CANTERBURY DISTRICT HEALTH BOARD

district annual plan

"A Year of Action – for a Sustainable Future"

2010-2011

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

DISTRICT ANNUAL PLAN
1 July 2010 – 30 June 2011

Produced in 2010 by the
Canterbury District Health Board
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www.cdhb.govt.nz

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Table of Contents

Message from the Chairman and Chief Executive

We are pleased to present our Annual Plan for the 2010/11 financial year. This document reflects our continued commitment to improving the health and wellbeing of the Canterbury population in line with the strategic priorities set in our District Strategic Plan. It also reflects our commitment to clinical leadership and to working collaboratively as 'one health system', with the patient at the centre.

Population growth, the increasing burden of long-term conditions, the current fiscal environment and the ageing of our population are placing significant pressure on our capacity to deliver services. With the growing demand for more complex health services and the corresponding ageing of our health workforce, there are major risks around the future viability of a range of services, particularly more specialised services and those used predominately by our older population groups.

If we make no change to the way we fund or deliver services, population growth and demand projections indicate that by 2020 - just to stand still - Canterbury will need an additional hospital the size of Christchurch Hospital, 2,000 additional rest home beds and a 20% increase in the number of Canterbury GPs.

Knowing these challenges lie ahead, we have embarked on a collaborative journey with clinical leaders, stakeholders and consumers from across the system and agreed on a 'whole of system' approach to a sustainable future. Acting on our collaborative vision, we are transforming the way we work; developing alternative models of care, reconfiguring traditional models and redesigning patient pathways. Through this transformation, we are building the capacity required to meet the future needs of our community and improve health outcomes for our population. We have achieved a number of significant successes over the past year, which are highlighted throughout this document. These initial successes are only the beginning of a much longer journey. Over the coming year we will build on this momentum to redefine the way we deliver services to our community.

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

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

To further support our transformation of service models and patient pathways we have begun a major facilities redesign; embracing the opportunity to combine capital investment and effective service planning to significantly improve the performance of our health system. The key focus of this redesign will be the co-location of inter-related services to improve patient flow and the quality of care, take advantage of service delivery efficiencies and make better use of our valuable workforce.

This facilities redesign will sit alongside national momentum for change in primary care service delivery models and the implementation of the Government's '*Better, Sooner, More Convenient Health Care*' direction. In response to the Minister of Health's request, the Canterbury Clinical Network, supported by the DHB, has submitted a business case for the transformation of health services in Canterbury. We recognise that this is not just about primary care, but is part of the whole direction for Canterbury, and supporting the implementation of the business case will be a major priority for us in 2010/11.

We recognise the need to work closely with our regional DHB partners to address the challenges facing the health sector. We are formalising our long-standing clinical partnership arrangements with the West Coast DHB, along with joint CEO arrangements, clinical appointments, service development and service planning and shared back-office services. This closer collaboration will provide greater certainty in terms of both the planning and delivery of health services for the population of both DHBs, as well as supporting the development of a more appropriate workforce in both locations. Over the coming year, we will also make some key decisions around how we organise services across the whole of the South Island in order to ensure our wider population has access to sustainable services in the future.

The following document provides an overview of the busy life and exciting developments for the coming year. Compared to the activity of all the people working day and night for our patients and community, this is a small snapshot. The Plan is focused on the delivery of significant projects and transformation, in line with the priorities established in our District Strategic Plan and the expectations of the Minister of Health and our community.

As we move forward with the transformation of our health system, we expect to engage with our stakeholders, clinical partners and workforce and to consult our community on significant changes to service delivery models, land disposals and on the future direction of health services in Canterbury through the review of our District Strategic Plan.

We believe that the Canterbury health system has the foundations for a sustainable future, and while things are good, we want to keep making them better. We are proud of the partnerships we have established and the improvements we have achieved for our community over the past year. Thank you to all those people who have worked alongside us to make success possible. We look forward to another year of achievement to further improve the delivery of health and disability services to our community.

Signatories

Alister James Chairman CDHB	David Meates Chief Executive CDHB	Honourable Tony Ryall Minister of Health

Alister James (Chairman) at the opening of the Kaiapoi Dental Clinic, one of a network of new clinics that will improve the oral health of children and young people across both Canterbury and South Canterbury.

David Meates (CEO) receives Canterbury DHB's Certificate of Accreditation from Peter Rose, Chief Executive, Quality Health New Zealand.

David Meates helps lay the concrete for the bunker housing our new Linear Accelerator which will reduce radiation treatment wait times across the South Island.

Approval of the Minister of Health

Office of Hon Tony Ryall

Minister of Health
Minister of State Services

21 SEP 2010

Mr Alister James
Chair
Canterbury District Health Board
PO Box 1600
CHRISTCHURCH 8140

Dear Mr James

Canterbury District Health Board: 2010/11 District Annual Plan

This letter advises you that I have signed Canterbury District Health Board's (DHB) 2010/11 District Annual Plan (DAP) for three years and that the Board has my full support for implementing this plan.

Clinical and Financial Sustainability
I appreciate the efforts your Board and management have put in over the past year to manage your DHB in a sustainable manner. More work lies ahead to achieve long lasting sustainability, while ensuring that New Zealanders get an improved delivery of services. The challenge for us all is to achieve this.

All DHBs must budget within their allocations and improve financial performance. I note your planned financial position which incorporates cost avoidance in 2010/11. This covers areas such as Inter-District Flow revenue, procurement and results of a single system approach to delivering healthcare within available funding. The DHB's actions to achieve this and control costs will be important in the current fiscal environment in 2010/11 and the out years. I expect the DHB to provide the NHB with greater details of this plan by 30 September 2010.

My approval of your DAP does not mean acceptance of your assumptions in the out years.

Health Targets
The Ministry of Health has advised that it considers there are heightened risks associated with your achievement of the agreed health targets for Shorter Stays in Emergency Departments (ED)s, Improved access to Elective Surgery and Shorter Waits for Cancer Treatment. I require your DHB to focus on the achievement of the four week wait target for Cancer treatment, including the use of private capacity where appropriate. I expect that your DHB remains committed to improving performance in this and other health target areas, and that it will work closely with the Ministry of Health, and in particular, the Health Target Champions, to ensure good progress is made.

Between 2008/09 and 2010/11, ED attendances increased by 22.5 percent. In the 2010/11 DAP I note that the DHB intends to maintain ED attendances near its 2009/10 levels. I expect primary care to have a role in managing ED attendances. Please keep the Ministry of Health updated on the DHB's plan to manage its ED attendances levels.

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand. Telephone 64 4 817 6804 Facsimile 64 4 817 6504

Mental Health Ring-Fence
While I am not viewing your mental health ring-fence spending as an impediment to the overall approval of your DAP, I expect the DHB to work with the Ministry during 2010/11 to ensure my expectations regarding the mental health ring-fence are met. This includes ensuring that funding not allocated in accordance with ring-fence expectations is tagged for mental health and addiction services, to be allocated in out years.

This should include your DHB working with the Ministry's Mental Health Group to determine the appropriate level of service delivery for the DHB's population; and in 2011/12 and out years, allocating sufficient funding to support this. The NHB will ensure that this work is undertaken as it forms part of my agreement to your 2010/11 DAP.

As part of this discussion, it will be important to establish whether any proposed changes to mental health service models, including integrating primary and secondary mental health services, should be considered under the service change protocols outlined in the 2010/11 Operational Policy Framework (OPF).

Policy Priorities
New Zealanders want better access to a wider range of services closer to home. I expect your DHB to make substantial progress with integrating hospital services into community settings in 2010/11. The DHB and the wider Canterbury Clinical Network have made a strong start to this work through the Better Sooner More Convenient business case. The DHB will need to keep the Ministry of Health well informed of its progress in this priority area.

I note that your Board has significant plans for closer working with West Coast DHB which is commendable. I also expect greater levels of collaboration and evidence of effective decision making across the South Island DHBs, focused on planning for vulnerable services and a shared approach to future capital planning. As the major tertiary centre, I expect your DHB to provide stronger leadership in regional planning. I would like to know by the end of July 2010 details of how your DHB intends to work with, and provide stronger leadership for, regional collaboration with the South Island DHBs.

DAP Approval
The approval of your DAP does not constitute approval of proposals for service changes or service reconfigurations. You will need to comply with the requirements of the Operational Policy Framework and advise the Ministry of Health where any proposals may require my approval.

My approval of your DAP does not mean approval for any capital projects requiring equity or new lending, or self-funded projects that require the support of the Capital Investment Committee. Approval of such projects is dependant on both completion of a sound business case, and evidence of good asset management and health service planning by your DHB. Approval for equity or new lending is also managed through the annual capital allocation round.

I wish you, your Board and management every success with the implementation of your 2010/11 DAP, and thank you for your contribution and efforts towards a unified health system.

Finally, please ensure that a copy of this letter is attached to the copy of your signed DAP held by the Board and to all copies of the DAP made available to the public.

Yours sincerely

Hon Tony Ryall
Minister of Health

1 Introducing the Canterbury DHB

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

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

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

As the Canterbury DHB we:

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

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

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

1.1 Organisational Structure

"Members of the public are welcome to attend, and observe, any Board or Statutory Committee meeting where decisions will be made. Meeting notices can be found on the DHB's website www.cdhb.govt.nz."

ALISTER JAMES
Chairman, Canterbury DHB

We have an established governance and organisational structure, based on the requirements of the NZPHD Act, through which the DHB functions (Appendix 1 provides an organisational chart of the Canterbury DHB).

Governance and Corporate Division - the Management of the DHB

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

relationships with the Minister of Health, Parliament and the Canterbury community. Seven Board members are elected by the Canterbury community and four are appointed by the Minister of Health. There are currently two Māori members on the Board and three practicing clinical members.

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

- *The Hospital Advisory Committee* - monitors the financial and operational performance of our hospital and specialist services, assessing strategic issues relating to those services and providing advice to the Board.
- *The Community and Public Health Advisory Committee* and *the Disability Support Advisory Committee* (delivered through the same body of membership) - provide the Board with advice on the health and disability needs of our population, assess how the services we fund or provide and the policies we adopt will impact on our population and promote the inclusion, participation and independence of people with disabilities.
- *The Quality, Finance, Audit and Risk Committee* - enhances the Board's governance function by monitoring and providing advice on the financial operation of the DHB and monitoring quality and clinical risk issues.
- *The Remunerations and Appointments Committee* - manages the employment of the Chief Executive and other specific industrial and employment matters.
- *The Facilities Development Project Committee* - monitors and reviews the overall planning, progress and direction of the Canterbury DHB Facilities Development Programme.

While responsibility for the DHB's overall performance rests with the Board, it has a delegation policy assigning operational and management matters to the Chief Executive. The Chief Executive is supported by an Executive Management Team, which includes General Managers of Planning and Funding, Community and Public Health, Finance, Communications, Human Resources and Corporate Services, along with the Executive Director of Māori and Pacific Health, the Chief Medical Officer, the Director of Allied Health and the Executive Director of Nursing, who provide cultural and clinical leadership, input into Board and Committee decision making and oversight of patient safety and quality.

Planning and Funding Health and Disability Services

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

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

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

Providing Health and Disability Services

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

[1] *There are 5 clinical members on the Hospital Advisory Committee and 4 on the Community and Public Health and Disability Advisory Committee.*

provided through our Hospital and Specialist Services Division, which consists of six service divisions: Medical and Surgical Services, Mental Health Services, Rural Health Services, Women's and Children's Services, Older Persons' Health and Rehabilitation Services, and Hospital Support and Laboratory Services (Appendix 2 provides an overview of the hospital and specialist services provided by the Canterbury DHB.)

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

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

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

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

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

Promoting Community Health and Wellbeing

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

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

"Empowering our population to make healthy lifestyle changes relies heavily on a comprehensive cross-sector approach and a true partnership, not just with other community organisations, but with the community itself."

EVON CURRIE
GM Community and Public Health

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

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

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

1.2 Shared Decision Making Approach

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

Clinical Governance

A commitment to quality and patient safety places responsibility on the DHB to have effective mechanisms in place for planning, monitoring and managing the quality of clinical care provided. Our Clinical Board is a multidisciplinary clinical forum, whose membership includes representatives from the primary, secondary and community sectors. There are 26 members on the Clinical Board, 17 of whom are elected, and the Board is chaired by the DHB's Chief Medical Officer.

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

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

Māori Participation in Decision Making

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

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

"Participation in planning health services should be a partnership between the DHB and consumers at all levels. We are expecting the Consumer Council to take an active role in influencing policy to better reflect consumer needs."

DAVID MEATES
Chief Executive, Canterbury DHB

Consumer and Community Input

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

Our Consumer Council provides input into decision making as a permanent advisory group for the Chief Executive and supports a partnership model that provides a strong and viable voice for the community and consumers in health service planning and service delivery.

The Council consists of 15 representatives nominated by consumers and consumer lobby and advocacy groups and covers 10 key areas: family health, older persons' health, disabilities, Māori health, Pacific health, long-term conditions, mental health, rural communities, primary health care and refugees. Networks support each representative in their role and facilitate wider communication across the Canterbury community.

1.3 Clear Prioritisation and Decision Making Principles

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

The prioritisation principles that guide our decision making are:

- *Effectiveness:* Services should be effective, producing more of the outcomes desired, such as a reduction in pain, maintenance of daily activity, greater independence and the prevention of premature death.
- *Equity:* Services should reduce significant inequalities in the health and independence of our population.

- *Value for Money:* Our population should receive the greatest possible value (in terms of effectiveness and equity) from public spending on health and disability services.
- *Whānau Ora:* Services should have a positive impact on the holistic health and wellbeing of the person and their family and whānau. This has particular significance for Māori, but relevance for all cultures.
- *Acceptability:* Services should be consistent with community values. Consideration will be given as to whether consumers or the community have had involvement in the development of the service.
- *Ability to implement:* Our ability to implement the service is carefully considered, including the impact on the whole system, workforce considerations and any risk and change management requirements.

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

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

1.4 Unleashing Our Health System

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

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

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

At a Board level, we have focused on allocating resources to the right activity for our populations (*buying the right things*) and releasing our clinical workforce to take a lead in establishing the best way of delivering services (*doing things the right way*). The consequence of our transformational focus has been a significant increase in productivity, as evidenced by our reductions in waiting times, increases in direct care time on wards, increases in virtual activity (such as First Specialist Assessment), increased access to services across the community (such as spirometry, sleep assessments, skin lesion removals, specialist advice and diagnostics without the need for a hospital appointment) and $35 million worth of costs avoided through our whole of system approach to delivering more within the same resources.

In the coming year we will develop new approaches that better support our partnerships and treat the Canterbury health system as a whole. At the core of the new approach is a decision making process where the Government/DHB retains the right to define *what is to be funded* and the *outcomes* that need to be achieved with public funds; but as many decisions as possible are moved into the hands of clinicians or providers by devolving the determination of *how* the required outcomes should be achieved. Clinicians and providers in the front line of health care provision are in the best position to improve technical efficiency (*doing things the right way for the patient*) and thereby releasing resources to increase overall capacity across the system.

This decision making approach will involve less detailed specification and more of a reliance on transparency of information, quality processes and agreed outcomes to ensure accountability and best value for investment. It aims to align the interests of all parties to facilitate the delivery of the best possible services for the population and supports the opportunity to jointly decide where resources released due to improved efficiency could best be invested. This new approach allows efficiencies from partnerships to be realised and will inform the contractual relationship between the DHB and relevant provider organisations.

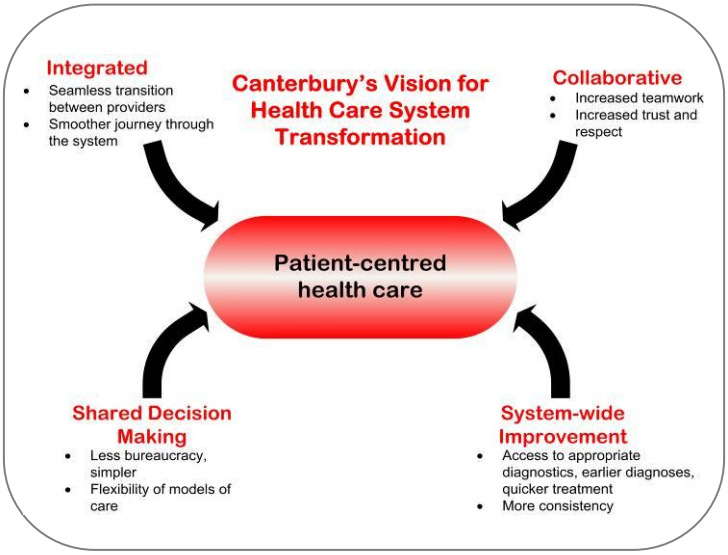


Figure 1: Canterbury's Vision for Health Care System Transformation

1.5 Achieving Service Coverage and National Consistency

We recognise the need for national consistency across services, and in all of our work we comply with key Government policies, including the National Service Framework and Service Coverage Schedule, which set out expectations around minimum service delivery requirements for our population.

While we expect to meet the national service coverage requirements for our population in the coming year, there are a number of services which are considered to be 'vulnerable', where challenges such as workforce shortages, private profit margins or quality and patient safety issues may put service delivery at risk. These services include but are not limited to: paediatric diabetes, paediatric oncology, dermatology, community services for older people, neurosurgery and maternity services (particularly in rural areas).

There are also a number of areas where our transformation work is providing a clearer picture of future need and the growing demand for services and where IDFs are increasing as other DHBs refer their more complex patients to Canterbury, such as cancer services, respiratory services and mental health services.

All six South Island DHBs collaborate to support services that are identified as being potentially at risk of service failure, whether short to medium term or through an unexpected event. Mitigation strategies for those services seen as most vulnerable will be further progressed as part of the development of the South Island Regional Clinical Services Plan which will be completed in June 2010. We also expect there will also be some adjustment with the establishment of the National Health Board and National Shared Services Agency and through our closer collaboration with the West Coast DHB.

