementation. Q2: Active participation by midwifery leaders in national CCDM forums.	

Planning Priority: First 1000 days (conception to 2 years of age)		E L W

Expectations:

- Identify the most important focus areas to ensuring the population needs for pregnant women, babies, children and their whānau are well understood and identify key actions that demonstrate how the DHB will meet these needs including realising a measurable improvement in equity for your DHB. Actions should include a comprehensive approach to prevention and early intervention services across priorities via maternity, Well Child Tamariki Ora, National SUDI Prevention Programme, and other services.
- Identify what action you will take to identify barriers to achieving well integrated services across the first 1000 days.
- Identify the actions the DHB is taking to increase the proportion of children at a healthy weight in their first 1000 days to be measured by the proportion of children at a healthy weight at age four.

Actions to Improve Performance	**Milestones**	**Measures of Success**
Complete the development of a comprehensive, system-wide Maternity Strategy, to support an integrated approach to improving the health and wellbeing of pregnant women, babies, children and whānau. (EOA) *Feedback from co-design workshops will be incorporated into the Strategy with a targeted focus on Māori and Pacific women, those living in lower decile areas and younger mothers as populations of higher need.*	Q1: Final consultation on the Maternity Strategy complete and feedback incorporated. Q2: Maternity Strategy approved by the Board with focus areas clearly identified. Q3: Implementation underway.	85% of new-borns are enrolled with general practice by 3 months of age. 70% of babies are fully/exclusively breastfed at 3 months of age. 95% of eight-month old babies are fully immunised. 95% of children (aged 0-4) are enrolled with School & Community Oral Health Services. 90% of four-year-olds are provided with a B4 School Check (B4SC). 95% of four-year-olds (identified as obese at their B4SC) are offered a referral for clinical assessment and family-based nutrition, activity and lifestyle intervention.
Continue to invest in key programmes of work that support the most important focus areas across the first 1,000 days of a child's life. *Delivery is overseen by the cross-sector Child & Youth Health Alliance Work Stream who support and champion the integration of child and youth services.*	Ongoing: Actions to address the key modifiable risk factors for SUDI (see page 12). Ongoing: Actions to increase the proportion of smokefree households (see page 12). Ongoing: Actions to maintain high rates of childhood immunisation (see page 9).	
Refocus actions to promote breastfeeding, as an important component, alongside other nutrition interventions, in reducing the risk of obesity in children – and as an area of ongoing inequity for Māori and Pacific children. (EOA *Strong Māori and Pacific representation on the Breastfeeding Steering Group will ensure actions are targeting engagement by high need populations.*	Q1: Cross-sector Breastfeeding Steering Group established to provide leadership and oversight to the development of strategies and actions to support improved breastfeeding rates. Q2: Priority actions identified for focus.	
Prioritise health promotion initiatives in early childhood settings with a focus on good oral health – as an area of ongoing inequity for Māori and Pacific children. (EOA)	Q1: Menemene Mai (Smile) Early Childhood Oral health promotion resources pro-tested.	
Continue to invest in the All Right? Initiative to promote population wellbeing, with a focus on supporting parents of children under five through the review and relaunch of the 'Tiny Adventures' app.	Q1: Tiny Adventures App relaunched.	
Participate in the regional Hauora Alliance, to support South Island collective initiatives to address barriers to achieving a well-integrated women and children's service.	Q2: Regional priorities, actions and implementation plan agreed.	

Planning Priority: Family Violence and Sexual Violence (FVSV)		Q E C
Expectation: Identify the actions that the DHB considers are the most important contribution to reducing family violence and sexual violence, including the reasons why the action(s) are important and the impact you expect them to achieve.		
Actions to Improve Performance	**Milestones**	**Measures of Success**
Continue to invest in the Violence Intervention Programme (VIP) in line with the agreed Strategic Services Plan. *This will include a focus on training to ensure staff understand and implement Child Protection & Partner Abuse and Neglect policies and procedures – including use of the National Alert System.*	Ongoing: Staff in core areas are provided with core, refresher or advanced VIP training. Q4: Staff participation in training reviewed and gaps addressed.	Continued compliance with the National Child Protection Alert Policy. Number of staff attending VIP Training sessions – 458 baseline 2017/18. Violence Intervention Programme audit results >80/100. Reduction in repeated family harm incidents in Canterbury.
Continue to participate in the Police-led Integrated (cross-agency) Safety Response Pilot, to support a rapid response from government and social agencies to the needs of people and families affected by family violence. (EOA) *The programme has been established with a Whānau Ora approach to overall whānau well- being to support the most vulnerable families and reduce repeated harm.*	Ongoing: All cases allocated for a health response are undertaken successfully. Ongoing: Continued development of data and information sharing between relevant agencies to support rapid implementation of safety plans.	
Support the development of a Trauma Informed Care Pathway to support young people 0-18, exhibiting a change in behaviour following March 15, to access additional appropriate care and support. (EOA) *The initial pathway development will be facilitated by the Mana Ake Team with strong input from Refugee, Māori and Pacific advisors to ensure an appropriate response.*	Q1: Co-design of Trauma Pathway underway. Q2: Pathway developed. Q3: Training programme delivered. Q4: Expansion of the programme considered.	
Develop a transalpine Canterbury/West Coast DHB Elder Abuse & Neglect Policy, to support our growing older population from harm. *Feedback from Kaumatua will ensure culturally appropriate responses to disclosures are embedded.*	Q1: Elder Abuse and Neglect Policy in place. Q2: Elder Abuse Training programme developed. Q4: Compliance review completed.	

Planning Priority: SUDI		E L W C
Expectation: Describe contributions towards building strong working relationships across the Maternal and Child Health sector to address the key modifiable risk factors for SUDI.		
Actions to Improve Performance	**Milestones**	**Measures of Success**
In delivering against the DHB's SUDI Prevention Plan, finalise the SUDI HealthPathway, to ensure general practice have current information and update SUDI information in HealthInfo to support parents and families.	Q1: Health Info reviewed and updated. Q2: HealthPathway completed and promoted.	A responsive and sustainable safe sleep programme is operating. A minimum of 710 safe sleep devices provided to whānau identified at risk. Increased percentage of babies living in smokefree homes – baseline 61% (WCTO data June 2018). Reduction in the equity gaps for Māori and Pacific homes to 0.85 and 0.75.
Invest in an enhanced and sustainable model for the distribution of safe sleep devises, including education and advice to support families to reduce SUDI risk. Develop criteria to identify high risk infants who would benefit from receiving a safe sleep space. (EOA)	Q1: Safe sleep devices available in all inpatient settings where babies are inpatients or borders. Q2: Key community-bases established for the distribution of safe sleep spaces. Q3: High risk response in place.	
Enhance links with the Young Parents Support Services, provided by Mother and Pepi, Whānau Ora and Early Start services, to support young parents. (EOA)	Q3: Process in place to ensure all young parents birthing in DHB maternity facilities, are offered referral to family support.	
Strengthen the delivery of a wrap-around stop smoking service for pregnant women (and their partners) who want to stop smoking, to increase the number of babies living in smokefree homes – with a strong focus on Māori and Pacific families who have higher smoking rates. (EOA) *Links between the Stop Smoking and Safe Sleep programmes will provide wrap-around support for high risk families. All pregnant women attending initial stop smoking consultations, are now offered safe sleeping spaces.*	Q3: Results from the 2019 evaluation of the Incentivised Stop Smoking Programme are used to identify and implement quality improvements. Q4: Insights from analysis of patient level smoking data used to develop actions to increase the number of Canterbury babies in smokefree homes.	

Invest in the development of coordinated services for whānau who have experienced the death of a baby due to SUDI.	Q4: Access to appropriate psycho-social support is available for bereaved whānau. Q4: Partnership is developed with Police and MSD, to enable agencies to work more collaboratively when SUDI occurs.	

2.2 Improving mental wellbeing

Government Theme: Improving the well-being of New Zealanders and their families

Planning Priority: Inquiry into mental health and addiction	E L Q C

Expectations: DHBs are to outline actions contributing to the direction identifying opportunities to build on existing foundations and include actions in relation to improving and/or addressing all of the following areas of focus:

Embedding a wellbeing focus

- Demonstrate a focus on wellbeing and equity at all points of the system.
- Improve the physical health outcomes for people with mental health and addiction conditions.

Building the continuum / increasing access and choice

- Work in partnership with the Ministry, Māori and Pacifica, youth, people with lived experience, primary and community organisations, NGOs, and other stakeholders to plan an integrated approach to mental health, addiction and wellbeing and roll out new primary level responses from Budget 2019.
- Strengthen and increase the focus on mental health promotion, prevention, identification and early intervention.
- Continue existing initiatives that contribute to primary mental health and addiction outcomes, and align with the future direction set by He Ara Oranga, including strengthening delivery of psychological therapies.
- Identify options to strengthen connections and build support across the full continuum of care.

Suicide prevention – *refer to population mental health section below*

Crisis response – *refer to population mental health section below*

NGOs

- Identify how you will use cost pressure funding from Budget 2019 to ensure NGOs in your district are sustainable.

Workforce

- Partner with workforce centres to strengthen current workforces, including a focus on retention, recruitment and training.
- Demonstrate a commitment to lived experience and whānau roles being supported and employed across all services.
- Support workforce development of the appropriate knowledge and skills to support people with mental health and addiction needs.

Mental Health and Wellbeing Commission

- Work collaboratively with any new Commission.

Forensics

- Work with the Ministry to improve and expand the capacity of forensic responses from Budget 2019.
- Contribute, where appropriate, to the Forensic Framework project.

Actions to Improve Performance	Milestones	Measures of Success
In partnership with Pasifika Futures, invest in the design and development of an innovative Whānau Ora service model to improve the health and wellbeing of our Pacific population. (EOA)	Q2: Whānau Ora, wellbeing focused, contract in place with Etu Pasifika. Q3: Mental health incorporated into wellbeing screening for Etu Pasifika's enrolled population.	>500 young people (0-19) access brief intervention counselling in primary care. >4,500 adults (20+) access brief intervention counselling in primary care. >3.1% of the population (0-19) access specialist mental health services. >3.1% of the population (20-64) access specialist mental health services. 80% of young people (0-19) referred to
Trial a new model of mental health service delivery in primary care, with a dedicated mental health and wellbeing resource working in general practice, to build the continuum of care and support an immediate response to people's mental health needs. Initial trial across two urban-based practices, a rural-based practice and a pacific health practice.(EOA)	Q1: Additional mental health and wellbeing resource in place in a rural-based practice. Q2: Additional resources in place across remaining identified practices. Q4: Trial complete and model implemented with outcome based monitoring framework in place.	
Implement agreed Pay Equity uplift to support the sustainability of local NGO service providers.	Ongoing: Pay Equity uplift applied to contracts as renewed.	
Through the Mental Health Education & Resource Centre (MHERC), support peer support workers and cross-sector agencies to gain the knowledge and skills to better support people with mental health needs.	Q1: AOD training delivered to Housing First workforce. Q2: Psychological first aid training delivered to people working with Muslim communities.	
Work with the Ministry to improve and expand the capacity of forensic services in line with Budget 2019	Q1: Additional FTE capacity confirmed to support community and inpatient teams.	

investment, including participating in how best to allocate increased FTE capacity across regions. Collaborate with CHCH Women's Prison, to pilot an alternative (Single Point of Entry) triage function, to better meet service demands and improve outcomes for this high need population group. (EOA) Provide input into the national Forensic Framework Project as this work commences. *This work will focus on increasing capacity across community and inpatient teams to manage increased prison and justice workload and meet increased clinical and safety needs.*	Q1: Stocktake of existing workforce development plans and programmes provided to the Ministry. Q1 Risk assessment of increasing forensic roles on other essential services, including mitigation provided to the Ministry. Q2: Audio Visual Link suite upgraded to enable AVL prison assessments at Hillmorton, to reduce wait times and clinical time spent on travel. Q3: Single Point of Entry Pilot commenced. Q3: Consumer rehabilitation programme expanded to provide occupational therapy 7 days a week (dependant on additional resources). Q4: Establishment of new roles confirmed.	specialist mental health services are seen within 3 weeks. 95% of young people (0-19) referred to specialist mental health services are seen within 8 weeks.
Work collaboratively with any new Mental Health and Wellbeing Commission, to support He Ara Oranga actions.	Ongoing.	

Planning Priority: Population mental health		L Q C

Expectations: The DHB will improve population mental health and addiction by increasing uptake of treatment and support earlier intervention, further integrating mental health, addiction and physical health care, and co-ordinating mental health care with wider social services - especially for priority populations including vulnerable children, youth, Māori and Pacific populations.

Include actions in relation to all the focus areas below (relevant actions may be cross referenced to the Inquiry response section above):

- Options across the primary care spectrum to help ensure early intervention and continuity of care.
- Improved options for acute responses, including improving crisis team responses and improved respite options.
- Suicide prevention and postvention efforts to provide a range of activities such as mental health literacy and suicide prevention training, community-led prevention and postvention initiatives and integration of mental health and addiction services.
- Equally Well, to improve the physical health outcomes for people with low prevalence mental health and addiction conditions.
- Ongoing commitment on reporting to PRIMHD.
- Improving access (MH01) and reducing waiting times (MH03). – *refer also the mental health and addictions table below.*
- Ongoing commitment to transition/discharge plans and care plans for people using mental health and addiction services (*refer table below*).

DHBs should also include actions in relation to improving some of the areas of focus below:

- Supporting Parents Healthy Children (COPMIA) to support early intervention in the life course.
- Improving co-existing problems responses via improved integration and collaboration between other health and social services.
- Reducing inequities including reducing the rate of Māori under community treatment orders.
- Improving employment, education and training options for people with low prevalence conditions.
- Implementing models of care for addiction treatment, reference to Substance Addiction (Compulsory Assessment and Treatment) Act 2017.

Actions to Improve Performance	**Milestones**	**Measures of Success**
Complete implementation of the new model of mental health service delivery in the Kaikoura and Hurunui districts to help ensure early intervention and continuity of care. (EOA)	Q2: Model fully implemented Q4: Impact of new model reviewed.	>500 young people (0-19) access brief intervention counselling in primary care. >4,500 adults (20+) access brief intervention counselling in primary care. >3.1% of the population (0-19) access specialist mental health services. >3.1% of the population (20-64) access specialist mental health services. 80% of young people (0-19) referred to specialist mental health services are seen within 3 weeks. 95% of young people (0-19) referred to specialist mental health services are seen within 8 weeks.
Complete implementation of the new community-based acute residential service, to provide alternative options for people experiencing acute episodes of mental illness.	Q1: Seven beds available in the community.	
Maintain an integrated approach to suicide prevention and postvention, with active oversight from the cross-sector Suicide Prevention Governance Committee. (EOA) *Ensure a strong Māori and Pacific voice (as high need populations) in the development of strategies and initiatives.*	Q2: Canterbury Suicide Prevention Website launched. Q3: Cross-agency Suicide Prevention Action Plan released in line with the national Plan.	
Collaborate with primary care partners to agree a more targeted approach to the utilisation of Equally Well consultations by Māori and Pacific populations, to improve physical health outcomes for people with low prevalence mental health and addiction conditions. (EOA)	Q3: Future focus agreed.	
Continue to monitor local service utilisation data, and report (using PRIMHD), to national systems, to support improved decision-making and service planning.	Ongoing: Balancing metrics/data captured and reported through PRIMHD.	
Invest in the provision of group treatment programmes for people with moderate to severe anxiety, through a partnership between primary care and specialist services to improve service access and integration.	Q4: A minimum of four group treatment programmes provided.	

Work closely with other agencies and organisations to provide a locally-led and integrated wellbeing and resilience response to the March 2019 mosque attacks, to ensure people get the help they need when they need it.	Q1: Muslim Community Team established. Q1: SMHS access pathways streamlined for people with Post Traumatic Stress Disorder. Q2: Psychoeducation workshops provided.	

Planning Priority: Mental health and addictions improvement activities

Expectations:

Outline your commitment to the HQSC mental health and addictions improvement activities including:

- Actions to support a continued focus on minimising restrictive care (including the aspirational goal of eliminating seclusion by 2020)
- Actions to improve transitions (aligned to performance measure MH02) and engagement with the next steps of the HQSC programme.

Actions to Improve Performance	Milestones	Measures of Success
Participate in regionally-based learning opportunities and co-design workshops related to seclusion reduction, to support shared learning and collective change. Develop a programme of change ideas, based on feedback and thematic analysis, to support a reduction in incidents and a continued focus on minimising restrictive care. Support a strong focus on ensuring culturally safe approaches to improve the experience and support for Māori and Pacific mental health consumers and their whānau. (EOA)	Quarterly: Balancing metrics/data captured and reported to HQSC – including: use of seclusion, use of restraint, use of sedatives. Q1: Programme of change ideas developed. Q1: Collaboration across acute adult inpatient Safer for All working groups to ensure shared learnings and collective change. Q2: Change ideas evaluated in terms of impact on incidents, restraint and seclusion. Q3: Effective changes implemented, with focus on sustainability and spread.	Reduction in the rate of assaults. 95% of clients discharged will have a transition or wellness plan in place. 95% of audited files meet accepted good practice. 90% of clients (17+), identified as requiring ongoing care and treatment, have a co-produced 'youth to adult' transition plan in place. 80% of acute inpatients access community services within 7 days of discharge.
Develop an effective treatment plan platform to further support improved discharge and transition planning, including the use of exemplars to improve consistency of documentation.	Q1: Exemplars in place. Q2: Treatment plan platform developed. Q2: Audit tool implemented.	
Develop and implement a programme of improvement for youth to adult transitions, focused on improving the experience of transition, collaborative service delivery and effective preparation for transition, to support this vulnerable population group. (EOA)	Q1: Change ideas developed through co-design and model for improvement process. Q2-Q4: Testing and implementing effective change ideas including transition indicators. Q3: Improved preparation for transition processes embedded. Q4: Balancing metrics/data defined, captured and reported to HQSC.	

Planning Priority: Addiction

Expectations:

- Identify actions to improve performance against the MH03 performance measure (addition related waiting times), to support an independent/high quality of life for people with addiction issues.
- Provide (Q1) an outline of the existing and planned AOD services for your region including those for women, Māori and Pacific, older people, opioid substitution and criminal justice clients, and LGBTIQ communities, ensuring equitable health for all New Zealanders.
- Outline how you will ensure the quality of AOD services to support healthier New Zealanders live an independent high-quality life.
- Describe how your DHB is giving appropriate priority to meeting service demands within baseline funding.

Actions to Improve Performance	Milestones	Measures of Success
Pilot an integrated approach to the provision of Opioid Substitution Treatment that enhances the role of pharmacists, to improve the management of treatment and refocus clinical time on recovery orientated treatment.	Q2: Pilot underway in three pharmacies. Q4: Pilot evaluation report completed.	Delivery of Annual Plan actions. 80% of people referred to specialist addiction services are seen within 3 weeks 95% of people referred to specialist addiction services are seen within 8 weeks.
Embed an innovative programme of peer support for people engaged in Opioid Substitution Treatment, to enhance people's independence and quality of life.	Q2: Peer support programme operational. Q4: Review of programme uptake.	
Strengthen the monitoring and governance of the AOD pathway for offenders, to identify opportunities to improved engagement with treatment services. (EOA)	Q2: AOD Offenders process reviewed and opportunities for improvement identified. Q3: Process changes implemented.	

Complete a review of existing and planned AOD services, to support a sustainable response to increasing service demand and address inequities for Māori as a high-need population group. (EOA)	Q1: Outline of existing and planned AOD services provided to the Ministry. Q2: Review informs 2019/20 contracting round.	
Facilitate a stocktake of AOD services across the South Island, to identify and address gaps and inequities in terms of access and outcomes between regions. (EOA)	Q2: Regional stocktake complete. Q3: Recommendations from stocktake reviewed by regional stakeholders.	

Planning Priority: Maternal mental health services	L C

Expectations:

- Informed by the outcome of your 2018/19 stocktake of primary maternal mental health services in your district, and the volumes of women accessing these services, identify the actions you plan to take in 2019/20 to improve access and to address any identified issues.
- Indicate how equity of access and outcomes for Māori and Pacific women will be addressed and measured.

Actions to Improve Performance	Milestones	Measures of Success
Continue to invest in current community-based services to support women, and their partners in need of additional support before and after the birth of a child. (EOA)	Ongoing: Provide free brief intervention counselling for people needing mild-moderate mental health support. Ongoing: Provide free Plunket-led individual and group programmes for people needing higher-level post-natal mental health and parenting support.	Updated co-designed Maternal Mental Health Pathway in place. Proportionate uptake of programmes by ethnicity.
Engage with maternal mental health service providers, consumers and stakeholders from across the system to inform a refresh of Canterbury's maternal mental health pathway. (EOA). *As part of the refresh, options to improve and sustain community-based support for women with mid-moderate issues will be a focus, particularly Māori and Pacific women as populations of higher need.*	Q1: Continuum of maternity services mapped and Maternal Mental Health Service gaps identified. Q2: Key stakeholders identified and engaged in Maternal Mental Health service development. Q3: Service recommendations presented. Q4: Refreshed maternal mental health pathway agreed and socialised across the system.	

Planning Priority: Mental health support in earthquake affected schools	Q L C

Expectation: Commit to continuing to lead work with the Ministries of Health and Education, and other social sector organisations and stakeholders, on the implementation of the Mana Ake programme in primary schools across the Canterbury DHB District.

Actions to Improve Performance	Milestones	Measures of Success
Continue to embed the Mana Ake initiative, supporting implementation across all school clusters, undertaking regular monitoring to enable schools to flex resources to match identified need and working with stakeholders to clarify and enhance pathways for support. (EOA) *Maintain active oversight of the initiative through the CCN Mana Ake Service Level Alliance and provider networks.*	Quarterly: Forums held for school clusters to share progress and identify opportunities for improvement. Q1: 219 Schools engaged in Mana Ake. Q2: 95 topics covered on Leading Lights. Q4: 110 topics covered on Leading Lights.	Number of children and whānau accessing services. Improved ratings for children across Presence, Engagement & Wellbeing, and Learning & Achievement domains. Positive student/ parent/whānau/ teacher voice survey reports on impact of support. Number of pathways available on the Leading Lights website. Increasing numbers of returning Visitors to Leading Lights.
Continue to work with the provider network to identify, appoint and support Kaimahi with appropriate skills, knowledge and experience to support the success of the initiative.	Quarterly: Provider Network forums held, to identify and respond to emerging issues. Q1: 80 Mana Ake Kaimahi (workers) engaged. Q2: Kaimahi workforce plan agreed across the Provider Network. Q4: Full range of group programme offered by Mana Ake is accessible across clusters.	
Implement an agreed Outcome and Evaluation Framework, to support continuous improvement and understand the longer-term impact of the initiative.	Q1: Outcome and Evaluation Framework agreed and in place. Q2/Q4: Programme impact report provided to the Mana Ake SLA.	

2.3 Improving wellbeing through prevention

Government Themes: Improving the well-being of New Zealanders and their families
Build a productive, sustainable and inclusive economy

Planning Priority: Cross-sectoral collaboration		
Expectation: Outline how the DHB has, and will continue to, demonstrate leadership in the collaboration between and integration of health and social services, especially housing.		
Actions to Improve Performance [3]	**Milestones**	**Measures of Success**
Continue to take a lead in Healthy Greater Christchurch, to foster collaboration between agencies, respond to emergent health issues and ensure policy incorporates a health perspective. *Healthy Greater Christchurch is a cross-sector collaboration between 200+ signatory organisations (based on the WHO Healthy Cities model).*	Q1: Expansion of Healthy Christchurch to Healthy Greater Christchurch to include the Waimakariri and Selwyn districts. Q4: Annual Hui identifies cross sector priorities and provides for information sharing and learning.	Improved population wellbeing results across the Canterbury Wellbeing Index metrics. Number of people participating in the Step-Up programme. 25% of total clients engaged in the Step-Up service achieve an 'off benefit' outcome.
Take the lead in supporting the Greater Christchurch Psychosocial Committee transition from a psychosocial recovery focus to supporting broader population wellbeing. Maintain the Canterbury Wellbeing Index to inform local collaboration, planning and focus.	Q1: Tiny Adventures 'All Right' app relaunched. Q4: Canterbury Wellbeing Index updated.	
Continue to work in partnership with the Ministry of Social Development and Pegasus Health, to expand the primary care service 'Step Up' to support people with health conditions or disabilities back into the workforce. (EOA)	Q1: Eligibility criteria widened to increase access to the service. Q4: Increased participation in the programme.	
Work in partnership with the Department of Corrections to identify and implement initiatives that will improve access to primary care for people on release from prison, to support this high need group to improve their physical and mental health and wellbeing. (EOA)	Q1: Low cost access pathway to general practice enabled for people on release from a corrections facility or deported from Australia. Q2: Current processes mapped and areas for improvement and integration identified.	

Planning Priority: Climate Change		
Expectations: ▪ Identify and undertake further areas for action to positively mitigate or adapt to the effects of climate change and its impacts on health. ▪ Identify actions that improve the use of environmental sustainability criteria in procurement processes.		
Actions to Improve Performance	**Milestones**	**Measures of Success**
Maintain CEMARS certification and Energy Mark certification by identifying further opportunities to reduce energy use, costs and emission.	Q2: Stocktake of current actions completed.	CEMARS certification and Energy Mark certification maintained. Reduction in energy consumption per square kilometre – baseline 2017/18 (402.7 kWh/m^2). Reduction of DHB carbon emissions.
Through the Sustainability Governance Group, agree a regional position statement to guide future action.	Q2: Regional Environmental Sustainability Position Statement developed.	
Increase emphasis on sustainability requirements in DHB procurement policies and practices to positively mitigate environmental impacts on health.	Q1: Sustainability questions included in tenders. Q4: Procurement policy updated, in line with MBIE guidance (once released).	
Replace the Christchurch Hospital coal boiler with carbon neutral biomass boiler to reduce emissions.	Q2: Biomass Boiler detailed design completed. Q4: Biomass Boiler installed and operational.	

[3] The DHB has a number of significant cross-sectoral projects and initiatives underway. The projects covered here are those not otherwise highlighted in other priority areas in this Plan. Also refer to sections 3.1 Partnering for Better Outcomes and 3.11 Cross-sector Investment.

Planning Priority: Waste Disposal	L G
Expectation: Identify further areas for action to support the environmental disposal of hospital and community (e.g. pharmacy) waste products (including cytotoxic waste).	

Actions to Improve Performance	Milestones	Measures of Success
Continue to promote clear messages to the public that people should return their surplus/expired medicines and used medicine sharps to pharmacies for safe disposal.	Q1: Educational materials distributed to local pharmacies.	Reduction of waste.
Work with the local disposal agent and product suppliers to identify solutions for improving mixed, plastic and eco recycling opportunities.	Q2: Options for mixed and plastic recycling reviewed with disposal agent. Ongoing: Options for supplier-reduction/removal, of waste and packaging material considered as part of procurement and service contracts.	
Partner with Medsalv to pilot an innovative single use device reprocessing, cost and waste reduction solution.	Q1: Pilot underway. Q2 Pilot evaluation completed and future direction confirmed.	
Utilise existing staff engagement mechanisms to promote participation of staff in identifying actions which could contribute to reducing waste.	Quarterly: Promotion and recognition of positive initiatives and change.	

Planning Priority: Drinking Water	E L G C
Expectation: Provide actions the DHB will undertake to support their Public Health Unit to deliver and report on the drinking water activities in the environmental health exemplar.	