2 Our Environment - Identifying the Challenges

2.1 Major Drivers: Demographics, Mortality and Risk Factors

2.1.1 Demographics

The Canterbury region is home to 510,915 people, representing 12% of the population of New Zealand and making Canterbury the second largest DHB in terms of population. The need for change is starkly apparent in the future demographic projections for the Canterbury population and the resulting impact of these demographic changes if we do not alter our current approach to health service delivery.[3]

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

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

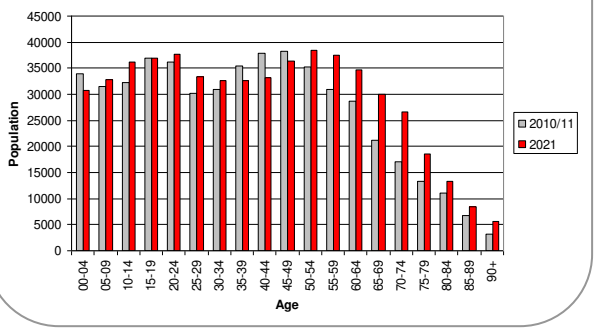
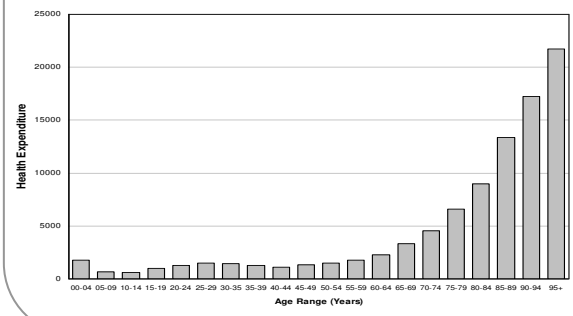


FIG 3: POPULATION HEALTH EXPENDITURE*
MEAN ANNUAL PER CAPITA HEALTH SPEND 2001



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

Age is a strong indicator of the need for health services. As we age, we often have more complicated health needs and co-morbidities (multiple health conditions) than people in younger age groups and therefore consume more health resources. This is influenced by growing trends in a number of long-term conditions that become more common with age including: heart disease, stroke, cancers, respiratory disease and dementia. Health expenditure increases from an annual mean per person of $674 for the 5-9 age group, to $977 for 15-19 year olds, $1,292 for 35-39 year olds, $3,321 for those 65-69, $8,981 for 80-84 year olds and $21,738 for those aged 95+.[4] This is particularly relevant in Canterbury where the demand

[3] *Data in this section based on 2001 Census and actual population projections from the 2006 Census information from Statistics NZ.*
[4] ** Figures from 2001 year - Population Ageing and Health Expenditure: New Zealand 2002-2051. Wellington: Ministry of Health 2004.*

for services used predominately by our older population groups is growing at an even faster rate than the growth in our population and in rural areas where our populations are older.

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

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

2.1.2 Key Health Trends - Mortality and Morbidity

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

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

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

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

2.1.3 Health Behaviours and Risk Factors

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

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

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

When it comes to alcohol, our population is as likely as other New Zealanders to drink in a hazardous manner (21% of both populations). However, this corresponds to over 103,000 people in Canterbury, constituting a major public health concern. Hazardous drinking has a wide range of adverse effects on health, including cirrhosis of the liver, pancreatitis,

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[5] *The data in this section is from Mortality Demographic Data 2006 NZ Health Information Service, 2009.*
[6] *The exception is neoplasms (cancers) in the 5-14 age range, where Canterbury rate is slightly higher than the national average.*
[7] *Obesity in New Zealand: How obesity is measured, Ministry of Health, 2009.*
[8] *Obesity: Genetic, molecular and environmental aspects, Barness LA, Opitz JM, Gilbert-Barness E – A J of Med, Genet Part A 143A:3016-3034.*

high blood pressure, haemorrhagic stroke, and a range of cancers. It also contributes to death and injury on the roads, suicide, assaults and domestic violence and some mental health disorders and sexual health problems. If consumed in a hazardous manner during pregnancy, alcohol can also lead to birth defects in infants, including foetal alcohol syndrome.

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

2.2 Operating Pressures

2.2.1 Demand Growth

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

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

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

Volume Growth of Key Canterbury DHB Services – at all Canterbury DHB sites [10]

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

Because acute services often take priority and use the same resources as elective (planned) services, any increase in acute demand puts at risk our ability to deliver elective services to our population. We delivered 1,740 additional elective services discharges in 2008/09, increasing from 11,500 in 2007/08 to 13,240. Nine months in to 2009/10, we have delivered 11,282 - well on track to deliver 14,369 discharges, a 1,129 increase on last year.[11] Our ability to continue to

[9] *Public Health Information Online, www.phionline.moh.govt.nz.*
[10] *Source: CDHB Measures Cube February 2010 – including SAP data, therefore all CDHB activity including ACC, SMH and OPH.*
[11] *These elective surgical discharges are aligned to the national health target definition and exclude elective cardiology and dental procedures.*

increase our electives delivery is of particular relevance, as we need to achieve compliance with national electives indicators and the national health target to maintain access to a number of significant funding streams that enable us to direct funding into other priority areas.

Demand for Primary and Community Services

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

Demand pressure is also evident in the aged residential care sector. Compared to other DHBs, we already have the fifth highest utilisation of aged residential care services and a higher than national average utilisation of home-based support services (age-standardised per capita). In 2008/09, 8% of people over 65 received a residential care subsidy in Canterbury (for rest home, long-stay hospital or dementia care). If we don't change current admission practices, future forecasts indicate that we will need to fund and staff an additional 2,000 residential care beds in Canterbury by 2021.[12]

FIG 4: CANTERBURY DHB HEALTH SERVICES PLAN
MAJOR DIAGNOSTIC DISCHARGES (2006 VS 2021)

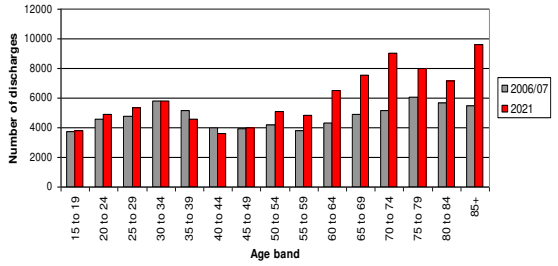
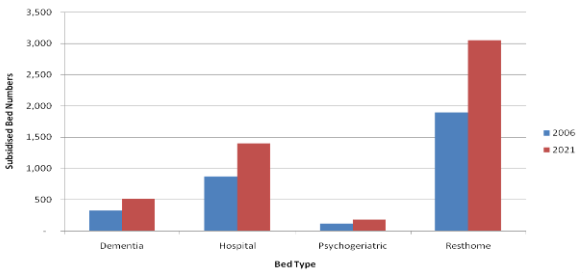


FIG 5: CANTERBURY DHB HEALTH SERVICES PLAN
PROJECTED SUBSIDISED RESIDENTIAL CARE BEDS



Demand for Regional Services

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

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

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

2.2.2 Workforce Pressures

Our ability to meet demand for services is also heavily reliant on having the right people, with the right skills, in the right place. As the greater proportion of our population reaches traditional retirement age, it presents us with concerns over the availability of sufficient workforce capacity to continue to meet predicted increases in demand for services. The impact of demographic changes is more significant in rural areas, where isolation makes recruitment more difficult and where the average age of our workforce is higher. Workforce pressures will have the greatest effect on our current clinical working models, as clinical staff make up 80% of our total workforce.

This is a significant issue for the whole of the health sector. National and international competition for scarce workforce resources in some clinical specialties and nursing areas, coupled with a decreasing working age population, makes it

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

increasingly difficult to recruit and retain health professionals. To address this, we are taking a strategic approach to planning and sourcing workforce across the whole of our health system.

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

Workforce pressures pose a relatively greater challenge to smaller primary and community health service providers. We must also consider the workforce pressures on smaller DHBs in the South Island, particularly in terms of the viability of specialist or 'vulnerable' services in neighbouring regions. As the largest provider in the South Island, we acknowledge our critical role as a regional provider and our need to work collectively to respond to these workforce pressures.

2.2.3 Fiscal Pressures

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

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

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

If an increasing share of our funding continues to be directed into meeting volume and cost growth, we will create a deficit position. Not only will our ability to maintain current service delivery to our population be at risk, but also our ability to invest in capital, new initiatives and transformation of our services to meet future demand.

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

2.3 Regional Collaboration - Provision of Services for the South Island

The South Island DHBs collectively serve a population of over 1,039,400 and collaborate to improve service delivery, the patient experience and the health of the wider South Island population.[14] It is clear to us all that continuing to provide and fund services as we do will not be clinically or financially sustainable. Alongside demographic and demand changes, health sector costs have risen, and continue to rise, much faster than funding growth. In order to deliver Government priorities while living within budget, and to reduce and control costs while ensuring that patient care is not compromised, the South Island DHB CEOs and Chairs approved a framework to support the delivery of clinically and fiscally sustainable health services into the future.

[13] *Local DHB figures come from our Workforce Profile Report, as at 31 March 2008, with national figures from the DHBNZ Future Workforce Health Workforce Information Base Data Report as at June 2008.*
[14] *2010/11 projected population from the 2006 Census, Statistics NZ.*

In considering the future, there were a number of concepts that needed to be agreed to enable individual DHBs and providers to plan and move forward while the formal South Island Health Services Planning was completed. The collectively approved framework provides direction for the type and level of services required to best meet the needs of the South Island population; while allowing discussion and debate about how services can be configured and organised.

The acknowledged concepts around which our collective health service planning is based include:

- Health professionals will need to work differently, in different settings, across different sectors to coordinate patient care and ensure smooth transition for patients to appropriate levels of care;
- Secondary and tertiary services need to be provided across a number of DHBs in a linear structure based on professional teams and collegial networks across DHB boundaries to provide services to local, sub-regional and regional populations;
- More health care will be provided at home and in the community for long term conditions and rehabilitation. A highly developed primary care sector is fundamental to meeting the future demands on health services;
- Clinical networks will provide a more formal forum for clinical leadership and a partnership between management and clinicians across the service continuum to support delivery of a quality health service;
- Traditional facilities aligned with the levels of service delivered will continue to blur as services are delivered in a variety of places, including the home. Models of care, clinical networks and new technologies will need to change to support service delivery in different environments to those traditionally recognised; and
- The current configuration of facilities across the South Island will need to evolve. Traditional DHB boundaries and patient flows will need to be challenged to ensure services across the South Island are supported in a sustainable manner. The structure of facilities across the South Island is likely to be a mix of Integrated Family Health Centres, Community Hospitals, Secondary Hospitals and Tertiary Centres.

The goal is to have a collective regionally coordinated system of health service planning and service delivery that will deliver lasting improvements in the sustainability, quality and accessibility of clinical services. Our agreed framework supports this by establishing agreed terms of reference that focus on decision making for the good of the South Island population as a whole and an agreed process for collective decisions making, which includes clearly defined principles, together with an escalation pathway where consensus cannot be reached. The South Island DHBs' agreed principles are: Equity of Access, Māori Health Service Needs, Clinical Engagement, Patient-Centred Consumer Involvement, Community Acceptance, Quality and Safety, Continuum of Care, Fiscal Sustainability and Clinical Sustainability.

Much of the work already undertaken regionally focused on greater sharing and optimal use of resources and the introduction of more flexible approaches. Other work has been around planning and aligning resources to meet the future needs of the wider South Island population.

A number of formal clinical networks operate in the South Island and help to drive regional planning and ensure the future sustainability of services. These include the Southern Cancer Network, South Island Regional Mental Health Network and the Regional Health of Older Persons Network. In addition, there are a number of service-related project groups established under the South Island Health Services Planning group to support regional delivery of services. These groups include neurosurgery, child health and ophthalmology, as well as the surgical service clusters that are forming as part of the Elective Services Initiative.

Through our joint South Island Shared Services Agency and with the support of our clinical networks, the South Island DHBs have used the framework and agreed principles to established clear agreed actions for collaboration and delivery over the coming year around elective services, mental health services, older persons' health services, cancer services and public health services. These agreed actions are outlined in Appendix 3 and throughout the relevant sections of this document.

We have also commenced a wider collaborative planning process around elective services. We will deliver a Regional Electives Production Plan (August 2010) which over the next three years will:

- Improve equity and access to surgical services that contribute to improved health outcomes for our populations;
- Ensure we have the capacity to deliver the required levels of service to meet Government expectations;
- Ensure southern region DHBs provide efficient and effective delivery of services; and
- Monitor and evaluate the delivery of elective services and establish mechanisms to manage variance in performance.

This will coincide with the delivery of our Regional Clinical Service Plan (September 2010) covering:

- A 10-year focus within a 20-year horizon;
- The regional and sub-regional work and activity undertaken in 2009/10;
- The gaps and potential future collaborative work streams and activity to meet these;

- Services related to capital investment proposals that are expected in the next three years; and
- Configuration changes that will contribute to financial viability.

Collectively, we will continue to support services that are identified as being potentially at risk of service failure, whether short to medium term or through an unexpected event. Mitigation strategies for those services seen as most vulnerable will also be further developed as part of our South Island Regional Clinical Services Plan.

As the major tertiary provider for the South Island, Canterbury has a lead role to play in supporting the sustainable delivery of services for the future, and we are committed to participating in this regional health services planning. Alongside this work, we will also continue to take a lead in identifying efficiencies within the system and reducing duplication and waste. A number of positive successes have been achieved over the past year which we will build on in the coming year:

- Using teleconference technology, we support peer review and education forums to enable clinical support and shared learning between DHBs without the costs normally associated with conference attendance, or the wait times previously associated with providing specialist advice.
- Providing centralised laboratory systems for all of the South Island and the lower half of the North Island, we remove the need to replicate capability and infrastructure funding across multiple DHBs. In terms of laboratory services, this also improves turnaround times, reduces variation and improves testing quality.
- Implementing joint arrangements focused on the provision of common 'back office' services, we reduce duplication and costs. This includes our West Coast/Canterbury HR team with centralised recruitment, payroll, administration and health and safety services. We also operate a financial management information system in partnership with the Bay of Plenty and Waikato DHBs.

2.4 Key Risks

We will meet and address ongoing challenges as we balance our population's growing need and demand for services against increasing treatment-related costs and the need to support clinical quality. Alongside the identified pressures above, the most immediate risks are:

High Level Identified Risks	Mitigation Strategies
The Needs of Our Ageing Population Growing demand for ARC and Home Based Support (HBS) services is already outstripping the growth in funding. Workforce is also an issue with the average age of the workforce higher and a reliance on part-time, locum and agency staff placing pressure on quality, continuums of care and patient safety.	Locally – Continued work with ARC and HBS service providers to find effective solutions and support quality improvements. Regionally - Work with other DHBs to address wider aspects of demand related to our ageing populations and the cost of ARC services.
Growing Demand for Acute Services Acute discharges have increased 17% over the past five years; a faster rate of increase than the growth in our population and in our funding. Even if funding, bed space and resources were not limited, we could not find the workforce required to cope if acute demand continues to increase at current rates.	Locally – A 'whole of system' approach to reducing and managing acute demand: working with primary and secondary services on supporting people to stay well, better manage their long-term conditions and seek appropriate intervention early, reducing presentations to ED; improving the flow of patients through the hospital system; and better supporting hospital discharges back into the community.
Sustained Capacity to Deliver Elective Services In 2008/09 we delivered 1,740 additional elective surgical services to our population, and we will deliver a further 1,129 increase this year.[15] We need to continue this positive momentum to keep pace with the demand driven by population growth, demographic changes and long-term conditions and to ensure service access levels for our population are equitable to those of those of other DHBs.	Locally - Emphasis on internal production planning, reducing duplication and waste in our system and enhancing public/private partnerships to increase elective surgical volumes for our population. Continued development of clinically led primary/secondary patient pathways to improve our capacity to deliver the right services to the right people. Regionally - Formal partnership with the West Coast DHB to better plan the assistance we provide, help to build a more

[15] *Elective Surgical Discharges are based on the national health target definition, which excludes cardiology and dental discharges.*

	appropriate workforce in both locations and improve continuums of care for the benefit of both populations. Progress of the Regional Clinical Services Plan to improve South Island planning and better support 'vulnerable' services.
Managing the Costs of Wages and Salaries Wage and salary settlement costs are a significant national challenge. A number of wage negotiations will be completed in the next year, and the flow-on effect of DHB agreements into the primary and community sector is also a risk in terms of price increase expectations and the longer-term sustainability of smaller providers faced with similar wage expectations.	Locally - Working smarter and supporting clinical governance and clinical leadership models to drive technical efficiencies and release clinical staff to provide more direct patient care. Nationally – Supporting a strategic approach to remuneration, working collectively on sector-wide negotiations with different workforce groups and maintaining close communication with sector and clinical leaders.
Continuing Momentum for Efficiencies and Change We have been successful in realising significant efficiencies as we implement new models of care across the system. However, ongoing management of resources and a continuing passion for improving outcomes is essential to ensure that we keep delivering services effectively and efficiently. Objectives cannot be achieved unless there are continuing improvements in organisational culture, behaviour and capability.	Locally - Clinical/management partnerships, clinical leadership and ongoing staff training and engagement in the future vision. Continued use of lean thinking principles for process improvements, embedding this way of working in internal training programmes and project methodologies, including the Improving the Patient Journey Programme and Xcelr8 and Partici8 programmes.[16]
Recognising Transformation 'Wins' As we reorient the system so that our secondary services deal with more complex cases, the average length of hospital stay will increase and more of the less complex procedures and assessments will be done in primary care. A risk exists around the 'counting' of these procedures and an external perception that less secondary care activity means a reduction in productivity. An associated risk is that clinical staff will become disengaged from leading and supporting the changes required to ensure our longer-term sustainability.	Locally - Demonstrating productivity and delivery across the whole of the Canterbury health system, rather than just at a hospital level, to support engagement with transformation and better recognise success. Nationally - Working with the Ministry to establish performance indicators that provide positive incentives for change and recognise the different approaches of DHBs.
Maintaining Patient Safety and Clinical Quality Patient safety is a significant issue for all modern health services. Adverse events occur at an unacceptable level which, as well as causing avoidable harm to patients, drives unnecessary costs.	Locally - Genuine commitment to patient safety improvement through our Clinical Board, strengthening clinical governance and leadership to ensure a safe patient journey through the health system and a philosophy of Zero Harm.[17] Nationally - Active participation in Quality Improvement Committee programmes including Optimising the Patient Journey, the Incident Management Project, Infection Prevention and Control and Safe Medicines Management, as well as participation in the Health Round Table.
Treatment-Related and New Technology Cost Pressures As activity increases, so does the consumption of treatment related items such as implants, instruments, blood products, patient food and referred services (pharmaceuticals, laboratory services and diagnostic services); significant pressure is placed on the DHB to meet these costs. Population growth and the changing demographics of our population influence this expenditure, as does new technology and changing expectations around clinical practice. An increased national focus on population screening for diseases like HIV, diabetes and CVD risk assessment is a more recent,	Locally - Work in partnership with clinicians, providers and referrers to develop new agreements for services, better manage the growth in demand for services and align clinical and financial accountability through a range of shared decision making mechanisms and processes. Continue to implement purchasing initiatives to better manage costs. Regionally - Support clinical leadership around the introduction of new technologies, prioritisation of capital expenditure and investment and the evaluation of national programmes and initiatives that come with additional treatment related cost.