Actions to Improve Performance	Milestones	Measures of Success
Maintain an accredited Drinking Water Unit and accredited Assessors to support the role of the DHB's Public Health Unit in ensuring drinking water safety and support the Public Health Unit in their role in managing and mitigating public health risks.	Q2: IANZ accreditation of Unit. Ongoing: IANZ accreditation of Drinking Water Assessors. Ongoing: Management and mitigation of public health risks from drinking water discussed with Council staff and elected officials as required.	100% of network suppliers (serving 100+ people) receive compliance reports. 100% of Water Safety Plans assessed and reported on within 20 working days. 100% of drinking water suppliers have had a Water Safety Plan inspection completed in the last 3 years. Percentage of networked drinking water supplies compliant with the Health Act.
Conduct an annual review of network drinking-water supplies, serving more than 100 people, and provide a report to water suppliers on their compliance.	Q1: Annual review completed. Q2: Compliance reports completed.	
Undertake assessments of water suppliers' Water Safety Plans, as required, and provide a timely report to suppliers to support effective management of any risks to supplies.	Ongoing: Water Safety Plans assessed as required. Quarterly: Monitoring of assessments.	
Conduct inspections of drinking water supplies with approved Water Safety Plans, to certify implementation of the Safety Plans.	Ongoing: All drinking water supplies with a Water Safety Plan inspected every 3 years. Quarterly: Monitoring of inspections.	
Contribute to Māori health and wellbeing through the ongoing provision of technical advice on drinking water to local Rūnanga and Marae, to improve access to potable (safe to drink) water. (EOA)	Ongoing: Participation in the ECan/ Ngāi Tahu Tuia partnership initiative. Q3: Q4: Training on the Iwi Management Plan provided to Health Protection and Policy staff involved in resource management work.	

Planning Priority: Healthy Food and Drink	L C
Expectations: ▪ Commit to implementing Healthy Food and Drink Policies in DHBs that align with the National Healthy Food and Drink Policy. ▪ Commit to including a clause in your contracts with health provider organisations stipulating an expectation that they develop a Healthy Food and Drink Policy covering all food and drinks sold on site/s, and provided by their organisation to clients/service users/patients (excluding inpatient meals and meals on wheels), staff and visitors under their jurisdiction. Any policy must align with the Healthy Food and Drink Policy for Organisations (https://www.health.govt.nz/publication/healthy-food-and-drink-policy-organisations). ▪ Commit to reporting in Q2 and Q4 on the number of contracts with a Healthy Food and Drink Policy, and as a proportion of total contracts.	

- Work with your PHU to commit to reporting in Q2 and Q4 on the number of Early Learning Settings, primary, intermediate and secondary schools that have current 1) water-only (including plain milk) policies, and 2) healthy food policies. Healthy food policies should be consistent with the Ministry of Health's Eating and Activity Guidelines.

Actions to Improve Performance	Milestones	Measures of Success
Review the DHB's Healthy Food Policy against the National Policy to identify opportunities for improvement. Socialise and implement the Canterbury DHB's Healthy Food and Drink Policy.	Q1: Re-engagement on the DHB's Policy. Q2: Communication of the DHB Policy. Ongoing: Policy implemented across DHB sites.	Healthy Food and Drink Policy implemented across all DHB sites. Healthy Food and Drink Policies implemented by health provider organisations. Water-only and Healthy Food Policies implemented by education providers.
Update food and drink provider contracts, to ensure compliance with the DHB's Healthy Food and Drink Policy.	Q2: Food and drink provider contracts updated.	
Work regionally to agree a consistent approach to health service provider contracts that stipulates the expectation they will develop and implement a Healthy Food and Drink Policy, in line with the national policy for organisations. Engage with providers to provide support and advice in developing their Policies, with a focus on Māori and Pacific providers to target higher need populations. (EOA) Track the number of provider contracts with a Healthy Food and Drink Policy.	Q2: Service provider contract clause agreed. Q3: Forum held to support development of provider policies. Q4: Service provider contracts include Healthy Food and Drink Policy expectations. Q2:Q4: Monitoring report on progress.	
Work with education providers in early learning settings, primary, intermediate and secondary schools to support the adoption of water-only and healthy food policies in line with the Healthy Active Learning Initiative.	Q2:Q4: Monitoring report on progress and adoption of policies.	

Planning Priority: Smokefree 2025	L C W

Expectation: Identify activities that advance progress towards the Smokefree 2025 goal, including supporting Ministry funded wrap-around stop smoking services for people who want to stop smoking, and which address the needs of hāpu, wāhine and Māori.

Actions to Improve Performance	Milestones	Measures of Success
Maintain an integrated approach to achieving Smokefree Aotearoa 2025, with active oversight of smokefree activity and the Canterbury Health Tobacco Control plan from the CCN Alliance and Smokefree Canterbury.	Q1: Tobacco Control Plan reviewed for 2019/20. Q4: Implementation plan developed for the Smokefree Health Precinct and surrounding areas.	90% of pregnant women, identifying as smokers on registration with an LMC, are offered brief advice and support to quit. 90% of PHO enrolled patients who smoke are offered brief advice and support to quit. 95% of hospitalised patients who smoke are offered brief advice and support to quit. 90% of households with a newborn have their smoking status recorded at the first WCTO core check. Increased rate of conversion of Te Hā - Waitaha referrals into service enrolments – baseline established.
Continue to provide smokefree advice across all settings and integrate the delivery of wrap-around cessation services through Canterbury's Te Hā – Waitaha service. Monitor Te Hā – Waitaha enrolments for opportunities to improve the service, particularly for Māori, Pacific, pregnant, CALD, and low-income clients. (EOA) Complete a process mapping exercise to understand client flow and improve consistency of data across the service.	Quarterly: Monitoring (by ethnicity) of smokefree advice, cessation service referrals and quit rates. Q1: Pegasus Health PHO successfully integrated as a formal partner in the Te Hā – Waitaha service, expanding capacity of the service. Q3: Stop Smoking Practitioners trained to provide "Vape to Quit" support. Q3: Process mapping exercise complete.	
Complete the evaluation of the Pregnancy Incentive Programme to identify opportunities to further enhance the service and assess the viability of introducing another targeted incentive programme. (EOA)	Q2: Pregnancy Incentive Programme evaluation complete. Q3: Second targeted programme identified.	
Provide training, support and resources to engage health professionals, community services and education providers and employers in creating smokefree environments and pathways for referrals to Te Hā – Waitaha. Build community awareness of Te Hā – Waitaha, by promoting and advertising the service and participating in local marae health hui and networking events. (EOA)	Q4: Stop smoking clinics arranged with six workplaces. Q4: Referral pathway established for women on release from prison.	

Planning Priority: Breast Screening	L C
Expectation: All DHBs will set measurable participation and equity targets from baseline data and describe actions to: ▪ Achieve participation of at least 70% of women aged 45-69 years in the most recent 24-month period. ▪ Ensure equity gaps are eliminated for priority group Pacific women.	

Actions to Improve Performance	Milestones	Measures of Success
Work closely with ScreenSouth to facilitate the alignment of the Breast and Cervical Screening Programmes, to capture opportunities for joint promotion and delivery of screening, support the recall of women for both programmes and provide process education to general practices. (EOA) *ScreenSouth has adopted a strong focus on priority group women (Māori and Pacific) and is working closely with all three Canterbury PHOs to lift coverage rates. - including the introduction of monthly screening appointment targets and a DNA process for women who don't make appointments.*	Monthly: Monitoring of screening appointment targets to ensure continuous improvement. Q2: Pasifika Health Promotor engaged to work alongside Pacific community groups and support providers to reach Pacific women. Q2:Q4: Provision of 'Top and Tail' screening clinics, in locations targeted to support priority women.	Reduction in the equity gap for priority women (current baseline to March 2019): Māori 70.4% Pacific 62.6% Other 75.5% Non-Māori 76.6% 70% of all women (45-69) have has a breast screen in the last two years (24 months).
Coordinate and facilitate bi-ennial screening appointments for women living in the Chatham Islands, who have to travel to Christchurch for mammograms. (EOA) *The DHB works with ScreenSouth, Ha O Te Ora O Wharekauri Trust and the Chatham's Medical Centre to arrange travel and accommodation and ensure all eligible women sign up for the screening appointments.*	Q3: Upcoming screening appointment promoted through local news and Medical Centre. Q4: Screening appointment held in Christchurch.	

Planning Priority: Cervical Screening	E L C
Expectation: All DHBs will set measurable participation and equity targets from baseline data and describe actions to: ▪ Achieve participation for at least 80% of women aged 25-69 years in the most recent 36-month period. ▪ Ensure equity gaps are eliminated for priority group women.	

Actions to Improve Performance	Milestones	Measures of Success
ScreenSouth has adopted a strong focus on priority group women (Māori, Pacific and Asian) and is working closely with all three Canterbury PHOs to lift coverage rates. Facilitate the alignment of the Breast and Cervical Screening Programmes, to capture opportunities for joint promotion and delivery of screening, and support the recall of women for both programmes. Provide administrative assistance to practices (with high numbers of priority women) to ensure women are recalled for cervical screens every three years. Provide monthly data match reports to the PHOs/practices to support planned recalls of priority group women. (EOA) Provide free cervical smears to eligible, unscreened and under-unscreened, women. (EOA) Deliver 'Top and Tail' and community-based screening clinics in target locations, to support priority women. (EOA)	Ongoing: Primary Care Liaison visits practices to discuss issues and support practices with recall. Quarterly: Performance report on number of practices supported, data match reports provided, clinics run and women screened. Q1:Q4: >40 practices provided with recall support. Q1:Q4: >6 'Top and Tail' clinics held. Q1:Q4: >4 targeted community-based clinics held. Q1:Q4: >560 free smears provided.	Reduction in the equity gap for priority women (current baseline to March 2019): Māori 67.6% Pacific 79.5% Asian 69.0% Other 75.9% 80% of all women (25-69) have had a cervical smear in the last three years (36 months).
Oversight of these actions will be driven through the CCN Population Health & Access SLA, actions are also reflected in DHB's SLM Improvement Plan. Collaborate with the Maui Collective (of Māori and Pacific service providers) to identify opportunities for promoting cervical screening to priority women. (EOA) Deliver an annual cervical screening clinic on the Chatham Islands to ensure access for these women. (EOA) Undertake a stocktake to establish where there is a shortage of smear takers with a focus on low-cost providers. (EOA) Identify opportunities for employers to support cervical screening, to increase access to free screening tests for priority women. (EOA)	Quarterly: Cervical screening results reviewed by the Population Health & Access SLA. Q2: Presentation at service providers Hui and opportunities explored with providers. Q3: Chathams' screening clinic delivered. Q3: Gaps in availability of smear takers identified and opportunities to address this explored with screening providers. Q4: Opportunities for additional employer funded cervical smear tests identified.	

2.4 A strong and equitable public health and disability system

Government Theme: Improving the well-being of New Zealanders and their families

Planning Priority: Engagement and obligations as a Treaty partner		E E C
Expectations: Specify in the annual plan the processes the DHB uses to meet Tiriti o Waitangi obligations including: ▪ Actions to establish/maintain processes that enable Māori to participate in, and contribute to, strategies for Māori health improvement. ▪ Actions to foster Māori capacity for participating in the health and disability sector and for providing for the needs of Māori. ▪ Actions to build the capability of all DHB staff in Māori cultural competency and Te Tiriti o Waitangi.		
Actions to Improve Performance	**Milestones**	**Measures of Success**
Maintain a Memorandum of Understanding with Manawhenua Ki Waitaha to actively engage Māori leaders in the planning and design of services and strategies to improve Māori health outcomes. (EOA)	Q2: Attendance of rural leads at Manawhenua Ki Waitaha Board hui, to enrich planning around support for rural-based Māori.	Progress against the SLM Improvement Plan actions. Reduction in equity gaps across identified SLM population health measures.
Develop a longer-term collective strategy for improving Māori health outcomes, supported by regular monitoring of equity outcomes across the Canterbury health system, to support open discussion and identify further areas for improvement. (EOA)	Q2: Co-design process launched to support development of long-term Māori health strategy. Q3: Equity reporting framework developed and implemented.	
Continue to invest in initiatives to build Māori provider capability and capacity through the Maui Collective to influence and shape practice and promote Whānau Ora approaches across the region to improve the experience of Māori presenting to our services. (EOA)	Q2: Maui action plan and key priorities developed to support future investment. Q4: Ten Health Hui held on Rehua Marae.	
Strengthen Māori engagement in the CCN Alliance work streams and service level alliances to bring a strong Māori perspective to the redesign of local services. (EOA)	Q1: Targeted equity actions agreed in Canterbury's System Level Measures (SLM) Improvement Plan. Q2: Learnings, where equity focus has been successful, documented and shared.	

Planning Priority: Delivery of Whānau Ora		E W C
Expectations: Identify the significant actions that the DHB will undertake in this planning year to: ▪ Contribute to the strategic change for whānau ora approaches within the DHB systems and services, across the district, and to demonstrate meaningful activity moving towards improved service delivery ▪ Support and to collaborate, including through investment, with the Whānau Ora Initiative and its Commissioning Agencies and partners, and to identify opportunities for alignment. (All Pacific priority DHBs need to also include Pasifika Futures in this activity).		
Actions to Improve Performance	**Milestones**	**Measures of Success**
Continue to invest in programmes of work that enable Whānau Ora approaches and support improved service delivery and engagement with health services. (EOA) Promote the use of patient and whānau stories and data driven evidence to highlight the success of Whānau Ora models.	Q1: Feedback from co-design workshop with Māori and Pacific women guides the framework for the DHB's Maternity Strategy, to support an integrated approach to the wellbeing of women, children and whānau. (page 11) Ongoing: Continued investment in the Mana Ake initiative, supporting schools, teachers and whānau when children are experiencing ongoing issues that impact their wellbeing. (page 16) Ongoing: Continued participation in the cross-agency Safety Response Pilot, taking a Whānau Ora approach to support the most vulnerable families and reduce repeated harm. (page 12)	Service development teams are inclusive of Māori and Pacific voices. 90% of households with a newborn have their smoking status recorded at the first WCTO core check. Reduction in the equity gap that exists for ASH (avoidable hospital admission) rates between Canterbury's Pacific and Total 0-4-year-old populations. 70% of all women (45-69) have has a breast screen in the last two years (24 months). 80% of all women (25-69) have had a cervical
Continue to invest in initiatives to build Māori provider capability and capacity through the Maui Collective (of Māori and Pacific Providers) to influence and shape practice and promote Whānau Ora approaches across the region to improve the experience of Māori and Pacific people presenting to services. (EOA) Reach agreement on a strategic approach to: workforce development and cultural competency development for kaimahi and providers.	Q2: Maui action plan and key priorities developed to support future investment. Q4: Workforce development plan in place across Maui Collective providers. Q4: Evaluation framework agreed and implemented.	

Develop and agree an evaluation framework for tracking the impact being made on the health and wellbeing of whānau that includes story-telling opportunities for providers, kaimahi and whānau.		smear in the last three years (36 months). Reduction in the equity gap that exists in the Acute Hospital Bed Day rate for Canterbury's Māori, Pacific and Total populations.
In partnership with Pasifika Futures, invest in the design and development of an innovative Whānau Ora service model to improve the health and wellbeing of our Pacific population. (EOA)	Q2: Whānau Ora, wellbeing focused, contract in place with Etu Pasifika. Q3: Mental health incorporated into wellbeing screening for Etu Pasifika's enrolled population. Q4: Provision of low-cost dental services at Etu Pasifika scoped and options presented.	
Collaborate with Te Pūtahitanga to identify opportunities for alignment between DHB-funded kaimahi and Te Pūtahitanga Whānau Ora Navigators to increase support to whānau. (EOA)	Q4: Opportunities for collaboration identified.	

Planning Priority: Care Capacity Demand Management (CCDM)		
Expectations: ▪ Detail the actions that you will take towards implementing Care Capacity Demand Management (CCDM) for nursing by June 2021 in your annual plans. ▪ Outline the most significant actions the DHB will undertake in 2019/20 to progress implementation of CCDM for nursing. Ensure the equitable outcomes actions (EOA) are clearly identified.		
Actions to Improve Performance	**Milestones**	**Measures of Success**
Establish a CCDM Governance Council to provide leadership and oversight of the care capacity demand management programme to ensure it is planned, coordinated and appropriate for staff and patients. (EOA) *The CCDM Council will consider the function of the CCDM in relation to equity outcomes as part of their oversight of the programme. Māori and Pacific nurses will be represented on the working groups.*	Q1: CCDM Council established. Q1: Approved terms of reference and meeting plan in place for the year (including regular meetings with health unions). Q1: Stocktake on CCDM standards commenced with Safe Staffing healthy workplaces Unit. Q1: High level implementation plan drafted.	The Council meets according to frequency stated in their terms of reference and have 80% attendance by all listed parties. All inpatient areas have a patient acuity tool in place by June 2020. 100% attainment of the vendor standards by August 2020. CCDM staffing methodology used to establish staff and skill mix for each ward/unit. Core data set is used to evaluate the effectiveness of CCDM. Variance response management system demonstrates staffing resource is consistently matched with patient demand.
Implement the validated patient acuity tool (TrendCare) in all inpatient areas, to underpin the delivery of the CCDM programme. *This includes the implementation of systems, processes and training to ensure the validated acuity tool is used accurately and consistently.*	Q1: CCDM Implementation Business Case approved. Q1: Rollout Plan agreed. Q2: Roll out of the patient acuity tool underway across the DHB, beginning in general medicine.	
Following implementation of the patient acuity tool: Establish a balanced set of CCDM measures (core data set) to inform improvements and evaluate the effectiveness of CCDM overtime. Agree a systematic process to establish and budget for staffing FTE, staff mix and skill mix, to ensure the provision of timely, appropriate and safe services. Establish a variance response management system, to provide the right staff numbers, mix and skills to support effective patient care. (EOA)	Q2:Q3: Working groups established to support each stream of work. Q2:Q3: Stocktake on current data measures completed, to inform development of a core data set. Q2:Q3: Stocktake of current systems and processes completed, to inform development of processed to support CCDM.	

Planning Priority: Disability	

Expectations:

- Commit to ongoing training for front line staff and clinicians that provides advice and information on what needs to be considered when interacting with a person with a disability. Report on percentage of staff completing the training by the end of Q4 2019/20.
- Outline how the DHB collects and manages patient information to ensure staff know which patients have visual, hearing, physical and/or intellectual disabilities.

Actions to Improve Performance	Milestones	Measures of Success
Implement the first stage of the Health Learn (learning management system) upgrade, to support delivery of learning modules and enable reporting on uptake.	Q1: First stage system upgrade complete.	Increase in the number of modules dedicated to, or inclusive of, content targeted at raising disability awareness. Percentage of staff completing disability training modules. Percentage of staff rating disability content positively. 90% compliance with utilisation of the Bedside Boards.
Engage subject matter experts to develop disability training modules, building on the e-learning work completed in 2017/18. (EOA) Engage with the DHB Disability Steering Group and Māori and Pacific leads to ensure content is consumer focused and culturally appropriate. (EOA) Track uptake and feedback on modules as a means of evaluation and to identify improvements.	Q2: Development of training modules complete. Q2: Disability training modules launched. Q3: Report on uptake of training modules by staff commenced.	
Continue to use Bedside Boards to identify and display information about a patient's impairment close to all hospital beds (excluding Specialist Mental Health) so that staff interacting with patients are informed of their needs.	Q3: Expand the use of Bedside Boards into the new Acute Services Building.	

Planning Priority: Planned Care	

Expectations: DHBs need to outline the actions they will take in order to support the following:

Part One (p1): Current Performance Actions

- Outline actions to sustain or improve Planned Care delivery to meet increasing population health need and maintain timely access to Planned Care services including Radiology Diagnostics and Elective services. Actions need to include how DHBs will enable delivery of the agreed level of Planned Care interventions; and ensure that patients wait no longer than four months for a First Specialist Assessment and Treatment. Delivery and improvements will be measured against the agreed Planned Care Measures, and quarterly qualitative reports.

Part Two (p2): Three Year Plan for Planned Care

- DHBs are required to plan, design and start implementation of a Three-Year Plan to improve Planned Care services. The plan is required to include a description of actions that demonstrate how DHBs will address the following five Planned Care Priorities:
  - Gain an improved understanding of local health needs, with a specific focus on addressing unmet need, consumer's health preferences, and inequities that can be changed;
  - Balance national consistency and the local context;
  - Support consumers to navigate their health journeys;
  - Optimises sector capacity and capability; and
  - Ensures the Planned Care Systems and supports are designed to be fit for the future.
- DHBs are expected to engage with DHB Consumer Councils and other key stakeholders in the development of their plan.
- DHBs should identify for both part one and two who in their population is experiencing inequities and include actions or strategies to be implemented to address the identified inequities.

Actions to Improve Performance	Milestones	Measures of Success
Increase clinical capacity to reduce current ESPI 2 non-compliance in General Surgery, ensuring all general surgery patients accepted for a first specialist assessment are seen within four months of referral.	Q2: Internal clinical outpatient capacity increased by 372 appointments to meet end of year deadline for compliance.	Green status for ESPI 2 in General Surgery by 31 Dec 2019.
Develop and implement operational plans to reduce any loss of planned care capacity during the migration of services to the new Hagley Building.[4]	Q2: Migration plan developed. Q3: Hospital move initiated. Q4: Hospital move completed.	Delivery against planned care targets.

[4] This service migration is the biggest hospital move in New Zealand history to date and there is considerable risk that the delivery of planned care will be significantly disrupted if the shift is not achieved in a measured and coordinated way. Solutions to ensure continued delivery of services during this time may include increased outsourcing of planned care during this period.

Monitor planned care referral and access rates by ethnicity to identify equity gaps for population groups. Investigate and address the barriers and behaviours driving these equity gaps. (EOA)	Q1: Processes and reporting required to determine gaps developed. Q3: Three focus areas identified, using Q1-Q2 data. Q4: Improvement plans implemented for the three focus areas, with targets set to reduce equity gaps.	Focus areas identified. Reduction of identified equity gaps in access to planned care.
Work with primary and secondary partners to design a three year plan for the delivery of Planned Care services in Canterbury, in line with national expectations. Engage in analysis of service demand and consultation with stakeholders to identify local health needs, priorities and preferences as part of the development of the plan. Use service referral and access data to determine where opportunities exist to improve equity of access across population groups. (EOA) Incorporating updates to HealthPathways and HealthInfo to reflect the three-year plan and support people to navigate their health journey. Take the first steps in implementing the agreed approach to the delivery of Planned Care in Canterbury.	Q1: Outline of the proposed approach to development the three-year plan provided to the Ministry of Health, including engagement, analysis and development activities. Q2: Analysis of changes that can be made to Planned Care services undertaken. Q3: Canterbury's three year plan to improve Planned Care services submitted to the Ministry. Q4: First update on actions taken to improve Planned Care provided to the Ministry.	Outline of proposed approach to developing the three-year plan submitted. Three year plan is completed. Delivery of actions outlined in the three year plan.

Planning Priority: Acute Demand		QEEC
Expectations: ▪ Provide a plan on how the DHB will implement SNOMED coding in Emergency Departments to submit to NNPAC by 2021. For example, this should include a description of the information technology actions and ED clinical staff training actions, milestones and timeframes. ▪ Patient Flow: Provide an action that improves management of patients to ED with long-term conditions. ▪ Patient Flow: Provide an action that improves patient flow for admitted patients.		
Actions to Improve Performance	**Milestones**	**Measures of Success**
Continue implementing SNOMED coding in the Emergency Department (ED) through the new ED At A Glance (EDaaG) Patient Management System implementation.[5] Focus on reviewing data quality, creating logic and making visible meaningful information derived from SNOMED for clinical teams, to supplement the near-real-time viewers already in place.	Ongoing: Monitoring of SNOMED data to identify opportunities to improve data capture and quality. Ongoing: Training for clinical teams in the use of SNOMED within EDaaG. Q2: SNOMED reports live on internal systems. Q3: Links into near-real-time viewers and current ED system reports established.	SNOMED coding in NNPAC by 2021. >30,000 acute demand packages of care provided in the community. 95% of patients are admitted, discharged, or transferred from the Emergency Department (ED) within six hours. <15% of patients admitted from ED observation to inpatient wards (national guidelines <20%). ED attendances maintained at <185 per 1,000 people – baseline at June 2018.
Review the scope and utilisation of the Acute Demand Management Service, at a general practice and population level, to ensure the Service is appropriately targeting Māori and Pacific as populations of high need. (EOA). Review the rural stabilisation package, to support rural practices to manage patient flows closer to home. (EOA)	Q2:Q4: Monitoring (by ethnicity and locality) of ADMS performance metrics by Urgent Care SLA. Q2: Data Deep Dive used to inform areas of focus and continuous improvement. Q3: Rural stabilisation package reviewed and opportunities for further improvement identified.	
Decant and shift services into the Hagley facility (acute services building) as the new facility becomes operational. Chiefs and Chairs will use data to identify opportunities to improve the interface between receiving specialties and ED, to reduce delays in accepting admissions and support improved patient flow across the hospital. *General medicine and general surgery flows have already been enabled and this work will look to build on the lessons learnt and optimise opportunities within the new facility.*	Q2: Decant to the new Hagley building complete. Q2:Q4: Review of ED wait times and acute bed days to identify opportunities to reduce the lengths of people's hospital stay. Q3: Alternative pathways and/or interventions introduced to support improved patient flow.	
Maintain the mental health crisis resolution service response in ED, to streamline access to mental health services, particularly for Māori and Pacific people as high need populations. (EOA)	Q2:Q4: ED length of Stay for mental health patients reviewed by ethnicity, to inform continuous improvement.	

[5] SNOMED is a system of terminology consisting of over 300,000 clinical concepts and 1,000,000 terms which enable findings, diagnoses, conditions, procedures etc. to be easily and consistently recorded at point of care.

Planning Priority: Rural health		
Expectations: Outline how the DHB has considered the health needs and the factors affecting health outcomes for rural populations when making decisions regarding access to and sustainability of health services.		
Actions to Improve Performance	**Milestones**	**Measures of Success**
Through the Rural Service Level Alliance, continue to support the Rural Sustainability Programme, to identify challenges, develop resilient rural primary care services and support equitable access to services for our rural communities. (EOA)	Q2:Q4: Monitoring of activity underway to strengthen rural workforce including the role of nurse practitioners and PRIME practitioners. Ongoing: Progress the agreed recommendations to support the implementation of the Hurunui and Oxford Models of Care.	Acute hospital bed day rate maintained below the national average. Average elective inpatient length of stay at or below 1.54 days. Readmission rates (at 28 days) maintained below the national average.
Complete a stocktake of current demand and service performance, with regards to the emergency response pathway in rural localities	Q4: Stocktake report identifies opportunities for improvement.	
Trial a new patient observation protocol, to avoid transfer to hospital of rural patients who could be safely treated and observed close to home. (EOA)	Q1: Protocols established for the Rural Observation Service in the Hurunui and Oxford.	
Invest in the development of rural-based restorative model of care for rural people following hospital-discharge, to support care closer to home. (EOA)[6]	Q4: Rural-based restorative supported discharge model implemented in two rural localities.	
Upgrade telehealth facilities in rural localities, as the national broadband rolls-out, facilitating easier access for rural communities to specialist consultations, clinical education and peer support. (EOA)	Q4: Telehealth expanded in two rural localities.	