[16] The Improving the Patient Journey Programme and the Xcelr8 and Patic8 programmes have been established by the DHB to encourage participants to positively influence the effectiveness and efficiency of the organisation and to improve patient outcomes.

[17] Zero Harm, while ambitious, is a vision that requires a well planned methodological approach to system and culture change and strong clinical leaderships that does not accept a culture where 'incidents happen'.

but significant, driver of costs.	Nationally - Support the National Shared Services Agency's purchasing and procurement activity to help maximise cost benefits and enable more favourable supply contracts.
Sector Reorganisation The establishment of the National Health Board and Shared Services Agency is likely to influence the way we work in the future. Decisions about central versus regional funding may affect certain areas, such as public health and disability support services for people under 65. Formal decisions are also likely to be made on a number of services considered vulnerable, due to the highly complex nature of the service and the shortage of resources available, such as paediatric oncology or neurosurgical services. There are both risks and opportunities with a national approach.	Regionally - Establish formal arrangements with regional DHB partners to ensure sustainable service provision and continue to support Clinical Networks, particularly around highly specialised services and when considering arrangements between South Island DHBs. Nationally - Support the involvement of clinical leaders in national discussions around service arrangements and work closely with the National Health Board, Shared Services Agency and the Ministry around any devolution of services.
Integration of Primary and Secondary Services In line with our vision and with Government expectations, we are investing in the development of primary/secondary patient pathways and closer integration of services. There are a number of barriers to successful and sustainable integration, such as the sharing of patient information which is currently fenced and sits with various providers rather than the patient. This and similar provider segregation and contractual barriers make shared clinical decision making difficult and increase bureaucracy, paper-loads and time delays for patients.	Locally – Continue to support clinical leaders to develop multidisciplinary primary/secondary pathways focused on the patient and not the provider. Develop a shared Electronic Referral Management System as a base for primary/secondary activity to improve clinical decision making and better identify unmet need. Engage clinical professional and provider groups in a new shared decision making approach to prioritisation and service management decisions to support shared accountability in a complex environment.

3 Our Strategic Vision - Meeting the Challenges

3.1 Developing the Vision

Knowing from future population projections that our health system faces an unsustainable reality, we are making significant changes to the way we fund, provide and deliver health services to our population. We are taking a collaborative approach to the planning of future health services and have collectively developed a Health Services Plan for the Canterbury region. This Plan includes key directions and principles that will to be used to inform our service development activity and our physical infrastructure needs for the next twenty years. Critically, these principles are enabling us to inform substantial capital works, including the redevelopment of our hospital facilities, without losing focus on the equally important development of primary and community services.

"The vison of the Canterbury Health System puts the patient at the centre so the right patient receives the right care and support at the right time and from the right people."

DAVID MEATES
CHIEF EXECUTIVE

Our health services planning process involved extensive participatory engagement with over 1,000 key stakeholders, consumers and clinical staff from across our health system. With overwhelming consensus we began to enhance integration across the whole of the health system; reorienting the system around the needs of the person, rather than the needs of the provider.

With strong clinical leadership and through our *Improving the Patient Journey* and *Canterbury Initiative* Programmes, we have already developed more innovative models of care, reconfigured traditional service delivery models and redesigned patient pathways. This work has improved access to services and is supporting people to better manage their long-term conditions while at the same time allowing us to focus on service efficiencies; significantly reducing delays in the patient journey, improving the utilisation of our valuable clinical workforce and removing duplication, variation and waste from our system.

In moving forward we are actively engaging and collaborating with our workforce and the whole of the Canterbury health system in the reorientation of the system around the needs of the patient, and breaking down traditional boundaries to achieve the best possible health outcomes. Our central concept is to develop a holistic system of health, within which there is a flow of seamless care for an individual, rather than a series of episodic events.

We are showcasing our vision to inspire participants with the transformation work that is being achieved, in order to support continued momentum in improving the delivery of health services in Canterbury. This work is also supporting the review of our District Strategic Plan and setting of the strategic direction for Canterbury DHB for the next 10 years.

Figure 6: Canterbury's Vision – One Health System (adapted from The King's Fund UK: www.kingsfund.org.uk)

3.2 Service Planning Principles - Sustainable Transformation

The reorientation of our health system around the patient and their journey is having major implications on service design, professional roles, technology, information management and infrastructure design.

We are implementing three key service shifts in line with our future direction:

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

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

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

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

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

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

3.3 Our Population Model of Care

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

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

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

Because the model is based on the patient journey, it is inherently more robust and sustainable longer-term. It is not reliant on any particular provider or organisation, but is centred on the patient's needs and what works for them and supports the right people receiving the right treatment, at the right time, from the right provider and in the right setting.

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

- What do we need to do to keep people well in the community?
- What do we need to do to ensure early detection and early intervention?

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

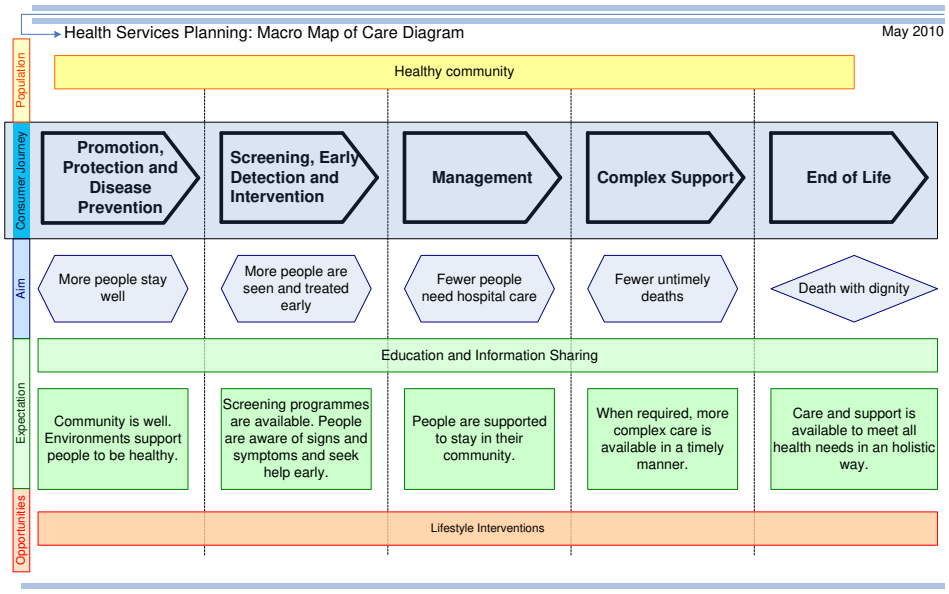


Figure 7. Canterbury DHB Population Model of Care

3.4 Partnerships - Working as One Health System

The degree of change inherent within our new direction is significant. While health service planning implicitly requires a degree of planned change, there is also a desire to allow change to emerge based on the energy and innovation of those providing services and the needs of our patients and consumers.

We recognise that we cannot achieve this kind of transformational change across the whole of the system on our own. Our relationships with the organisations we fund are more than contractual relationships; they are partnerships based on a shared vision and transparent, open processes. The involvement of consumers, clinical staff and operational teams across community, primary and secondary settings is critical to ensure the change we are making is sustainable. This active involvement is facilitated through our model of shared management and clinical leadership at all levels throughout the Canterbury health system and is supported by our sector-wide engagement and partnerships.

Cross sector clinical partnerships have already demonstrated their value with new service models for elective and acute management and the development of over 160 successful patient-focused pathways designed and agreed upon by clinical groups across the sector. This collaboration has allowed us to share resources, combine effort and reduce duplication, variation and waste across the Canterbury system. Our collaborative system-wide response to the H1N1 pandemic was an outstanding example of what can be achieved by combining resources and putting the patient first. We were the only DHB to implement Community Based Assessment Centres where, on average, primary and secondary health staff collaborated to assess 117 people and answer 831 Flu Line calls every day. The clinically led Canterbury H1N1 Pandemic response was rated as excellent by the Ministry of Health.

We will further enhance our partnerships over the coming year to continue to improve the patient journey through our health system and ensure a seamless transition between primary and secondary services. Consistent with this approach, we will introduce a new outcomes-based approach to decision making, support the implementation of the *Better, Sooner, More Convenient* Business Case and establish formal clinical and operational agreements with our regional DHB partners

The Canterbury Initiative – Primary/Secondary Care Partnerships

As part of our focus on the whole of the health system, our secondary care teams are working closely with primary care teams and General Practitioners (GPs) through the unique setup of the *Canterbury Initiative*, which is driving the development of new patient pathways that support integrated service delivery. Pathway development brings together a range of clinical representatives from general practice, hospital specialities and the community and removes traditional boundaries by ensuring consistent services are delivered in the most appropriate and convenient settings.

GPs and secondary care specialists are providing clinical leadership in the design and implementation of the new pathways and integrated models of care. The focus on shared care, structured around the patient and supported by evidence-based practice, is helping to minimise waits and unnecessary hospital visits. Supporting our hospital specialists to train and up-skill GPs to remove skin lesions (skin growths, including skin cancer) has enabled the removal of over 500 subsidised skin lesions in primary care in the past six months, which would have otherwise required a hospital referral. GPs can now also make referrals to their colleagues, rather than putting their patients on hospital waiting lists, and the service is on track to treat 2,300 patients in its first year.

The face of the Canterbury Initiative is presented online via a website www.healthpathways.org.nz that contains information and resources specifically developed to help general practice navigate the established patient pathways, including information on referrals, specialist advice, diagnostic tools, GP to GP referral and GP procedure subsidies.

The Canterbury Clinical Network – Whole of System Partnerships

More recently, we have supported the establishment of the *Canterbury Clinical Network* (CCN), an alliance of Canterbury's health professionals including GPs, secondary care specialists, practice nurses, community nurses, physiotherapists, community pharmacists, Māori and Pacific health providers, PHOs, Independent Practitioners' Associations (IPAs) and the DHB. The Network has been established with the explicit inclusion of the DHB (as the funder) as a key partner to enable a 'whole of system' approach to service performance and provides a genuine alliance between clinical leaders and management which will develop solutions and drive change and transformation in our health system over the next few years.

The CCN's current focus is the development and implementation of the *Better, Sooner, More Convenient* Business Case, which is being supported by the Canterbury DHB. Transparent two-way communication on issues such as the ethnical use of finite resources will be inherent in the way in which the CCN will operate, supported by an outcomes-based approach to joint decision making. The agreed implementation plan for the Business Case is outlined in section 5.2.

Canterbury and the West Coast DHB - Regional Partnerships

As part of our focus on integrated service delivery and a seamless transition between services for patients, our Board has a commitment to the development of formal clinical networks and to regional health services planning. Through this commitment, the collective South Island DHBs will implement solutions that will improve the patient experience and the health of our wider populations and reduce and control costs, while ensuring that patient care is not compromised.

In line with this commitment, and after a recent report into the future provision of health services by the West Coast DHB, Canterbury and the West Coast have mutually agreed to formalise long-standing clinical partnership arrangements and work together to plan sustainable and effective services for our regions.[18] This collaboration is a natural progression of the long-standing links that we have had with each other. However, formalising our partnership will allow us to more actively plan the assistance we provide, help to build a more appropriate workforce in both locations and improve patient safety; without having any detrimental affect on services provided to our own population.

As part of our active engagement, Canterbury will provide chief executive services to the West Coast for the next five years, and our CEO will lead both the Canterbury and West Coast management teams effective from 1 July 2010. Formalising our clinical arrangements will also mean future specialist clinical staff appointments, such as the recent appointment of a Director of Allied Health, will now be joint appointments between both DHBs.

This approach allows us to share 'back office' services, workforce resources, experience, knowledge and understanding without increasing wage and salary costs and will reduce duplication and waste between the two DHBs.

Human Resources and Payroll functions are amongst the functions where considerable progress has already been made, and this work is being undertaken with little additional resources. Both DHBs are also committed to working closely on the implementation of our *Better, Sooner, More Convenient* Business Cases, particular the rural health components, to ensure a consistency of approach across the wider region and alignment between our services.

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

The following table outlines the agreed timeframes for progression of our active partnership with the West Coast DHB.

Area of Activity	Action	Timeframe
Governance Arrangements	West Coast DHB Board to adopt Canterbury standing orders, committee structure and terms of reference to harmonise governance practice and reduce administration cost.	Effective March 2010
	CEO to assume joint responsibility for Canterbury and West Coast DHBs.	Effective 1 July 2010
	Formal integration of the Planning and Funding teams of both DHBs with focus on joint appointments, service planning and work plans, sharing data sets and introducing common process and tools.	Effective 1 July 2010
Clinical Partnership Arrangements *Including: joint appointments of clinical staff and clinically led work streams at speciality and service levels to develop models of care, standard protocols, patient pathways and shared education programmes.*	Agreement by both Boards to formalise clinical partnership arrangements and move to joint clinical governance framework.	Effective March 2010
	Joint Paediatrician SMO appointment to improve functional linkages between nursing and midwifery services on West Coast and neonatal and paediatric service in Canterbury.	Commenced Feb 2010
	Joint Director of Allied Health appointment to improve professional input, leadership and direction for both DHBs.	Commenced April 2010
	Obstetric and Gynaecology work stream to ensure 24/7 senior medical cover for West Coast women.	Commencing Dec 2009
	Urgent Care (ED) work stream established to improve functional linkages and support West Coast clinical teams.	Commencing July 2010
	Mental Health work stream focused on joint appointments, workforce planning, sharing data sets and common processes for serious incidents.	Commencing April 2010
	Canterbury Initiative work stream to support the development of clinically led patient pathways and HealthPathways site for West Coast.	Commenced May 2010
	Better, Sooner, More Convenient Business Case work stream focused on coherent strategy for rural services development including clinical and financial sustainability.	Effective Sept 2010
Back Office Service Arrangements	Occupational Health and Safety - single safety team with focus on standardising processes and systems for workplace safety.	Effective 1 July 2010
	Human Resources - single team with focus on standard processes, joint appointments and digital recruitment processes to reduce time and costs.	Commenced Sept 2009
	Payroll System - Alignment of systems and joint appointments.	Commenced Sept 2009 Effective April 2010.
	Finance Systems - Implementation of the Convergence Project R12 upgrade for the Oracle finance system to enable sharing of procurement policies, ordering of supplies and financial functions.	Commenced Feb 2010
	Information Systems – Investigate integration of laboratory information systems as a first step in a common information systems environment.	Commenced September 2009

3.5 Transforming Our Facilities - Supporting the Change

It is clear that the environment in which the health and disability sector operates is not static, but subject to the constant changes in population demographics, technological advancements, models of care and the expectations of communities and funders. The redesign of our health facilities is essential to support the ongoing implementation of our patient-centred models of care – models that are collaborative, integrated with primary care, interdisciplinary, anticipatory and focused on the patient journey through the whole of the system.

In transforming the way we work, our current facilities configuration has proven to be a block that has to be worked around. Our new patient pathways highlight the inefficiency of current and traditional service models that deal in terms of

fragmented services stretched across multiple locations. The physical geometry of our facilities provides no opportunity for co-location of services, current facilities do not meet current health facility guidelines or seismic requirements, and we have exhausted expansion capabilities on our Christchurch Hospital site. It is imperative that the transformation we are delivering is underpinned by a hospital system that is responsive and supports flexibility of service provision.

"We aim to support the current momentum and to fully capture the opportunities of our system-wide transformation through the substantial redesign of our hospital facilities."

DAVID MEATES
Chief Executive, Canterbury DHB

In redesigning our facilities, we will co-locate inter-related services, take advantage of workforce and service delivery efficiencies and make better use of our valuable resources. Facilities will be anticipatory and will have the flexibility to allow alteration of their use in the future to meet the challenges of an ever-changing health sector. Most importantly, by removing current constraints, we will be able to further improve patient pathways and continue to remove duplication and waste from our system. The solutions we will implement include a move to ambulatory care models of practice (separating planned day-only activity from acute), diversion of patients away from emergency care, improved clinical synergies and more interdisciplinary models of care.

We have reviewed the configuration on each key site, identified the best potential alignment of services and assets and adopted a progressive redevelopment of our facilities in line with our service transformation. We have completed a Strategic Stage Analysis, a Ministry of Health requirement to show what we plan to do and how we plan to do it; and an independent review has endorsed our proposed direction of travel. The first two of a series of national 'gateway reviews' have been completed, and business cases for the first stage of development at Christchurch Hospital and the development of Health Services for Older People are underway.

During the next stages of the project, a range of frameworks are being established to oversee all the activity that is occurring. This includes a Clinical Services Reference Group to provide clinical oversight for the project and a wide range of clinical service work streams to ensure that there is broad engagement and that the facilities developed are appropriate for modern models of care and capture opportunities around co-location of services to improve clinical synergies.

Public consultation will take place in April on the proposed land swap and Stage One of the Christchurch Hospital redevelopment, and we will work alongside the Christchurch City Council in this process. We will also provide updates on our website on what is happening with our facility redevelopment.