Planning Priority: Healthy Ageing		
Expectations: ▪ Identify actions, working with ACC, HQSC and the Ministry of Health, to promote and increase enrolment in S&B programs and improvement of osteoporosis management especially in alliance with Primary Care as reflected in the associated "Live Stronger for Longer" Outcome Framework ▪ Identify actions to align local DHB service specifications for home and community support services (HCSS) to the vision, principles, core components, measures and outcomes of the national framework for HCSS. ▪ Outline current activity to identify and address the drivers of acute demand for people 75 plus presenting at ED (or at lower ages for disadvantaged populations)		
Actions to Improve Performance	**Milestones**	**Measures of Success**
Continue enhance and integrate falls and fracture prevention services to reduce the harm from falls: Engage with Sport Canterbury to accredit community Strength & Balance (S&B) classes designed for and targeted towards Māori and Pacific people. (EOA) Embed the fracture pathway to ensure people with a fractured Neck-of-Femur (hip) or Humerus (arm) are referred to the in-home Falls Prevention Programme, to reduce future harm. Implement the Fracture Liaison Service pathway in Primary Care, to ensure people with a frailty fracture receive appropriate support and follow-up.	Q2: 3 Māori and Pacific S&B classes accredited. Q2: Fracture referral pathway finalised. Q2: Automatic referrals to the Falls Prevention Programme piloted. Q4: Fracture Liaison Service pathway implemented. Q4: 150 places available at targeted (Māori and Pacific) community-based S&B class.	12,000 places available at accredited community Strength & Balance classes. 1,200 people access the Falls Prevention Service. 2,100 people access the Fracture Liaison Service. 95% of long-term HCSS clients have an InterRAI assessment and a completed care plan in place. Increasing number of people with Advance Care Plans in place. Proportion of people (75+) presenting to ED
Continue to enhance the restorative model of care, across home and community support services (HCSS): Pilot the new HCSS referral process and introduce electronic forms to support streamlined service referrals. Work with community older persons health teams to identify barriers to equitable and timely assessment of people's needs, using the InterRAI assessment tool. (EOA) Complete the development of an Ethical Framework to support decision-making around HCSS resources allocation.	Quarterly: Monitoring (by ethnicity) of InteRAI assessment rates. Q2: HCSS referral process piloted. Q2: Key drivers of longer wait times for InterRAI assessments identified and addressed. Q3: Ethical Framework completed and agreed.	

[6] This work was delayed in 2018/19 while the DHB completed work on the review of the associated CREST service model. The rural model will be prioritised in 2019/20.

Trial the provision of rural kahukura day programmes in one rural area, with a view to planning a further programme at a second rural location. (EOA)	Q2: Day programme trial underway. Q4: Second locality identified.	maintained below the national average.
Promote the use of Personalised Care Plans, Acute Care Plans and Advance Care Plans to enable the delivery of consistent, patient-driven care and reduce unnecessary ED presentations for more vulnerable population groups. (EOA)	Quarterly: Monitoring (by ethnicity) of the number of completed care plans. Q3 Advance Care Plan flyers provided with all new InterRAI assessments.	

Planning Priority: Improving Quality	

Expectations:

- Identify actions to improve equity of outcomes, measured by the Atlas of Healthcare Variation (choose gout, asthma or diabetes)
- Identify actions to improve patient experience as measured by your DHB's lowest-scoring responses in the Health Quality & Safety Commission's national patient experience surveys.
- Please ensure that the local measure included in your plan relates to the action in your plan.
- Identify actions to align activities with the New Zealand Antimicrobial Resistance Action Plan (MoH 2017).

Actions to Improve Performance	Milestones	Measures of Success
In response to the higher rates of hospital admission for children due to asthma or wheeze, highlighted in the Atlas of Healthcare Variation, work with general practices and LMCs to identify key actions that will reduce asthma and respiratory related hospital admissions. (EOA) *This work is reflected in the DHB's SLM Improvement Plan with a focus on supporting Māori and Pacific children as high need population groups.*	Q1: Targeted cessation smoking related actions agreed in the SLM Improvement Plan (to reduce ambulatory sensitive admissions for children 0-4). Quarterly: Progress against the SLM actions. Quarterly: Monitoring of Atlas Variation and O-4 ASH rates to gauge improvement in rates.	Reduction in the equity gap that exists in ASH rates between Canterbury's Pacific and Total 0-4-year-old populations. Reduction the rate of childhood admissions due to asthma or wheeze – base 5.2 per 1,000 2016. Improved result for the Patient Experience survey question "Did hospital staff include your whānau or someone close to you in discussion about your care?" baseline 57% at June 2018.
Complete implementation of the 'nominated' contact person process, to improve results against the DHB's lowest scoring Patient Experience Survey question: "Did hospital staff include your whānau or someone close to you in discussion about your care?" (Partnership Domain). [7] Undertake a co-design process with consumers and whānau to develop education material that reinforces the role of a nominated person in the early stages of admission. Focus on engagement with Maori and Pacific groups to ensure processes are culturally appropriate. (EOA) Provide staff training to reinforce the need to establish and engage with the patient's nominated person.	Q2: Co-design focus groups run. Q2: information system changes made to include nominated contact person and draft procedure for contact details collection finalised. Q2: Education material and tools agreed. Q3: New process launched in Ward 27 as a pilot site, to test processes and information. Q3: Staff training underway, incorporating lessons being learnt from the pilot Ward. Q4: Full rollout underway across remaining 40 sites.	
Take the lead in the expansion of ICNET to support real-time notification of organisms requiring infection prevention and control input. Establish links to ensure information flows to Public Health Teams and Aged Residential Care to support and advise on the management of infectious outbreaks including antibiotic resistant organisms.	Q2: Interface between PatientTrack and ICNet explored. Q3: Workflow process documented and agreed between DHB IPC service, Public Health and ARC. Q4: Real-time interface initiated between ICNET and DHB information data warehouse.	Local antimicrobial guidelines updated, based on local susceptibility patterns, national/international guidelines and evidence, and local expert opinion. Quinolone usage sustained at ≤25 defined daily doses per 1,000 bed-days. Regional agreement reached on hospital antimicrobial guidelines for key indications. Adoption of national antimicrobial guidelines.
Establish an overarching Strategic Antimicrobial Stewardship (AMS) Group to oversee AMS activities in Canterbury, via alignment of two existing groups – the CDHB Antimicrobial Stewardship Committee (hospital-focused) and the Canterbury Community Antibiotic Response Steering Group (primary-care focused). *The two latter groups will remain operationally focused.*	Q2: Strategic Antimicrobial Stewardship Group in place and first meeting held. Q3:Q4: Regular Strategic Antimicrobial Stewardship Group Meetings held, to support a collaborative approach to Antimicrobial Stewardship across the Canterbury health system.	
Through the DHB's Antimicrobial Stewardship Committee, maintain an ongoing focus on reducing the inappropriate use of quinolone antimicrobial agents to protect their effectiveness and minimise their toxicity.	Q1: Empiric intra-abdominal infection and pyelonephritis guidelines updated. Q2: Review of pyelonephritis management in the Emergency Department and in Christchurch Women's Hospital completed.	

[7] The inclusion of a family/whanau member or significant other for patients is an important indicator of a partnership with patients and a factor in ensuring good outcomes. Currently the DHB has limited ability to capture and record a contact other than next of kin. This work is part of the DHB's Always Event project and will expand our ability to recognise other people who are important to the patient and ensure staff recognise the importance of engaging with them.

	Q2: Audit on moxifloxacin use completed. Q3: Bulletins communicated to DHB clinical staff about appropriate quinolone use, and shared with primary care colleagues.	
Participate in development of the ACC-funded national antimicrobial guidelines to assist with improving antimicrobial prescribing. (EOA) Support regional meetings to establish South Island Hospital Antimicrobial Guidelines for key indications. (EOA) *These guidelines will promote equity across the health system and between DHBs, and will offer a tool with which to audit prescribing compliance and appropriateness.*	Q1:Q4: Attend national meetings to progress antimicrobial guideline planning. Q1: Share access to Canterbury DHB's Pink Book (antimicrobial guidelines) with West Coast DHB. Q2:Q4: Meet with five South Island DHBs to seek agreement on regional hospital prescribing guidelines.	

Planning Priority: Cancer Services	
Expectations: ▪ Describe actions to ensure equity of access to timely diagnosis and treatment for all patients on the Faster Cancer Treatment (FCT) pathway (e.g. system/service improvements to minimise breaches of the 62-day FCT target for patient or clinical consideration reasons) ▪ Identify two priority areas for quality improvement from the Bowel Cancer Quality Improvement Report 2019. ▪ Commit to working with the Ministry to develop a Cancer Plan and to implementing and delivering on the local actions from within the Plan.	

Actions to Improve Performance	**Milestones**	**Measures of Success**
Building on the Cancer Kōrero developed by other South Island DHBs, produce an informative Cancer booklet for Māori, to raise awareness of how to reduce risk, warning signs, screening and treatment options and where to get help and support. (EOA)	Q2: Draft Kōrero reviewed and accepted. Q3: Kōrero launched.	90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks. 85% of patients receive their first cancer treatment (or other management) within 31 days of the decision-to-treat.
Continue to use data/intelligence systems to monitor the 62-day and 31-day wait times for access to treatment. Participate in the clinically-led regional Lung Cancer Pathway review to identify opportunities to reduce process delays, ensure equity of access, and improve the experience of people in our Respiratory service. (EOA)	Quarterly: Monitoring (by ethnicity) of cancer wait times, analysis of any cases outside of time frames and action to address emergent issues. Q4: Identified opportunities from the Regional Lung Cancer Pathway review shared across services.	
Support the Haematology Department to take a lead on improving cultural awareness across cancer services, as part of the DHB's commitment to improving equity and the experience of Māori in our services. (EOA)	Q1: Review of the integration of cultural competency standards into DHB policy around the return or disposal of tissue complete. Q4: Initiatives to support increased use of Te Reo Māori implemented across Haematology.	
Informed by the 2018 national Bowel Cancer Quality Improvement Report, appoint a Project Manager to lead the DHB's preparation for initiating the bowel cancer screening programme.	Q1: Bowel Cancer Project Manager in place. Ongoing: Development of an implementation and improvement plan for bowel cancer care.	
Work with the Ministry to develop a national Cancer Plan and deliver on the local actions identify within the Plan.	Ongoing: Development of a local action plan once the national Cancer Plan is developed.	

Planning Priority: Bowel Screening	

Expectations:

All DHBs will describe actions to ensure diagnostic colonoscopy wait time indicators are consistently met; this requires active management of demand, capacity and capability.

DHBs providing the National Bowel Screening Programme will describe actions to:

- Implement initiatives that contribute to the achievement of national targets for NBSP. All initiatives will demonstrate clear strategies for increasing health gains for priority groups and improving equitable participation and timely access to services.
- Ensure screening colonoscopy wait time indicators (indicator 306: time to first offered diagnostic assessment) is consistently met.
- Achieve participation of at least 60% of people aged 60-74 years in the most recent 24-month period.
- Ensure participation equity gaps are eliminated for priority groups.

Actions to Improve Performance	Milestones	Measures of Success
Create capacity across colonoscopy services to reduce current wait times (in preparation for the rollout of the national Bowel Screening Programme) by developing a production plan, using trend and service forecasts to establish current and future demand and identifying opportunities for service enhancement. Monitor colonoscopy wait times to identify and respond to capacity issues.	Q1. Service utilisation data and forecasts reviewed. Q1: Production plan completed. Q2-Q4: Progress against production plan and waiting times tracked to mitigate risk and respond to capacity issues for meeting required targets	90% of people accepted for an urgent diagnostic colonoscopy wait no more than 14 calendar days, 100% wait no more than 30 days. 70% of people accepted for a non-urgent diagnostic colonoscopy wait no more than 42 calendar days, 100% no more than 90 days. 70% of people waiting for a surveillance colonoscopy wait no more than 84 calendar days past the planned date, 100% no more than 120 days. National Bowel Screening Programme commenced in Canterbury.
Assess current outsourced/outplaced colonoscopy procedures against the service forecasts and production plan, to identify if further outsourcing is required and to understand capacity available if required.	Q2: Stocktake of outsourcing completed.	
Seek support from the Southern Regional Network and Population Health & Access SLA to raise awareness across general practice and support GP teams to provide information and support to patients. Engage with the Māori and Pacific Health Provider Collective (Maui) to raise awareness of the start of the National Bowel Screening Programme in Canterbury and connect with hard to reach populations. (EOA) Work regionally with South Island DHB colleagues to capture Bowel Screening rollout lessons learned and successful implementation strategies that can be implemented in Canterbury in 2020.	Q3: Further strategies for supporting the rollout of the screening programme identified. Q2:Q4: Regional input is captured to support development of a successful Bowel Screening implementation plan.	
Progressively work toward increasing capacity to support delivery of the National Bowel Screening Programme with Canterbury beginning screening in May 2020. Review the colonoscopy production plan to prepare for the increase demand as the screening programme goes live.	Q2: Draft production plan distributed. Q4: Increased SMO capacity in place to meet procedural requirements.	

Planning Priority: Workforce – Workforce Diversity	Q E E

Expectations:

- Set out workforce actions, specific to your DHB that you intend to work on in the 2019/20 planning year.
- Outline how these actions relate to both a strong public health system and EOA focus area actions.
- Ensure that you have considered workforce actions for the priority areas in your plan, especially mental health and child health.

Work in collaboration with DHB Shared Services and, where appropriate, with the Ministry of Health to:

- Identify workforce data/intelligence that is collected and understand workforce trends to inform workforce planning
- Understand workforce data/intelligence requirements that best support DHBs in order to undertake evidence-based workforce planning
- Support your responsibility to upskill, provide education and train health work forces
- Provide training placements and support transition to practice for eligible health work force graduates and employees. Planning must include PGY1, PGY2 and CBA placements, and how requirements for nursing, allied health, scientific and technical health work forces in training and employment will be met
- Form alliances with training bodies such as educational institutes (including secondary and tertiary), professional colleges, responsible authorities, and other professional societies to ensure that we have a well trained workforce.
- DHBs are expected to develop a sustainable approach to nursing career pathways. In 2019-20, it is expected that DHBs will develop actions that support equitable funding for professional development for nurse practitioners.

Actions to Improve Performance	Milestones	Measures of Success
Establish the Tō Tātou Ora (Our Health) Programme to deliver on the vision outlined in the Occupational Health Service Review and support the improved health and wellbeing of our people. Develop pathways and resources to create a better understanding of what people can do to stay and get well and key roles and responsibilities regarding fitness to work, return to work, or transition from work.	Q1: Sick Leave Task Force established. Q2:Q4: New service established to effectively manage illness-related absences.	Decrease in absenteeism both number of sick days taken and number of people on long term sick leave.
Establish and develop the Diversity, Inclusion & Belonging programme (aligned with the People Strategy: Care Starts Here) to build a culture that encourages and welcomes diverse groups of all cultures, genders and race, enrich the organisation with different viewpoints and attract and retain the best talent available. (EOA)	Q1: Programme implementation plan created and key stakeholder groups agreed. Q2: Rainbow Tick accreditation programme launched.	Rainbow Tick accreditation achieved.
Work in tandem with the West Coast DHB to support and encourage greater participation of Māori in our health workforce and build on the learnings from the joint workshops held in 2018/19. (EOA)	Q3: Targeted attraction and recruitment programme for Māori workforce developed. Q4: Targeted attraction and recruitment programme for Māori workforce launched.	Māori workforce closer aligned to the proportion of Māori in the population – base 2.8% April 2019.[8]
Continue to develop the rural nursing workforce with investment in a Rural Nurse Specialist development pathway and ongoing recruitment, training and development of nurse practitioners. Review Canterbury's current allocation for Nurse Practitioner professional development to identify opportunities to ensure resources offered are consistent with continuing competence requirements and enable access to forums that promote professional contributions to quality care and ongoing improvement.	Q1: Regional discussions instigated to explore opportunities for standardisation of a professional development package. Q3: Review of current allocation complete with recommendations for improvements made to executive team. Q4: New Nurse Practitioner professional development package finalised and implemented.	Improved professional development package in place for Nurse Practitioners.
Expand and promote the Essentials of Leadership and Management programme (aligned with the People Strategy: Everyone Enabled to Lead) to lift the capability of clinical and operational leaders through anytime, anywhere learning. *Success will be measured on the level of engagement with new learning content and ongoing learning evaluation with a focus on behaviour change.*	Q1: Our Learning Pathways launched in conjunction with a refreshed user experience via online resources. Q2: Delivery of 12 'User Stories' to the organisation, which include feedback and evaluation processes for learners. Q3: A reviewed roadmap document for 2020 published for stakeholder engagement. Q4: Delivery of a further 12 'User Stories'.	An increase in engagement through the electronic direct mail channel measuring the number of opens vs. 'clicks/taps' from 68% and 17%. >12% completion rate for learning modules.

[8] This figure is likely to be understated, 18% of DHB employees have no ethnicity declared. Of those declaring their ethnicity 3.4% have identified as Māori.

Planning Priority: Workforce - Health Literacy	E E C

Expectations:

- As a result of the health literacy review completed in the 2018/19 planning year (if you do not have one already in place), develop a Health Literacy Action Plan that describes the service improvements you plan to make in the short, medium and long term.
- Outline actions within the Health Literacy Action Plan that support a health system focus on: services being easy to access and navigate, effective health worker communication, clear and relevant health messages that empower everyone to make informed choices.

Where health literacy actions are set out in other sections of the annual plan ensure that these are considered within the Health Literacy Action Plan, as well as briefly cross-referencing these actions in this section.

Actions to Improve Performance	Milestones	Measures of Success
Conduct a collaborative health literacy review to assist in the formulation of a formal Health Literacy Action Plan, with the intent that health literacy improvements and resources are developed in collaboration with the people/communities for whom the improvement or resource is aimed to benefit. (EOA)	Q2: Health Literacy Review scoped, and team is formed to undertake the Review. Q4: Health Literacy Review report is complete and recommendations made to inform a Health Literacy Action Plan.	Patient satisfaction ratings across the two inpatient survey domains: Communication and Partnership.
Review the accessibility of Interpreter Services across the Canterbury health system, to address gaps and implement best practice guidelines. (EOA)	Q3: Best practice guidelines developed. Q4: Review complete and used to guide development and improvement of services.	

Planning Priority: Delivery of Regional Service Plan (RSP) Priorities	Q C

Expectations: Identify significant actions the DHB is undertaking to deliver on the Regional Service Plan in the following areas:

- Actions to support the implementation of the New Zealand Framework for Dementia Care.
  - Provide input into a regional stocktake of dementia services and related activity, which will be completed and provided to the Ministry by the end of quarter two (via the S12 measure).
  - Using the stocktake, work with your regional colleagues to identify and develop an approach to progress your DHB's priority areas for implementing the Framework by the end of quarter four.
  - Report on work to progress the implementation of the New Zealand Framework for Dementia Care in quarters three and four.
- Identify the DHB's role in supporting the delivery of the regional hepatitis C work and objectives.
  - Describe how the DHB will work in collaboration with other DHBs in the region to implement the hepatitis C clinical pathway
  - Describe how the DHB will work in an integrated way to increase access to care and promote primary care prescribing of the new pangenotypic hepatitis C treatments.

Actions to Improve Performance	Milestones	Measures of Success
Capture the range of Dementia Services available in Canterbury and build a map of services to support people with dementia, their partners and families. Using the stocktake and in line with the national NZ Framework for Dementia Care, identify priorities to address service gaps and improve the experience of people with dementia and their families. Engage with primary, community and aged care partners to develop strategic and service responses that support earlier diagnosis and referral to services and improve access to support for those caring for people with dementia. *This work is supported locally by the Dementia Stakeholders Group and feeds into the actions identified in the South Island Regional Alliance's Dementia Initiative 'Dementia is Everybody's Business'.*	Q1: Stocktake of Dementia services in Canterbury complete. Q2: Dementia Map for service users developed. Q2: Priority focus areas identified and response underway. Q2: Dementia education session delivered to primary care to support earlier diagnosis. Q3:Q4: Report on progress implementing the NZ Framework for Dementia Care.	Progress against the regional initiative Dementia is Everybody's Business'. Progress in implementing the NZ Framework for Dementia Care.
Take the lead in the regional Hepatitis C work stream to support implementation of an integrated approach to the screening, treatment and management of Hepatitis C. Develop and deliver against a local action plan, aligned with Regional Plan, which ensures at-risk and 'treatment naïve' populations are reached. (EOA) Engage with primary care partners to support them to provide the majority of treatment services for individuals with Hepatitis C. *Refer to the 2019/20 Regional Health Services Plan for more detail on the Hepatitis C work plan.*	Q1: Regional Hepatitis C work plan is agreed. Q2: Local Action Plan is developed. Q2: Local HealthPathway aligned to national guidelines. Q3:Q4: Report on progress against the regional Hepatitis C work plan.	Each GP practice with known Hep C+ patients has active engagement with a secondary care community clinic nurse. At risk individuals are tested, those lost to follow-up are identified.

2.5 Better population health outcomes supported by primary health care

Government Theme: Improving the well-being of New Zealanders and their families

Planning Priority: Primary Health Care Integration	LEEC
Expectations: ▪ DHBs should ensure clear accountability throughout the entire alliance structure - include a description of this accountability cascade from PHO and DHB Boards to the Alliance Leadership Team (ALT) and then to individual Service Level Alliances including decision making, reporting, budget to support the Alliance and total budget available to the ALT for service planning and delivery. ▪ DHBs are expected to continue to work with their district alliances on integration including: strengthening their alliance (e.g., appointing an independent chair, establishing an alliance programme office, expanding the funding considered by the alliance); broadening the membership of their alliance; developing services, based on robust analytics, that reconfigure current services and address equity gaps. ▪ Identify actions you are taking with your Rural Service Level Alliance to develop resilient rural primary care services. ▪ Identify actions to assist in the utilisation of other workforces in primary care settings, particularly nurses and pharmacists in rural areas. ▪ Identify actions to improve access to primary care services, particularly for high needs patients.	

Actions to Improve Performance	**Milestones**	**Measures of Success**
Continue to invest in the Canterbury Clinical Network (CCN) District Alliance as a mechanism for leading service and system improvements in Canterbury and support increase connectively between the CCN and other local and regional alliances to capture learnings and enhance programme development.[9]	Quarterly: Monitoring of system performance (against Canterbury's Outcome Framework) and progress against the CCN Alliance work plans. Q3: Options for increased consumer engagement identified and trialled. Q4: Opportunity for increased connectivity and alignment between the Health Precinct Advisory Council (HPAC) and the CCN formalised.[10]	>95% of the population are enrolled with general practice. Improved system performance in line with the 2017/18 SLM Improvement Plan. Reduction in the equity gap that exists for ASH (avoidable hospital admission) rates between Canterbury's Pacific and Total 0-4-year-old populations. Reduction in the equity gap that exists in the Acute Hospital Bed Day rate for Canterbury's Māori, Pacific and Total populations.
Refresh and refine the System Level Measure (SLM) Improvement Plan, agreeing collective activity to improve performance in 2019/20 with a deliberate focus on closing health equity gaps. (EOA)	Q1: Refreshed SLM Improvement Plan agreed and available on the DHB and CCN website.	
Through the Rural Service Level Alliance, continue to support the Rural Sustainability Programme, to develop resilient rural primary care services and support equitable access to services for our rural communities. (EOA)	Refer to Rural Health Action Table – page 25.	
Trial a new model of mental health service delivery in primary care, with a dedicated resource working in general practice, to support an immediate response to people's mental health needs. (EOA)	Refer to Population Mental Health Action Table – page 14.	
Invest in initiatives that support improved access to primary care services for high needs patients, to support improved health and wellbeing. (EOA)	Q1: Low cost access to general practice enabled for people on release from a corrections facility or deported from Australia.	

[9] The Canterbury Clinical Network is the broadest health alliance in the country with twelve system partners and whole-of-system engagement. It has an independent Chair and small Programme Office, funded by the DHB and hosted by Pegasus Health Limited. For further information on the role and responsibilities of the Alliance and the Service Level Alliances and the work plans for 2019/20, see www.ccn.health.nz.

[10] The Health Precinct Advisory Council is a strategic leadership group comprising senior leaders from key health and tertiary education organisation, including the DHB, Universities of Canterbury and Otago and Ara. The role of the HPAC is to bring people together to work in new ways, enable innovation, and ensure a strategic approach across partners' institutional activities.

Planning Priority: Pharmacy	Q C

Expectations:

- Identify actions to support the work to enable the separation of dispensing into separate ICPSA schedules (medicine and supply and clinical advice) by June 2020.
- Identify actions to support the vision of the Pharmacy Action Plan and the Integrated Community Pharmacy Services Agreement (ICPSA) by working with pharmacists, the public, primary care and the wider health care team to commission integrated local services that prioritise local need and support equitable health outcomes.
- Identify local strategies that support pharmacy and other immunisation providers to work together to improve influenza vaccination rates in Māori, Pacific and Asian people over 65 years of age.
- Commit to reporting the outcomes of these local strategies to improve influenza vaccination rates in Q2 of the following financial year.

Actions to Improve Performance	Milestones	Measures of Success
Participate in the national review of the Integrated Community Pharmacy Services Agreement (ICPSA), to better support the role of pharmacists in the integrated health care team.	Q4: Offer and explain the revised national ICPSA agreement to pharmacies, including the opportunity to improve integration of local services.	>1,000 people receive a Medicines Use Review (MUR). >200 people receive a Medicines Therapy Assessments (MTA). Increased uptake of MURs and MTAs by high need populations. Fewer people (65+) being dispensed 11+ long term medications (rate per 1,000).
Continue to invest in pharmacist-led services and improve access to pharmacist advice and support, to reduce harm from medications use, with a focus on people with chronic conditions and on multiple or high- risk medications. (EOA) *Māori and Pacific populations suffer from chronic conditions more than other groups and prevalence increases with age.*	Quarterly: Monitoring of the delivery of Medicines Use Review (MUR) and Medicines Therapy Assessments (MTA) by community pharmacists. Q4: Guides released to pharmacists and general practice, to support medicines reconciliation. Q4: Patient feedback on delivery of medication reviews on Marae used to inform service review.	
Pilot a new integrated approach to the provision of Opioid Substitution Treatment that enhances the role of pharmacy as part of the health care team, to improve the management of treatment. (EOA)	Q1: Pilot underway in three pharmacies. Q4: Pilot evaluation report completed.	
Work with PHO and pharmacy leads to identify local strategies to support an integrated approach to improving influenza vaccination rates, with a focus on older people and Māori and Pacific, as high need groups. (EOA)	Q1: Current influenza vaccination rates reviewed for equity gaps and areas of improvement. Q3: Plan for 2019/20 season developed. Q4: Promotion of free flu vaccinations from general practice and community pharmacies.	75% of the population aged 65+ receive a free influenza vaccination. Report on outcomes of local strategies (Q2 2020).

Planning Priority: Diabetes and other long term conditions	L Q C

Expectations:

- Identify the most significant actions the DHB will take across the sector to strengthen public health promotion to focus on the prevention of diabetes and other long-term conditions.
- Identify how the DHB will ensure all people with diabetes will have equitable access to culturally appropriate diabetes self-management education and support services and how the DHB will measure programme outcomes or evaluate their effectiveness.
- Commit to monitoring PHO/practice level data to improve equitable service provision and inform quality improvement.
- Identify actions to improve early risk assessment and risk factor management for people with high and moderate cardiovascular disease risk, by supporting the spread of best practice from those producing the best and most equitable health outcomes.

Actions to Improve Performance	Milestones	Measures of Success
Continue to promote and support healthy food and 'water only' policies and messaging in priority settings (schools, sports clubs, and marae), to strengthen awareness around risk factors for diabetes, cardiovascular disease and other long-term conditions.	Ongoing: Professional development sessions provided in school settings to support messaging. Q4: Increased number of priority settings engaged in 'water only' promotion.	>100 people engage in Motivational Conversations training. >3,000 people provided with a Green Prescription (for support with additional physical activity). >90% of the population identified with diabetes have an annual HbA1c test.
Continue to invest in Motivating Conversation Training, to support general practice to engage people in difficult conversations about risk behaviours and taking greater responsibility for their own health and wellbeing.	Quarterly: Monitoring (by ethnicity) of access to Green Prescriptions. Q3: Motivating Conversation Training extended to incorporate a focus on alcohol.	
Maintain an integrated approach to the prevention of diabetes, with active oversight from the CCN Alliance Integrated Diabetes Services Development Group.	Six Monthly: Monitoring of diabetes service performance data to improve equitable service provision and inform quality improvement.	

Progress the redesign of the diabetes patient education model, to improve engagement with services and increase health literacy of high-need Pacific populations. (EOA)	Q1: Diabetes Education Quality & Monitoring Working Group in place. Q2: Revised education model action plan agreed.	>60% of the population identified with diabetes (having an HbA1c test) have good or acceptable glycaemic control (HbA1c <64 mmol/mol).
Further integrate the diabetes nursing workforce, to support service delivery closer to communities of need, and establish pathways to improve equity of access (regardless of the complexity of people's diabetes).(EOA)	Q2: Workshop held to develop roadmap. Q4: Implementation plan for the reorientation of diabetes services completed and approved.	
Pursue opportunities to increase access to dietetic and nutrition services in the community and seek to align the workforce to the location of service delivery.	Q3: Opportunities identified to reduce barriers to access, particularly for high need population groups.	
Establish an integrated approach to the prevention and management of cardiovascular disease (CVD) and the introduction of the new national guidelines for CVD Risk Assessment and Management in Primary Care. (EOA) *Oversight will be provided through a joint PHO/DHB Clinical Leadership Group. Engagement with Māori, as a high risk population group, will be a key focus for this work.*	Ongoing: Monitoring of CVD risk assessment rates and targeted support to practices with lower rates. Q1: Joint CVD Improvement Plan approved. Q2: Education/training provided on new algorithm. Q3: Joint messaging delivered on the importance of delivering and taking up CVD Risk Assessments.	Percentage of people assessed as high risk who have had an annual review.[11]

[11] This is a new measure and baselines are yet to be confirmed.

Financial Summary

Further details on the DHB's financial outlook and assumptions for 2019/20 can be found in Appendix 5 of this Plan.

2.6 Prospective Statement of Financial Performance – for 2019/20 to 2021/22

Prospective Statement of Comprehensive Income	2019/20 Plan $'000	2020/21 Plan $'000	2021/22 Plan $'000
REVENUE			
Ministry of Health revenue (Note 1)	1,841,187	1,916,465	2,003,288
Other government revenue	38,778	39,996	41,596
Earthquake repair revenue redrawn	10,800	14,700	10,000
Other revenue	54,945	58,934	63,032
Total Revenue	**1,945,710**	**2,030,095**	**2,117,916**
EXPENSE			
Personnel	895,964	945,495	994,158
Outsourced (Note 2)	29,193	28,325	27,753
Clinical supplies	159,795	174,358	182,813
Earthquake building repair costs	10,800	14,700	10,000
Infrastructure & non clinical (excl Earthquake repairs)	119,360	125,552	127,386
Payments to non-CDHB providers	773,439	762,475	784,943
Total Expense Before Depreciation & Capital Charge	**1,988,551**	**2,050,905**	**2,127,053**
Surplus/(Deficit) Before Depreciation & Capital Charge	**(42,841)**	**(20,810)**	**(9,137)**
Depreciation and amortisation	83,165	83,066	73,465
Capital charge and interest expense	54,464	69,518	72,672
Total Depreciation, Capital Charge & Interest Expense	**137,629**	**152,584**	**146,137**
Surplus/(Deficit)	**(180,470)**	**(173,394)**	**(155,274)**
OTHER COMPREHENSIVE REVENUE & EXPENSE			
Revaluation of property, plant & equipment	-	-	-
Total Comprehensive Income/(Deficit)	(180,470)	(173,394)	(155,274)

2.7 Prospective Financial Performance by Output Class – for 2019/20 to 2021/22

Prospective Summary by Output Class	2019/20 Plan $'000	2020/21 Plan $'000	2021/22 Plan $'000
Prevention			
Total Revenue	50,022	52,191	54,449
Total Expenditure	53,217	55,152	56,897
Net Surplus/(Deficit)	**(3,195)**	**(2,961)**	**(2,448)**
Early Detection and Management			
Total Revenue	377,932	394,323	411,381
Total Expenditure	414,022	429,076	442,649
Net Surplus/(Deficit)	**(36,090)**	**(34,753)**	**(31,268)**
Intensive assessment & treatment			
Total Revenue	1,229,107	1,282,413	1,337,890
Total Expenditure	1,344,274	1,393,153	1,437,221
Net Surplus/(Deficit)	**(115,167)**	**(110,740)**	**(99,331)**
Rehabilitation & Support			
Total Revenue	288,649	301,168	314,196
Total Expenditure	314,667	326,108	336,423
Net Surplus/(Deficit)	**(26,018)**	**(24,940)**	**(22,227)**
Total Comprehensive Income/(Deficit)	(180,470)	(173,394)	(155,274)

MEDIUM-TERM OUTLOOK

How are we organising our business to achieve our vision?

3

Managing Our Business

This section highlights how we will organise and manage our business to support the realisation of our vision, enable the delivery of equitable, integrated and sustainable services and improve the health and wellbeing of our population.

3.1 Partnering for better outcomes

Our vision is based on bringing to life a truly integrated health system where everyone is working together to do the right thing for the patient and the system.

Working collaboratively has enabled us to respond to the changing needs of our population and is a critical factor in achieving our goals and objectives. The DHB's major strategic partnerships include:

Our District Alliance: The Canterbury Clinical Network (CCN) is where the DHB and its partner organisations come together to improve the delivery of health services and realise opportunities to improve health outcomes. This focus includes delivery of Canterbury's annual System Level Improvement Plan, which is incorporated into the DHB's Annual Plan.

Consumer Council: The DHB is committed to a culture that focuses on the patient and supports consumer participation in the design of services and strategies to improve health and wellbeing. This includes input into the work of our Alliance with consumers represented on work streams. The DHB also has a Consumer Council, where members ensure a strong and viable voice in health service planning and service redesign.

Clinical Partnerships: Clinical leadership is intrinsic to our success and a clinically-led management-enabled approach is embedded at all levels of our organisation, and across our local and regional alliances. The DHB also has a Clinical Board and Realign Alliance (across Christchurch Hospital campus) where members work together to influence the DHB's vision and play an important role in raising standards of patient care.

Public Health Partnerships: Our Community and Public Health (CPH) division takes the lead in the delivery of public health strategies and services to promote and protect the health and wellbeing of our population. CPH also serves as the Public Health Unit for South Canterbury and West Coast DHBs.

Collective public health focused initiatives include: Waha Toa Ora (Healthy Greater Christchurch), a DHB-led cross-sectoral partnership (based on the WHO Healthy Cities model), Healthy Christchurch, supporting community wellbeing including the 'All Right?' partnership with the Mental Health Foundation and the Greater Christchurch Partnership, supporting, a 'health in all policies' approach and the Community Workstream of the Urban Development Strategy. Our wellbeing focus is outlined in our Public Health Action Plan, which is incorporated into our Annual Plan.

3.2 Commitment to Māori

The values of our organisation, the way in which we work, and the manner in which we interact with others are all key factors in our success.

As a Crown agency, we recognise our responsibilities to uphold our obligations under the Te Tiriti o Waitangi. We work to improve the quality of care and equity of health outcomes for Māori and to address any systemic inequity, consistent with the recognised Tiriti principles of partnership, participation and protection.

The relationships and partnerships we build with our Māori stakeholders are fundamental to this work. We have a memorandum of understanding with Manawhenua Ki Waitaha, where we actively engage with Māori leaders in the planning and design of health services and strategies to improve Māori health outcomes. Members of the CCN Alliance's Māori Caucus and the Maui Collective (of Māori & Pacific Providers) bring a Māori perspective to the redesign of services and building of capacity across community services and support workforce development.

We also promote a culture that addresses inequitable health outcomes through open discussion, use of the Health Equity Assessment Tool (HEAT), universal performance targets and professional development and mentoring. In the coming year we will work with our partners to establish a clear collective strategy for improving Māori health outcomes in Canterbury.

3.3 Commitment to quality

The Canterbury DHB is committed to health excellence, with a strong focus on service quality and system performance using data and information to inform systematic improvement by teams and services. Working in partnership with patients and whānau is central to improved performance and we have made a commitment to using our inpatient experience survey results to improve the way we communicate with patients and their families.

The national Health Quality and Safety Commission (HQSC) Quality & Safety Markers supplement local performance framework and are reported to our governance groups to monitor patient safety and track the effectiveness of improvement activity. We report quarterly to our Clinical Governance Committee and the Board's Quality, Finance, Audit & Risk Committee. Performance against the Quality & Safety Markers is also reported publicly in our Annual Quality Accounts which can be found on our website.

The delivery of externally contracted services is aligned with national quality standards, and auditing of contracted providers includes quality audits. We also work with the other South Island DHBs, as a partner in the regional Quality & Safety Alliance, to implement quality and safety improvements.

3.4 Performance management

To support good governance, we have an outcome-based decision-making and accountability framework that enables our Board to monitor service performance and provide direction. We have also invested in the development of 'live data' systems where real-time operational information from within our hospitals enables responsive decision making and planning.

At the broadest level, we monitor health system performance against a core set of desired population outcomes, captured in our outcomes framework. The framework defines success from a population health perspective and is used as a means of evaluating the effectiveness of our investment decisions.

The DHB's service and financial performance is monitored through monthly and quarterly reporting to our Board and to the Ministry of Health against key financial and non-financial indicators aligned to the national performance framework. Our service performance is also audited annually against our Statement of Performance Expectations (Appendix 4). The results are published in our Annual Report which can be found on our website.

3.5 Asset management

Having the right assets in the right places and managing them well is critical to the ongoing provision of high-quality and cost-effective health services.

As at 30 June 2019 the DHB's forecast asset value is $756M (book value). As an owner of Crown assets, we are accountable to the Government for the financial and operational management of those assets.

Since the earthquakes, our capital intentions have been updated to reflect known changes in our asset state and future intentions, in line with our earthquake repair programme and Christchurch Hospital campus redevelopments. In doing so, the DHB has developed and implemented an Asset Management Policy and Asset Management Strategy and a five-year Asset Management Maturity Improvement Plan.

In response to Treasury requirements for monitoring investments across government, the DHB is also redeveloping its Long-term Investment Plan with a ten-year outlook. This Plan reflects the anticipated impact of changing patterns of demand and new models of care on our future asset requirements and will support investment decisions going forward.

Refer to Appendix 5 for a summary of the DHB's major capital investments to 2023.

3.6 Risk management

The DHB manages and monitors risk to ensure we are meeting our obligations as a Crown Entity. Our risk management processes are aligned to the main elements of the International Standard for Risk Management AS/NZS ISO 31000:2009.

We also maintain Divisional Risk Registers, identifying and providing assurance on the management of the most significant risks faced by the DHB. The top tier risks are reviewed by the Executive Management Team and the DHB Board's Quality, Financial, Audit & Risk Committee every two months, and the full Risk Register is reviewed twice a year by our Board.

3.7 Ownership interests

The Canterbury DHB has a number of ownership interests that support the delivery of health services including two operational subsidiaries, both of which are wholly owned by the DHB.

Canterbury Linen Services Limited: provides laundry services to DHB hospitals and external commercial clients. The Canterbury DHB owns all shares, as well as the land and buildings.

Brackenridge Estate Limited: provides residential care, respite services and day programmes for people with intellectual disability and high dependency needs. The primary source of funding is service contracts with the Ministry of Health. The DHB is the sole shareholder.

The South Island Shared Service Agency Limited: functions as the South Island Alliance Programme Office. It is jointly owned and funded by the five South Island DHBs and provides audit services and supports regional service development on our behalf.

The New Zealand Health Partnership Limited: is owned and funded by all 20 DHBs and aims to enable DHBs to collectively maximise and benefit from shared service opportunities. Canterbury participates in the Finance, Procurement and Supply Chain programme.

The New Zealand Health Innovation Hub: is a joint partnership between Canterbury, Counties Manukau, Waitemata and Auckland DHBs. The Innovation Hub engages with clinicians and industry to develop, validate and commercialise health technologies and improvement initiatives that will deliver health and economic benefits to the system.

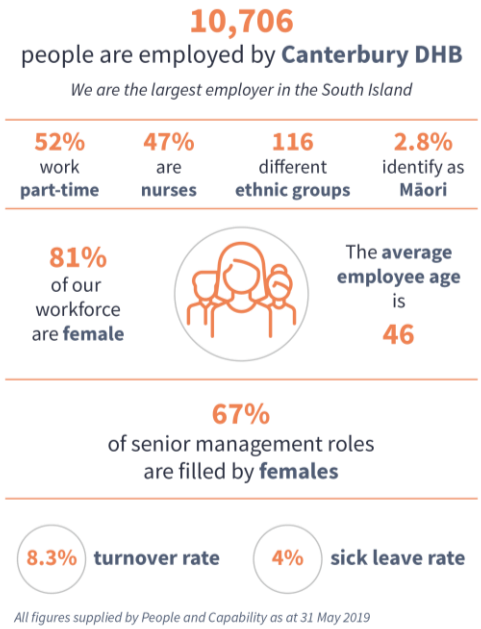
The DHB has plans to enter into two further agreements in the coming year:

HealthPathways: is an online tool providing clinical and process guidance for patient management. The content is owned by the Canterbury DHB with the software and process owned by Streamliners Ltd. The parties are proposing to enter into a cross-licensing agreement and establish a Charitable Trust with the primary purpose of funding the ongoing development of HealthPathways locally. The DHB will be seeking Ministerial consent for the proposal.

HealthOne: is a shared data repository jointly developed by the DHB and Pegasus Health. There is the prospect of licensing HealthOne to other NZ health providers and the parties propose to enter into a Limited Partnership to formalise the relationship and support this work. The DHB will also seek Ministerial consent for this proposal.

Building our capability

3.8 Investing in our people



Many of our people are still facing challenges, both at home and at work. The earthquakes have driven increased demand and health need, and we are still working through our repair and redevelopment programme which is disruptive and stressful.

The DHB is committed to being a good employer. We promote equity, fairness, a safe and healthy workplace, and have a clear set of organisational values and core operational policies. These include a Code of Conduct, Equality, Diversity and Inclusion Policy and a Wellbeing Policy. The DHB will also implement the national Care Capacity Demand Management agreement by June 2021.

We are reviewing our people processes and systems and engaging in conversations about how we can put our people at the heart of all that we do. There is a strong commitment to making things better. The DHB has adopted a People Strategy to ensure actions which will positively support the wellbeing of our people.

A range of initiatives will be developed and rolled out to deliver on the priorities in our People Strategy and in doing so we will create a culture where:

- Everyone understands their contribution
- Everyone can get stuff done
- Everyone is empowered to make it better
- Everyone is enabled to lead
- Everyone is supported to thrive.

Future Health Workforce: Alongside our People Strategy, we identify available talent and expand workforce capability and support the training and education of our future workforce through: participation in the regional Workforce Development Hub; links with the education sector; sharing training resources; and support for internships and clinical placements in our hospitals.

Utilising our Dedicated Education Units, there is a well-developed pipeline of nursing students trained within the Canterbury health system, with over 900 nursing student placements each year. This student cohort feeds into the Canterbury Nursing Entry to Practice (NetP) Programme and New Entry to Specialty Practice Mental Health & Addiction Programme that successfully employs over 260 new registered nurses annually.

The DHB is currently working on a long term nursing workforce development plan, examining: future nursing roles and pathways for advancing nurses to ensure people are working at top of scope. To ensure a consistent approach across our health system, and across the South Island, we will work with regional nursing leaders to explore opportunities to establish a standardised approach to professional development for Nurse Practitioners. This will involve identifying current processes and models to ensure nurse practitioner professional development is well supported, with a view to agreeing a regional approach to investment across the South Island.

The DHB is also working on the development of an Allied Health Strategy to support the re-orientation of allied health, with a stronger focus on wellbeing, prevention, early intervention and enablement. The strategy will examine future allied health roles, looking at build capability and expanding the skill mix, experience and diversity of our allied health workforce. This will include regional work to build talent pipelines and identify a wider recruitment pool to support a workforce more representative of our population.

In addition, the DHB remains fully committed to providing a high standard of education and training for our Resident Medical Officers (RMOs) and meeting all our obligations and requirements for prevocational and vocational training in accordance with the Medical Council of New Zealand and Vocational Specialist Colleges. This is evidenced by the establishment and ongoing support of clinical governance and operational structures and processes, such as the Medical Education and Training Unit, to support education and training for RMOs across the DHB.

Māori Health Workforce: The DHB has made an overarching commitment to encourage greater participation of Māori in the health workforce. Employee ethnicity data shows Māori make up 9.2% of our population but just 2.8% of the DHB workforce.[12]

[12] This figure is likely to be understated. In April 2019, 18% of staff had no ethnicity declared, of those who did 3.4% identified as Māori.

In support of this direction we participate in the national Kia Ora Hauora programme, aimed at increasing the number of Māori working in health, by supporting pathways into tertiary education, local health scholarships and work placements.

We have established a blended model for a NetP Māori Initiative titled 'Korimako', in partnership with Pegasus Health and the Maui Collective (of Māori & Pacific Providers). This includes annual funding for new graduate registered nurse positions as a sustainable pathway for building a primary care registered Māori nursing workforce.

The DHB is also working with the West Coast DHB to review recruitment practices, particularly those that might unintentionally limit job placement prospects for Māori and Pacific applicants. With 18% of staff having no ethnicity recorded, we are engaging with staff to improve the collection and recording of ethnicity data to improve workforce planning.

Other areas of workforce development and investment for the period of this Plan are highlighted in the National Priorities action table on page 28.

3.9 Investing in information systems

Connecting up health information services is central to the DHB's vision and, by realising opportunities to reduce waste and duplication, is a key factor in the future sustainability of our health system.

National, regional and local engagement has led the DHB's Information Service Group to identify eight strategic areas of focus as a means of supporting the delivery of health services:

Digital transformation

Projects supporting facilities redevelopment

Capabilities maintenance

ISG support for our people and the DHBs we serve

Developing our team dynamic

Operations maintenance

Security and assurance compliance

Disaster recovery.

In support of this work, the DHB is taking a lead in rolling out information solutions that transform the way health professionals across the South Island make requests, send referrals and share patient information, such as: HealthOne; Health Connect South; and the South Island Patient Information Care System (SI PICS). Our transalpine partnership with the West Coast DHB also makes shared information important, with a focus on aligning IT systems to facilitate staff working across both DHBs. A combined transalpine service desk will be implemented in Q1 2019/20.

Areas of investment for the period of this Plan include:

Telehealth, videoconferencing and mobile technology that support staff working remotely are an important factor in improving service capacity and equity of access for patients and their families. This includes scoping a proposal for lone worker duress for community workers, commencing updates for our end user mobile device management and implementing Microsoft G2018 licenses for Teams, Exchange Online and Office 365 by Q4 2019/20 (EOA).

We will continue to connect up services and systems electronically with the digitalisation of our new hospital which includes the development of a business case for a mobility suite, exploring the viability of a staff on call/duty application and implementing Cortex for nine services by Q4 2019/20.

We are also reviewing and enhancing our infrastructure to ensure the reliability of clinical and business systems and to comply with approved standards and architecture. This includes continued implementation of national expectations around a move to Cloud technology and adoption of national systems, to improve patient safety and the quality of services we deliver.

Supporting the national bowel screening programme: As one of four national providers of ProVation MD (gastroenterology procedure documentation software), the DHB is working with the National Bowel Screening Programme to improve information flow. Vendor agreements are expected to be in place by Q1 2019/20. We will then work with the vendor to develop an implementation plan to support the rollout of the Screening Programme which will support improved detection and management of bowel cancer. (EOA)

Moving to Cloud technology: Canterbury DHB is planning to move to a hybrid Cloud technology to achieve operational capability improvements including disaster recovery. By Q3 2019/20 the DHB will have established a Cloud business office which will support the processes, technology and people capability required to run the hybrid Cloud environment. We will then establish a migration plan in Q3. As part of this programme of work the DHB will continue to improve our cyber security, aligned to NZ Cyber security goals. We expect this work to be completed by Q4.

The DHB will report quarterly to the Ministry of Health (Data and Digital) on the DHB's ICT investment to support collective decision making and maximise the value of sector investment.

3.10 Investing in facilities

In the same way that workforce and information technology underpin and enable our transformation, health facilities can both support and hamper the quality of the care we provide.

The Canterbury DHB is in the midst of a significant redevelopment and repair programme, impacting on almost every facility we own. Completion of the Hagley

Building (Acute Services) on the Christchurch Hospital site (along with the newly completed Outpatients facility) will allow us to regain some of the capacity lost after the earthquakes. These fit-for-purpose facilities will also allow us to make efficiency savings by co-locating and consolidating services and supporting more responsive and integrated service models.

Delays with the building programme have meant the DHB has been operating with significantly reduced capacity and has been unable to realise anticipated efficiency gains for the past several years. Increased construction and fixtures and fitting costs are also creating significant pressure. It is critical that the Hagley Building is completed without further delay.

Our growing population and increasing service demands also mean solutions need to be found to increase our capacity beyond what will be restored once the redevelopment is complete. A number of business cases and masterplans are underway.

Areas of investment for the period of this Plan include:

Christchurch Hospital Energy Centre: The Boiler House servicing the Christchurch Hospital campus and Canterbury Health Laboratories is seismically compromised. The design of a new Energy Centre to replace the Boiler House, is underway, with completion anticipated by early/mid 2021.

The Princess Margaret Hospital: The detailed business case for the relocation of specialist mental health services from The Princess Margaret Hospital to the Hillmorton Hospital campus has been approved, with an estimated capital cost of $79m (funded by crown capital funding). The project is being managed by the DHB and planning and design has commenced. At this stage we anticipate relocation will be complete in 2023.

Hillmorton Hospital: Longer-term master-planning is also underway to determine the future use of other existing buildings and facilities on the Hillmorton Hospital campus including Adult Acute Services. The masterplan is expected to be complete in 2019/20.

Christchurch Hospital: In late 2018, as part of the indicative prioritisation of DHB capital projects the Ministry of Health advised that the Christchurch Hospital Campus Redevelopment (Parkside) had been prioritised for investment. Work is progressing with long-term master-planning for the campus, with the Masterplan and Indicative Business Case for Parkside and new tower developments expected to be complete by mid-2019. With approval, the DHB will progress development of a detailed business case.

Canterbury Health Laboratories: An initial strategic assessment was submitted in regards to a future facility for Canterbury's laboratory services. This will now be included in a wider programme business case to consider and determine the optimal phasing of future investments, including a future Cancer Centre.

Over the coming year the DHB will continue to progress with upgrading and repairing the remaining earthquake damaged buildings and will also consider the future use of all of its rural hospital facilities.

3.11 Cross-sector investment

Recognising the wider influences that shape the health and wellbeing of our population, the DHB works in partnership with organisations from outside the health sector to improve health outcomes for our population.

Earthquake recovery and the mosque attacks are an important focus of our cross-sectoral work. This involves support and advice into policy processes, community resilience initiatives, and psycho-social recovery—all of which contribute to our vision of a healthier Canterbury.

We are also working closely with ACC, Corrections and the Ministries of Social Development, Education and Justice, investing in a number of initiatives aimed at improving health outcomes for the most vulnerable in our community.

Areas of investment for the period of this Plan include:

Mana Ake: Stronger for Tomorrow: The DHB is taking the lead in implementing this significant initiative, working through the CCN alliance with the Ministry of Education to develop a wellbeing support system for children, their families/whānau and teachers.

Wellbeing and Resilience Response: The DHB is working closely with other agencies and organisations to provide a locally-led and integrated response to the March 2019 mosque attacks and to ensure people get the help they need when they need it. This work includes the development of an online Resilience Hub, a central point for health and wellbeing support with links to housing, welfare, education etc.

Canterbury Children's Team: The DHB will continue to work in a collaborative partnership with Oranga Tamariki as they transition to a new model, to ensure support for children and young people in Canterbury.

The Integrated Safety Response Pilot: The DHB participates in this Police-led social investment strategy to pilot rapid responses from government and social agencies to better meet the needs of people affected by family violence.

DHB/Police Watch-house Nurse Initiative: The DHB will continue to support this initiative where our nurses work 24/7 alongside police custody staff in the police watch-house to assess people in custody for mental health, alcohol and other drug issues and help to reduce their risks to themselves and others.

The All Right? Social Marketing Campaign: The DHB will continue to work in partnership with the Mental Health Foundation to support people's mental health and wellbeing after the earthquakes.

Pasifika Futures: The DHB is working in partnership with the Whānau Ora Commissioning Agency to build the capability and capacity of Pacific families. This includes support for the Etu Pasifika healthcare clinic.

Te Putahitanga: The DHB will also seek to develop a closer partnership with the Whānau Ora Commissioning Agency, Te Putahitanga, to enable whānau-centered support for Māori living with long-term conditions.

Step Up: The DHB is working alongside the Ministry of Social Development and Pegasus Health to implement a new prototype primary care service to support people with health conditions back into employment.

Pathway for Offenders: The DHB is working in partnership with the Department of Corrections to improve links with primary care to support the health and wellbeing of people on release from a corrections facility or deported from Australia.

Strength and Balance Programmes: The DHB is partnering with ACC to enhance our Falls Prevention Programme by providing increased access to community-based programmes designed to reduce harm from falls, particularly for our older population.

Spinal Cord Impairment Initiative: The DHB is partnering with Counties Manukau and ACC to support improved outcomes for people with spinal cord injuries. Canterbury is one of two spinal centres in the country and provides treatment for patients from the middle of the North Island (Turangi) to the bottom of the South including Stewart Island and the Chathams.

Non-Acute Rehabilitation Pathways: The DHB is also partnering with ACC to better meet the needs of people with injuries and improve long-term outcomes, by adopting a more restorative approach to recovery.

Service Configuration

3.12 Service coverage & redesign

All DHBs are required to deliver a minimum level of service to their population, in accordance with the national Service Coverage Schedule. The Schedule is incorporated as part of the Crown Funding Agreement, under Section 10 of the NZ Public Health and Disability (NZPHD) Act 2000, and is updated annually.

Responsibility for ensuring service coverage is shared jointly between the DHB and the Ministry of Health. The DHB works to identify service coverage risk through the monitoring of performance indicators, risk reporting, formal audits, complaints and the ongoing review of patient pathways and takes appropriate action to ensure service coverage is maintained.

At this stage we are not seeking any formal exemptions to the Service Coverage Schedule for 2019/20. However, in our current circumstances, there are obvious service coverage risks related to resource and capacity constraints, infrastructure damage, rebuild delays, and evolving service demand.

We are also mindful of continuity risks while we decant and transfer services into the new Hagley Building, particularly with regards to radiology and operating services. We are working with neighbouring DHBs and the Ministry of Health to assess and alleviate these risks, but anticipate that meeting national expectations will be a challenge during this period.

In the coming year, we will review capacity and costs across all service areas, and look to prioritise resources onto areas of immediate or greatest need and services that provide the greatest return on investment. This includes aligning practice and intervention rates with national service specifications or accepted practice in other DHBs, and may impact on the configuration, scope and location of some services.

Consistent with our shared decision-making principles we work in partnership with clinical leaders and other service providers to redesign the way we deliver health services to meet the needs of our population and to ensure the future sustainability of our health system.

We anticipate that new models of care will continue to emerge and we may wish to negotiate, enter into, or amend service agreements or arrangements to assist in meeting our objectives and delivering against the vision and goals outlined in this document. In doing so (pursuant to Section 24(1) and Section 25 of the NZPHD Act 2000), we will seek to ensure that any resulting agreements or arrangements do not jeopardise our ability to meet our statutory obligations in respect to our agreements with the Crown.

Anticipated service changes, identified for the period of this Plan, are highlighted in the table on the following page.