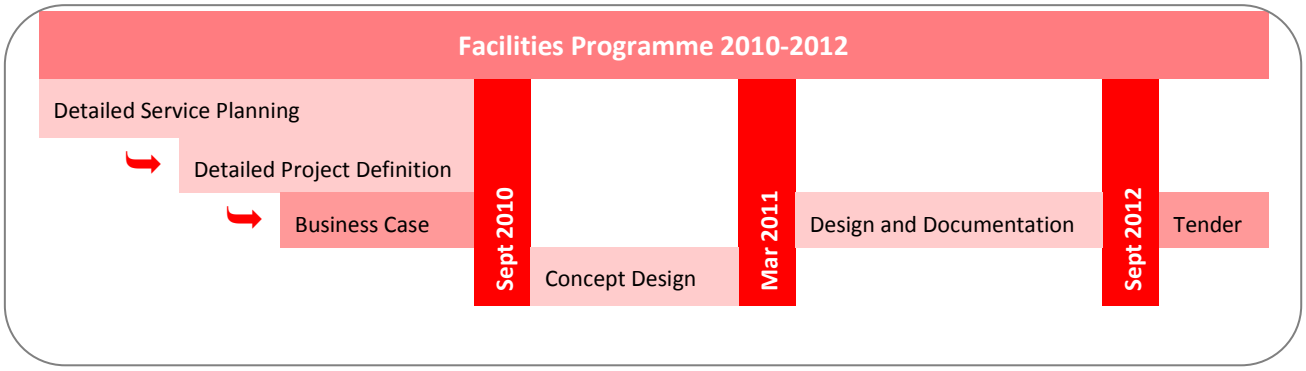


Figure 7: Proposed Capital Works Process

3.6 Service Redesign and Reconfiguration

Over the coming year, we will continue to collaborate closely with clinical leaders, stakeholders, consumers and the Ministry of Health to transform the way the Canterbury Health System works.

Alongside service transformation, we will continue to make efficiency gains by delivering the same service in more productive ways and by reducing duplication between services and providers. Quality improvements will standardise processes, reduce variation and waste and improve patient outcomes by freeing clinical staff for more direct patient contact time. Production planning will also improve our use of staff and resources and reduce costs in our hospital and specialist services.

We will ensure value for our investment through the regular review and evaluation of current services and by using our prioritisation principles and new contracting frameworks to question whether we can improve outcomes by delivering services in different ways. We will also continue to implement Government policy and national strategies and meet the expectations of the Minister of Health, particularly in regards to the delivery of national health targets and the integration of primary/secondary services.

It is anticipated that new models of care and patterns of service delivery will emerge as this work progresses, and it is possible that this will result in service change or changes to service arrangements, the extent of which is unknown at this stage. In most instances we anticipate that the changes will be in funding models, models of care or service delivery methods, aimed at ensuring the right person is seen at the right time, by the right person and in the right place.

It is noted that, in line with legislation and the clear expectations of our Board, any significant reconfigurations will be preceded by consultation with the affected resident population groups and the Ministry of Health. We have a policy of participatory engagement and will endeavour to keep a steady steam of information flowing across the sector on the direction and planned transformation of Canterbury health services. We will also consult with our regional DHB partners where service redesign or reconfiguration may affect their populations and as we work to implement relevant recommendations from regional reviews and plans. The Canterbury DHB will follow the requirements of the Operational Policy Framework in relation to all service changes signalled.

Service changes anticipated over the coming year fit into five categories:

- Redesign of service delivery models as a result of internal reviews, initiatives or reconfigurations to reduce bureaucracy and improve productivity, value for investment, patient safety and clinical quality;
- Redesign of service and delivery models across the whole of the Canterbury health system to ensure continuation of service delivery, build capacity to meet future population growth, improve health outcomes and reduce inequalities in health status;
- Redesign of service and delivery models across our Hospital and Specialist Services' Surgical and Medical Divisions, Older Persons' Health Services and Mental Health Services to be more responsive and to ensure the DHB can continue to provide services to those most in need, within available resources;
- Redesign of service and delivery models across primary care services as a result of the implementation of the *Better, Sooner, More Convenient* Business Case; and
- Implementation of external national policy, reviews or strategy to ensure consistency across the sector, provide equity of access to service and improve health outcomes.

The key areas of focus are outlined in this document and in our previous year's District Annual Plan. Our Statement of Intent also provides clear expectations around the outcomes we expect to deliver for our population. It is recommended that these documents be read together. All of our accountability documents can be found on our website www.cdhb.govt.nz.

4 The Fit with the National Direction

4.1 The Minister of Health's Expectations

When planning actions and activity for the coming year, we must consider the Minister of Health's expectations which are highlighted each year in the Planning Package (between the Ministry and DHBs). This Package provides annual expectations, priorities and parameters and helps to maintain consistency across the sector.

In setting expectations for 2010, a clear signal has been given that DHBs must deliver services and achieve national health targets within existing resources and within budget. The Minister of Health wants the public health system to deliver *Better, Sooner, More Convenient* health care by focusing on enhancing performance, increasing outputs, improving quality and effectively managing resources. There is also a strong focus on improving front line services and operating within approved financial budgets.

The Minister continues to support strengthened clinical leadership and constructive staff engagement, and expects to see improvements in hospital productivity, patient safety and quality. The Minister has also signalled a commitment to Whānau Ora and expectations that DHBs will work to improve Māori health status.

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

- Improve service delivery and reduce waiting times - increased elective surgery and first specialist assessments and reduced emergency department and cancer treatment waiting times.
- Implement the next steps in the Primary Health Care Strategy - closer integration of services across the care continuum to improve convenience for patients and reduce pressure on hospitals. Specifically:

  Work with community and hospital clinicians to provide a wider range of service in community settings;

  Provide these services at no cost to patients; and

  Actively investigate and facilitate the opportunities that exist to consolidate PHOs where appropriate.
- Improve clinical leadership - strengthened clinical engagement from governance level throughout the organisation.
- Regional cooperation - accelerated collaboration between neighbouring DHBs to maximise clinical and financial resources and evidence of real gains from this collaborative endeavour.
- More unified systems - working constructively with the National Health Board and Shared Services Board to ensure public health services are not reinventing the wheel 21 times.

4.2 Achieving National Health Targets

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

While the health targets capture perhaps only a small part of what is necessary and important to our community's health, they do provide a focus for action and improved performance across a range of areas, from prevention and early intervention through to access to hospital and secondary services. In this sense, achievement of the targets is a reflection of how well the health system is improving the lives of New Zealanders.[19]

We are committed to making continued progress towards achieving the national health targets, and the goals we intend to reach over the coming year are set out in the table below. If factors beyond our control prevent anticipated gains, we will take appropriate corrective action to achieve the best possible outcome and to meet the Minister's expectations. The activity planned to deliver on these health targets is outlined in sections 5-7.

[19] *Information regarding the health targets can be found on the Ministry's website www.moh.govt.nz.*

National Health Target	DHB Target - by July 1st 2011	Section
Shorter stays in Emergency Departments.	95% of people presenting at a Canterbury Emergency Department will be admitted, discharged or transferred within six hours.	5.5
Improved access to elective surgery. [20]	A total of 15,478 elective surgery discharges will be delivered.	7.1
Shorter waits for cancer treatment. [21]	100% of people needing radiation oncology treatment will receive it within four weeks of the decision to treat.	6.4
Increased Immunisation rates.	91% of all two year olds in Canterbury will be fully immunised.	6.1
Better help for smokers to quit. [22]	90% of hospitalised smokers provided with advice and help to quit smoking. 80% of smokers attending primary care provided with advice and help to quit smoking.	6.3
Improved diabetes and cardiovascular services.	An increased percentage of the eligible adult population will have had their CVD risk assessed in the last five years. Māori Pacific Other Total 62.9% 60.1% 73.9% 73.0%	6.5
	An increased percentage of people with diabetes will have received a free annual diabetes check. Māori Pacific Other Total >44% >40% >53% >52%	6.6
	An increased percentage of people with diabetes will have improved diabetes management (HbA1c8% or less). Māori Pacific Other Total >70% >56% >80% >79%	

4.3 Our Local Priorities

Alongside national expectations, the DHB will continue to be guided by its District Strategic Plan (adopted in 2006) and pursue the overarching priorities and directions outlined in this Plan in a way that best meets the needs of our local community and maximises health gain for our population. Added to this is the imperative that any initiatives or programmes developed will enable the Canterbury health system to build the foundations essential to drive transformational change and improvements in our challenging environment.

The District Strategic Plan sets out nine priority areas for improving health and reducing inequalities in Canterbury: Older Persons' Health, Child and Youth Health, Māori Health, Primary Care, Disease Prevention and the Management of Chronic Conditions, Cancer, Cardiovascular Disease, Diabetes and Respiratory Disease.

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

Our strategic vision and our chosen priorities for 2010/11 fit well with the current national direction, and Figure 8 on the following page demonstrates the significant cross-over of local and national priorities and the alignment of our direction with achievement of the national health targets and the expectations of the Minister of Health.

[20] *Elective surgical discharges exclude elective cardiology and dental procedures.*
[21] *This target excludes Category D patients, who have scheduled treatment start dates.*
[22] *Similar targets for primary care will be introduced nationally from July 2010 through the PHO Performance Programme (PPP).*

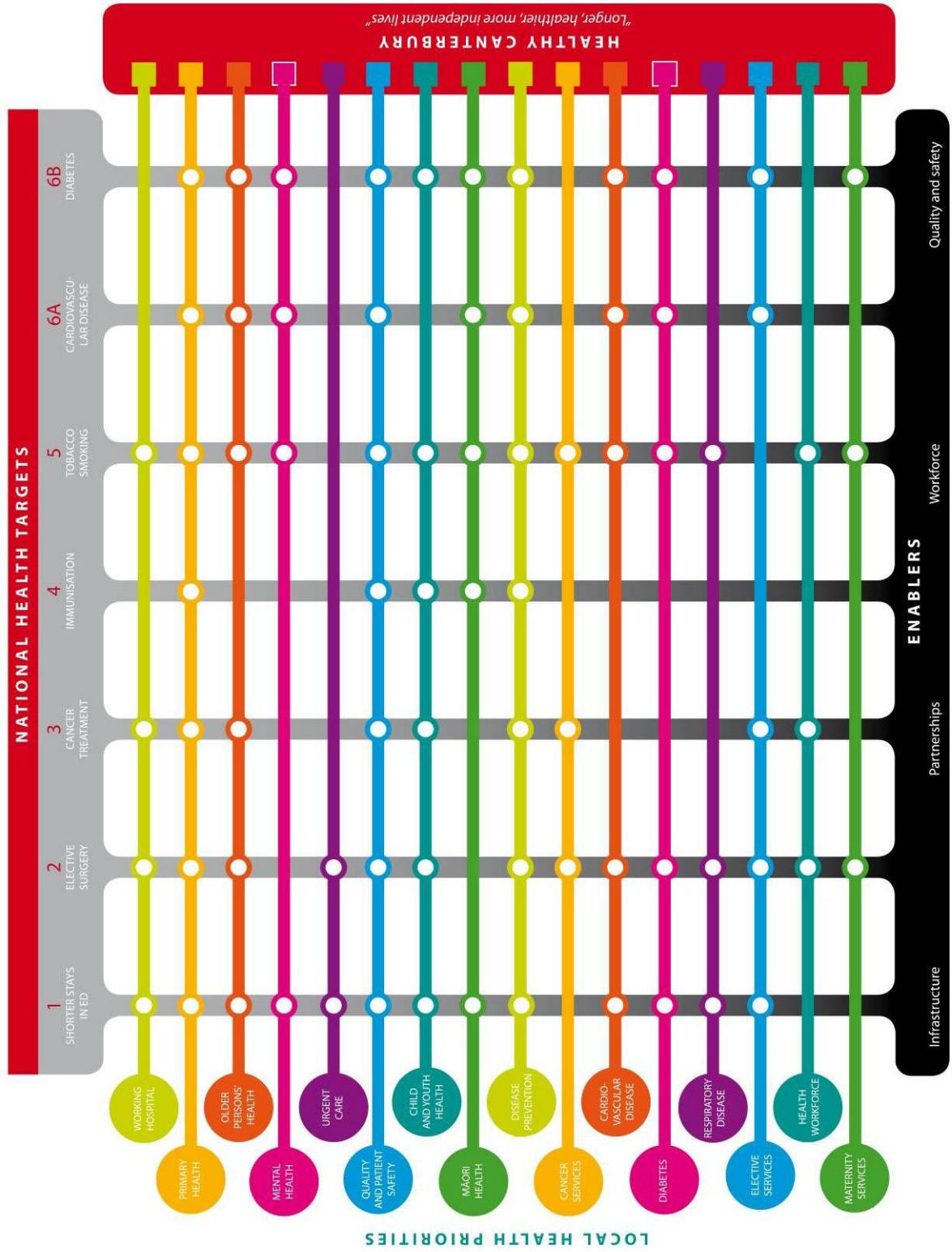


Figure 8. Alignment of Local and National Priorities.

4.4 Monitoring and Reporting Performance

All DHBs are required to monitor and report on their performance, and we meet our obligations through a number of internal and external reporting streams including:

- Regular reporting to the Ministry of Health against service contract requirements and our Crown Funding Agreement and monthly financial reporting and reporting into national data collections. Quarterly risk reporting and performance reporting against quality benchmark indicators and national health targets. Ad-hoc service and disease-specific reports, such as data relating to elective surgical services and waiting times and Ministerial Requests.
- Regular reporting to our Board and its Committees with performance monitoring against a mix of financial and non-financial indicators, goals and targets set in our Annual Plan and Statement of Intent and reporting on achievement at public meetings, along with the yearly publishing of an Annual Report which is tabled in Parliament.

Our Board and statutory committee reports are available to the public on our website. We also support the Minister of Health's expectation that the public should be provided with better information on health system performance by publishing on our website and in local newspapers Canterbury's quarterly performance against the national health targets.

Alongside the national health targets the Ministry has established a number of Indicators of DHB Performance (IDP) to monitor activity in priority areas and compare DHB's performance. We report against these on a quarterly basis to the Ministry who make the results available on their website. Local targets have been set for 2010/11 based on expectations expressed by the Ministry, the latest national data and the latest Canterbury DHB-specific data. (Refer to Appendix 4 for the Indicators of DHB Performance for 2010/11.)

There are a number of indicators in this IDP mix where our ability to improve outcomes is not through direct service provision but through funding and influencing other providers, and in some cases, influencing our community. Where the DHB is funding the service but is contracting a third party to deliver improved outcomes, there is more of a risk around meeting Ministry expectations. We rely on contracting methods, facilitation and the development of partnerships to achieve the goals for each performance indicator.

"Our planned actions will only be successful if they lead to a discernible improvement in the health of our population. It is important therefore that we identify measurable targets by which we can determine our success."

DAVID MEATES
Chief Executive, Canterbury DHB

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

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

Performance Improvement Actions

In 2010/11 DHBs are also required to respond to the Government's request that all Crown entities develop Performance Improvement Actions as part of *'Improving the Business of Government: Delivering Better, Smarter Public Services for Less'*. Performance Improvement Actions are intended to reflect a vital few actions to improve efficiency, effectiveness and alignment with the Governments priorities. (Canterbury's Performance Improvement Actions are attached as Appendix 6.)

5 Key Focus for 2010/11 - Transformational Change

The key focus areas for 2010/11 are:

- Making Our Hospitals Work;
- Delivering *Better, Sooner, More Convenient* Health Services;
- Older Persons' Health Services;
- Mental Health Services;
- Urgent Care Services; and
- Quality and Patient Safety.

Building pathways of care across primary/secondary services and improving quality and patient safety have a crucial role to play in improving urgent care and in managing the burden of long-term conditions (particularly the disproportionate burden which falls on Māori and Pacific people, older people and those in lower income groups).

The focus that will be placed on service improvement is reflective of the Minister's emphasis on *Better, Sooner, More Convenient* health care, and much of the activity planned will involve primary, secondary and community service providers taking a 'whole of system' approach to improving the health status of our population.

Continued momentum will complete some of the major transformations and allow us to further recognise improved capacity and effectiveness, to move released resources into patient services and to ensure investment is improving health outcomes for our population. The facilities redevelopment that we will embark on in the coming year will further support improvements in the patient journey and realisation of the vision of one joined-up health service with the patient at the centre.

5.1 Making Our Hospitals Work - Removing Duplication, Variation and Waste

We will reduce variation, duplication and waste from the system to improve service quality, increase capacity and deliver timely interventions that will improve the health of our population.

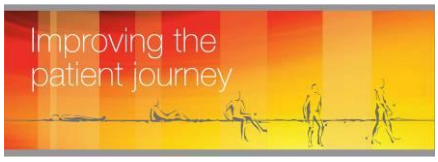
Why is this important?

Population growth, the increasing burden of long-term conditions and the changing demographics of our population all combine to increase the demand for secondary care services, and as our population gets older, people are presenting with more complex health issues that require higher levels of intervention.

We are the major provider of hospital and specialist services in Canterbury and across the South Island. To ensure we remain clinically and financially sustainable, and continue to provide good quality health care to our population, we are making significant transformational changes to the way we work.

Our significant challenges are around freeing up our secondary care services to cope with increasingly complex demand, integrating services across the whole system to share capacity and capability and reducing variation, duplication and waste across the whole system. Variation in the patient journey has a major impact on quality, time and satisfaction both for patients and for our workforce. Our emphasis on improving quality by reducing variation in service, practice and processes is creating a more focused approach to managing patient outcomes in an efficient and effective manner and is improving the patient journey through the Canterbury health system.

How are we improving outcomes for our population?



In Canterbury clinical leadership is seen as key to making improvements in service quality and patient safety and we are in the sixth year of our clinically led '*Improving the Patient Journey*' programme. Improving the Patient Journey is a continuous quality improvement programme underpinned by our Quality Strategic Plan and an investment in constraint theory, 'lean thinking', variation management and production planning processes.

Improving the Patient Journey works at two levels through our organisation:

- Strategic operational level changes focused on identifying system-wide constraints to achieving outcomes such as: variation in clinical practice and variation of patient flow caused by individual behaviours, and increasing or shifting capacity to the most appropriate location or the most appropriate provider; and
- Worksite change (frontline staff driven), focused on standardising worksites to reduce clinical risk and reducing wasted staff time to increase direct care time with patients.

We have engaged our clinical workforce in identifying improvement opportunities and driving more effective use of resources by reducing waste and variation in our system.[23] Combining this engagement with our proven production planning tools is enabling us to shift the focus from financial discussions to understanding the blockages in the system and improving capacity without additional investment.

- We delivered 13,240 elective surgery discharges in 2008/09 – 1,740 more than in the previous year. We are on track to deliver 14,369 discharges this year.[24]
- 99% of patients are currently waiting less than six months for their first specialist assessment, and 98% of patients to whom we have given a commitment to treat are being treated within six months.