Area Impacted	Description of Change	Anticipated Benefit	Driver
Rural Health Services	The DHB will continue to support the redesign of service models across our rural communities (under the guidance of the CCN), including the development of integrated family health services and sustainable after-hours' service models.	Increased service capacity, integration and sustainable service delivery.	Local
Home & Community Based Support Services	The DHB will complete the redesign of the model of care for home and community-based support services to response to increasing demand and evolving need. This will also include a review of home-based support services delivered by the DHB.	Increased service capacity integration, improved patient outcomes and reduced service costs.	Local
Primary & Community Services	The DHB will work with primary and community partners to review service contracts across primary and community services to ensure sustainability of service models and prioritisation of resources into areas of most immediate or greatest need and services that provide the greatest return on investment.	Sustainable service delivery and reduced service costs.	Local National
Rehabilitation Services	The DHB will review the flow of patients across hospital and community-based rehabilitation services and consider the redesign and/or reconfiguration of current service models to meet increasing demand.	Increased service capacity, integration, improved patient outcomes and reduced service costs.	Local
Diabetes Services	The DHB will implement the recommendations of the Diabetes services review to better meet the needs of our population as part of a wider more integrated service model and in line with the national diabetes quality standards.	Improved access, increased integration and improved patient outcomes.	Local
Maternity Services	The DHB will support the direction of travel outlined in its Maternity Strategy to better meet the needs of our population as part of a more integrated service model. This will result in the reconfiguration, relocation and/or redesign of maternity services.	Increased service capacity, sustainable service delivery integration and improved patient outcomes.	Local
Colposcopy Services Disability Support Respiratory Services Food Services Laboratory Services Regional ISG support	The DHB will review service capacity and costs across a number of heavily subsidised service areas and explore alternative options for service delivery. This may result in the reconfiguration and/or redesign of some services.	Increased service capacity, sustainable service delivery, and reduced service costs.	Local Regional
Community Pharmacy Services	The DHB will engage with pharmacy providers to implement the national pharmacy contract and redesign of local services in alignment with the national Pharmacy Action Plan.	Increased integration and improved service quality and patient outcomes.	Local National
Mental Health Services	In line with the national Mental Health Review and in response to increased and evolving need, the DHB will seek to reconfigure the model of care for mental health services with a focus on community capacity and staff and patient safety.	Increased service capacity integration, and improved patient outcomes and experience.	Local National
Alcohol and Other Drug Services	Alongside the ongoing redesign and reconfiguration of Mental Health Services, the DHB will consider alternative service models for the delivery of AOD services.	Increased service capacity, integration and improved patient outcomes.	Local National

IMPROVING HEALTH OUTCOMES

Are we making a difference?

Monitoring Our Performance

As part of our accountability to our community and Government, we need to demonstrate whether we are succeeding in achieving our objectives and improving the health and wellbeing of our population.

DHBs have a number of different roles and associated responsibilities. In our governance role we are concerned with health equity and outcomes for our population and the sustainability of our health system. As a funder, we strive to improve the effectiveness of the health system and the return on our investment. As an owner and provider of services, we are focused on the quality of the care we deliver, the efficiency with which it is delivered and the safety and wellbeing of the people who work for us.

There is no single performance measure or indicator that can easily reflect the impact of the work we do and we cannot measure everything that matters for everyone. In line with our vision for the future of our health system, we have developed an over-arching intervention logic and system outcomes framework.

The framework helps to illustrate our population health-based approach to performance improvement, by highlighting the difference we want to make in terms of the health and wellbeing of our population. It also encompasses national direction and expectations, through the inclusion of national targets and system level performance measures.

At the highest level the framework reflects our three strategic objectives and identifies three wellbeing goals, where we believe our success will have a positive impact on the health of our population.

Aligned to each wellbeing goal we have identified a number of population health indicators which, over time, will provide insight into how well our system is performing.

These outcome measures are set out in detail in our Statement of Intent and reported annually in our Annual Report. The long-term outcomes are also captured in our local System Level Measure Improvement Plan, where we collaborate with our partner organisations to improve health outcomes for our population.

Refer to Appendix 3 for the Intervention Logic Diagram which illustrates how the services we fund or provide will impact on the health of our population. The diagram also demonstrates how our work contributes to the goals of the wider South Island region and delivers on the expectations of Government.

4.1 Accountability to our community

Over the shorter-term, we evaluate our performance by monitoring ourselves against a forecast of the service we plan to deliver to our community and the standards we expect to meet.

The results are reported publicly in our Annual Report, alongside our year-end financial performance.

Refer to Appendix 4 for the DHB's Statement of Performance Expectations for 2018/19 and Appendix 5 for the DHB's Statement of Financial Performance for 2018/19.

4.2 Accountability to the Minister

As a Crown entity, responsible for Crown assets, the DHB also provides a wide range of financial and non-financial performance reporting to the Ministry of Health on a monthly, quarterly and annual basis.

The DHB's obligations include quarterly performance reporting in line with the Ministry's non-financial performance monitoring framework. This framework aims to provide a rounded view of DHB performance in key priority areas and uses a mix of performance markers across five dimensions. These dimensions reflect the key areas of national priority:

- Improved Child Wellbeing (CW)
- Improved Mental Health Wellbeing (MH)
- Improved Wellbeing through Prevention (PV)
- Better population health outcomes supported by a Strong and equitable public health and disability System (SS)
- Better population health outcomes supported by Primary Health Care (PH).

The national framework and expectations for 2019/20 are set on the following pages.

National DHB Performance Framework 2019/20

Performance Measure		Performance Expectation		
CW01	Children caries free at 5 years of age	Year 1		67%
		Year 2		67%
CW02	Oral health: Mean DMFT score at school year 8	Year 1		0.72
		Year 2		0.72
CW03	Improving the number of children enrolled and accessing the Community Oral health service	Children (0-4) enrolled	Year 1	>=95%
			Year 2	>=95%
		Children (0-12)not examined according to planned recall	Year 1	<=10%
			Year 2	<=10%
CW04	Utilisation of DHB funded dental services by adolescents from School Year 9 up to and including 17 years	Year 1		>=85%
		Year 2		>=85%
CW05	Immunisation coverage at 8 months of age and 5 years of age, immunisation coverage for human papilloma virus (HPV) and influenza immunisation at age 65 years and over	95% of eight-month olds fully immunised.		
		95% of five- year olds fully immunised.		
		75% of girls and boys fully immunised – HPV vaccine.		
		75% of 65+ year olds immunised – Influenza vaccine.		
CW06	Child Health (Breastfeeding)	70% of infants are exclusively or fully breastfed at three months.		
CW07	New-born enrolment with General Practice	55% of new-borns enrolled in General Practice by 6 weeks of age.		
		85% of new-borns enrolled in General Practice by 3 months of age.		
CW08	Increased immunisation (two-year-olds)	95% of two-year olds will have completed all age-appropriate immunisations due between birth and age two years.		
CW09	Better help for smokers to quit (maternity)	90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.		
CW10	Raising healthy kids	95% of obese children identified in the Before School Check (B4SC) programme are offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.		
CW11	Supporting child wellbeing	Provide report as per measure definition		
CW12	Youth mental health initiatives	Initiative 1: Report on implementation of school based health services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities and actions undertaken to implement *Youth Health Care in Secondary Schools: A framework for continuous quality improvement* in each school (or group of schools) with SBHS.		
		Initiative 3: Youth Primary Mental Health.		
		Initiative 5: Improve the responsiveness of primary care to youth. Report on actions to ensure high performance of the youth service level alliance (SLA) and actions of the SLA to improve health of the DHB's youth population.		
CW13	Reducing rheumatic fever	Reducing the Incidence of First Episode Rheumatic Fever to ≤ 0.2 per 100,000.		
MH01	Improving the health status of people with severe mental illness through improved access	Age (0-19) Māori , other & total	>3.1% of the population access specialist services	
		Age (20-64) Māori , other & total	>3.1% of the population access specialist services	
		Age (65+) Māori , other & total	>3.0% of the population access specialist services	
MH02	Improving mental health services using wellness and transition (discharge) planning	95% of clients discharged will have a quality transition or wellness plan.		
		95% of audited files meet accepted good practice.		
MH03	Shorter waits for non-urgent mental health and addiction services	Mental Health (Provider Arm)	80% of people seen within 3 weeks.	
			95% of people seen within 8 weeks.	
		Addictions (Provider Arm & NGO)	80% of people seen within 3 weeks.	
			95% of people seen within 8 weeks.	
MH04	Rising to the Challenge: The Mental Health and Addiction Service Development Plan	Provide reports as specified.		
MH05	Reduce the rate of Māori under the Mental Health Act: Section 29 Community Treatment Orders	Reduce the rate of Māori under the Mental Health Act (s29) by at least 10% by the end of the reporting year.		
MH06	Output delivery against plan	Volume delivery for specialist Mental Health and Addiction services is within 5% variance (+/-) of planned volumes for services measured by FTE; 5% variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day; actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan.		
PV01	Improving breast screening coverage and rescreening	70% coverage for all ethnic groups and overall.		
PV02	Improving cervical screening coverage	80% coverage for all ethnic groups and overall.		

SS01	Faster cancer treatment (31 days)		85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.		
SS02	Ensuring delivery of Regional Service Plans		Provide reports as specified.		
SS03	Ensuring delivery of Service Coverage		Provide reports as specified.		
SS04	Delivery of actions to improve Wrap Around Services for Older People		Provide reports as specified.		
SS05	Ambulatory sensitive hospitalisations (ASH adult)		<2,596 per 100,000 people		
SS06	Better help for smokers to quit in public hospitals		95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking.	Only applies to specified DHBs	
SS07	Planned Care Measures	Planned Care Measure 1: *Planned Care Interventions*	30,675 planned care interventions delivered as per agreed delivery plan		
		Planned Care Measure 2: *Elective Service Patient Flow Indicators*	ESPI 1	100% (all) services report Yes (that more than 90% of referrals within the service are processed in 15 calendar days or less)	
			ESPI 2	0% – no patients are waiting over four months for FSA	
			ESPI 3	0% - zero patients in Active Review with a priority score above the actual Treatment Threshold (aTT)	
			ESPI 5	0% - zero patients are waiting over 120 days for treatment	
			ESPI 8	100% - all patients were prioritised using an approved national or nationally recognised prioritisation tool	
		Planned Care Measure 3: *Diagnostic waiting times*	Coronary Angiography	95% of patients with accepted referrals for elective coronary angiography receive their procedure within 3 months (90 days)	
			Computed Tomography (CT)	95% of patients with accepted referrals for CT scans receive their scan, and scan results are reported, within 6 weeks (42 days).	
			Magnetic Resonance Imaging (MRI)	90% of patients with accepted referrals for MRI scans receive their scan, and scan results are reported, within 6 weeks (42 days).	
		Planned Care Measure 4: *Ophthalmology Follow-up Waiting Times*	No patient will wait more than or equal to 50% longer than the intended time for their appointment. The 'intended time for their appointment' is the recommendation made by the responsible clinician of the timeframe in which the patient should next be reviewed by the ophthalmology service.		
		Planned Care Measure 5: *Cardiac Urgency Waiting Times*	All patients (both acute and elective) will receive their cardiac surgery within the urgency timeframe based on their clinical urgency. *(Only the Five Cardiac units are required to report for this measure)*		
		Planned Care Measure 6: *Acute Readmissions*	<11.0%		
SS08	Planned care three year plan		Provide reports as specified		
SS09	Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections	Focus Area 1: Improving the quality of data within the NHI	New NHI registration in error (causing duplication)	2% to ≤4%	
			Recording of non-specific ethnicity in new NHI registration	>0.5% and < or equal to 2%	
			Update of specific ethnicity value in existing NHI record with a non-specific value	>0.5% and < or equal to 2%	
			Validated addresses excluding overseas, unknown and dot (.) in line 1	>76% and < or equal to 85%	
			Invalid NHI data updates	Still TBC	
		Focus Area 2: Improving the quality of data submitted to National Collections	NPF collection has accurate dates and links to NNPAC, NBRS and NMDS for FSA and planned inpatient procedures.	> or equal to 90% and <95 %	
			National Collections completeness	> or equal to 94.5% and <97.5%	
			Assessment of data reported to the NMDS	> or equal to 75%	
		Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)	Provide reports as specified		
SS10	Shorter stays in Emergency Departments		95% of patients will be admitted, discharged or transferred from an emergency department (ED) within six hours.		
SS11	Faster Cancer Treatment (62 days)		90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.		
SS12	Engagement and obligations as a Treaty partner		Reports provided and obligations met as specified.		
SS13	Improved management for long term conditions (CVD, Acute	Focus Area 1: Long term conditions	Report on actions to support people with LTC to self-manage and build health literacy.		
		Focus Area 2: Diabetes services	Report on the progress made in self-assessing diabetes services against the *Quality Standards for Diabetes Care.*		
			Ascertainment: target 95-105% and no inequity HbA1c<64mmols: target 60% and no inequity No HbA1c result: target 7-8% and no inequity		

	heart health, Diabetes, and Stroke)	Focus Area 3: Cardiovascular health	Provide reports as specified
		Focus Area 4: Acute heart service	**Indicator 1:** Door to cath - Door to cath within 3 days for >70% of ACS patients undergoing coronary angiogram.
			Indicator 2a: Registry completion- >95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days of discharge and **Indicator 2b**: ≥ 99% within 3 months.
			Indicator 3: ACS LVEF assessment- ≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF (i.e. an echocardiogram or LVgram).
			Indicator 4: Composite Post ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication/intolerance >85% of ACS patients who undergo coronary angiogram should be prescribed, at discharge - Aspirin*, a 2nd anti-platelet agent*, statin and an ACEI/ARB (4 classes), and LVEF<40% should also be on a beta-blocker (5-classes). ** An anticoagulant can be substituted for one (but not both) of the two anti-platelet agents.*
			Indicator 5: Device registry completion- ≥ 99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS QI Device forms within 2 months of the procedure.
		Focus Area 5: Stroke services	**Indicator 1** ASU: 80% of stroke patients admitted to a stroke unit or organised stroke service, with a demonstrated stroke pathway
			Indicator 2 Thrombolysis: 10% of potentially eligible stroke patients thrombolysed 24/7
			Indicator 3: In-patient rehabilitation: 80% of patients admitted with acute stroke who are transferred to in-patient rehabilitation services are transferred within 7 days of acute admission
			Indicator 4: Community rehabilitation**:** 60 % of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge.
SS15	Improving waiting times for Colonoscopy		90% of people accepted for an urgent diagnostic colonoscopy receive (or are waiting for) their procedure in 14 calendar days or less, 100% within 30 days or less.
			70% of people accepted for a non-urgent diagnostic colonoscopy receive (or are waiting for) their procedure in 42 calendar days or less, 100% within 90 days or less.
			70% of people waiting for a surveillance colonoscopy receive (or are waiting for) their procedure in 84 calendar days or less of the planned date, 100% within 120 days or less.
			95% of participants who returned a positive FIT have a first offered diagnostic date that is within 45 calendar days of their FIT result being recorded in the NBSP IT system.
SS16	Delivery of collective improvement plan		Deliverable tbc
SS17	Delivery of Whānau ora		Provide reports as specified.
PH01	Delivery of actions to improve system integration and SLMs		Provide reports as specified.
PH02	Improving the quality of ethnicity data collection in PHO and NHI registers		Provide reports as specified.
PH03	Access to Care (PHO Enrolments)		Meet and/or maintain the national average enrolment rate of 90%.
PH04	Primary health care :Better help for smokers to quit (primary care)		90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months
Annual plan actions – status update reports			Provide reports as specified.

APPENDICES

Further Information

5

Appendices

Appendix 1	Glossary of Terms
Appendix 2	Minister of Health's Letters of Expectation 2019/20
Appendix 3	Overarching Intervention Logic Diagram
Appendix 4	Statement of Performance Expectations 2019/20
Appendix 5	Statement of Financial Performance 2019/20
Appendix 6	System Level Measures Improvement Plan 2019/20
Appendix 7	Public Health Action Plan 2019/20

Documents of interest

The following documents can be found on the Canterbury's DHB's website: www.cdhb.health.nz. Read in conjunction with this document, they provide additional context to the picture of health service delivery and transformation across the Canterbury health system.

- Canterbury DHB Statement of Intent
- Canterbury System Level Measures Improvement Plan
- Canterbury DHB Public Health Action Plan
- Canterbury Disability Action Plan
- South Island Regional Health Services Plan
- Canterbury DHB Quality Accounts

References

Unless specifically stated, all Canterbury DHB documents referenced in this document are available on the Canterbury DHB website: www.cdhb.health.nz. Referenced regional documents are available from the South Island Alliance Programme Office website: www.siapo.health.nz. Referenced Ministry of Health documents are available on the Ministry's website: www.health.govt.nz. The Crown Entities Act 2004 and the Public Finance Act 1989, referenced in this document, are available on the Treasury website: www.treasury.govt.nz.

Appendix 1 Glossary of Terms

ADMS	Acute Demand Management Service	Refers to the service whereby general practice and acute community nursing deliver packages of care that enable people who would otherwise need an ED visit or hospital admission to be treated in the community or in their own homes.
CCN	The Canterbury Clinical Network District Alliance	The CCN is a collective alliance of healthcare leaders, professionals and providers from across the Canterbury Health System. The Alliance provides leadership to enable the transformation of the health system in collaboration with system partners and on behalf of the population.
CREST	Community Rehabilitation Enablement and Support Team	Community Rehabilitation Enablement and Support Team supports the frail elderly who would otherwise be re-admitted to hospital or residential care. The Team is a collaboration across primary and secondary services and has been instrumental in reducing acute demand for hospital services and rates of aged residential care.
	Crown Entity	A generic term for a range of government entities that are legally separate from the Crown and operate at arm's length from the responsible or shareholding Minister, but are included in the financial statements of the Government.
ERMS	Electronic Referral Management System	ERMS is available from the GP desktop, and enables referrals to public hospitals and private providers to be sent and received electronically. Developed in Canterbury, it is now being rolled out South Island-wide and has streamlined the referral process by ensuring referrals are efficiently directed to the right place and receipt is acknowledged.
ESPIs	Elective Services Patient flow Indicators	The Elective Services Patient flow Indicators are a set of six indicators developed by the Ministry of Health to measure whether DHBs are meeting required performance standards in terms of the delivery of elective (non-urgent) services including wait times from referral to assessment and wait times from decision to treatment.
	Health Connect South	A shared regional clinical information system that provides a single repository for clinical records across the South Island. Already implemented in Canterbury, West Coast and South Canterbury, it is being rolled out across the rest of the South Island.
interRAI	International Resident Assessment Instrument	A suite of geriatric assessment tools that support clinical decision making and care planning by providing evidence-based practice guidelines and ensuring needs assessments are consistent and people are receiving equitable access to services. Aggregated data from the assessments is also used as a planning tool to improve the quality of health services and better target resources across the wider community according to need.
NHI	National Health Index	An NHI number is a unique identifier assigned to every person who uses health and disability services in NZ.
	Outcome	A state or condition of society, the economy or the environment, including a change in that state or condition (e.g. a change in the health status of a population).
PBF	Population-Based Funding	The national formula used to allocate each of the twenty DHBs a share of the available national health resources.
PHO	Primary Health Organisation	Funded by DHBs, PHOs ensure the provision of essential primary health care services to people who are enrolled with them, either directly or through its provider members (general practice). The aim is to ensure general practice services are better linked with other health services to ensure a seamless continuum of care.
	Public Health Services	The science and art of preventing disease, prolonging life and promoting health and efficiency through organised community effort.
	Secondary Care	Specialist care that is typically provided in a hospital setting.
	Primary Care	Professional health care received in the community, usually from a general practice team, covering a broad range of health and preventative services.
SIAPO	South Island Alliance Programme Office	A project office that supports the five South Island DHBs to work together to support the delivery of clinically and financially sustainable service across the South Island.
	Tertiary Care	Very specialised care often only provided in a smaller number of locations.

Appendix 2 Minister of Health's Letters of Expectation

Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance

Dr John Wood
Canterbury District Health Board

12 JUL 2019

Tēnā koe John

UPDATE: Letter of Expectations for district health boards and subsidiary entities for 2019/20

This letter sets out an update to the Government's expectations for district health boards (DHBs) and their subsidiary entities for 2019/20. This builds on my December 2018 letter, attached for your reference. I want to emphasise that my strong focus remains on the expectations set out in that letter.

I also want to acknowledge your engagement with the important conversations we have been having on improving financial sustainability and clinical performance.

While I recognise there are a number of challenges, it is my expectation that DHBs ensure their local communities can access high quality sustainable services that deliver equitable outcomes.

Wellbeing Budget

Budget 2019 is about delivering better wellbeing for all New Zealanders and driving intergenerational change. There are five key priorities – taking mental health seriously, improving child poverty, supporting Māori and Pasifika aspirations, building a productive nation, and transforming the economy.

Budget 2019 builds on last year's Vote Health investment. A record $19.871 billion is being invested for 2019/20 to support a stronger, more sustainable health and disability system.

Our Government has signalled a willingness not just to invest, but also to make the fundamental changes needed to deliver long term and sustainable change. Budget initiatives are also based around evidence on what will make the greatest contribution to the long term improvement of living standards and wellbeing.

Monitoring improved performance

High performing DHBs are needed to support the delivery of the Government's priorities. I am concerned about the sector's overall financial position, and some areas of service performance.

As you are aware I have worked with the Ministry of Health (Ministry) to ensure DHB performance is supported through a stronger performance programme. This will help DHBs to be more sustainable, and to improve financial and clinical performance to ensure better and more equitable outcomes for New Zealanders. I have made it clear that you have a responsibility to address the range of performance challenges in partnership with the Ministry.

1

+64 4 817 8709 Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand d.clark@ministers.govt.nz beehive.govt.nz

Your DHB's performance will be reported to me regularly, and I support the use of data and benchmarking to identify variation as well as opportunities for improvement. This will also support collaboration across DHBs regionally and nationally to make the most of our collective capability. I expect all DHBs to contribute to, and participate in, such work to help ensure the system is safe, equitable, efficient, and maximises the resource use across the whole system.

Fiscal responsibility

I have made my expectations on improving financial performance very clear, and DHBs need to have a plan to return to financial sustainability.

You have been provided with your confirmed budget allocations for 2019/20 and I expect you to be considering ways to contain expenditure, including maximising available capability and resources in the system, tightly managing recruitment and staff leave, and improving consistency of clinical pathways and decision-making.

Continuing to do things in the same way as we are now is not sustainable operationally, clinically or financially. There will be a dedicated focus in 2019/20 on strengthening sustainability planning and establishing an on-going sustainability programme.

You will be aware that Budget 2019 invests an extra $94.7 million over four years to help improve DHB financial sustainability. This new funding will enable DHBs to work more collaboratively across your regions, to share and build on best practice, to implement new service models that transform the way we use workforce and facilities, and to make the best use of the available funding and capacity in your region.

Capital investment

Budget 2019 invests $1.7 billion over two years for capital investment projects, building on last year's investment to restore our hospitals and health facilities. This funding will be prioritised for mental health projects, high growth areas with increased demand, and health facilities that are no longer fit for purpose. I urge that in all investment, environmental sustainability be a significant consideration.

Some business cases for new infrastructure projects are already well advanced and have been indicatively prioritised for consideration. I expect this process to be completed with DHBs being advised of the outcomes in July/August 2019.

The Ministry of Business, Innovation and Employment is developing a new framework which will focus on skills development and training as a requirement of construction projects. New construction procurement guidelines will also be applied across government. I expect you to apply the changes to the procurement of new construction projects.

National Asset Management Plan

In the long term, we need to better map out future infrastructure requirements. This will enable the Government to make more informed decisions, and better prioritise remediation work and plan for new facilities.

I am pleased that you are actively supporting the National Asset Management Plan programme of work. I expect that any requests for information from the project team are responded to in a timely manner.

It is also my expectation that you will update your DHB's Asset Management Plans. These are a requirement of the Ministry, and will assist in the formulation of the capital investment pipeline, and the ongoing work on the National Asset Management Plan.

The Budget also provides some funding to lift capacity and capability within the Ministry, notably to establish a new health infrastructure unit that will provide better support to DHBs.

Update on my priority areas

Improving child wellbeing

As you know, child wellbeing is a key priority for this Government. I expect your annual plans to reflect how you are actively working to improve childhood immunisation coverage and eliminate inequity, especially for Māori.

As I have said in my earlier letter of expectations, I expect you to support the reduction of family violence and sexual violence through addressing abuse as a fundamental healthcare responsibility.

Improving mental wellbeing

Mental health and addiction is a top priority in the Wellbeing Budget with $1.9 billion over four years being invested into a range of mental wellbeing initiatives and mental health and addiction facilities. These strongly align with the Government's response to He Ara Oranga, the report of the independent inquiry into mental health and addiction.

We have a unique opportunity to improve the mental health and wellbeing of all New Zealanders. We need to embed a focus on wellbeing and equity at all points of the system. We also need to focus more on mental health promotion, prevention, identification, and early intervention.

It is my expectation that you will work closely with the Ministry and key partners in your region to help drive this transformation; your leadership is essential.

Improving wellbeing through prevention

Our Government's vision is for a welfare system that ensures people have an adequate income and standard of living, are treated with respect, can live in dignity and are able to participate meaningfully in their communities. DHBs have an important and ongoing role working alongside social sector partners to improve the welfare and health system outcomes for their population.

I have introduced a new priority section in DHB annual plans, given the considerable overlaps between people engaging with the welfare system as well as the health and disability support system. Over half the proportion of working age people receiving a main benefit have a health condition or a disability, or care for someone with a health condition or disability.

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

Planned Care

I am confident that the changes to how planned care is planned, funded and monitored will remove the current disincentives to developing better ways of delivering services.

The new planned care approach will enable DHBs to deliver more appropriate, timely, high quality services to support the health and wellbeing of New Zealanders. DHBs will be able to provide care in the most appropriate setting, with the right workforce.

There will also be a greater focus on equity, quality, and people's experience of our services. I expect DHBs to create robust plans for these services and to consistently meet volume, waiting time, and other quality expectations.

Cancer Action Plan

I have asked the Ministry to work with you and other stakeholders to develop a Cancer Action Plan. I expect you to support and drive the development of this important work, and to deliver on the local actions within your Plan.

Health Research Strategy Implementation

Research, evidence and innovation is critical to addressing inequities and in continuously improving the quality and outcomes of services provided.

I am aware that the Ministry is working with DHBs and other government agencies to develop a work programme to implement the Health Research Strategy. I encourage you to continue to work closely with the Ministry to progress this important work.

Workforce

DHBs have a key role in training our health and disability workforce. I expect that all DHBs continue to maintain a strong focus on this area to build capacity and capability, and to implement an equitable approach to funding professional development.

In your current annual plan I expect you to develop a sustainable approach to nursing career pathways, including actions to support equitable funding for professional development for nurse practitioners.

Care Capacity Demand Management

At the end of last year I outlined my expectation that DHBs are to implement Care Capacity Demand Management (CCDM) in line with the process and timetable set out in the 2018-2020 MECA.

I expect to see significant progress on CCDM implementation this year, as well as detailed planning to ensure full implementation by June 2021.

I expect you to confirm that you have met my expectation to include implementing CCDM in the performance expectations of your Chief Executive and that you are updating these expectations to include implementation in midwifery services.

Devolution of the pay equity appropriation

I have supported the devolution of the pay equity appropriation. I expect you to work with the Ministry to ensure a seamless transition of responsibilities.

The Ministry has an ongoing stewardship responsibility to ensure that Care and Support Workers (Pay Equity) Settlement Act obligations are met.

The Government's agenda to improve the health and wellbeing of New Zealanders is significant, as evidenced by the sizable investments being made. I am confident that DHBs will present strong plans to support delivery of our priorities and I am looking forward to seeing progress against both measures and activities during the year.

I have appreciated the willingness shown by DHB teams to focus on equity and outcomes, and have confidence that you will all embrace the direction and implement plans to deliver it.

Thank you for your continued dedication and efforts to provide high quality and equitable health care and outcomes for New Zealanders.

Ngā mihi nui

Hon Dr David Clark
Minister of Health

Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance

19 DEC 2019

Dr John Wood
Chair
Canterbury District Health Board

Dear John

Letter of Expectations for district health boards and subsidiary entities for 2019/20

This letter sets out the Government's expectations for district health boards (DHBs) and their subsidiary entities for 2019/20.

In early September, the Prime Minister announced a long-term plan to build a modern and fairer New Zealand; one that New Zealanders can be proud of. As part of the plan, our Government commits to improving the wellbeing of all New Zealanders and their families, and ensuring that the economy is growing and working for all.

Our health system has an important role in supporting the Government's goals. To do this we need to be sure that our public health system is: strong and equitable, performing well, and focused on the right things to make all New Zealanders' lives better.

Achieving equity within the New Zealand health system underpins all of my priorities. Māori as a population group experience the poorest health outcomes. As you consider equity within your district, there needs to be an explicit focus on achieving equity for Māori across their life course. Māori-Crown relations is a priority for this Government and I expect your DHB to meet your Treaty of Waitangi obligations as specified in the New Zealand Public Health and Disability Act 2000. I am expecting you to report on progress with how you are meeting these obligations as part of your Annual Plan reporting.

Unmet need also represents a significant barrier to achieving equity in health outcomes for all populations groups across New Zealand. I expect your Annual Plan to contain actions that will enable progress towards achieving equity and to address the key areas of unmet need especially for Pacific peoples and other population groups in your regions with poorer health outcomes.

Our approach

DHB Chairs are directly accountable for their DHB's performance. We expect Boards to be highly engaged and to hold Chief Executives and management to account for improved performance within their DHB, in relation to both equity of access to health services and equity of health outcomes. In addition, I will also be working towards ensuring that Māori membership of DHB Boards is proportional to the Māori population within your district.

+64 4 817 8709 Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand d.clark@ministers.govt.nz beehive.govt.nz

Fiscal responsibility
Strong fiscal management is essential to enable delivery of better services and outcomes for New Zealanders. I expect DHBs to live within their means and maintain expenditure growth in line with or lower than funding increases.

My expectation is that DHBs have in place clear processes to ensure appropriate skill mix and FTE growth that supports changes in models of care and use the full range of the available workforce and settings. This is essential for ensuring financial and clinical sustainability of our health system.

A better collective understanding of the demand for services, drivers of deficits and financial risks remains a very significant priority and I expect you to work closely and proactively with the Ministry of Health on these matters. I will continue to meet and speak with you frequently during the year to discuss performance, and I will be looking particularly closely at your ability to deliver in the Government's priority areas, to keep within budget and to manage your cash position.

Strong and equitable public health and disability system

Building infrastructure
My expectation is for timely delivery of Ministers' prioritised business cases. I remind you that capital projects over $10 million are subject to joint Ministers (Minister of Health and Minister of Finance) approval. Business cases will be assessed to ensure that they are in line with the Health Capital Envelope priorities. I also expect you ensure that your agency is aware of the expectation that upcoming construction projects will be used to develop skills and training and that the construction guidelines will be applied for all procurement of new construction from this point onwards. I will be writing to you separately about this with further detail.

National Asset Management Plan
I expect you to support the National Asset Management Plan programme of work. I encourage you to actively interact with the project as, long term, the National Asset Management Plan will formulate the capital investment pipeline, and ensure DHBs' future infrastructure needs are met.

Devolution
I am considering devolution of certain services and expect to be making decisions in the New Year. DHBs will be consulted during the process to ensure the financial and service implications are well understood. Once any decisions have been made, I will expect you to work with the Ministry of Health to ensure a seamless transition of responsibilities.

Workforce
I expect DHBs to develop bargaining strategies that are consistent with the Government Expectations on Employment Relations in the State Sector, and to act collaboratively to ensure that any potential flow-on implications across workforces and/or across DHBs are understood and addressed in the bargaining strategies. A Government priority is raising the wages of the least well-paid workforces, which will require a different approach to the traditional one based on across-the-board percentage increases. I also expect DHBs to implement Care Capacity Demand Management in accordance with the process and timetable set out in the 2018-2020 MECA. I note that the State Services Commissioner has included wording that reflects the commitments in the New Zealand Nurses Organisation Accord in the performance expectations of the Director-General of Health and I ask you to consider including similar wording in the performance expectations of your Chief Executive.

DHBs have an essential role in training our future workforce and I expect you to support training opportunities for the range of workforce groups. As part of this, you should work closely with training bodies such as tertiary education institutes and professional colleges and bodies to ensure that we have a well trained workforce and to support research. I continue to expect DHBs will adhere to the Medical Council's requirement for community-based attachments for PGY1 and PGY2 doctors.

Bowel Screening
The National Bowel Screening programme remains a priority for this Government, and I expect you to develop a sustainable endoscopy workforce, be it medical or nursing, including the strategic support of training positions for both nursing and medical trainees in order to meet growing demand in this area. It is crucial that symptomatic patients are not negatively impacted by screening demand and the Ministry of Health will work closely with you on workforce issues to support this.

Planned Care
I am enabling DHBs to take a refreshed approach to the delivery of elective services under a broader "Planned Care" programme. Timely access to Planned Care remains a priority. The refreshed approach to Planned Care will provide you with greater flexibility in where and how you deliver services and will enable more care to be delivered within the funding envelope. I urge you to take advantage of the opportunity that will be made available, and support your teams to develop well considered delivery plans that align with your population's needs, support timely care, and make the best use of your workforce and resources.

Disability
Disabled people experience significant health inequalities and they should be able to access the same range of health services as the rest of the general population. My expectation is that DHBs are working towards or are implementing the Convention on the Rights of Persons with Disabilities. I expect DHBs to implement policies for collecting information, within their populations, about people with disabilities. In addition, please ensure your contracts with providers reflect their requirements to either ensure accessibility or put in place concrete plans to transition to a more accessible service.

System Level Measures
As part of your focus on improving quality, I expect you to continue to co-design and deliver initiatives to achieve progress on System Level Measures with primary health organisations (PHOs) and other key stakeholders.

Rural health
The Government expects DHBs with rural communities to consider their health needs and the factors affecting health outcomes for rural populations when making decisions regarding health services.

Mental health and addiction care

Mental health and addiction remains a priority area for this Government and I expect your DHB to prioritise strengthening and improving mental health and addiction service areas in your 2019/20 Annual Plan. The Mental Health and Addiction Inquiry report is under consideration by the Government and it is my expectation that DHBs are ready to move on implementing the Government's response to its recommendations.

Over the last year a number of deaths across the country have been attributed to use of synthetic cannabinoids. I expect DHBs to consider the role of both public health and specialist treatment services in providing coordinated local responses to emerging drug threats such as synthetic cannabinoids.

Child wellbeing

Child wellbeing is a priority for our Government. I expect your annual plans to reflect how you are actively working to improve the health and wellbeing of infants, children, young people and their whānau with a particular focus on improving equity of outcomes.

In supporting the Government's vision of making New Zealand the best place in the world to be as a child I expect DHBs to have a specific focus on:

- supporting the development of the Child Wellbeing Strategy, particularly the First 1000 days of a child's life and child and youth mental wellbeing
- contributing to the review of the Well Child Tamariki Ora programme
- supporting the reduction of family violence and sexual violence through addressing abuse as a fundamental health care responsibility.

Maternity care and midwifery
High quality maternity care is recognised as a fundamental part of child wellbeing. I am listening to the issues the community is raising with me, and I take the concerns about the level of capacity in the midwifery workforce seriously. It is my expectation that DHBs implement a plan to support improved recruitment and retention of midwives, including midwives in the community and midwives employed in all maternity facilities.

Smokefree 2025
I also expect you to advance progress towards the Smokefree 2025 goal, particularly community-based wrap-around support for people who want to stop smoking, with a focus on Māori, Pacific, pregnant women and people on a low income. I also want to see DHBs collaborating across their region to support smoking cessation including, where appropriate, amongst programme providers, with a view to sharing and strengthening knowledge and delivery of effective interventions.

Primary health care

Improved access to primary health care brings significant benefits for all New Zealanders as well as our health system. Removing barriers to primary health care services and improving equity are key priorities for this Government. I also want to see closer integration of primary health care with secondary and community care. I intend to continue to invest in primary health care and expect all DHBs to support this important priority.

Non-communicable disease (NCD) prevention and management

As our major killers, NCDs, particular cancers, cardiovascular disease and type 2 diabetes need to be a major focus for prevention and treatment for your DHB. I want you to continue a particular focus on type 2 diabetes prevention and management, including an emphasis on ensuring access to effective self-management education and support. I want to see an increased focus on prevention, resilience, recovery and wellbeing for all ages, as part of a healthy ageing approach. You should also use PHO and practice-level data to inform quality improvement.

Public health and the environment

Environmental sustainability
I expect you to continue to contribute to the Government's priority outcome of environmental sustainability and undertake further work that leads to specific actions, including reducing

carbon emissions, to address the impacts of climate change on health. This will need to incorporate both mitigation and adaption strategies, underpinned by cost-benefit analysis of co-benefits and financial savings and I expect you to work collectively with the Ministry of Health on this important area.

Healthy eating and healthy weight
As part of your sector leadership role, I strongly encourage you to support healthy eating and healthy weight through continuing to strengthen your DHB's Healthy Food and Drink Policy This includes increasing the number of food options categorised as 'green' in the National Policy and moving towards only selling water and milk as cold drink options. I actively encourage you to support other public and private organisations to do the same. There is a strong rationale for DHBs providing such leadership in their communities to both set an example and to 'normalise' healthy food and drink options. In particular I would like you to work directly with schools to support them to adopt water-only and healthy food policies.

Drinking water
You will be aware that our Government is undertaking system-wide reform of the regulatory arrangements for drinking water and I am confident that you will support any developments that may result. I expect you to work through your Public Health Unit across agency and legislative boundaries to carry out your key role in drinking water safety with a focus on the health of your population.

Integration
Improving equity and wellbeing and delivering on several other expectations I am setting in this letter will not be possible without strong cross-sectoral collaboration. I expect DHBs to demonstrate leadership in the collaboration between and integration of health and social services, especially housing.

Planning processes

Your DHB's 2019/20 Annual Plan is to reflect my expectations and I also ask you to demonstrate a renewed focus on your strategic direction, by refreshing your Statement of Intent in 2019/20.

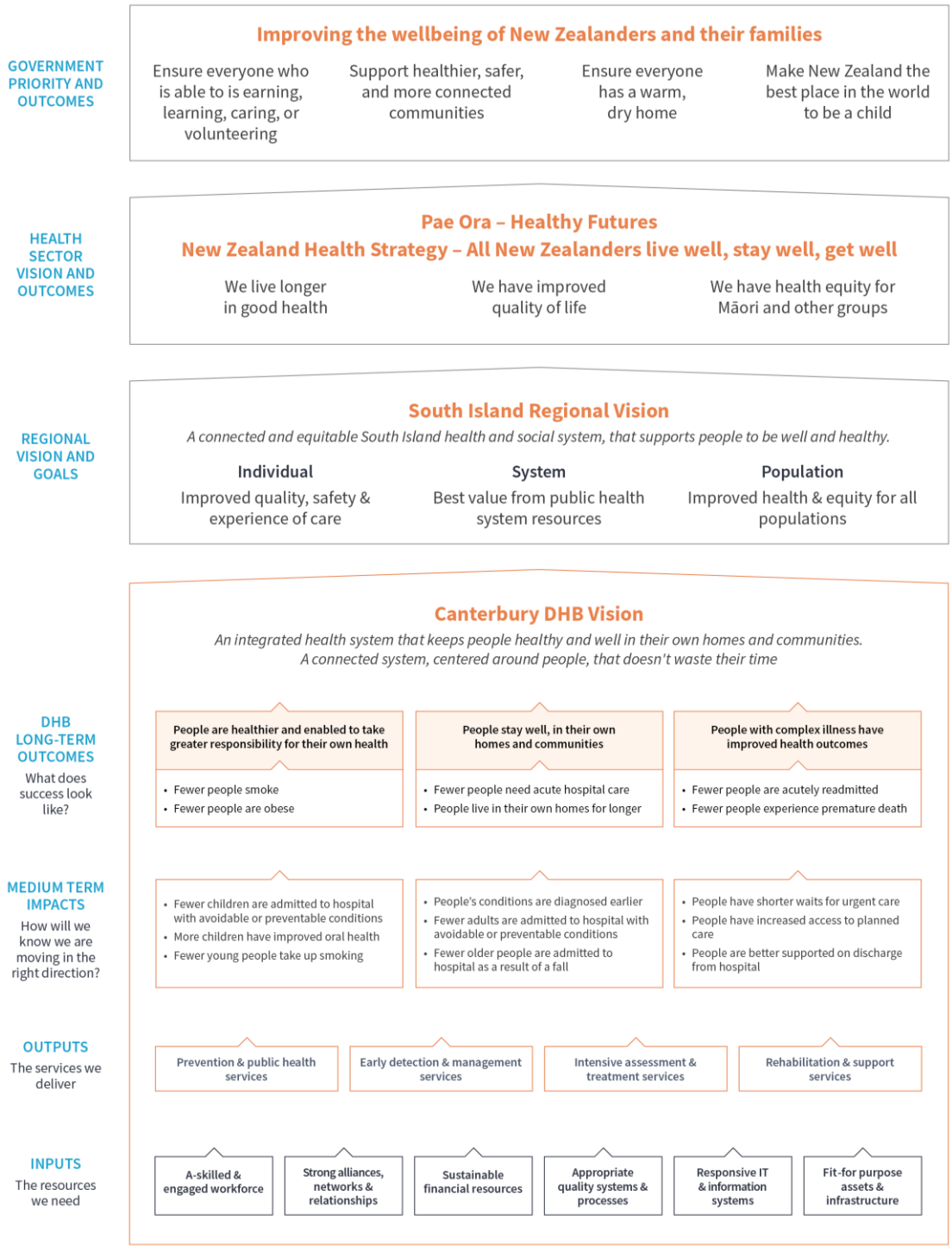
I believe providing you with my expectations in December will support your planning processes, however I also acknowledge that some important decisions will be made in the coming weeks, including detail related to implementation of the Mental Health and Addictions Inquiry recommendations. To ensure my expectations are clear, it is my intention to provide an update to this letter in the New Year.

I would like to take this opportunity to thank you, the Board and your staff for your dedication and efforts to provide high quality and equitable outcomes for your population.

Yours sincerely

Hon Dr David Clark
Minister of Health

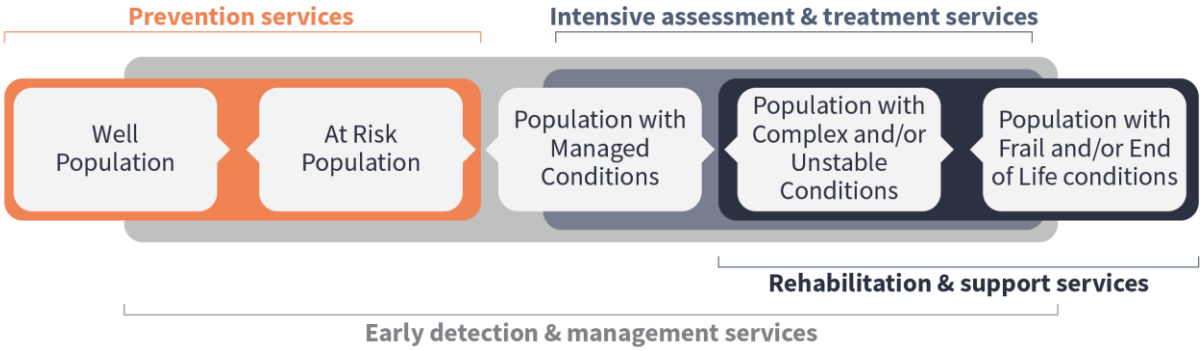
Appendix 3 Overarching Intervention Logic Diagram



Te Tiriti O Waitangi

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

Appendix 4 Statement of Performance Expectations



As both the major funder and provider of health services in Canterbury, the decisions we make and the way in which we deliver services have a significant impact on people's health and wellbeing.

Having a limited resource pool and a growing demand for health services, we are strongly motivated to ensure we are delivering the most effective and efficient services possible.

Over the longer term, we evaluate the effectiveness of our decisions by tracking the health of our population against a set of desired population health outcomes, encompassed in our Outcomes Framework. These longer-term health indicators are highlighted in the DHB's Statement of Intent.

On an annual basis, we evaluate our performance by providing a forecast of the services we plan to deliver and the standards we expect to meet. The results are then presented in our Annual Report at year end.

The following section presents the Canterbury DHB's Statement of Performance Expectations for 2019/20.

IDENTIFYING PERFORMANCE MEASURES

Because it would be overwhelming to measure every service delivered, services have been grouped into four service classes. These are common to all DHBs and reflect the types of services provided across the full health and wellbeing continuum (illustrated above):

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

Under each service class we have identified a mix of service measures that we believe are important to our community and stakeholders and provide a fair indication of how well the DHB is performing.

In health, the number of people who receive a service can be less important than whether enough of the right people received the service, or whether the service was delivered at the right time.

To ensure a balanced, well rounded picture, the mix of measures identified address four key aspects of service performance that matter most to our population:

Access (A)
Are services accessible, is access equitable, are we engaging with all of our population?

Timeliness (T)
How long are people waiting to be seen or treated, are we meeting expectations?

Quality (Q)
How effective is the service, are we delivering the desired health outcomes?

Experience (E)
How satisfied are people with the service they receive, do they have confidence in us?

SETTING STANDARDS

In setting performance standards, we consider the changing demography of our population, areas of increasing demand and the assumption that resources and funding growth will be limited.

Targets reflect the strategic objectives of the DHB: increasing the reach of prevention programmes; reducing acute or avoidable hospital admissions; and maintaining access to services - while at the same time reducing waiting times and delays in treatment.

We also seek to improve the experience of people in our care and public confidence in our health system.

While targeted interventions can reduce service demand in some areas, there will always be some demand the DHB cannot influence such as demand for maternity, dementia or palliative care services.

It is not appropriate to set targets for these services, however they are an important part of the picture of health need and service delivery in our region. Service

level estimates have been provided to give context in terms of the use of resources across our health system.

Wherever possible, past years' results have been included to give context in terms of current performance levels and what we are trying to achieve.

SETTING PERFORMANCE EXPECTATIONS

With a growing diversity and persistent inequities across our population, achieving equity of outcomes is an overarching priority for the DHB. All of our targets are universal, with the aim of reducing inequities between population groups.

A number of focus areas have been identified as health priorities for Māori and the associated measures will be reported by ethnicity in our Annual Report.

Canterbury is still contending with the ongoing consequences of the earthquakes. The operational impact is being felt, most markedly, in an increased demand for mental health and emergency services and reduced capacity within our hospitals due to the loss of buildings and space. The relentless disruption from repairs and construction is also having a negative impact on services and on the wellbeing of our staff.

In considering this pressure and our reduced capacity, we have retained 2018/19 standards against a number of our discretionary measures. However, many of the performance targets presented in our forecast are national expectations set for all DHBs.

While we remain committed to maintaining high standards of service delivery, some national expectations (particularly those relating to increased delivery in our hospitals) will be particularly challenging in our current operating environment.

NOTES FOR THE READER

Rather than repeating footnotes, the following symbols have been used in the performance tables:

Δ Performance data is provided by external parties and baseline results can be subject to change, due to delays in invoicing or reporting.

† Performance data relates to the calendar year rather than the financial year.

◇ The measure is reported nationally as a key DHB performance target and in line with national performance reporting, fourth quarter (April-June) results are reported as the annual result.

E Services are demand driven and no targets have been set for these service lines. Estimated service volumes have been provided to give context in terms of the use of health resources

◆ This measure has been identified as a key focus area for Māori. Progress by ethnicity will be reported in the DHB's Annual Report.

Where does the money go?

In 2019/20 the DHB will receive approximately $1.945 billion dollars with which to purchase and provide the services required to meet the needs of our population.

The table below presents a summary of our anticipated financial split for 2019/20, by service class.

	2019/20
Revenue	Total $'000
Prevention	50,022
Early detection & management	377,932
Intensive assessment & treatment	1,229,107
Rehabilitation & support	288,649
Total Revenue - $'000	1,945,710
Expenditure	
Prevention	53,217
Early detection & management	414,022
Intensive assessment & treatment	1,344,274
Rehabilitation & support	314,667
Total Expenditure - $'000	2,126,180
Surplus/(Deficit) - $'000	(180,470)

Prevention services

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

By supporting people to make healthier choices, we can reduce the major risk factors that contribute to poor health such as smoking, poor diet, obesity, lack of physical exercise and hazardous drinking. High-need population groups are also more likely to engage in risky behaviours, or live in environments less conducive to making healthier choices. Prevention services are therefore one of our foremost opportunities to target improvements in the health of high-need populations and reduce inequities in health status and health outcomes. Prevention services are designed to spread consistent messages to a large number of people and can therefore also be a very cost-effective health intervention.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Population Protection Services – Healthy Environments				
These services address aspects of the physical, social and built environment in order to protect health and improve health outcomes.	Notes	2016/17 Result	2017/18 Result	2019/20 Target
Number of submissions providing strategic public health input and expert advice to inform policy in the region and/or nationally	Q [13]	116	78	E. 90
Licensed alcohol premises identified as compliant with legislation	Q [14]	79%	83%	90%
Networked drinking water supplies compliant with Health Act	Q [15]	96%	85%	97%

Health Promotion and Education Services				
These services inform people about risk factors and support them to make healthy choices. Success is evident through increased engagement and healthier choices.	Notes	2016/17 Result	2017/18 Result	2019/20 Target
Mothers receiving breastfeeding and lactation support in the community	A [16]	1,026	980	>600
Babies exclusively/fully breastfed at three months	Q [16]◆	60%	61%	70%
People provided with a Green Prescription for additional physical activity support	A [17]	3,800	4,087	>3,000
Green Prescription participants more active six to eight months after referral	Q	-	61%	>50%
Smokers, enrolled with a PHO, receiving advice and support to quit smoking (ABC)	Q [18]◆	90%	93%	90%
Smokers, identified in hospital, receiving advice and support to quit smoking (ABC)	Q ◆	96%	95%	95%
Pregnant women, identified as smokers at confirmation of pregnancy with an LMC, receiving advice and support to quit smoking (ABC)	Q [19]◆	93%	86%	90%

[13] Submissions are made to influence policy in the interests of improving and protecting the health of the population and providing a healthy and safe environment for our population. The number of submissions varies in a given year and may be higher (for example) when Territorial Authorities are consulting on long-term plans.

[14] New Zealand law prevents alcohol retailers from selling alcohol to young people aged under 18 years. The measure relates to Controlled Purchase Operations which involve sending supervised volunteers (under 18 years) into licensed premises. Compliance can be seen as a proxy measure of the success of education and training for licensed premises and reflects a culture that encourages a responsible approach to alcohol.

[15] This measure relates to the percent of (water) network supplies compliant with sections 69V and 69Z of the Health Act 1956. This includes all classes of supplies: large, medium, minor, small and rural agricultural.

[16] Evidence shows that infants who are breastfed have a lower risk of developing chronic illnesses during their lifetimes. Breastfeeding measures are part of the national Well Child/Tamariki Ora Quality Framework, data from providers is not able to be combined so performance from the largest provider (Plunket) is presented. Updated information has allowed baselines to be reset to present a full (12 month) result rather than the final quarter (six months) as previously presented.

[17] A Green Prescription is a health professional's written advice to a patient to be physically active, as part of their health management. Standards are set nationally and performance data is sourced from a biannual national patient survey competed by Research NZ on behalf of the Ministry of Health.

[18] The ABC programme has a cessation focus and refers to health professionals asking about smoking status, providing Brief advice and providing Cessation support. The provision of profession advice and cessation support is shown to increase the likelihood of smokers making quit attempts and the success rate of those attempts. The baselines for the hospital smoking measure has been reset to present full year (12 month) results, rather than the final quarter of each year (April-June).

[19] This data is sourced from the national Maternity Dataset Dataset which only covers approximately 80% of pregnancies nationally, as such, the results indicate trends rather than absolute performance. Standards have been set nationally in line with other smoking targets and baselines have been reset to present full year results.

Population-Based Screening Services				
These services help to identify people at risk and support earlier intervention and treatment. Success is evident through high levels of engagement with services.	Notes	2016/17 Result	2017/18 Result	2019/20 Target
Four-year-olds provided with a B4 School Check (B4SC)	A [20] ◆	93%	97%	90%
Four-year-olds (identified as obese at their B4SC) offered a referral for clinical assessment and family-based nutrition, activity and lifestyle intervention	Q [21] ◆	86%	98%	95%
Women aged 25-69 having a cervical cancer screen in the last 3 years	A [22] ◆	74%	74%	80%
Women aged 50-69 having a breast cancer screen in the last 2 years	A [22] ◆	76%	76%	70%

Immunisation Services				
These services reduce the transmission and impact of vaccine-preventable diseases. High coverage rates are indicative of a well-coordinated, successful service.	Notes	2016/17 Result	2017/18 Result	2019/20 Target
Children fully immunised at eight months of age	A [23] ◆	94%	94%	95%
Proportion of eight-month-olds 'reached' by immunisation services	Q	98%	98%	95%
Young people (girls and boys Year 8) completing the HPV vaccination programme	A [24] † ◆	59%	65%	75%
Older people (65+) receiving a free influenza ('flu') vaccination	A [25] † ◆	63%	62%	75%

[20] The B4 School Check is the final core check, under the national Well Child/Tamariki Ora schedule, which children receive at age four. It is free and includes assessment of vision, hearing, oral health, height and weight, allowing concerns to be identified and addressed early.

[21] Obesity is particularly concerning in children as it is associated with a wide range of health conditions and increased risk of illness. It can also affect a child's educational attainment and quality of life. The referral allows families to access support to maintain healthier lifestyles. This is a national performance measure and baselines differ from those previously presented having been reset to reflect a full year (12 month) result rather than the final quarter result (Jan-June).

[22] Cervical cancer is one of the most preventable cancers and breast cancer one of the most common. Risk increases with age and regular screening reduces the risk of dying by allowing for earlier intervention and treatment. The measures refer to participation in national screening programmes and standards are set nationally.

[23] Immunisation at eight months is a national performance measure and the subset, children 'reached', is defined as children fully immunised and those whose parents have been contacted and provided with advice - but may have chosen to decline immunisations or opt off the National Immunisation Register. Baselines differ from those previously presented having been reset to reflect a full year (12 month) result rather than the final quarter of the year (April-June).

[24] The Human Papillomavirus (HPV) vaccination aims to protect young people from HPV infection and the risk of developing HPV-related cancers later in life. The programme consists of two vaccinations and is free to young people under 26 years of age. The target group for 2019/20 is the proportion of young people born in 2006 completing the programme. Baseline results refer to young girls only, the programme was widened in 2019/20.

[25] Almost one in four New Zealanders are infected with influenza each year. Influenza vaccinations can reduce the risk of flu-associated hospitalisation and have also been associated with reduced hospitalisations among people with diabetes and chronic lung disease. The vaccine is especially important for people at risk of serious complications, including people aged over 65 and people with long-term or chronic conditions.

Early detection and management services

WHY ARE THESE SERVICES SIGNIFICANT FOR THE DHB?

Early detection and management services help to maintain, improve and restore people's health. These services include detection of people at risk, identification of disease and the effective management and coordination of services for people with long-term conditions. These services are by nature more generalist and accessible from multiple providers at a number of different locations. Providers include general practice, allied health, personal and mental health service providers and pharmacy, radiology and laboratory services providers.

The New Zealand health system 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 increases with age. Cancer, cardiovascular disease, diabetes, and respiratory disease are the four leading long-term conditions for our population.

Our vision of an integrated system presents a unique opportunity. By promoting regular engagement with primary and community services, we can better support people to maintain good health, identify issues earlier and intervene in less invasive and more cost-effective ways. Our integrated approach is particularly effective where people have multiple conditions requiring ongoing intervention or support and reduces the burden of long-term conditions through improved self-management and the avoidance of complications, acute illness and unnecessary hospital admissions.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

General Practice Services				
These services support people to maintain their health and wellbeing. High levels of engagement with general practice are indicative of an accessible, responsive service.	Notes	2016/17 Result	2017/18 Result	2019/20 Target
Proportion of the population enrolled with a Primary Health Organisation (PHO)	A ◆	94%	93%	95%
Newborns enrolled with a PHO by three months of age	A [26]◆	80%	82%	85%
Young people (0-19) accessing brief intervention counselling in primary care	A [27]Δ	679	579	>500
Adults (20+) accessing brief intervention counselling in primary care	A [27]Δ	5,861	6,396	>5,500
Number of skin lesions (growths, including cancer) removed in primary care	A Δ	2,520	2,609	>2,000
Number of integrated HealthPathways in place across the health system	Q [28]	644	691	E. >600
Proportion of general practices using the primary care patient experience survey	E [29]	42%	62%	>65%

Long-Term Condition Services				
These services are targeted at people with high health needs with the aim of supporting people to better manage and control their conditions.	Notes	2016/17 Result	2017/18 Result	2019/20 Target
Number of spirometry tests provided in the community rather than in hospital	A [30]Δ	1,897	2,493	>2,000
People receiving subsidised diabetes self-management support when starting insulin	A Δ	381	400	>300
Population identified with diabetes having an HbA1c test in the last year	A [31]Δ◆	89%	90%	>90%
Population with diabetes having an HbA1c test and acceptable glycaemic control	Q [31]Δ◆	75%	74%	>60%

[26] This is a national performance measure and results have been reset in June 2019 as national data sources move from the PHO register to the National Enrolment Service (NES). The Ministry of Health provided estimates for DHB's annual enrolment rates for 2018 and 2019 based off the new system.