We are proud of the additional service delivery provided to our population and the improvements in certainty we are able to provide. Empowering clinical decisions close to the point of contact and putting the patient at the centre of what we do - *focusing on the right person, receiving the right care and support, at the right time, irrespective of provider* – has enabled us to make a number of changes that have increased our capacity. This clinical leadership has also led to a number of changes to traditional practice that might over time reduce the number of elective services or first specialist assessments that we deliver (traditionally used as measures of 'productivity' in DHBs). However, these changes are improving patient outcomes and reducing delays in service delivery; for example:

[23] *Engagement in Canterbury is led through a number of streams in addition to the Improving the Patient Journey programme; notably Vision 2020 and Showcase, Xcelr8 and Partic8 programmes and the clinically led Canterbury Initiative.*

[24] *Elective Surgical Discharges are based on the national health target definition, which excludes cardiology and dental discharges. The total number of elective surgical discharges delivered was 14,830 – an increase of 1,790 on the previous year.*

- When appropriate for the condition of the patient, cholecystectomy, prostatectomy and removal of kidney stones are now performed acutely. Traditionally elective procedures, this change in clinical practice will avoid multiple acute admissions and readmissions for these patients and reduce waiting times and waste across the system.
- GPs are being provided the opportunity to expand their skills with training from hospital specialists to remove skin lesions (skin growths, including skin cancer). Previously, many people had to wait for a specialist assessment and skin lesion removal in hospital, but now they can be treated by a GP in the community, freeing up specialist services to focus on more complex cases.

Over the next year we will work closely to improve the way we measure service delivery across the whole of the Canterbury health system to support momentum and ensure that improved outcomes for our population are recognised.

The tools of lean thinking are also being applied in our new way of working, and we are placing greater emphasis on patient 'value-streams' - looking at the shared services within the system (such as radiology, laboratories, theatres and staff) and how these can better support clinical services and improve the patient journey. [25] Through this work, we have identified opportunities to improve our resource capacity, such as theatre time, radiology reporting and nursing time.

The measures of success for our work are focused on aspiration patient-based goals and include:

- No patient should spend longer than 4 hours in an Emergency Department; and
- No patient should wait longer than 24 hours to access an Acute Theatre.

A number of significant successes have been achieved through this programme, which are making a real difference in capacity and service quality in our hospital and specialist services:

- The average wait time for a radiology report, previously 3 days, has been reduced to an average of 3 hours. The benefits are felt throughout the wider hospital, with timely reports facilitating prompt diagnosis and treatment;
- Through our 'Making Time for Caring' project, registered nurses' direct patient care time has increased to 45%. This translates to 1,615 hours of extra direct care time or an extra full time staff member on each ward at no extra cost;
- 81% of our elective surgery admissions are now Day of Surgery Admissions, a 4% improvement on the previous year. This not only frees up beds previously being used unnecessarily, but is also less disruptive for patients, who can spend the night before surgery in their own homes; and
- We delivered 1,740 more elective surgery discharges in 2008/09 than in the previous year. We are on track to deliver 14,369 discharges in the 2009/10 year. [26]

2010/11 will be another busy year for Canterbury. Most of our larger clinical services including: General Surgery, General Medicine, Neurosurgery, Cardiology, Oncology, Urology and Diabetes Services are investigating significant service improvements and the redesign of service models improve capacity and patient outcomes. The strength of our clinical leadership and support for system-wide partnerships is escalating the pace and scale of this change.

We recognise that our ability to meet our population's increasing demand for services is often compromised by increased demand from other DHBs for the more specialised services we are able to provide. To achieve our objectives, we will take a lead in working collaboratively with our regional DHB colleagues and take a formal approach to the delivery of services for neighbouring DHBs. By formalising existing clinical networks and service provision, the collective South Island will be better able to plan capacity and workforce needs and improve regional outcomes.

Meeting the Minister's Expectations

We have committed to increasing elective services delivery by an additional 1,109 discharges in the coming year. We are also committed to achieving compliance with Elective Services Patient Flow Indicators (ESPIs), achieving the national ED Health Target, increasing the percentage of hospitalised smokers given advice and support to stop smoking and reducing wait times for cancer radiation oncology treatment.

We will meet these expectations by valuing patient time and focusing our attention on the way patient activity is organised to further improve the patient experience and identify waste and delays in our system. The improvements we are making to the patient journey will free up beds and resources to enable more people to be appropriately treated within shorter time frames.

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[25] Lean Thinking practice originated from the Toyota Production System (lean thinking applied to manufacturing), where Toyota became the world automotive leader in quality, manufacturing efficiency and profitability as a direct result of its focus on lean techniques.

[26] Elective Surgical Discharges are based on the national health target definition, which excludes cardiology and dental discharges. The total number of elective surgical discharges delivered was 14,830 – an increase of 1,790 on the previous year.

ACTIONS 2010/11		
OBJECTIVE	**OUTPUTS**	**IMPACTS**
What are we trying to achieve?	*What action will we take to make this happen?*	*What impact will this have?*
Communicate our vision. *To engage our workforce and whole community in the challenges and in supporting the transformation of our health system.*	Complete public consultation and community engagement to review the District Strategic Plan for the Canterbury region. Share our achievements and transformations with interest groups and our community to provide a greater understanding of the challenges for the health sector and how we can all respond to these challenges. Increase opportunities across the health system to actively engage in the challenges and participate in 'making it better'.	Stakeholders are engaged and supported with balanced and objective information to assist them in understanding the opportunities, problems, alternatives and solutions. Increased response rate to DHB consultation processes. Increased participation in Xcelr8 and Particip8 programmes.
Improve capacity to deliver within our means. *To improve access, quality and service responsiveness and to enable the DHB to meet future needs within available resources.*	Engage services in production planning and the development of whole of DHB plans and volume schedules. Support weekly production planning to deliver to capacity and to proactively respond to changes in demand. Utilise valumetric principles to apply lean thinking to the theatre environment and support surgical teams to establish performance benchmarks to improve start times and patient turnaround and increase available theatre time for additional elective procedures. Standardise theatre equipment sets to reduce theatre delays, decrease clinical risk and streamline sterile service processes. Increase vascular and neurosurgical services capacity by employing an additional surgeon resource and redesigning service models. Improve cardiothoracic services capacity and sustainability by employing a third surgeon and reducing reactive dependency on private providers. Implement clinically led lean thinking in histology to reduce turnaround time between reading and reporting results.	Hospital outputs are delivered within 3% of overall plan. 15,478 elective services discharges delivered in Canterbury facilities. Improved Elective Services Standardised Intervention Rates. Improved utilisation of theatres.[27] Increased percentage of acute patients received surgery within 24 hours >85%.
Improve the patient journey. *To reduce waste and variation in service delivery and improve the quality of patient care by adopting a clinically led and standardised approach.*	Deliver clinically appropriate elective procedures in acute settings where outcomes are more beneficial for the patient, including delivery of new patient pathways for prostate and renal colic patients. Support a culture that ensures, where clinically appropriate, day surgery and day of surgery admissions (DOSA) are normal practice. Support the clinical redesign of the general medicine service delivery model across five wards in Christchurch Hospital, including an increase of 28 beds and provision of more personalised patient care with use of 'home wards', to reduce variation and waste and improve patient outcomes. Consolidate 'Making Time for Caring' on existing 18 wards to support the implementation of the redesigned general medicine service delivery model and continue to fast-track the rollout across other wards to increased direct patient care time. Relocate the urology ward to enable the additional bed	60% of elective and arranged surgeries are day surgeries. 90% of elective and arranged day surgeries are DOSA. Continued compliance with ESPIs. Elective and arranged inpatient average length of stay maintained at 4.02 days. Acute inpatient length of stay maintained at 4.01 days. 30 day mortality rates maintained at <1.62.

[27] *The Canterbury DHB will implement the national theatre utilisation measures once agreed.*

	capacity in general medicine to be accommodated. Implement the redesigned cardiology service model, including an extended operating day and redesign of cardiology services from 5 to 7 days a week to reduce waiting time for patients. Change the traditional approach to providing gynaecology surgical services and implement the redesigned model of care from surgical intervention to medical management to deliver additional electives capacity and improve patient outcomes.	
Improve organisational fitness. *To identify opportunities to centralise, consolidate or improve business practices and enable the DHB to meet future needs within available resources.*	Continue to identify and integrate appropriate services across the Canterbury health system. Continue to support the Supply Chain Strategy to reduce stock holding, improve turnaround time from order to supply and reduce supply chain costs. Re-engineer the clinical coding process to improve efficiency and capacity and deliver up-to-date coding every month. Support national Shared Services Establishment Board initiatives to achieve efficiencies, economies of scale and standardisation across the health sector. Progress the replacement of end-of-life Patient Administration Systems.	Further reduction in consumable costs across the DHB. 80% of all electronic purchasing through the Supply Chain Department catalogue. Improved National Minimum Data Set Coding timeliness to between 2%-5%.
Undertake Facilities Redesign. *To ensure services are appropriate for modern models of care, capture opportunities around improved clinical synergies and ensure the DHB has the capacity and flexibility to meet the future needs of our population.*	Use production planning to identify and feed new requirements, including theatres, into the facilities master planning process. Complete business cases for first stage development at Christchurch Hospital and Health of Older Persons Services. Establish Clinical Services Reference Group to provide clinical oversight for the Facilities Redesign project. Establish clinical work streams to ensure there is broad engagement and facilities developed are appropriate for modern models of care and capture opportunities around co-location of services. Undertake public consultation on the proposed land swap with the Christchurch City Council that will allow stage one of the Christchurch Hospital redevelopment to proceed. Progress with the design and development of the Facilities Master Plan and Business Case.	Business cases submitted through next 'gateway review stage' in September 2010. Concept design completed by March 2011. Design and documentation completed by September 2012.
Align strategic activity across the Southern region. *To make the most effective use of resources and workforce and ensure equity of access for our populations.*	Support the development of clinically led multidisciplinary patient pathways on the West Coast through sharing of the Canterbury Initiative process to support the integration of primary/secondary services between the DHBs. Formalise regional clinical service arrangements to allow for improved planning of capacity, workforce and infrastructure. Work in partnership with other South Island DHBs to agree a regional production plan and action plan by August 2010 to identify capacity available in the region and collectively ensure equitable access to elective services.	8 patient pathways developed for West Coast DHB services. Increased volume of elective services delivered across the South Island, with >1,288 additional discharges delivered in 2010/11.

We will ensure the people of Canterbury have access to a wider range of integrated services, in more convenient locations, to further improve the overall health status of our population.

Why is this important?

Primary care is most people's first point of contact with health services and is also the point of continuity in health; providing services from disease prevention and management through to palliative care. Population growth, the increasing burden of long-term conditions and the changing demographics of our population all combine to increase the demand for health services, and as our population gets older, people develop more complex health issues that require higher levels of intervention. To free up our secondary care services to cope with increasingly complex demand, we are supporting the integration of services across the whole of the system and building capacity in our primary and community services to support this direction and to improve health outcomes for our population.

How are we improving outcomes for our population?

There are a number of initiatives underway in Canterbury to transform service delivery models in line with our Health Services Plan and our agreed vision for the Canterbury Health System. Some changes are facilitated; others are happening spontaneously as a result of an environment of positive relationships and empowered clinical leadership.

We are improving continuums of care by supporting primary and community services to safely provide more appropriate services to individuals and their families in community settings and closer to their own homes. We are simplifying referrals and the transfer of care between settings, improving discharge planning to better support people in the community. We are also enabling rapid diagnosis by enhancing access to diagnostics and providing general practice with access to secondary care specialist advice without the need for a hospital referral.

This shift of appropriate services out of hospital-based settings is consistent with international research, evidence and experience on improving patient outcomes by providing the right service, at the right time and in the right place. It also meets the clear expectations of the Minister of Health for DHBs to provide '*better, sooner, more convenient health care*' for their populations.

A significant number of the initiatives established across the primary/secondary interface over the past two years have been driven through the unique set up of the Canterbury Initiative, which is driving the development of new patient pathways that support integrated service delivery. This model works by fostering clinical leadership, bringing together a range of clinical representatives from general practice, hospital specialities and the community to work together to identify and address challenges and design new pathways and models of care to improve the journey for the patient.

The Canterbury Initiative has built credibility through the delivery of results within short timeframes and by supporting change with quality communication and education. Where appropriate, the solutions have been delivered through existing structures, keeping systems lean, and ensuring funding flows support the clinical solutions developed.

The focus on shared care, structured around the patient and supported by evidence-based practice, is helping to minimise waits and unnecessary hospital visits. As a next step in this work, and as part of wider national direction, there are a number of transformation initiatives planned for front line primary care services over the next three years, which will continue to contribute to better, sooner and more convenient health services for our population.

To take these next steps we have supported the establishment of the Canterbury Clinical Network (CCN), an alliance of Canterbury's health professionals, clinical leaders, health providers and health organisations, consumers and the DHB. The Network has been established with the explicit inclusion of the DHB as a key partner to enable a collaborative planning approach across the whole of the Canterbury health system. The CCN will further support clinically led prioritisation, service design and decision making; identify, agree and run an annual programme of health service improvement initiatives; support activities in partnership with the DHB and provide the opportunity for wide participation by health service providers, community organisations and Māori and Pacific and communities.

Meeting the Minister's Expectations

The CCN's initial focus has been the development of a response to the invitation from the Minister of Health to primary health care providers, organisations or networks to complete an Expression of Interest proposing how they would "*help deliver the Government's priority intention for a more personalised primary health care system that provides services closer to home, makes Kiwis healthier and reduces pressure on hospitals*".

The proposal from the CCN was one of nine across the country to be approved through to the next stage, and the Business Case is a whole of system response to this opportunity. The DHB has a strong commitment to the service improvement process that will be driven through the implementation of the Business Case, and we are working in partnership to implement the direction as part of the whole transformation of health services in Canterbury. The acceptance of the Business Case has provided the opportunity to extend, evolve and accelerate change in the Canterbury health system.

The breadth and pace of transformation in Canterbury will require effective leadership as well as a number of enabling mechanisms and technical support. The CCN has established a representative Transitional Leadership Board (TLB) to move it into the next stage of ensuring rapid delivery against the Business Case. The TLB includes primary, secondary and community leadership, as well as PHO and DHB representation. With the TLB established, Canterbury is in a position to execute a District Alliance Agreement and the eventual replacement of the TLB with a District Alliance Leadership Team. The Business Case will be implemented using existing resources from the represented organisations and by reprioritising services and redeploying staff from existing teams. To support this, Canterbury's PHOs have entered into a Memorandum of Understanding to collaborate and cooperate on the delivery of services and undertake collective allocation of resources to support the transformation and to deliver the best mix of services for our population, within the resources available.

The TLB has developed and agreed a plan for the initial implementation phases of the Business Case which has a number of key work streams, and planning for each has been undertaken within the context of the Canterbury 'model of care' framework. The following table reflects the agreed priority actions under each work stream, and the impacts that we expect to see through this transformation.[28] The work stream activity is also reflected in the relevant sections of this document, where the actions will contribute to achieving desired outcomes in other priority areas, specifically the Urgent Care and Aged Care work streams.

Substantial patient and system benefits are anticipated from health and social service providers working collaboratively in community networks and emphasis is being placed on the development of Integrated Family Health and Social Services Networks and ensuring effective communication between the members of the multidisciplinary team in those Networks. Rural Networks will be supported to continue to evolve and deliver sustainable, integrated services that meet the needs of their communities. The engagement of pharmacy and laboratory providers is also essential to support the optimal use of referred services across the system and implement demand-side management strategies to reduce increases in expenditure on pharmaceuticals, laboratory tests and diagnostics.

ACTIONS 2010/11		
OBJECTIVE	**OUTPUTS**	**IMPACTS**
What are we trying to achieve?	*What action will we take to make this happen?*	*What impact will this have?*
Implement the Urgent Care Work Stream. *To provide the most appropriate urgent care options to meet patient need at a given time.*	Q1: Expand nurse-led after hours phone triage services. Q1: Establish acute ambulance triage pathways for alternatives to hospital admission. Q4: Further develop and target flexible community based urgent care (admission avoidance) options/packages. Q4: Establish acute patient pathways to improve access to urgent clinical information and triage. Q4: Reduce after hours care cost barriers for urban and rural high needs people/populations.	A reduction in the growth rate of ED attendances and admissions. Contribution to achieving ED Health Target -95% of people admitted, transferred or discharged within 6 hours of ED presentation. An increase in access to general practice care (24/7) for people requiring urgent access to care. Increase in people access urgent care packages in the community - 14,000.
Implement the Aged Care Work Stream. *To enable older people to live well at home and in their community.*	Q1: Implement integrated GP/Nurse/Pharmacist Liaison roles and support the alignment of clinical assessment and/or care workers to general practice. Q1: Implement a sustainable falls prevention programme, including an integrated care pathway and training. Q1: Implement My7Q tool to measure clinician satisfaction with Older Persons' Specialist Services. Q1: Increase the ratio of clinical assessors to provide more	Delayed entry to residential care and extension of independent living. Reduced acute hospital and residential care admissions and readmissions. Reduced proportion of the population aged over 65 admitted to hospital as a result of a fall.