[27] The Brief Intervention Counselling service supports people with mild to moderate mental health concerns, including depression and anxiety. The service includes the provision of free counselling sessions (or extended consultations) and include face-2-face and phone consultations.

[28] Clinically designed HealthPathways support general practice teams to manage medical conditions, request advice or make secondary care referrals. The pathways support consistent access to treatment and care, no matter where in the health system people present.

[29] The Patient Experience Survey is a national online survey being rolled-out across the country to determine patients' experience in primary care and how well their overall care is managed. The information will be used to improve the quality of service delivery and patient safety.

[30] Spirometry is a tool for measuring and assessing lung function for a range of respiratory conditions. Providing this service in the community means people do not need to wait for a hospital appointment and conditions can be identified and treated earlier.

[31] Diabetes is a leading long-term condition and contributor to many other conditions. An annual HbA1c test (of blood glucose levels) is a means of assessing the management of people's condition. A level of less than 64mmol/mol reflects an acceptable blood glucose level.

Oral Health Services

These services support lifelong health and wellbeing. High levels of enrolment and timely access to treatment are indicative of an accessible and efficient service.	Notes	2016/17 Result	2017/18 Result	2019/20 Target
Children (0-4) enrolled in DHB-funded oral health services	A [32]†◆	62%	76%	95%
Children (0-12) enrolled in DHB funded oral health services, who are examined according to planned recall	T [32]†◆	90%	88%	90%
Adolescents (13-17) accessing DHB-funded oral health services	A [32]†	61%	63%	85%

Pharmacy and Referred Services

These are services which a health professional uses to help diagnose or monitor a health condition. While largely demand driven, timely access to services enables improved clinical decision-making and reduces unnecessary delays in treatment.	Notes	2016/17 Result	2017/18 Result	2019/20 Target
Number of laboratory tests completed for the Canterbury population	A Δ	2.8m	2.9m	E.<2.8m
Number of subsidised pharmaceutical items dispensed in the community	A Δ	6.8m	6.8m	E.<8m
People on multiple medications receiving medication management support	A [33]Δ	1,361	1,316	>1,200
People (65+) being dispensed 11 or more long term medications (rate per 1,000)	Q [34]†	4.2	4.0	E.<4.6
Number of community-referred radiology tests completed	A Δ	45,227	49,832	E.>40,000
People receiving their urgent diagnostic colonoscopy within two weeks	T [35]	94%	93%	90%
People receiving their Magnetic Resonance Imaging (MRI) scans within six weeks	T [35]	39%	41%	90%
People receiving their Computed Tomography (CT) scans within six weeks	T [35]	86%	69%	95%

[32] Oral health is an integral component of lifelong health and wellbeing. Early and regular contact with oral health services helps to set lifelong patterns and reduce risk factors such as poor diet, which have lasting benefits in terms of improved nutrition and healthier body weights.

[33] The Medical Management Review programme helps to ensure the safe and appropriate use of medications. The programme offers more intense medication therapy assessments for the most complex patients and less complex medication use reviews for others.

[34] The use of multiple medications is most common in the elderly and can lead to reduce drug effectiveness or negative outcomes. Concerns include increased adverse drug reactions, poor drug interactions and higher costs for the system with little health benefits. Multiple medication use requires monitoring and review to validate whether all of the medications are complimentary and necessary. Data is sourced from the HQSC Atlas of Healthcare Variation.

[35] By improving clinical decision-making, timely access to diagnostics enables earlier and more appropriate intervention and treatment. This contributes to improved quality of care and health outcomes and by reducing long waits for diagnosis or treatment, improves people's confidence in the health system. A colonoscopy is a test that looks at the inner lining of a person's large intestine (rectum and colon). The radiology measures are national DHB performance indicators referring to wait times for non-urgent scans. Baselines differ to previously printed results, having been reset from the year-end results (June of each year) to full year (12 month) results.

Intensive assessment and treatment services

WHY ARE THESE SERVICES SIGNIFICANT?

Intensive assessment and treatment services are more complex services provided by specialists and health professionals working closely together. They are usually (but not always) provided in hospital settings, which enables the co-location of expertise and equipment. A proportion of these services are delivered in response to acute events, others are planned, and access is determined by clinical triage, treatment thresholds, capacity, and national service coverage agreements.

Timely access to intensive assessment and treatment can significantly improve people's quality of life through corrective action and is crucial to improving survival rates for complex illness such as cancer. Responsive services and timely access to treatment also enable people to establish more stable lives and result in improved confidence in the health system.

As an owner of specialist services, the DHB is committed to ensuring the quality of its service provision. Adverse events and delays in treatment cause harm to patients and drive unnecessary costs. Improved processes will support patient safety, reduce the number of events causing injury or harm, and improve health outcomes for our population.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Quality and Patient Safety				
These are national quality and patient safety markers and high compliance levels indicate robust quality processes and strong clinical engagement.	Notes	2016/17 Result	2017/18 Result	2019/20 Target
Staff compliant with good hand hygiene practice	Q [36◇]	83%	82%	80%
Inpatients (aged 75+) receiving a falls risk assessment	Q [36◇]	97%	97%	90%
Proportion of patients with a hospital acquired pressure injury	Q[36◇]	219	226	<204
Response rate to the national inpatient patient experience survey	E [37]	21%	22%	>30%
Proportion of patients who felt 'hospital staff included their family/Whānau or someone close to them in discussions about their care'	E [37]	68%	68%	>65%

Specialist Mental Health and Alcohol and Other Drug (AOD) Services				
These are services for those most severely affected by mental illness and/or addictions who require specialist intervention and treatment. Reducing waiting times, while meeting demand for services, is indicative of a responsive and efficient service.	Notes	2016/17 Result	2017/18 Result	2019/20 Target
Proportion of the population (0-19) accessing specialist mental health services	A [38Δ]	3.7%	3.6%	>3.1%
Proportion of the population (20-64) accessing to specialist mental health services	A [Δ]	3.8%	3.8%	>3.1%
People referred for non-urgent mental health and AOD services seen within 3 weeks	T [39]	77%	74%	80%
People referred for non-urgent mental health and AOD services seen within 8 weeks	T	94%	91%	95%

[36] The quality markers are national DHB performance measures set to drive improvement in key areas. High compliance indicates robust quality processes and strong clinical engagement. Standards are set nationally and in line with national reporting results for the quality measures refer to the final quarter of each year (April-June). The 2017/18 results have been update to reflect the final quarter's results which were not previously available. Further detail and quarterly results for the full year can be found on the Health Quality and Safety Commission website www.hqsc.govt.nz. Pressure injuries are considered preventable and represent avoidable harm. They cause unnecessary pain and suffering and can cause disability or even death. Prevention of hospital acquired pressure injuries is a fundamental component of the Canterbury DHB Patient Safety Programme.

[37] There is growing evidence that patient experience is a good indicator of the quality of health services. Better experience, stronger partnerships with consumers, and patient and family-centred care have been linked to improved health, clinical, financial, service and satisfaction outcomes. The DHB inpatient experience survey covers four domains of patient experience: communication, partnership, co-ordination and physical and emotional needs. Baselines have been reset to align with internal reporting aligned and reflects full year, rather than quarterly results as previously presented. Further detail can be found on the Health Quality and Safety Commission website www.hqsc.govt.nz which includes results against these measures by quarter.

[38] There is a national expectation that around 3% of the population will need access to specialist level mental health services during their lifetime. The short timeframe presented does not reflect the extent of increase in demand for mental health services in Canterbury. Access rates in December 2010 (prior to the earthquakes) were 1.7% for youth and 2.2% for adults. Data is sourced from the national PRIMHD dataset and results are three months in arrears.

[39] Timely access to appropriate intervention and treatment, by reducing long waits for diagnosis or treatment, contributes to improved quality of care and health outcomes and improves people's confidence in the health system. This measure is a national DHB performance indicator (MH03) and standards are set nationally. Data is sourced from the national PRIMHD database and results are three months in arrears.

Maternity Services				
While largely demand driven, service utilisation is monitored to ensure services are accessible and responsive to need.	Notes	2016/17 Result	2017/18 Result	2019/20 Target
Women registered with a Lead Maternity Carer by 12 weeks of pregnancy	A [40]†◆	78%	n.a	80%
Number of maternity deliveries in Canterbury DHB facilities	A	6,048	6,056	E.6,000
Proportion of maternity deliveries made in Primary Birthing Units	Q [41]	14%	16%	>13%

Acute and Urgent Services				
Acute services are delivered in response to accidents or illnesses that have an abrupt onset or progression. Because early intervention can reduce the impact of the event, multiple options and shorter waiting times are indicative of a responsive system.	Notes	2016/17 Result	2017/18 Result	2019/20 Target
Number of acute demand packages of care provided in community settings	A [42] Δ	34,853	32,701	>30,000
Number of presentations at Canterbury Emergency Departments (ED)	A [43]	96,854	103,116	E.<110k
Proportion of the population presenting in ED (per 1,000 people)	Q	173	185	<190
Patients (referred with a high suspicion of cancer and a need to be seen within two weeks) receiving their first treatment within 62 days of referral.	T [44]	85%	95%	90%
Average acute inpatient length of stay (bed days per 1,000 people)	Q [45]	2.40	2.38	<2.35

Elective and Arranged Services				
Elective and arranged services are provided for people who do not need immediate hospital treatment. Reducing waiting times, while meeting demand for services, is indicative of a responsive and efficient service.	Notes	2016/17 Result	2017/18 Result	2019/20 Target
Number of First Specialist Assessments provided	A	72,049	73,913	E.>60,000
Proportion of First Specialist Assessments that were non-contact (virtual)	Q [46]	17%	19%	>15%
Number of planned care intervention delivered	A [47]	new	new	30,675
Proportion of people receiving their surgery on the day of admission	E [48]	91%	94%	>85%
Average elective inpatient length of stay (bed days per 1,000 people)	Q	1.54	1.57	<1.54
Number of outpatient consultations provided	A	672,348	694,629	E.>650k
Outpatient appointments where the patient was booked but did not attend (DNA)	Q [49]	4%	4%	<5%

[40] Early registration with a Lead Maternity Carer (LMC) is encouraged to promote the good health and wellbeing of mother and the developing baby. Data is sourced from the national Maternity Clinical Indicators report the 2017/18 data is yet to be released.

[41] The DHB aims to increase people's acceptance and confidence in using primary birthing units rather than having women give birth in secondary or tertiary facilities when it is not clinically indicated. This enables the best use of resources and ensures limited secondary services are more appropriately available for those women who need more complex or specialist intervention.

[42] Acute demand packages of care are provided through Canterbury's community-based Acute Demand Management Service with the aim of supporting people in their own homes or in the community rather than having people presenting to emergency or hospital for treatment.

[43] This measure is aligned to the national shorter stays in ED indicator and counts presentations to Christchurch and Ashburton Hospitals. In line with the national definition, this measure excludes those who do not wait and those with pre-arranged appointments.

[44] This is a national DHB performance measure and baselines differ to previously printed results, having been reset from final quarter (rolling six months from Jan-June of each year) to full year (12 month) results. There was a definition change for this measure in 2017/18, allowing patients to delay their treatment or for treatment to be delayed due to clinical considerations without impacting on the result, 2016/17 results are therefore not directly comparable.

[45] By shortening the average length of stay, the DHB delivers on the national improved hospital productivity priority and frees up beds and resources to provide more elective (planned) surgery. Addressing the factors that influence a patient's length of stay includes reducing the rate of complications and infection and integration activity to support patients to return home sooner, which improve patient outcomes. This is a national DHB performance indicator and standards are set nationally.

[46] Non-contact assessments are those where assessment is provided without the need (or the wait) for a hospital appointment. This direction aligns to the DHB's vision of reducing waiting times and unnecessary delay in treatment for patients.

[47] The new planned care intervention measure reflects a change in national expectation that continues to recognise the delivery of elective surgery but also recognises the delivery of minor procedures and non-surgical interventions that are required to improve people's health and wellbeing. The new measure also recognised interventions delivered in both hospital and community settings. Canterbury's planned care interventions target is made up of three components: elective surgical discharges (19,182), Minor Procedures (11,385) and Non-Surgical Interventions (108).

[48] With the introduction of the DHB's new patient information system the definition for this measure has been reset. Previous year's results are not directly comparable.

[49] When patients fail to turn up to scheduled appointments, it can negatively affect their recovery and long-term outcomes and it is a costly waste of resources for the DHB. This measure is the proportion of all medical and surgical outpatient appointments where the patient was expected to attend on the day, but did not.

Rehabilitation and support services

WHY ARE THESE SERVICES SIGNIFICANT?

Rehabilitation and support services provide people with the assistance they need to live safely and independently in their own homes, or regain functional ability, after a health-related event. Services are mostly provided to older people, or people with mental health or complex personal health conditions, following a clinical 'needs assessment'. Support services also include palliative care for people who have end-of-life conditions. It is important that they and their families are appropriately supported so that the person is able to live comfortably and have their needs met in a holistic and respectful way, without undue pain and suffering.

These services are considered to provide people with a much higher quality of life as a result of being able to stay active and positively connected to their communities. Even when returning to full health is not possible, access to responsive support services enables people to maximise their independence. In preventing deterioration, acute illness, crisis or deterioration of function, these services have a major impact on the sustainability of our health system, by reducing acute service demand and the need for more complex interventions or residential care. These services also support patient flow by enabling people to go home from hospital earlier.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Assessment, Treatment and Rehabilitation (AT&R) Services				
These services restore or maximise people's health or functional ability following a health-related event such as a fall, heart attack or stroke. Service utilisation is monitored to ensure people are appropriately supported after an event.	Notes	2016/17 Result	2017/18 Result	2019/20 Target
People accessing community-based pulmonary rehabilitation courses	A [50]	325	270	>250
People (65+) accessing the community-based falls prevention service	A [51]	1,815	1,653	>1,500
People supported by the Community Rehabilitation and Support Team (CREST)	A [52Δ]	1,741	1,839	>1,600
Proportion of inpatients referred to an organised stroke service after an acute event	Q[53]	81%	80%	80%
Proportion of AT&R inpatients discharged to their own home rather than ARC	Q [54]	88%	86%	>80%

Home-Based and Community Support Services				
These are services designed to support people to maintain functional independence. Clinical assessment ensures access to services is appropriate and equitable.	Notes	2016/17 Result	2017/18 Result	2019/20 Target
People supported by district nursing services	A [Δ]	7,798	7,698	E. >7,000
People supported by long-term home-based support services	A [Δ]	7,922	8,554	E. >8,000
Proportion of the population (65+) receiving long-term, home-based support	A [Δ]	9.8%	9.7%	E. 10%
People supported by long-term home and community support services who have had a clinical assessment of need using the InterRAI assessment tool	Q [55Δ]	97%	92%	95%
People supported by hospice or home-based palliative services	A [Δ]	4,060	4,033	E. 4,000
People with Advance Care Plans in place to support end of life care	A	-	697	>700
Proportion of people with Advance Care Plans, dying in their place of choice	Q[56]	-	68%	>70%

[50] Respiratory and lung diseases are major contributors to avoidable hospital admissions in Canterbury, particularly over winter. Pulmonary rehabilitation programmes are designed to help patients with Chronic Obstructive Pulmonary Disease (a type of obstructive lung disease) to manage their symptoms and learn breathing, lifestyle and day-to-day living techniques to help them better manage their condition.

[51] Falls are one of the leading causes of hospital admission for people aged over 65. The aim of the Falls Prevention Programme is to provide better care for people both 'at-risk' of a fall, or following a fall, and to support people to stay safe and well in their own homes.

[52] The Community Rehabilitation Enablement and Support Team (CREST) provides a range of short-term home-based rehabilitation services to facilitate early discharge from hospital, or avoid admission entirely through proactive referral. The measure is the number of people having received unique packages of care.

[53] This is a national DHB performance measure. Baselines differ to previously printed results, being reset from final quarter to full year results, one quarter in arrears.

[54] While living in Aged Residential Care (ARC) is appropriate for a small proportion of our population, for most people remaining safe and well in their own homes provides a higher quality of life. A discharge home reflects the effectiveness of services in terms of assisting that person to regain their functional independence.

[55] The International Residential Assessment Instrument (InterRAI) is a suite of evidence-based geriatric assessment tools used nationally to support clinical decision making and care planning. Evidence-based practice guidelines ensure people receive appropriate and equitable access to services.

[56] This measure is based on the number of people who have died during the period, where we know the location of death, and this corresponds with their wishes as articulated in their Advance Care Plan. These people may have created their Plans in an earlier period.

Respite and Day Support Services				
These services provide people with a break from a routine or regimented programme, so that crisis can be averted or a specific health need can be addressed. Largely demand driven, service utilisation is monitored to ensure services are accessible.	Notes	2016/17 Result	2017/18 Result	2019/20 Target
People supported by community-based mental health crisis respite services	A Δ	904	1,081	E.>850
Occupancy rate of mental health crisis respite beds	A[57]Δ	73%	85%	85%
Older people supported by day care services	A[58]Δ	728	727	E.>550
Older people accessing aged care respite services	AΔ	1,715	1,697	E.<1,500
People supported by aged care respite services, being discharged to their own home	Q[59]Δ	86%	84%	>80%

Aged Residential Care Services				
The DHB subsidises ARC for people who meet the national thresholds for care. While our ageing population will increase demand, slower demand growth for lower-level care is indicative of more people being supported in their own homes for longer.	Notes	2016/17 Result	2017/18 Result	2019/20 Target
Proportion of the population (75+) accessing rest home level services in ARC	A [60]Δ	4.6%	4.7%	E.<5.0%
Proportion of the population (75+) accessing hospital-level services in ARC	A Δ	6.0%	6.3%	E.6.5%
Proportion of the population (75+) accessing dementia services in ARC	A Δ	2.4%	2.7%	E. 2.6%
Proportion of the population (75+) accessing psychogeriatric services in ARC	A Δ	0.8%	0.8%	E. 0.8%
People entering ARC having had a clinical assessment of need using InterRAI	Q [61]Δ	88%	93%	95%

[57] 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 beds to imply that services are under-utilised and resources could be better directed to other areas.

[58] The measure includes people accessing day care services in the community and in ARC, largely aged 65+ but including people close in age and interest.

[59] Respite services aim to support people for short durations, to regain function or to give carers a break. The proportion of people being discharged home (rather than staying on in ARC) reflects the effectiveness of services in terms of assisting people to maintain or regain their functional independence.

[60] The Canterbury region has historically had higher ARC rates than national levels and by providing more services that help older people maintain functional independence for longer, they are able to remain in their own homes reducing the demand for rest-home-level care. Access rates for more complex care such as dementia and psychogeriatric care are less amenable and more attributable to the aging of our population. Measures refer to people accessing DHB funded ARC services and exclude people choosing to enter ARC privately or people living independently in retirement villages.

[61] The International Residential Assessment Instrument (InterRAI) is a suite of evidence-based geriatric assessment tools used nationally to support clinical decision making and care planning. Evidence-based practice guidelines ensure people receive appropriate and equitable access to services.

Appendix 5 Statement of Financial Expectations

Canterbury's financial outlook

Funding from the Government, via the Ministry of Health, is the main source of DHB funding. This is supplemented by revenue agreements with ACC, research grants, donations, training subsidies, patient co-payments and service payments from other DHBs.

Like the rest of the health sector, the Canterbury DHB is experiencing growing financial pressure from increasing demand and treatment costs, increasing wage settlements and heightened public expectations.

However, unlike other DHBs, we are also having to manage the extraordinary impacts of the country's largest natural disaster. These include: revenue volatility resulting from population and deprivation shifts; increased service demand; and the operational challenges of providing services in the midst of a significant and ongoing repair programme.

It is incredibly challenging to meet financial expectations while addressing the heightened needs of a more vulnerable population and rebuilding almost all of our entire health infrastructure.

Earthquake and rebuild costs continue to be evident in a number of areas: increased treatment costs; additional outsourcing to support service delivery while our capacity is reduced; unplanned repair costs; construction delays; depreciation; and capital charges.

Lost capacity costs: Our theatre and bed capacity was reduced by the earthquakes and the Christchurch Hospital redevelopment is considerably behind schedule. Construction costs are escalating and while we wait for the new facilities to be complete we are incurring significant additional costs to hire theatres and outsource surgeries. The delays are also impacting on our ability to achieve anticipated savings from the consolidation of services.

Repair costs: A significant proportion of our repair work is not covered by insurance proceeds. While we received the maximum $320 million insurance pay-out under our collective sector policy, damage estimates were over $518 million. Our repair programme has required, and will continue to require, ruthless prioritisation to remain affordable.

Depreciation and capital charges: Included in the cost pressures related to the earthquakes are the depreciation and capital charges the DHB must pay to the Crown. Because these are driven off upward movements in asset valuations, our repair work has resulted in significant additional unanticipated charges. In 2019/20, Canterbury will pay an estimated $54 million in capital charges to the Crown, based on existing capital charge regulations (currently under review by Crown agencies).

Increasing demand costs: Demand patterns have also changed. In line with other international recovery profiles, the post-disaster impacts on the health and well-being of our population are being acutely felt. This is particularly evident in the increased demand for mental health services with new presentations to children's mental health services especially high.

Post-earthquake population increases, changes in demand, and workforce shortages also mean that even after the DHB's new Outpatient and Acute Services facilities come online, capacity will continue to be stretched. Further solutions will need to be found to meet growing demand and further investment in facilities, technology and workforce will be needed.

In addition to the unique earthquake-related aspects the Canterbury Health Systems will also need to response to the yet emergent impacts of the March 2019 terrorist event.

Multi Employment Collective Agreement (MECA) settlement costs: While DHB received partial funding to offset some of the cost, the MECAs settled in the past year significantly exceeded the affordability parameters of the DHB. The flow on impact of these settlements, along with the substantial claims of unsettled expired MECAs and expectations of staff on Individual Employment Agreement, will put immense pressure on the DHB's financial sustainability.

Moving forward: There is no easy solution, and improving the health of our population is the only way to reduce the demand curve. These savings will be made, not in dollar terms, but in costs avoided through earlier intervention and more effective use of available resources. While these gains may be slow, this is the basis on which we will build a more effective and sustainable health system. The DHB is committed to continuing its deliberate strategy in this regard.

The DHB is also working with the Ministry of Health and other key government agencies to establish a stable and sustainable pathway forward, which considers our unique operating challenges. In doing so we are committed to continuing to review services and service models to ensure we are using our resources in the most effective and efficient way. Anticipated service changes for the coming year are highlighted earlier in this Plan.

Planned results

It is anticipated that the Canterbury DHB will receive $1.945 billion of total revenue, from all sources, with which to meet the needs of our population and the significant cost increases of Multi Employment Collective Agreements and other pay settlements reached in (and impacting on) 2019/20.

The Canterbury DHB is forecasting a $180.4 million deficit result for the 2019/20 year.

The forecasted deficit takes into account Canterbury's allocated share of population based funding (demographic and cost pressures). It also assumes that the $5.5 million annual funding provided to cover increased demand for mental health services following the earthquakes (due to expire in 2018/19, but extended through 2019/20) will be 'rolled-over' indefinitely until an alternative funding mechanism for these increased costs is addressed by the Crown. The forecast excludes any cost associated with the flow-on impact of the Holidays Act liability, which is being actively assessed by the DHB sector.

OUT-YEARS' SCENARIO

The post-earthquake reality in Canterbury will continue to create a high level of uncertainty with regards to both revenue and expenditure in out-years.

Our remaining unspent earthquake insurance proceeds are held by the Crown on behalf of the DHB. We are able to draw down these proceeds as revenue to offset earthquake-related operating repair costs and as equity to offset capitalised repair costs. However, equity drawdowns incur a capital charge in addition to the operational impact of depreciation.

Interest, depreciation and capital charge costs arising from earthquake repairs, new facilities and assets revaluation will have a significant impact on our out-year financials. These costs will increase significantly on completion of the Hagley Building on the Christchurch Hospital campus (2019/20) and the mental health services facilities at Hillmorton for services to relocate from The Princess Margaret Hospital (2022/23).

The combined annual depreciation, overdraft interest and capital charge will increase from $79 million in 2018/19 to approximately $152 million by 2022/23.

The interplay between the nature of earthquake repairs, new building codes and construction cost escalations continues to be dynamic. Anticipated repair costs have been included but an accurate total overall cost is still difficult to pre-determine.

Also, due to the recognition of insurance proceeds in 2012/13 (as required under current NZ accounting standards and resulting in an 'atypical' surplus of $287M in 2012/13), some future costs are not able to be offset with the corresponding inflow of insurance proceeds. This creates a timing mismatch in current and out-years.

Major assumptions

Revenue and expenditure estimates for out-years have been based on current government policy, service delivery models and demand patterns. Changes in the complex mix of any of the contributing factors will impact on our results. In preparing our financial forecasts, we have made the following assumptions:

- The DHB will retain early payment arrangements.
- Out-years funding is assumed at the Treasury's mid-scenario forecasts for Canterbury DHB.
- Operating deficits will be fully funded as equity. The DHB has retained this assumption despite recent experiences where the deficit funded has been significantly less than the deficit incurred.
- Capital charge for out-years is based on the current rate of 6%. Any rate change in the future is assumed to be financially neutral.
- The cost differential between interest and capital charge associated with the debt/equity swap of pre-approved debt for the Hagley Building and Outpatient facility is fully funded.
- Any targeted funding to meet additional mental health service provision will be sustainable over the longer-term.
- The $5.5 million annual funding provided by the Ministry of Health in 2016, to cover increased demand for mental health services following the earthquakes, (due to expire in 2018/19, but extended through 2019/20) will continue indefinitely, and the Ministry will actively work with Canterbury DHB to ensure adequate funding to meet Mental Health service pressures.
- Costs of compliance with any new national expectations will be cost neutral or fully funded, as will any legislative changes, sector reorganisation or service devolvement.
- Assumption of responsibility for the population of the Chatham Islands will be cost neutral to the Canterbury DHB. The DHB is yet to clarify the funding stream to enable remediation of local facilities inherited in 2015.
- Funding for pay equity settlements will be cost-neutral and fully funded.
- $113 million (being the forecast, as at June 2019, of undrawn portion of Canterbury's $320 million earthquake settlement proceeds transferred to the Crown to minimise capital charge expenses), will be available to the DHB to fund the earthquake repair and reinstatement programme as required.
- As agreed with the Ministry of Health, the revenue and equity timing of the earthquake insurance draw down will be flexible and based on DHB requests rather than necessarily matching the earthquake capital and operating repair spend for a particular year.

- Capital charge associated with earthquake settlement proceeds redrawn as equity will be reviewed alongside the wider Crown proposal to modify the existing capital charge regulations.
- Additional saving targets requiring service changes and/or Ministerial consent are approved in a timely manner.
- Work will continue on the redevelopment of Canterbury facilities in accordance with the detailed business case agreed with the Ministry and previous Cabinet. Associated capital expenditure and resulting capital charge that will take place during the term of this Plan have been included, where appropriate.
- Revaluations of land and buildings will continue, and will impact on asset values. In addition to regular periodic revaluations, further impairment in relation to earthquakes may be necessary.
- Employee cost increases for expired wage agreements, including minimum wage flow-on impact if any, will be settled on fiscally sustainable terms, inclusive of step increases and the impact of accumulated leave revaluation. External provider increases will also be settled within available funding levels.
- Treatment related costs will increase in line with known inflation factors and foreseen adjustments for the impact of growth within services.
- National and regional savings initiatives and benefits will be achieved as planned.
- Transformation strategies will not be delayed or derailed due to sector or legislative changes and investment to meet increased earthquake-related demand will be prioritised and approved, in line with the Board's strategy.
- There will be no further disruptions associated with natural disasters or pandemics. Revenue and expenditure have been budgeted on current and expected operations with no further disruptions. Noting that the impacts of New Zealand's recent terrorist induced mass casualty incident are as yet unquantified.

Bridging the gap

While health continues to receive a large share of government funding, if we are to be sustainable, we must rethink how we will meet our population's need within a more moderate growth platform.

Since establishing our vision in 2006, we have been purposeful and deliberate in planning how we would meet growing demand for health services and make the best use of the resources we have available.

In the past eight years, our ability to absorb revenue and cost impacts related to the earthquakes has largely been delivered by slowing our growth rate of acute demand, reducing our dependence on aged residential care, reorganising laboratory services, and removing waste and duplication from our system.

Alongside the effective transformation of our health system, we are also focused on delivering efficiency and quality improvements to take the wait and waste out of our system. In the coming year, we will consider all options and opportunities to bridge the gap between revenue and expenditure including:

- Integrating systems, services and processes to remove variation, duplication and waste.
- Empowering clinical decision-making to reduce delays and improve the quality of care.
- Improving production planning to ensure we use our resources in the most effective way.
- Focusing expenditure on areas that are essential, and reducing the outsourcing of services.
- Prioritising investment into services that meet the most immediate demand, deliver maximum health benefits and are sustainable longer-term.
- Aligning policies and practice with other DHBs and with national service specifications to reduce treatment and service costs.
- Acknowledging fiscal constraints and limitations when considering the implementation of new technologies, initiatives or services.
- Reviewing service capacity and costs across heavily subsidised service areas and exploring alternative options for service delivery.
- Restraining cost growth including moderating treatment, back office, support, and FTE costs.
- Supporting the South Island Alliance to implement tighter cost controls and make purchasing improvements to limit the rate of cost growth by taking a lead in the regional Procurement and Supply Chain Workstream.

Anticipated service changes for 2019/20 are outlined in the DHB's Annual Plan.

Capital investment

NATIONAL BUSINESS CASES

The detailed business case for the redevelopment of the Christchurch Hospital site was approved in March 2013. Construction of both the Outpatients and Hagley Buildings have been significantly delayed. Whilst the Outpatients Building is now operational (November 2018), the Hagley Building is not scheduled for completion until the second half of 2019.

The detailed business case for replacement of our patient administration systems with one South Island Patient Information Care System was approved in 2014. Burwood was the first go-live site and Ashburton and Christchurch Hospital went live in 2018/19.

The detailed business case for the relocation of mental health services from The Princess Margaret Hospital, was approved in December 2018. This project is expected to be completed by 2023. A further business case will need to be developed for the relocation of Child and Family outpatient services, which were excluded in the approved business case.

A detailed business case for the future of the Christchurch Hospital Campus is being progressed alongside a re-purposed programme business case, incorporating key facility redevelopments to address the future service needs including but not limited to: inpatient; ambulatory; food services; laboratory; and oncology services. The critical projects and facilities concerned are an integral part of the blueprint for the ongoing development of the campus, as foreshadowed in the approved 2013 detailed business case outlined above. The plan addresses immediate needs as well as providing the foundation for the longer development solution for the campus to meet service and capacity demands.

The DHB has also completed an initial strategic assessment in regards to investment in a facility for Canterbury's tertiary laboratory and pathology services. This was submitted to the Ministry of Health for consideration and will be considered alongside the programme business case outlined above.

CAPITAL EXPENDITURE

Subject to the appropriate approvals, Canterbury's capital expenditure budget for 2019/20 totals $584 million, and is comprised of:

- $519 million for the Hagley Building (including CDHB funded scope)
- $7 million progress spend for the approved business case to relocate inpatient mental health services from The Princess Margaret Hospital
- $14 million for the capital expenditure portion of the strategic earthquake programme of works (excluding EQ works related spend on CDHB funded scope for Hagley accounted for above).
- $3 million in progress payments for the South Island Patient Information Care System and Electronic Medications (EMEDS) system.
- $5 million for Hillmorton AT&R and PSAID (Psychiatric Services for Adults with an Intellectual Disability) facility upgrade.
- $36 million for other baseline new/replacement assets and systems.

(Note: Circa $503 million relating to the Hagley Building is Crown equity funded which will be transacted as non-cash transfer).

Anticipated investment for out-years includes:

- Strategic Information Technology developments towards a digital hospital including: further implementation of the Patient Information Care System, Electronic Medication Management, HealthOne and investment in the patient portal.
- Repair and reinstatement of the Christchurch Hospital Energy Centre and Carpark.
- Completion of the Akaroa IFHC redevelopments in line with approvals.
- Continued repair and reinstatement of assets under the DHB's earthquake repair programme.
- Relocation of Child and Family mental health outpatient services currently located on The Princess Margaret Hospital site.
- Repurposing of the Canterbury Health Laboratories building per outcome of future detailed planning.
- Further Christchurch Hospital Campus redevelopment, incorporating the future of services currently located in earthquake damaged and/or below building code facilities (Riverside, Parkside and Food Services buildings) and other key facilities such as the Oncology building.

Out-years capital planning will also consider the future use of existing buildings and facilities, in line with our earthquake repair programme, and in response to population growth and service demand. This will include buildings on the Christchurch Hospital and Hillmorton Hospital campuses.

Any lengthy construction delays, changes in building codes or cost price increases for major redevelopment or repair projects are likely to have a significant impact on planned expenditure.

Debt and equity

In February 2017, all DHB Crown debts were converted to equity as part of the debt/equity translation process. Effective from 2016/17, DHBs have no Crown debt. The pre-approved debt for the new Hagley Building will also be translated to equity, with appropriate funding to offset the additional cost arising from the difference between interest and capital charge rates.

The Canterbury DHB repaid equity to the Crown of $180 million as part of our contribution towards the Burwood and Christchurch Hospital redevelopments.

The extent of damage to Canterbury DHB's insured facilities and equipment is well in excess of $518 million. However, the collective sector insurance in place at the time of the earthquake meant we were only able to access a total maximum loss capacity of $320 million. The gap between the insurance settlement and the total cost of the repairs will need to be met from our existing funds.

In June 2014, we paid $290 million (being the unspent portion of the $320 million as at June 2014) of our earthquake settlement insurance proceeds to the Crown to minimise capital charge expenses (arising from an abnormal surplus through recognising the settlement proceeds as income under current NZ

accounting standards). As agreed with the Ministry of Health, the $290 million is being progressively drawn down to fund the ongoing earthquake repair work.

The forecast amount drawn down as at 30 June 2019, is $177 million (a mix of revenue and equity) leaving a balance of $113 million yet to be drawn. This is now unlikely to be sufficient in light of unplanned costs coming out of this settlement related to the redevelopment of the Hagley Building and completion of the Boiler House and Energy Centre.

Taking into account projected equity movements over the next four years, the Crown's equity in the DHB will rise from $663 million as at June 2019 to $1.298 billion by June 2023. The higher equity balance will result in a significant increase in the capital charge payable to the Crown.

Additional considerations

DISPOSAL OF LAND

Under the NZ Public Health and Disability Act, no DHB may dispose of land without approval of the Minister of Health. Ministerial approval will only be given where the DHB has complied with its statutory clearance and public consultation obligations under the Act.

Anticipated activity for 2019/20 includes the potential disposal of a parcel of land on St Asaph Street and two parcels of land on Tuam Street within the Health Precinct as part of a land swap with the Crown (acting by and through Land Information New Zealand).

We are yet to determine the future of the former Christchurch Women's Hospital site in the central city and the Princess Margaret Hospital site in Cashmere. Over the coming year we will also consider the future use of all of our rural hospitals.

ACTIVITIES FOR WHICH COMPENSATION IS SOUGHT

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

ACQUISITION OF SHARES

Before the Canterbury DHB or any of our associates or subsidiaries can 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.

ACCOUNTING POLICIES

The accounting policies adopted are consistent with those in the prior year. For a full statement of accounting policies, refer to the DHB's Statement of Intent for 2019-2013, available on the DHB's website.

Group Statement of Financial Performance (Comprehensive Income)

	2017/18 Actual $'000	2018/19 Forecast $'000	2019/20 Plan $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000
REVENUE						
Ministry of Health revenue (Note 1)	1,647,882	1,744,116	1,841,187	1,916,465	2,003,288	2,086,198
Other government revenue	36,948	36,987	38,778	39,996	41,596	43,260
Earthquake repair revenue redrawn	3,240	4,460	10,800	14,700	10,000	2,200
Other revenue	48,031	52,665	54,945	58,934	63,032	67,033
Total Revenue	**1,736,101**	**1,838,228**	**1,945,710**	**2,030,095**	**2,117,916**	**2,198,691**
EXPENSE						
Personnel	755,125	829,945	895,964	945,495	994,158	1,038,865
Outsourced (Note 2)	28,801	31,127	29,193	28,325	27,753	27,188
Clinical supplies	144,638	134,853	159,795	174,358	182,813	190,451
Earthquake building repair costs	3,240	4,460	10,800	14,700	10,000	2,200
Infrastructure & non clinical (excl Earthquake repairs)	99,891	115,131	119,360	125,552	127,386	129,932
Payments to non-CDHB providers	679,357	756,453	773,439	762,475	784,943	799,504
Total Expense Before Depreciation & Capital Charge	**1,711,052**	**1,871,969**	**1,988,551**	**2,050,905**	**2,127,053**	**2,188,140**
Surplus/(Deficit) Before Depreciation & Capital Charge	**25,049**	**(33,741)**	**(42,841)**	**(20,810)**	**(9,137)**	**10,551**
Depreciation and amortisation	58,655	54,085	83,165	83,066	73,465	74,779
Capital charge and interest expense	30,353	24,753	54,464	69,518	72,672	77,458
Total Depreciation, Capital Charge & Interest Expense	**89,008**	**78,838**	**137,629**	**152,584**	**146,137**	**152,237**
Surplus/(Deficit)	**(63,959)**	**(112,579)**	**(180,470)**	**(173,394)**	**(155,274)**	**(141,686)**
OTHER COMPREHENSIVE REVENUE & EXPENSE						
Revaluation of property, plant & equipment	-	137,346	-	-	-	-
Total Comprehensive Income/(Deficit)	**(63,959)**	**24,767**	**(180,470)**	**(173,394)**	**(155,274)**	**(141,686)**

Note 1: Includes Inter District Flow and Inter-DHB revenue

Note 2: Excludes outsourced electives payments to Non-CDHB Providers

Group Statement of Financial Position

	30/06/18 Actual $'000	30/06/19 Forecast $'000	30/06/20 Plan $'000	30/06/21 Plan $'000	30/06/22 Plan $'000	30/06/23 Plan $'000
CROWN EQUITY						
Contributed capital	132,470	274,070	924,852	1,134,575	1,384,850	1,560,536
Revaluation reserve	289,058	426,404	426,403	426,403	426,403	426,403
Accumulated surpluses	74,743	(37,836)	(218,306)	(391,700)	(546,974)	(688,660)
Total Equity	**496,271**	**662,638**	**1,132,949**	**1,169,278**	**1,264,279**	**1,298,279**
REPRESENTED BY:						
CURRENT ASSETS						
Cash & cash equivalents	1,678	4,824	627	627	36,494	11,012
Trade & other receivables	90,396	96,846	96,848	96,848	96,848	96,848
Inventories	11,170	13,209	13,208	13,208	13,208	13,208
Restricted assets	14,577	14,685	14,685	14,685	14,685	14,685
Investments	750	750	750	750	750	750
Total Current Assets	118,571	130,314	126,118	126,118	161,985	136,503
CURRENT LIABILITIES						
NZHPL sweep bank account	17,376	36,574	63,024	17,486	-	-
Trade & other payables	111,190	123,995	123,995	123,995	123,995	123,995
Employee benefits	171,363	180,342	180,342	180,342	180,342	180,342
Restricted funds	14,593	14,701	14,701	14,701	14,701	14,701
Total Current Liabilities	314,522	355,612	382,062	336,524	319,038	319,038
Net Working Capital	(195,951)	(225,298)	(255,944)	(210,406)	(157,053)	(182,535)
NON CURRENT ASSETS						
Property, plant, & equipment	670,749	860,003	1,358,112	1,348,775	1,392,096	1,453,676
Intangible assets	27,634	33,818	36,667	36,795	35,122	33,024
Restricted assets	16	16	16	16	16	16
Total Non-Current Assets	698,399	893,837	1,394,795	1,385,586	1,427,234	1,486,716
NON CURRENT LIABILITIES						
Employee benefits	6,177	5,901	5,902	5,902	5,902	5,902
Total Non-Current Liabilities	6,177	5,901	5,902	5,902	5,902	5,902
Net Assets	**496,271**	**662,638**	**1,132,949**	**1,169,278**	**1,264,279**	**1,298,279**

Group Statement of Movements in Equity

	2017/18 Actual $'000	2018/19 Forecast $'000	2019/20 Plan $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000
Total equity at beginning of the year	517,833	496,271	662,638	1,132,949	1,169,278	1,264,279
Total comprehensive revenue and expense for the year	(63,959)	24,767	(180,470)	(173,394)	(155,274)	(141,686)
OTHER MOVEMENTS						
EQUITY REPAYMENTS						
Annual depreciation funding repayment	(1,861)	(1,861)	(1,861)	(1,861)	(1,861)	(1,861)
EQUITY INJECTIONS						
Earthquake repair capital redrawn	9,258	54,650	29,000	5,000	47,692	-
Kaikoura facility contribution	2,000	-	-	-	-	-
Operating deficit support (Note 3)	35,000	81,611	112,579	180,470	173,394	155,274
Approved Mental Health Relocation DBC (Note 4)	-	-	7,503	26,114	31,050	14,333
Approved Facilities Redevelopment DBC (Note 5)	-	-	-	-	-	7,940
New facilities redevelopment assets transferred from the Crown - original equity value (Note 6)	(232,985)	7,200	278,960	-	-	-
Debt to Equity swap - new facilities (Note 6)	85,000	-	224,600	-	-	-
Debt to equity swap - debt balance as at June 2016	145,985	-	-	-	-	-
Total Equity at End of the Year	**496,271**	**662,638**	**1,132,949**	**1,169,278**	**1,264,279**	**1,298,279**

Note 3: Assume operating deficit support is fully funded and received in the following year.

Note 4: Figures reflect indicative progressive draw down of equity.

Note 5: Relates to balance of 2012/13 approved Facilities Redevelopment DBC funding (for Parkside). The $7.9M represents the original approved amount for Parkside of $21M less $13.06M transferred to Hagley building per 21 February Minister of Health letter advice.

Note 6: 2019/20 amount is indicative only and subject to the final cost and agreed debt vs equity split of the Christchurch Hospital Hagley Building asset to be transferred from the Ministry of Health.

Group Statement of Cash Flow

	2017/18 Actual $'000	2018/19 Forecast $'000	2019/20 Plan $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000
CASH FLOW FROM OPERATING ACTIVITIES						
Cash provided from:						
Receipts from Ministry of Health	1,642,515	1,741,256	1,841,187	1,916,465	2,003,288	2,086,198
Earthquake repair revenue redrawn	3,240	4,460	10,800	14,700	10,000	2,200
Other receipts	67,993	90,239	92,814	97,830	103,411	108,965
Interest received	1,552	626	909	1,100	1,217	1,328
	1,715,300	1,836,581	1,945,710	2,030,095	2,117,916	2,198,691
Cash applied to:						
Payments to employees	760,305	822,566	895,964	945,495	994,158	1,038,865
Payments to suppliers	932,270	1,054,224	1,092,587	1,105,410	1,132,895	1,149,275
Capital charge and interest paid	30,352	211	54,464	69,518	72,672	77,458
GST - net	(1,338)	12,144	-	-	-	-
	1,721,589	1,889,145	2,043,015	2,120,423	2,199,725	2,265,598
Net Cash Flow from Operating Activities	**(6,289)**	**(52,564)**	**(97,305)**	**(90,328)**	**(81,809)**	**(66,907)**
CASH FLOW FROM INVESTING ACTIVITIES						
Cash provided from:						
Sale of property, plant, & equipment	460	123	-	-	-	-
Receipt from investments and restricted assets	43,758	-	-	-	-	-
	44,218	123	-	-	-	-
Cash applied to:						
Purchase of investments & restricted assets	43,158	1,087	-	-	-	-
Purchase of property, plant, & equipment	38,346	43,378	80,563	73,857	115,113	134,261
	81,504	44,465	80,563	73,857	115,113	134,261
Net Cash Flow from Investing Activities	**(37,286)**	**(44,342)**	**(80,563)**	**(73,857)**	**(115,113)**	**(134,261)**
CASH FLOW FROM FINANCING ACTIVITIES						
Cash provided from:						
Equity Injections						
Earthquake repair capital redrawn	9,258	1,104	29,000	5,000	47,692	-
Approved Mental Health Relocation DBC	-	-	7,503	26,114	31,050	14,333
Approved Facilities Redevelopment DBC (Note 7)	-	-	-	-	-	7,940
Operating deficit support	35,000	81,611	112,579	180,470	173,394	155,274
	44,258	82,715	149,082	211,584	252,136	177,547
Cash applied to:						
Annual depreciation funding repayment	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 Cash Flow from Financing Activities	**42,397**	**80,854**	**147,221**	**209,723**	**250,275**	**175,686**
NET CASHFLOW						
Net increase/(decrease) in cash and cash equivalents	(1,178)	(16,052)	(30,647)	45,538	53,353	(25,482)
Cash and cash equivalents at beginning of year	(14,520)	(15,698)	(31,750)	(62,397)	(16,859)	36,494
Cash and cash equivalents at end of year	**(15,698)**	**(31,750)**	**(62,397)**	**(16,859)**	**36,494**	**11,012**

Note 7: Relates to balance of 2012/13 approved Facilities Redevelopment DBC funding (for Parkside). The $7.9M represents the original approved amount for Parkside of $21M less $13.06M transferred to Hagley building per 21 February Minister of Health letter advice. Assume as 'cash' transaction for transparency purpose only, until further advice is received.

Summary of revenue and expenses by arm

	2017/18 Actual $'000	2018/19 Forecast $'000	2019/20 Plan $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000
Funding Arm						
REVENUE						
Ministry of Health revenue	1,581,224	1,670,002	1,764,225	1,836,622	1,920,569	2,000,607
Other government revenue	2,713	2,916	2,269	2,050	2,132	2,218
Other revenue	927	1,250	1,452	1,452	1,452	1,452
Total Revenue	**1,584,864**	**1,674,168**	**1,767,946**	**1,840,124**	**1,924,153**	**2,004,277**
EXPENSE						
Personal Health	1,159,426	1,250,093	1,348,842	1,398,540	1,454,499	1,500,049
Mental Health	163,044	167,916	174,444	182,518	190,112	198,059
Disability Support	282,149	297,587	308,895	321,653	332,543	343,286
Public Health	4,438	4,469	4,417	3,796	3,913	4,027
Maori Health	1,856	1,958	2,111	2,126	2,190	2,252
Total Expense Before Depreciation & Capital Charge	**1,610,913**	**1,722,023**	**1,838,709**	**1,908,633**	**1,983,257**	**2,047,673**
Surplus/(Deficit) Before Depreciation & Capital Charge	**(26,049)**	**(47,855)**	**(70,763)**	**(68,509)**	**(59,104)**	**(43,396)**
Depreciation and amortisation	-	-	-	-	-	-
Capital charge and interest expense	-	-	-	-	-	-
Total Depreciation, Capital Charge & Interest Expense	**-**	**-**	**-**	**-**	**-**	**-**
Surplus/(Deficit)	**(26,049)**	**(47,855)**	**(70,763)**	**(68,509)**	**(59,104)**	**(43,396)**
Other comprehensive revenue and expense	-	-	-	-	-	-
Total Comprehensive Income/(Deficit)	**(26,049)**	**(47,855)**	**(70,763)**	**(68,509)**	**(59,104)**	**(43,396)**
Governance & Funder Admin						
REVENUE						
Ministry of Health revenue	3,992	4,139	4,061	4,267	4,460	4,663
Other government revenue	-	-	-	-	-	-
Other revenue	10	167	10	10	10	10
Total Revenue	**4,002**	**4,306**	**4,071**	**4,277**	**4,470**	**4,673**
EXPENSE						
Personnel	9,129	9,895	10,382	10,640	10,904	11,174
Outsourced	1,442	1,458	1,486	1,402	1,374	1,347
Clinical supplies	206	208	212	216	220	224
Earthquake Building Repair Costs	-	-	-	-	-	-
Infrastructure & non clinical (excl Earthquake repairs)	(5,754)	(8,602)	(8,369)	(8,341)	(8,388)	(8,432)
Payments to Non-DHB Providers	-	-	-	-	-	-
Total Expense Before Depreciation & Capital Charge	**5,023**	**2,959**	**3,711**	**3,917**	**4,110**	**4,313**
Surplus/(Deficit) Before Depreciation & Capital Charge	**(1,021)**	**1,347**	**360**	**360**	**360**	**360**
Depreciation and amortisation	362	292	360	360	360	360
Capital charge and interest expense	-	-	-	-	-	-
Total Depreciation, Capital Charge & Interest Expense	**362**	**292**	**360**	**360**	**360**	**360**
Surplus/(Deficit)	**(1,383)**	**1,055**	**-**	**-**	**-**	**-**
Other comprehensive revenue and expense	-	-	-	-	-	-
Total Comprehensive Income/(Deficit)	**(1,383)**	**1,055**	**-**	**-**	**-**	**-**

Summary of revenue and expenses by arm—continued

	2017/18 Actual $'000	2018/19 Forecast $'000	2019/20 Plan $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000
Provider Arm						
REVENUE						
Ministry of Health revenue	994,222	1,035,545	1,138,171	1,221,734	1,276,573	1,329,097
Other government revenue	34,235	34,071	36,509	37,946	39,464	41,042
Earthquake repair revenue redrawn	3,240	4,460	10,800	14,700	10,000	2,200
Other revenue	47,094	51,248	53,483	57,472	61,570	65,571
Total Revenue	**1,078,791**	**1,125,324**	**1,238,963**	**1,331,852**	**1,387,607**	**1,437,910**
EXPENSE						
Personnel	745,996	820,050	885,582	934,855	983,254	1,027,691
Outsourced	27,359	29,669	27,707	26,923	26,379	25,841
Clinical supplies	144,432	134,645	159,583	174,142	182,593	190,227
Earthquake building repair costs	3,240	4,460	10,800	14,700	10,000	2,200
Infrastructure & non clinical (excl Earthquake repairs)	105,645	123,733	127,729	133,893	135,774	138,364
Total Expense Before Depreciation & Capital Charge	**1,026,672**	**1,112,557**	**1,211,401**	**1,284,513**	**1,338,000**	**1,384,323**
Surplus/(Deficit) Before Depreciation & Capital Charge	**52,119**	**12,767**	**27,562**	**47,339**	**49,607**	**53,587**
Depreciation and amortisation	58,293	53,793	82,805	82,706	73,105	74,419
Capital charge and interest expense	30,353	24,753	54,464	69,518	72,672	77,458
Total Depreciation, Capital Charge & Interest Expense	**88,646**	**78,546**	**137,269**	**152,224**	**145,777**	**151,877**
Surplus/(Deficit)	**(36,527)**	**(65,779)**	**(109,707)**	**(104,885)**	**(96,170)**	**(98,290)**
OTHER COMPREHENSIVE REVENUE & EXPENSE						
Revaluation of property, plant & equipment	-	137,346	-	-	-	-
Total Comprehensive Income/(Deficit)	**(36,527)**	**71,567**	**(109,707)**	**(104,885)**	**(96,170)**	**(98,290)**
In House Elimination						
REVENUE						
Ministry of Health revenue	(931,556)	(965,570)	(1,065,270)	(1,146,158)	(1,198,314)	(1,248,169)
Total Revenue	**(931,556)**	**(965,570)**	**(1,065,270)**	**(1,146,158)**	**(1,198,314)**	**(1,248,169)**
EXPENSE						
Payments to internal providers	(931,556)	(965,570)	(1,065,270)	(1,146,158)	(1,198,314)	(1,248,169)
Total Expense	**(931,556)**	**(965,570)**	**(1,065,270)**	**(1,146,158)**	**(1,198,314)**	**(1,248,169)**
Surplus/(Deficit)	-	-		-	-	-
Other comprehensive revenue and expense	-	-	-	-	-	-
Total Comprehensive Income/(Deficit)	-	-	-	-	-	-

Summary of revenue and expenses by arm—continued

CONSOLIDATED	2017/18 Actual $'000	2018/19 Forecast $'000	2019/20 Plan $'000	2020/21 Plan $'000	2021/22 Plan $'000	2022/23 Plan $'000
REVENUE						
Ministry of Health revenue	1,647,882	1,744,116	1,841,187	1,916,465	2,003,288	2,086,198
Other government revenue	36,948	36,987	38,778	39,996	41,596	43,260
Earthquake repair revenue redrawn	3,240	4,460	10,800	14,700	10,000	2,200
Other revenue	48,031	52,665	54,945	58,934	63,032	67,033
Total Revenue	**1,736,101**	**1,838,228**	**1,945,710**	**2,030,095**	**2,117,916**	**2,198,691**
EXPENSE						
Personnel	755,125	829,945	895,964	945,495	994,158	1,038,865
Outsourced	28,801	31,127	29,193	28,325	27,753	27,188
Clinical supplies	144,638	134,853	159,795	174,358	182,813	190,451
Earthquake building repair costs	3,240	4,460	10,800	14,700	10,000	2,200
Infrastructure & non clinical (excl Earthquake repairs)	99,891	115,131	119,360	125,552	127,386	129,932
Payments to non-DHB providers	679,357	756,453	773,439	762,475	784,943	799,504
Total Expense Before Depreciation & Capital Charge	**1,711,052**	**1,871,969**	**1,988,551**	**2,050,905**	**2,127,053**	**2,188,140**
Surplus/(Deficit) Before Depreciation & Capital Charge	**25,049**	**(33,741)**	**(42,841)**	**(20,810)**	**(9,137)**	**10,551**
Depreciation and amortisation	58,655	54,085	83,165	83,066	73,465	74,779
Capital charge and interest expense	30,353	24,753	54,464	69,518	72,672	77,458
Total Depreciation, Capital Charge & Interest Expense	**89,008**	**78,838**	**137,629**	**152,584**	**146,137**	**152,237**
Surplus/(Deficit)	**(63,959)**	**(112,579)**	**(180,470)**	**(173,394)**	**(155,274)**	**(141,686)**
OTHER COMPREHENSIVE REVENUE & EXPENSE						
Revaluation of property, plant & equipment	-	137,346	-	-	-	-
Total Comprehensive Income/(Deficit)	**(63,959)**	**24,767**	**(180,470)**	**(173,394)**	**(155,274)**	**(141,686)**

Appendix 6 System Level Measures Improvement Plan

Available on the DHB's website www.cdhb.health.nz.

Appendix 7 Public Health Action Plan

Available on the DHB's website www.cdhb.health.nz.

ANNUAL PLAN

Produced September 2019
Issued under Section 39 of the New Zealand Health and Disability Act 2000
Pursuant to Section 149 of the Crown Entities Act 2004

Canterbury District Health Board
PO Box 1600, Christchurch
www.cdhb.health.nz

ISSN: 2230-4223 (Print)
ISSN: 2230-4231 (Online)