[28] *With the exception of the immunisation and respiratory work streams, which are reflected in the Child Health and Respiratory Disease sections of this DAP.*

	planned and fewer acute assessments. Q1: Support Pharmacy to participate in the design, development and delivery of improved processes that will enable people to access care when they need it. Q2: Implement web-based access to InterRAI for general practice to enable access to information to support effective and consistent assessment across the sector. Q4: Support a redeveloped approach to assisted day care, respite services and ED services for older people to better identify and refer people at risk of deteriorating health.	250 targeted therapeutic medication reviews completed for older people with complex medication and support needs. 500 discharge follow-ups provided for older people with complex needs in general practice. 250 additional assessments provided for older people with complex needs that would benefit from an enhanced care management approach.
Implement the Primary Secondary Integration Work Stream. *To support the provision of the right care in the right place at the right time by the right provider.*	Q1: Expand the range of patient pathways agreed between general practice and hospital specialist (and available on HealthPathways) to include: cardiology, ophthalmology, diabetes, asthma and urology.[29] Q2: Enable pharmacy access to electronic discharge notes to reduce medication error and support optimal medicines consumption. Q4: Expand the range of funded radiology investigations available to general practice, with clear referral guidelines.	200+ patient pathways available to general practice on HealthPathways. Additional procedures delivered in the community: ▪ 2,428 excision of skin lesions; ▪ 171+ Mirena Insertions; and ▪ 171+ Pipelle biopsies. Reduced wait time to First Specialist Assessments (FSA) and increased conversion from FSA to surgery.
Implement the Integrated Family Health and Social Service Network Work Stream (Urban).[30] *To support health and social service providers coming together to work in a defined community to operate as an integrated team.*	Q1: Support a wide range of clinical professionals, community health providers, Whānau Ora providers, social service providers and service coordinators to establish Integrated Family Health and Social Service Networks. Q1: Support the implementation of the first pilot cluster of general practice in urban Canterbury. Q4: Support the implementation of the second pilot cluster of general practice in urban Canterbury. Q4: Pilot shared electronic health record between general practice, pharmacies and other health service providers.	Improved access to services closer to people's homes. Improved communication and coordination between providers, reducing the number of different providers that patients interact with. Reduced waiting times for access to support services and improved social supports, especially for the frail and those in need.
Implement the Rural Health Work Stream. *To ensure health services in the rural parts of Canterbury deliver comprehensive, integrated family health services equitably, efficiently and sustainability.*	Q1: Support the collective development of a single integrated facility in Kaikoura and implement a single funding model for Kaikoura services. Q4: Support the establishment of integrated family health centres in Amuri and Methven and integration of local health services around purpose-built facilities on hospital sites in Rakaia and Darfield. Q1: Further develop rural health services strategy in association with the West Coast DHB. Q1: Finalise alignment of PHO agreements with the broader business case initiatives and DHB strategy. Q4: Progress rural integrated family health centres and support Marae-based health clinics in each TLA. Q4: Support a review of PRIME versus other acute services including rural ambulance services.	Improved access to services closer to people's homes. Improved communication and coordination between providers, reducing the number of different providers that patients interact with. Reduced waiting times for access to support services and improved social supports, especially for the frail and those in need.
Implement the Long-term	Q1: Support primary care to provide increased evidence of	Avoided and deferred rest home

[29] The Canterbury Initiative is accessed online via www.healthpathways.org.nz with information/resources specifically developed to help general practice navigate patient pathways, i.e. information on referrals, specialist advice, diagnostic tools, GP to GP referral and procedure subsidies.
[30] In the context of Integrated Family Health and Social Service Networks, BSMC defines 'community' in rural areas as the population within the natural catchment of a general practice, and in urban areas as the population within a geographically contiguous cluster of general practices representing 15,000 to 35,000 people.

Conditions Work Stream. *To reduce the growth in the number of people with, and improve the outcomes of those who have, long-term conditions, including diabetes, cardiovascular disease and respiratory disease.*	diabetes review utilisation, with improved reporting to positively impact on the national Health Target. Q1: Support the implementation of a Diabetes/CVD screening programme to improve early detection of at risk urban and rural Māori. Q1: Support the implementation of text-to-remind programmes in general practices and pharmacies to support recalls and medicines reminders. Q2: Support the integration of health promotion/wellness plans including clinical education/cross-sector referrals. Q3: Support the implementation of a Pacific Diabetes/CVD screening programme. Q4: Support the implementation of the ABC smoking programme by pharmacists and general practice teams. Q4: Support the design and implementation of clinical/patient education and tools for self management of long-term conditions. Q4: Support Pharmacy to develop complementary services to support population health and long-term conditions initiatives, including medicine use reviews and safe medicines management processes.	admissions. Reduced growth in ED and acute hospital admissions. 52% of the expected population with diabetes have their diabetes systemically monitored. 79% of people with diabetes have improved diabetes management (HbA1c>=8%). 73% of the eligible population will have a CVD risk assessment every five years. 80% of smokers attending primary care will be provided with advice and help to quit smoking.
Implement the Māori Health Work Stream. *To promote Whānau Ora as the core 'future mindset' that allows us to change the way we think, plan and deliver our health services into the future.*	Q1: Support cultural competency workshops for general practice teams and the implementation of whānau engagement activities in primary care services. Q1: Support the implementation of Māori Diabetes/CVD screening programmes, with a target of 1,042 consultation subsidies for early detection of at risk Māori. Q1: Support monitoring systems sourcing ethnicity data and placing systems in clinical networks establishing more targeted information. Q1: Contribute to Māori health as a career programme and provide up to 10 scholarships for study in primary health care fields. Q3: Engage in partnerships with the Māori Indigenous Health Institute to run further Haoura Māori Health Days and research activities. Q4: Support the development of a Whānau Ora toolkit and the provision of training to primary care.	Māori whānau are supported socially to empower themselves to access health services and to navigate through and utilise health services. Increased referrals to and by Māori primary care services via general practice. Recognition of Māori cultural needs by clinicians and health services. Increased access to services: 44% of Māori with diabetes have their diabetes systemically monitored. 62.9% of eligible Māori have a CVD risk assessment every five years. 80% of Māori smokers attending primary care are provided with advice and help to quit smoking.
Implement the Pacific Health Work Stream. *To increase awareness and educate health professionals in best practice models of engagement with Pacific people.*	Q1: Support monitoring systems sourcing ethnicity data and placing systems in clinical networks establishing more targeted information. Q1: Engage in a multifaceted communications strategy for the Pacific community sending key health messages. Q2: Participate in a workshop with health providers on best practice engagement with Pacific and migrant communities. Q3: Support Pacific health as a career and the provision of scholarships for study in primary health care fields.	Increased Pacific enrolments with general practice. Reduced effects of long-term conditions through early intervention and screening for pacific people Reduction in ED presentations with appropriate support occurring more within the community. Recognition of Pacific cultural needs by clinicians and health services.
Implement the Engagement Work Stream. *To enable the transformation activities across Canterbury and*	Q1: Confirm a Communications and Engagement Plan. Q1: Participate in informing stakeholders and groups about progress, work programmes and priorities.	Stakeholders are engaged and supported with balanced and objective information to assist them in understanding the opportunities, problems, alternatives and solutions.

support the implementation of Business Case work stream initiatives.	Q2: Facilitate wider clinical and community engagement and participation as appropriate. Q2: Participate in maintaining and updating CCN website.	Increased use and awareness of website (www.ccnweb.org.nz) by stakeholders and interest groups.
Implement the Information Technology Work Stream. *To enable the transformation activities across Canterbury and support the implementation of Business Case work stream initiatives.*	Q1: Launch the Electronic Referral Management Service (ERMS) to expand GP triage, prioritisation, pathway development, active budget management, utilisation and performance measurement and clinical quality feedback. Q1: Implement web-based access to InterRAI. Q2: Integrate and complete the rollout of ERMS. Q3: Implement Shared Electronic Health Record in cluster pilots; scope and evaluate.	Capacity for GP triage, prioritisation, pathway development, active budget management, utilisation, performance measurement and feedback on clinical quality expanded through shared electronic referral management.
Implement the Alliance Framework Work Stream. *To enable the transformation activities across Canterbury and support the implementation of Business Case work stream initiatives.*	Q1: Implement a District Alliance Agreement which service and service provision alliance agreements will be party to. Q1: Support the formation of the Canterbury PHO Alliance and implement Canterbury PHO Alliance agreements. Q1: Support the formation of the Canterbury Pharmacy Alliance to support the design, implementation and operation of the overall Canterbury alliance structure and implement Canterbury Pharmacy Alliance agreements.	Clinical work streams and TLB understand how proposed transformations might be enabled and supported through particular contracting arrangements, and have an influence over the execution of those contracts. Contracts and agreements support system transformation.
Implement the Referred Services Management Work Stream. *To enable the transformation activities across Canterbury and support the implementation of Business Case work stream initiatives.*	Q1: Distribute rapid strep tests and urine dipsticks. Q1: Support the completion of a Preventive Care Manual. Q1: Engage in monitoring the utilisation of high cost, high volume pharmaceuticals and laboratory tests and provide feedback to primary/secondary prescribers and pharmacy. Q2: Support the development and delivery of an inter-disciplinary clinical education programme. Q2: Support access to lab positivity data through Éclair. Q4: Support Pharmacy to develop new dispensing arrangements for effective/efficient use of subsidised medicine and expert advice to prescribers and patients.	Work streams supported by clinical leadership, access to data, robust investigation and evidence-based research, delivery of the key messages through general practice and hospital services, and changes in clinical practice.
Implement the Pharmacy Work Stream. *To enable the transformation activities across Canterbury and support the implementation of Business Case work stream initiatives.*	Q4: Facilitate Pharmacy access to electronic discharge notes to reduce medication error. Q1: Support the expansion of pharmacist working within general practice pilot to facilitate therapeutic medication reviews, sharing of case notes. Q2: Engage Pharmacy in the piloting of IFHS clusters in urban and rural Canterbury.	Agreed collaborative and integrated service in place. 250 targeted therapeutic medication reviews completed for older people with complex medication and support needs.
Implement the Workforce Development Work Stream. *To enable the transformation activities across Canterbury and support the implementation of Business Case work stream initiatives.*	Q1: Support expansion of extensive clinical education programme to multi-disciplinary clinical groups. Q1: Contribute to Māori and Pacific student scholarships. Q3: Support Summer Studentships. Q4: Facilitate nurse role development and support NetP expansion within general practice. Q4: Support locum relief for remote rural practices.	Existing workforce nurtured and sustained. Flexible reconfiguration of the health workforce achieves the most effective and efficient use of each practitioner's skills, while maintaining viable and sustainable business models.

5.3 Older Persons' Health Services

We will support older people to stay healthy and well and in their own homes for as long as possible, and establish a sustainable level of service provision for the future.

Why is this important?

Canterbury's population is ageing, and as older people experience more illness and disability than other population groups, this is driving an increasing demand for health and disability services and aged residential care services. The number of older Māori and Pacific people in our population is also increasing, and these population groups are over-represented in terms of the long-term conditions experienced by older people, including diabetes, CVD and respiratory disease. We estimate that approximately half our resources are engaged in providing health services for people over 65.

Aged Residential Care (ARC) services continue to be our greatest challenge. Compared to other DHBs, we have the fifth highest age-standardised per capita utilisation of ARC services and a higher than national average utilisation of home-based support services. Demand forecasts demonstrate that at current utilisation levels, we will need over 2,000 additional residential care beds in Canterbury by 2021. If our utilisation were consistent with the national average, fewer beds would be required and more people could be supported to remain in their own homes.

How are we improving outcomes for our population?

While older people's health issues are likely to be more complicated, they can be supported to rebuild and even improve their functioning after illness. Providing people have adequate supports and have a manageable level of need, ageing in place will likely result in a much higher quality of life, and people may remain healthier for longer as a result of staying active and positively connected to their communities. Our *Healthy Ageing, Integrated Support* Strategy is aligned with our vision of integrated continuums of care and patient pathways across the whole of health system to enable better management of long-term conditions. The emphasis is on flexible, responsive, needs-based care, provided in the community to assist older people to stay well and in their own homes. This work will be further enhanced through the *Better, Sooner, More Convenient* Business Case, which includes a focus on age-related care.

In considering our capacity to meet the increasing demand for services, we will:

- Improve the quality of aged residential care and home-based support services;
- Consolidate and integrate assessment processes across primary and secondary care;
- Provide appropriate access to a range of support services in the community;
- More proactively manage care for older people with complex needs; and
- Support and maximise the recovery of older people on discharge from hospital.

We are focused on making the best use of ARC, home-based support and hospital and specialist services. In reviewing our model of care for older people, we are improving referrals pathways, ensuring coordinated and consistent needs assessment, building a strong community base and reviewing and reorganising day care services to ensure they meet the needs of our model health care environment. The focus of specialist health services for older people will continue to shift from inpatient assessment, treatment and rehabilitation beds to community-based integration with primary health care, and some reorientation of services is likely.

We will continue to focus on improving the quality of care for older people and work collaboratively with providers, around improving quality, capacity, consumer satisfaction and workforce development. Over the past year, we have implemented tagged funding for improving the quality of nursing supervision and retention in aged residential care through variation to relevant national contracts. We are also funding additional hospital-level urban planned respite care beds and rurally located dementia rest home planned respite beds. These beds will increase the capacity of planned respite from two beds to six and enhance consumers' and providers' ability to book respite arrangements ahead of time.

To ensure equity of access for our population and the population of the wider South Island, there will be a clear focus in the coming year on ensuring that thresholds for access to ARC facilities, home-based support services and district nursing services are being set and applied consistently across the whole of the South Island. Home-based support services will support those people assessed as having a range of priority needs. Appropriate service provision and any change to service provision will be determined for individuals only after comprehensive evidence-based assessment using InterRAI tools.[31] Services users can be assured of having their needs reviewed annually, or more frequently as required.

[31] *InterRAI – the International Resident Assessment Instrument is a comprehensive geriatric assessment tool.*

ACTIONS 2010/11		
OBJECTIVE	**OUTPUTS**	**IMPACTS**
What are we trying to achieve?	*What action will we take to make this happen?*	*What impact will this have?*
Improve the quality of aged residential care (ARC) services. *To ensure residents receive consistent and high quality health services.*	Continue to pilot the implementation of the InterRAI assessment tool suite in ARC settings to assess resident's needs. Support the improvement of quality of nursing and supervision in rest homes.	Reduction in variation of assessment through wider use of InterRAI. Capability to monitor quality in ARC. Reduced acute admissions from rest homes and reduced ARC issues-based audits.
Improve referral and assessment services for older people and simplify referral pathways. *To provide more timely and targeted responses to the needs of older people and enable them to maintain independence.*	Establish a single pathway into ARC with consistent eligibility criteria. Undertake assessments of need in Canterbury using the InterRAI assessment tool. Implement web-based access to InterRAI for general practice to enable access to information to support effective and consistent assessment across the sector. Increase the ratio of clinical assessors to provide more planned and fewer acute assessments.	Reduced unplanned acute admissions for people aged over 65. An increased number of people entering ARC services having been assessed using InteRAI. 250 additional assessments provided for older people with complex needs that would benefit from an enhanced care management approach.
Improve proactive care management for older people with complex needs. *To ensure older people with complex needs and their families are actively supported and enable older people to live well at home and in their community.*	Implement GP/Nurse/Pharmacist Liaison roles across the primary-secondary interface and support the alignment of clinical assessment/care workers to general practice. Implement a sustainable falls prevention programme, including an integrated care pathway and training. Implement My7Q tool to measure clinician satisfaction with Older Persons' Specialist Services. Support Pharmacy to participate in the design, development and delivery of improved processes that will enable people to access care when they need it. Support a redeveloped approach to assisted day care, respite services and ED services for older people to better identify and refer people at risk of deteriorating health.	Delayed entry to ARC and extension of independent living. Reduced unplanned acute admissions and readmissions. Reduced proportion of the population aged over 65 admitted to hospital as a result of a fall. 250 targeted therapeutic medication reviews completed for older people with complex medication and support needs.
Improve services on discharge from hospital for older people. *To enable people to return home with the necessary treatment and support to restore functioning and maintain independence.*	Provide a broader range of appropriate multidisciplinary services to support discharge. Complete the restorative home support implementation trial and roll it out across Canterbury. Provide a broader range of restorative support packages to support people to regain their independence.	Reduced re-admission rates for people 65+. 500 discharge follow-ups provided for older people with complex needs in general practice.
Align strategic activity across the Southern region. *To make the most effective use of resources and workforce and ensure equity of access for our populations.*	Work from an agreed South Island planning and funding plan for older people's services. Adopt common service specifications and consistent eligibility criteria and processes for Older Peoples services. Support regional identification of workforce capacity and capability and support of the carer workforce. Lead the national implementation of the InterRAI Assessment Tool and provide national InteRAI training and implementation support to other DHBs and providers. Provide one of two hosting sites for the InteRAI application software to support the national rollout.	Assessment for ARC and HBS is consistent across the South Island. Access to ARC and HBS services is in line with national access levels. Improved regional linkages and support for better use of limited resources across the South Island.

5.4 Mental Health Services

We will provide an integrated, responsive system of mental health care that provides timely access to services for people with mental illness and alcohol and other drug problems.

Why is this important?

It is estimated that at any one time, 20% of the New Zealand population have a mental illness or addiction and 3% are severely affected by mental illness. While suicide rates are reducing overall, this is still a key focus for the DHB and certain groups within our population continue to be at high risk. Research forecasts that depression will be the second leading cause of disability by 2020.[32]

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

How are we improving outcomes for our population?

Our system of mental health is based on a recovery approach for people with serious mental illness. We are shifting away from the focus on specialist hospital services towards a balance of specialist hospital services and community-based care, with increased collaboration between providers, service users and their families/whānau. This is consistent with our Health Services Plan direction: community-based care backed by specialist services, realignment of secondary services to be specialist and regional and support for a greater role and more responsibility for community and primary care services.

We have established a single point of entry for child and youth services, called CAF link, and a single point of entry for adult services. This enables GPs and Non-Government Organisations (NGOs) to telephone a consultant psychiatrist for treatment advice for people who do not require case management within specialist services. The initiative supports a continuum of care that provides the benefit of specialist advice without the need for a specialist appointment or a disruption to the primary or community care relationship.

A Pan-DHB Leadership Group is now in place to ensure transformation of the mental health system is appropriately led by clinicians, consumers and family and other mental health leaders. Through this group, we will review our assessment and service coordination pathways and identify service improvement opportunities across the continuum of care.

"95% of all long-term adult mental health clients have current relapse prevention plans in place, 16% higher than the national average. These plans are a means of ensuring quality and consistency across the continuum of care, support self management and reducing unplanned hospital admissions ."

SANDRA WALKER
GM, Specialist Mental Health Services

Simplifying access pathways and improving access to specialist clinical resource across mental health rehabilitation services is our major focus. Collaborative partnerships among mental health service providers across the whole of the Canterbury health system will continue to strengthen and will result in more integrated services, reflective of the needs of our population.

Integration within our own Hospital and Specialist Mental Health Services will be improved through the realignment of our community and inpatient service areas. We will provide increased community-based service options, using the 'packages of care' approach, ensuring people with complex mental health needs are well supported through flexible clinical and support services. This will be achieved by reconfiguring current resources from inpatient services to community services.

Increasing demand for Alcohol and Other Drug (AOD) services has also necessitated cross-sector collaboration to reconfigure our AOD system. The resulting AOD Framework sits within the wider scope of best practice and focuses on local solutions for Canterbury by using the extensive experience of local consumers, families, clinicians and other stakeholders. The changes that we will make over the coming year will provide support to people earlier and in a broader range of settings.

Using the knowledge and experience gained through the AOD and Psychiatric Rehabilitation Reorientation Projects, we will develop similar 'whole of system' approaches for Māori Mental Health Services and Mental Health Consumer Led Services.

Suicide prevention is also one of our priorities and is supported by strong pan-sector leadership along with strong local support from other government agencies. Our Suicide Prevention Initiative will benefit all people in Canterbury through improved and standardised evidence-based assessment, brief intervention and response post-attempt. It will be adopted across primary/secondary services and particularly in our Christchurch Hospital ED over the next 18 months.

[32] *The Canterbury DHB Mental Health and Addiction Strategy, May 2004.*

In the coming year, we will continue to examine the range of mental health services in Canterbury and critically evaluate whether this reflects the needs of service users and will enable us to meet future demands. This work will include a regional focus on regional alignment, integration and implementation of the Regional Mental Health Plan. (Appendix 3 outlines the agreed regional approach over the coming year.)

ACTIONS 2010/11		
OBJECTIVE	**OUTPUTS**	**IMPACTS**
What are we trying to achieve?	*What action will we take to make this happen?*	*What impact will this have?*
Reorient the psychiatric rehabilitation system to reflect current needs. *To improve access and service responsiveness for people with mental illness and to enable the DHB to meet future needs within available resources.*	Provide an increased range of community rehabilitation services, supported through reconfiguration of rehabilitation resources consistent with the rehabilitation systems framework. Support an increase in the number of people accessing rehabilitation services. Provide long-term clients with management plans in place to better coordinate care between providers and support self management.	Reduced unplanned readmissions. 2,000+ people access community mental health services. Increased access rates for HSS mental health services for people with severe mental illness (aged 0-19 2%, 20-64 2.5%). 95% of all long-term clients will have current relapse prevention plans in place.
Implement the Alcohol and Other Drug (AOD) Framework. *To improve access and service responsiveness for people with addictions and to enable the DHB to meet future needs within available resources.*	Realign existing services to ensure consistency with the AOD Framework. Provide an increased range of flexible community AOD support options. Support an increased in the number of people accessing AOD services in the community.	Reduced unplanned readmissions. Reduced wait times for AOD services.
Integrate community and secondary mental health services. *To improve service responsiveness and ensure continuity of care across services.*	Clinically realign DHB community and inpatient adult specialist mental health service teams to deliver a shared care response. Increase the range of community services available.	Reduced unplanned readmissions. Reduce reliance on inpatient and residential care services. 2,000+ people access community mental health services.
Implement the Suicide Prevention Initiative. *To improve service quality, remove duplication between providers and better support those people at risk.*	Implement consistent assessment of suicide risk across primary/secondary and ED services. Implement a consistent response to post-attempt care across primary/secondary and ED services.	At the completion of the 18 month pilot period, the evidence base will provide an evaluation of the initiative. Ongoing outcome measures will be developed.
Align strategic activity across the Southern region. *To make the most effective use of resources and workforce and ensure equity of access for our populations.*	Participate in the South Island Regional Mental Health Network. Support the development and achievement of a Regional Mental Health Work Plan. Collaborate with regional DHB partners to support national workforce and service development initiatives and guidelines.	Better regional perspective on mental health planning and funding improves effectiveness and reduces duplication. South Island mental health services reflect national guidelines.

We aim to reduce the growth in acute inpatient activity by ensuring that the right service is provided to the right patient, at the right time, in the right place and by the right provider.

Why is this important?

Approximately 80,000 people have presented at our Emergency Departments (ED) in the last year, with the vast majority attending Christchurch Hospital ED. Christchurch also has a 24 hour general practice service, which sees almost the same number of people every year. While on a per capita basis our ED presentation levels are lower than most equivalent urban EDs, attendance numbers grew by 7.7% between 2007/08 and 2008/09, or 5,634 attendances in that year. A significant portion of this growth is in the number of self and ambulance referrals to the ED.

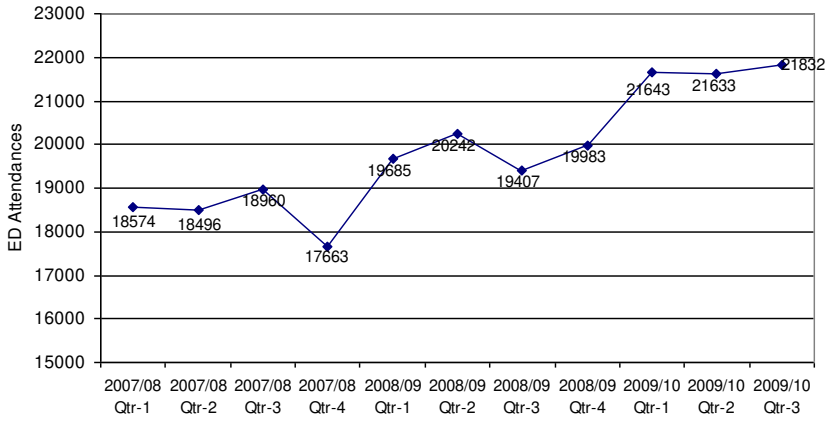


Figure 9: ED Attendances 2007/08 to 2009/10

Increasing ED presentations and acute admissions to our hospitals place pressure on the health system, which must be managed. Excessive growth in acute demand consumes resources and expenditure and places pressure on clinical care, diminishing the effectiveness of hospital activity. Reducing the need for acute admissions by supporting people to stay well, to better manage their long-term conditions and to seek appropriate intervention early will also improve health outcomes for our population.

How are we improving outcomes for our population?

The growth in acute demand can only be managed through initiatives focused across the whole of the health system. We will continue to take an integrated approach to managing acute demand by strengthening strategies to address *preload* (reducing acute demand, principally through primary health care), *contractility* (ensuring effective ED functioning) and *afterload* (ensuring hospital flow, reducing gridlock and improving community-based discharge services). This approach requires effective and affordable access to urgent care (cost is often a barrier to accessing alternative urgent care), rapid access to advice and diagnostics and alternative models of care for ambulance call-outs.

Ongoing analyses of ED attendances indicate that the largest group of patients who attend ED are self-referred. The provision of effective and well targeted primary and community-based services will improve the rate of early detection and intervention and will help to reduce unnecessary hospital admissions and improved management of patients with long-term conditions will further reduce the number of acute exacerbations requiring hospitalisation.

While we currently fund extensive acute demand management services, evidence suggests that there is a need to continue to improve the targeting of these services. We will focus on improved coordination of services and ensuring these services are reaching those who self-refer to ED. The *Better, Sooner, More Convenient* Business Case has a focus on this area with its urgent care work stream, which builds the role of primary care in integrating with and supplementing activities across the rest of the sector by working closely with ambulance services, aged residential care and Non-Government Organisations.

The sustainability and effectiveness of after-hours services in Canterbury play a key role in improving acute demand management. General practice after-hours care is designed to meet the needs of people who do not need acute hospital services but cannot be safely deferred until regular general practice services are next available. The sustainability and the affordability of these services requires attention, as there is some evidence that access to urgent primary care during and

after hours has decreased and is contributing to increased self and ambulance referrals to ED. We are extending the free nurse-led telephone triage system that has been successfully trialled in rural areas to make it available Canterbury-wide.

Meeting the Minister's Expectations

Shorter stays in ED is a national health target for all DHBs, with the expectation that 95% of patients will be admitted, discharged or transferred from ED within six hours. Canterbury has also set an internal target for reducing ED waiting times to 90% of patients within four hours.

The proportion of Canterbury patients waiting less than six hours improved to 90% at the end of the second quarter of 2009/10. We aim to consolidate and improve this performance to achieve the 95% target. We have a Delivery Plan for Shorter Stays in ED, which outlines a clear, multi-stranded, clinically led, 'whole of system' approach (addressing ED preload, contractility and afterload), and aims to improve patient flow and reduce ED length of stay by:

- Reducing ED attendances through improved targeting of the existing Acute Demand Management Service (ADMS);
- Improving access to urgent primary care with a budgeted investment of $2 million in after-hours care;
- Increasing flow through ED using the Acute Medical Assessment Unit (AMAU), Surgical Assessment Review Area (SARA) and Child Acute Assessment Unit (CAAU) to facilitate urgent access to relevant senior medical assessment;
- Developing innovative solutions for frequent attendees and supported discharge for people over 65; and
- Facilitating discharge from ED utilising the community-based Acute Nursing Service established as part of the ADMS.

We have recognised the importance of clinical leadership in improving acute care and have identified joint clinical champions from the primary (preload), ED (contractility) and secondary (afterload) streams to provide clinical leadership and enhance the focus on our 'whole of system' approach to improving access and delivery of urgent care. Advances are reliant on increasing data utilisation and analysis.

ACTIONS 2010/11		
OBJECTIVE	**OUTPUTS**	**IMPACTS**
What are we trying to achieve?	*What action will we take to make this happen?*	*What impacts will this have?*
Improve access to the most appropriate urgent care options to meet patient need at any given time. *To reduce ED presentations, especially in self and ambulance referrals, by ensuring appropriate referrals and supporting discharge (preload and afterload).*	Reorient existing acute demand services to focus on patients with the greatest capacity to benefit. Expand HML nurse-led telephone triage service. Establish acute ambulance triage pathways for alternatives to hospital admission. Further develop and target flexible community based urgent care (admission avoidance) options/packages. Establish acute patient pathways to improve access to urgent clinical information and triage. Reduce after hours care cost barriers for urban and rural high needs people/populations. Support a redeveloped approach to assisted day care, respite and ED services for older people to better identify and refer those at risk of deteriorating health. Enable pharmacy access to electronic discharge notes to reduce medication error.	Reduction in the growth rate of ED attendances and admissions. Increase in access to general practice care (24/7) for people requiring urgent access to care. Increased ED ratio of triage 1 to 3 versus 4 and 5. Increase in people access urgent care packages in the community to 14,000. 500 discharge follow-ups provided for older people with complex needs in general practice.
Deliver shorter stays in emergency departments. *To deliver ED services to patients in a timely manner that respects the patient's needs and values their time (contractility).*	Complete the implementation of the Project RED stream (Improving the Patient Journey) to improve the flow of patients through the ED, AMAU and SARA. Continue to improve information systems to track the patient journey time in ED and monitor time milestones for each patient. Support the Clinical Champions to provide leadership in improving acute care across the health system.	95% of people admitted, transferred or discharged within 6 hours of ED presentation. Reduction in number of people acutely admitted from AMAU/SARA. Reduction in total case weights but an increase in the average, as a measure of the complexity of acute admissions.

We will challenge everyone involved in providing health and disability services to continuously enhance the quality and safety of the services they provide, to improve health outcomes for our community.

Why is this important?

The environment in which the health and disability sector operates is not static. There are constant changes in population demographics, technological advancements, models of care and the expectations of communities and funders. To effectively respond to these changes, the health system needs to foster innovation, quality improvement and clinical leadership.

Improvements in quality will reduce variation in practice, duplication of effort and waste in the patient journey. Focusing on best practice and patient pathways will enable us to make savings through efficiency gains and to make better use of our clinical workforce and limited resources.

How are we improving outcomes for our population?

We are committed to a number of initiatives that support and encourage quality improvement and innovation to enhance service delivery and patient outcomes. We will continue to embrace this momentum, provide clinical leadership across the system and engage and support our workforce in these processes and initiatives. These initiatives are aligned to all of the quality goals in our Quality Strategic Plan and will continue to remain a focus for the coming year.

A focus on the safe patient journey is an effective mechanism for systematically identifying and managing problems and failures in the system and for informing the development of preventive strategies and redesigned patient care processes to eliminate repeated harm. Our Medical Director of Patient Safety works alongside quality leaders and DHB staff to eliminate the harm that can occur to patients in hospital settings and to promote our focus on quality and patient safety.

"Every system is perfectly designed to achieve exactly the results it gets. If we want a better result, we will have to change the system."

DONALD M BERWICK
Institute for healthcare improvement, USA

The safe patient journey will be backed by recognition and support for innovation and quality improvement across the system. We will continue to promote and publicly acknowledge excellent quality, innovation and improvement initiatives through our Quality and Innovation Awards. In 2009, fifteen projects were entered into the programme, all of which were honoured and outlined during the annual awards ceremony. To date, 120 quality projects have been recognised through this programme.

In December our Board approved the Business Plan for establishing a Health Innovation Hub in Canterbury, in collaboration with the Canterbury Development Corporation. The Business Plan is currently with the Ministry of Economic Development for presentation to the Ministers and ultimately Cabinet in early 2010. This Health Innovation Hub will specialise in the evaluation, management and commercialisation of intellectual property generated from the Canterbury health system. The Hub will improve both patient outcomes and the productivity of our health system through the accelerated adoption of proven service improvements and medical technology and through the improved attraction and retention of valuable staffing resource.

National emphasis centres on the priorities of the Quality Improvement Committee (QIC) and the aim to establish a nationally focused and coordinated approach to quality improvement and safety within public hospitals. Four key programme areas have been identified, and we work in collaboration with other DHBs on these projects and share the initiatives we have implemented locally to make the best use of joint resources.

Part of the New Zealand Incident Management Programme (one of the four priority projects) was a two-and-a-half day training session in Root Cause Analysis methodology. This training session was held in Christchurch in April and was attended by an impressive 120 people from across the Canterbury health system. In line with the national focus, we are also participating in Hand Hygiene New Zealand, Optimising the Patient Journey and the Medication Safety Project.

The ability to provide a safe patient journey through the health system also requires integrated information systems and the sharing of patient-focused information between primary and secondary providers. This information needs to be accurate, timely and available at the point of care, to allow the best decisions to be made about patient care.

Clinically relevant information has been stored in multiple systems, which are not integrated. Clinical staff move from patient to patient and need mobile access to patient data and information. The approach to these problems is to provide an integrated view of the available information through our Clinical Information System, which is a portal that brings into one view the clinical information held on patients and allows the entry of new data in an organised way. The Clinical Information System has been successfully rolled out and is in regular use in all of our facilities. Outpatient modules have

been implemented at Christchurch, Burwood and Ashburton hospitals. This includes a focus on the implementation of e-Discharges, which allow discharge summaries to be sent to GPs electronically and will significantly assist primary/secondary integration. We are committed to ensuring that the benefits of improved communication are realised and will continue to promote the use of the Clinical Information System to clinicians.

Part of the extended electronic medical record system is TestSafe South, an authoritative laboratory test results repository that will stretch across the Canterbury health system. TestSafe South enables clinicians in primary and secondary care to electronically access the same laboratory results, improving patient care and avoiding unnecessary duplicate test requests. This system will greatly enhance the quality of clinical decision making.

ACTIONS 2010/11		
OBJECTIVE	**OUTPUTS**	**IMPACTS**
What are we trying to achieve?	*What action will we take to make this happen?*	*What impact will this have?*
Progress Safe Patient Journey Initiatives. *To continuously improve the delivery of our health services such that there will be no needless harm, delays or waste.*	Develop a new Patient Safety Report with a corresponding review of existing performance indicators. Progress the 'Zero Harm' Preventable Falls Reduction Initiative. Work collaboratively with Counties Manakau and Capital and Coast DHBs to address medication safety, supporting the use of trigger tools to measure and then act on adverse drug events. Further develop incident management processes, including establishing an ongoing education programme and implementing a standardised approach to incident investigation. Implement national infections control and prevention initiatives including hand hygiene and catheter-related blood stream infections programmes.	Reduction in the number of adverse events including: serious harm injuries resulting from preventable patient falls, medication-related incidents and hospital acquired infections. Improved patient experience of the health system.
Recognise and support innovation and quality improvement. *To improve our processes and systems and to foster innovation and improvement in service quality.*	Work with the Canterbury Development Corporation to implement the Canterbury Health Innovation Hub model. Deliver the Quality Innovation Awards Programme. Promote quality improvement methodologies across the organisation.	Increased staff satisfaction and engagement.
Accelerate the Clinical Information System (CIS) implementation. *To provide improved clinical access to patient information, lower clinical risk and improve efficiency and patient outcomes.*	Provide an IT environment that supports clinical services. Upgrade Clinical Information System (Concerto), Laboratory Results Reporting (Éclair) and email (Exchange 2010). Replace the Storage Area Network. Roll out e-Referrals in secondary care facilities in line with the Canterbury Initiative programme.	Clinical application up-time in excess of 99.5% Increased number of e-Discharges and e-Referrals. Increase percentage of laboratory tests signed off electronically.
Implement TestSafe South. *To provide electronic access to clinical laboratory results in hospital and community settings, lowering clinical risks and reducing duplication.*	Capture and report Canterbury laboratory results into one results repository. Make results available to hospital and primary care clinicians. Manage the implementation of the new system, providing support services and communication throughout the rollout and implementation.	Reduction in duplicate lab tests.

6 Strategic Priorities - Improving the Health of Our Community

In 2005 the Board agreed on the vision for health services in Canterbury and developed a ten year strategy as to how this vision would be achieved. We developed this strategy in consultation with our community and the (then) Minister of Health, and the strategy is documented as our District Strategic Plan 2005-2010. This Plan identified nine Health Gain Priorities where we believed there was potential to make improvements in the health and wellbeing of our population, reduce inequalities in health status and improve the delivery or the effectiveness of the services provided.

These Health Gain Priorities are:

- Child and Youth Health;
- Older Persons' Health;
- Māori Health;
- Primary Health Care;
- Disease Prevention and the Management of Long-term Conditions;
- Cancer;
- Cardiovascular Disease;
- Diabetes; and
- Respiratory Disease.

Two of these Priorities are currently the focus of whole of system transformation and as such, older persons' health and primary care have been addressed in the previous section of this document.

For the remaining Priorities, the focus continues to be improving the overall health and wellbeing of our population, reducing inequalities for those people who have the poorest health status and improving the delivery and effectiveness of the services we provide or fund. We will build upon the skills, knowledge and capability across the Canterbury health system and seek advice from clinical leaders, stakeholders and our community about what will make a long-term difference in the health of the Canterbury population.

Our approach to making progress in these areas will be consistent; we will:

- Promote messages related to improving lifestyle choices, physical activity and nutrition and reducing risk behaviours, obesity and smoking to improve population health;
- Work collaboratively with the primary and community sectors to provide an integrated and patient-centred approach to service delivery for our population and to ensure the development of continuums of care that help to better manage long-term conditions and reduce acute demand and unnecessary hospital admissions;
- Work with our hospital and specialist services to provide timely and appropriate quality services to our population, support the development of continuums of care and improve productivity, efficiency and effectiveness; and
- Implement a more restorative focus through improved access to home and community-based support, rehabilitation services and respite care to support people to better manage their conditions or illness and to improve their wellbeing and quality of life.

6.1 Child and Youth Health

We will promote and improve the health of children and young people to enable them to make healthier choices and become healthier adults.

Why is this important?

A focus on child and youth health is seen as an investment in the future health and wellbeing of the population of Canterbury. Poor health in childhood can lead to poorer health outcomes, and behaviour patterns established in adolescence have a significant impact on health long-term.

How are we improving outcomes for our population?

We are committed to increasing protective behaviours and reducing risk behaviours, and over the past year we have supported the Baby Friendly Hospital Initiative, smokefree pregnancy services and breastfeeding support services. Key breastfeeding projects have been progressed, including peer support programmes, a successful collaborative breastfeeding Hui, the appointment of community-based lactation consultants and the establishment of a breastfeeding Advocacy Service.

We have reviewed immunisation services to understand all aspects of the process, and this has highlighted areas where we can make improvements in service delivery which will eventually support increased vaccination rates. Six months into 2009/10, we have exceeded the target of 85% percent of two year olds fully immunised for all populations except Māori, where we have achieved coverage of 84% (just 3 children short of the target). The increased number of children being reached reflects general practice effort, supported by the Canterbury National Immunisation Register (NIR) Team, to identify and recall children for early and catch-up vaccinations and to ensure the Register counts immunisations received overseas by Canterbury children. We will work to improve two year old immunisation rates to 91% in the coming year.

Improving utilisation of health and disability services by children and young people helps to improve long-term health and wellbeing, and diseases of the gums and teeth are amongst the most common health problems experienced by New Zealanders. With less than 5% of children in Canterbury having access to fluoridated water, enrolments in dental programmes are a key focus, along with good oral health promotion. We have developed a photo library to accompany key oral health promotion messages, such as tips for teeth brushing and foods for healthy teeth. Alongside our promotion activity, we continue to build the infrastructure to improve the delivery of oral health services in Canterbury and have established new community dental clinics in four communities, six Level One mobile clinics and one 6 chair clinic in Christchurch that has access for people with disabilities.

We have also implemented a 'single point of entry' to improve access to mental health services for children and young people with. In the coming year, we will continue to enhance the interface between Child, Youth and Family Services (CYF) through the newly established dedicated health service for CYF Care and Protection and Youth Justice residential facilities and through the development of the Mental Health Youth Forensic Service. Children and young people with mild to moderate mental health and alcohol and drug issues will also benefit from our increased investment in Youth Brief Intervention Services, expanding the capacity and scope, providing services in schools and offering mobile rural services.

We will continue to consolidate the 'B4 School Check' programme will continue throughout Canterbury. Although we aim to reach all four year olds, we will prioritise children with the highest need to support a strengthening of the relationship between high need families and their general practice team and to reduce the number of unnecessary (or preventable) hospital admissions for our young population groups.

We will also work collaboratively to improve and consolidate services for children and young people across the whole of the Canterbury health system and ensure that activities link with the implementation of the '*Better, Sooner, More Convenient*' Business Case deliverables. We will investigate delivery models for child health services to combine and streamline similar services, better support providers and improve data management. We will consider health activities delivered in schools and improve linkages between schools and primary care. This will include establishing a School Based Health Service in schools with the highest need.

We will also continue to focus on creating supportive environments to ensure good health outcomes for our younger population groups. We are working collaboratively with a wide variety of government agencies to strengthen our united approach to family violence. We will prioritise the prevention and management of child abuse and neglect by identifying the workforce requirements for a comprehensive service and supporting government promotions that address the prevention of child abuse and neglect such as the 'Protecting our Most Vulnerable Infants' initiative.

We have engaged in the national Child and Partner Abuse programme, and implementation of this programme will compliment the work of the Child Protection Service, with a caseworker in our Child Protection Service to provide

psych/social services for children and young people and a Child, Youth and Family hospital-based worker within our service to assist with interagency response and case management.

Meeting the Minister's Expectations

The Minister has indicated an expectation that regionally the six South Island DHBs will ensure 90% of all two year olds are fully vaccinated. We support this regional target and have set a local Canterbury target of 91%, which we will work closely with primary care to achieve over the coming year.[33]

ACTIONS 2010/11		
OBJECTIVE	**OUTPUTS**	**IMPACTS**
What are we trying to achieve?	*What action will we take to make this happen?*	*What impact will this have?*
Integrate child and youth health services. *To improve access and service responsiveness for children and young people and to enable the DHB to meet future needs within available resources.*	Increase the range of child and adolescent services available in Canterbury. Implement clinically led multidisciplinary patient pathways to improve the child health journey and improve access to services. Identify the best location for child health services from both a district and regional perspective. Incorporate a dedicated child health facility into the Facilities Master Plan, identifying facility requirements to meet population, physical, cultural and developmental needs.	Reduction in rates of avoidable hospital admissions for children 0-4 years <108. 60% of children aged four have received their B4 Schools Check. Reduction in wait times for child health services.
Reconfigure immunisation services *To integrate immunisation services across the sector and lift immunisation rates in Canterbury.*	Implement an agreed cohesive and streamlined immunisation coordination service that operates in an alliance principles-based arrangement. Incorporate appropriate outreach services for Māori and Pacific communities in the immunisation alliance, including links with Pharmacy. Ensure all babies are registered on the NIR and have an NIR number allocated. Work with the Ministry of Health to resolve data and system issues that will improve the accurate recording of fully immunised children, and assist in locating those who have not been fully immunised. Identify other childhood or adolescent services that can be incorporated into the delivery model.	Decreased hospitalisations due to vaccine-preventable diseases. 91% of all Canterbury children fully vaccinated at aged two. Parents received more accurate and up to date information regarding immunisation events in order to make more informed decisions. Parents have increased opportunities for immunisation, especially hard to reach populations.
Continue to implement the School and Community Dental Services redesign. *To better support oral health providers to improve oral health outcomes.*	Commission 8 Level One and 2 Level Two mobile dental clinics. Open seven community dental clinics. Expand the preventative care programme to high risk school aged children.	Decreased number of children requiring complex oral heath services. 65% of children are carries-free (no holes or fillings) at aged five. 90% of children enrolled in school and community dental services examined according to planned recall.
Implement the national family violence guidelines. *To identify and reduce violence against children and young people.*	Support Child Protection Service to provide timely assessment and multidisciplinary review for children at risk. Improve the training of health professionals in the identification of child abuse, neglect, harm and impacts of family violence.	70/100 for the child abuse component of the Violence Intervention Programme (VIP) audit. 140/200 for the combined audit of child and partner abuse components of VIP.

[33] *The 2010/11 target has been agreed on the assumption that the Ministry's assistance will help to resolve identified data and system issues which will ensure all 'fully immunised' children are counted as completed immunisations.*

6.2 Māori Health - He Korowai Oranga

We will work closely with stakeholders and providers to ensure that Māori and their whānau receive and have access to services that best meet their needs to achieve Whānau Ora.

Why is this important?

Although progress has been made, Māori still, on average, have the poorest health status of any population group in New Zealand and are less likely to access mainstream health and disability services. The Māori population in Canterbury is increasing, particularly in younger population groups, and Māori have higher rates of diabetes, cardiovascular disease and respiratory disease.

How are we improving outcomes for our population?

In developing our Māori Health Plan, *Whakamahere Hauora Māori ki Waitaha*, we recognise that Māori participation in service development needs to be fostered to improve the cultural responsiveness of mainstream services. This includes active participation at governance and advisory levels and a focus on Māori-led service provision and service development.

Māori are over-represented in terms of risk behaviours which effect long-term health and wellbeing, particularly smoking, poor nutrition, obesity and a lack of physical activity. Our ongoing success in establishing good foundations for our younger populations will assist in improving Māori health and reducing inequalities in health outcomes, but any improvement is dependant on a reduction in risk behaviours and an increased uptake of services such as immunisation programmes, B4 School Checks and free oral health services.

"We are focused on increasing the utilisation of services by Māori to enable improvements in overall health outcomes, including reducing barriers to access, improving the cultural awareness and responsiveness of our mainstream services and supporting community-based, Māori for Māori and peer support services."

HECTOR MATTHEWS
Executive Director, Māori & Pacific Health

Māori are also over-represented in terms of long-term conditions, particularly diabetes and respiratory disease. While they will benefit from our collaborative investment in establishing clear patient pathways and continuums of care across the Canterbury health system, we recognise the need to target programmes and initiatives in key areas to reduce specific inequalities.

In the past year we have also developed the Whānau Ora Assessment Tool, a practical tool that can be used with tūroro (patients) to support them and their whānau during their time in the mainstream hospital system. The tool encompasses a wide dimension of factors relating to the inpatient experience of tūroro and their whānau. These factors include: Whaka whānau ngatanga (connectedness), Hauroratia (history of patient health), Atua (spirituality), Nekenekehia (moving forward), Aroa (patient understanding), Uia (empowering the patient), Oranga (patient wellbeing), Ritenga (referrals) and Ahatia (what to do). The aim of the tool is to encourage and enable staff throughout the organisation to deliver culturally appropriate, comprehensive and quality services, which will in turn improve the health experiences for Māori patients in our hospital settings.

In the coming year, we will utilise our recently completed Māori Health Profile to identify the real gaps and inequalities in health outcomes at a local level, which will enable us to more effectively improve access and utilisation. The importance of accurately targeting health investment is evident in this Health Profile and is recognised in our Māori Health Plan, where effective ethnicity data collection, health status monitoring and identification of areas of inequality are a focus. Good quality data enables robust analysis and provides accurate measurement of success and value for investment. We will also look to review our Māori Health Plan with Manawhenua Ki Waitaha and align our direction with the national Whānau Ora direction.

The number of appropriately skilled Māori staff employed in the health sector is also a factor in improving access rates and the utilisation of services. We will continue our commitment to the regional Māori Health Workforce Plan and initiatives within that Plan, which will help to build the capability and capacity of Māori service providers and the responsiveness of our own services. Canterbury will also take the lead in the South Island for Kia Ora Hauora, a national initiative aimed at increasing the number of Māori studying towards health careers and working in health fields.

Another key focus will be our support of the transformation in primary care and the engagement streams initiated by the CCN to ensure Whānau Ora is central in the development of patient pathways and models of care for long-term conditions management. There is an expectation that DHBs will focus on improving Whānau Ora and we have signalled the development of a set of headline indicators for focusing the health system on improving Māori health status. We will work collaboratively across the Canterbury health system and the wider South Island region to combine resources to improve outcomes for our Māori population.

ACTIONS 2010/11		
OBJECTIVE	**OUTPUTS**	**IMPACTS**
What are we trying to achieve?	*What action will we take to make this happen?*	*What impact will this have?*
Progress our Māori Health Plan. *To support Māori participation in the development of services and to improve health outcomes.*	Establish a Māori Health Advisory Group to participate in the development of services and review of our Māori Health Plan. Establish a clear pathway for Māori participation. Provide six monthly updates of the Māori Health Plan to Board, staff, services providers and the wider community.	Māori participation in the review and progression of the Māori Health Plan with regular forums held with Māori providers. Outstanding actions in the DHB's Māori health Plan progressed.
Improve the planning and targeting of Māori health funding. *To identify local opportunities for improvement in Māori health status.*	Utilise Hauora Waitaha, the Canterbury Māori Health Profile, to provide a clear picture of local mortality, morbidity and risk factor prevalence. Establish clear areas of priority and inequity, and target resources to make the most of investment to improve health outcomes for Māori. Review funding for Māori health at a whole of system level to ensure improved outcomes are achieved for investment. Engage in partnerships with the Māori Indigenous Health Institute to run further Haoura Māori Health Days and research activities.	A 'report card' on Māori health progress agreed and reported back to the Board and Māori community annually. Improved long-term health outcomes for Māori in line with improvements for other population groups.
Reorient Māori Health Services to reflect the needs of Māori. *To reduce inequalities of access or health status between population groups and enable the DHB to meet future needs within available resources.*	Work with Māori health providers to implement a whānau-centred system based on individuals, whānau and community empowerment. Support the development of clinically led patient pathways to improve health outcomes for Māori. Support flexible and responsive collaborative programmes to better meet the needs of Māori and improve Māori health through the *Better, Sooner, More Convenient* Business Care including: ▪ Whānau engagement activities in primary care services. ▪ Māori Diabetes/CVD screening programmes with a target of 1,042 consultation subsidies for early detection of at risk Māori. ▪ A Whānau Ora toolkit and the provision of cultural training to primary care. Support Māori providers to reduced duplication of 'back-office' functions to free up resources for front-line services delivery.	Reduction in preventable hospital admissions for Māori across all ages. An increase in the percentage of our Māori population enrolled in PHOs. Māori whānau are supported socially to empower themselves to access health services and to navigate through and utilise health services. Increased referrals to and by Māori primary care services via general practice. Recognition of Māori cultural needs by clinicians and health services. Increased access/utilisation of services: ▪ 91% of Māori aged 2 fully immunised. ▪ 44% of Māori with diabetes have their diabetes systemically monitored. ▪ 62.9% of eligible Māori have a CVD risk assessment every five years.
Support Māori Workforce Development. *To increase the number of Māori working in health fields and support improvements in mainstream services and the capacity of Māori health services to meet future needs.*	Contribute to Māori health as a career programme and provide up to 10 scholarships for study in primary health care fields. Lead the implementation of Kia Ora Hauora, the national Māori Workforce Development Service.	An increase in the numbers of Māori choosing health as career – nationally, 1,000 Māori enrolled and studying towards careers in health within 3 years.

6.3 Disease Prevention and the Management of Long-Term Conditions

Through promoting healthy lifestyles and providing people with the tools to help them improve their quality of life, we will improve the health status of our population at risk of developing long-term conditions and reduce the prevalence and impact of these conditions.

Why is this important?

Long-term conditions account for a significant number of potentially preventable presentations at hospital emergency departments and admissions to primary care and hospital and specialist services. With an ageing population, this burden will increase. The World Health Organisation estimated that more than 70% of health care funds are spent on long-term conditions. Long-term conditions are also a barrier to independence and participation in the workforce and in society. Reducing risk factors will assist in mitigating the predicted increase in rates of long-term conditions, and effective management of long-term conditions can make a real difference by helping to prevent crises and deterioration and enabling people to attain the highest possible quality of life.

Many long-term conditions share common risk factors and are preventable. Current trends indicate that by 2011, 29% of our adult population will be obese. This has significant implications for rates of cardiovascular disease, diabetes, respiratory disease and some cancers, as well as poor psychosocial outcomes and reduced life expectancy.

How are we improving outcomes for our population?

Tobacco smoking contributes to a number of preventable illnesses and long-term conditions, resulting in a large burden of disease. In addition to the high public cost of treating tobacco-related disease, tobacco and poverty are inextricably linked. In some communities, a sizeable portion of household income is spent on tobacco, resulting in less money being available for necessities such as nutrition, education and health. Tobacco control remains the foremost opportunity to rapidly reduce inequalities and improve Māori health.

Our Tobacco Control Action Plan sets priority populations and environments where we will focus our efforts to reduce the harm caused by tobacco smoking, targeting Māori (especially young women), pregnant women, women of child bearing age, patients receiving secondary and specialist health services, children and young people (especially those with parents who smoke), mental health consumers and people who smoke at home and in cars. Our Plan for the coming year supports programmes to reduce the uptake of smoking and increase quit levels, particularly amongst identified high risk groups.

Over the past year, we have initiated primary health care practitioner involvement in cessation advice. We have also embedded the Ask, Brief, Cessation (ABC) programme in our hospital and specialist services, and the programme is making steady month by month progress. In January 2010, the seventh month of the programme, 39% of identified hospitalised smokers were provided with advice and support to quit. A system for documenting smoking status and cessation interventions has been implemented, with face to face training provided to 414 staff and a further 215 through our E-learning tool. A direct referral process from hospital to Quitline is in place to facilitate cessation support, and standing orders for nurse dispensing of Nicotine Replacement Therapy will be in place by the end of the year.

Inactivity, poor nutrition and rising obesity rates are also major contributors to an increase in long-term conditions. Our Healthy Eating Healthy Action (HEHA) Plan and public health promotion programmes are our approach to reducing these risk factors and are focused on population and personal health initiatives that target improved nutrition and physical activity. We are committed to our leadership role in HEHA and the partnerships that have been established across a number of key settings. We will continue to ensure a collaborative approach to improving health and lifestyles with further emphasis on sharing resources across the whole of the system and reducing duplication and waste.

Our patient-centred model of care supports a 'one system' approach, and the framework will ensure the patient journey through the health system will be timely and seamless between providers and offer the best quality outcomes. Part of the *Better, Sooner, More Convenient* focus in the coming year is centred on supporting this model of care to ensure people receive the right treatment, at the right time and in the most appropriate setting. Our activity over the coming year will promote a strengthening of whole of system workforce capacity and ensuring the best use of available resources by:

- Ensuring services located in hospital settings complement community-based services;
- Supporting a patient-centred focus and promoting the patient as leader in their own care;
- Minimising access barriers to services and co-locating services where possible in locations that are accessible; and
- Optimising health outcomes and encouraging innovation while 'delivering within our means'.

Meeting the Minister's Expectations

Providing better help for smokers to quit is a national health target for DHBs. Both hospital and primary care services are expected to identify current smokers and then offer brief intervention advice and support for smokers to quit. The ABC programme is now embedded in our hospital and specialist service divisions and we are committed to achieving the 90% target by the end of the 2010/11 year. We will also support primary care in their efforts to develop systems to record the identification and provision of advice and support in order to meet the primary care target by the end of the same year.

ACTIONS 2010/11		
OBJECTIVE	**OUTPUTS**	**IMPACTS**
What are we trying to achieve?	*What action will we take to make this happen?*	*What impact will this have?*
Support collaborative programmes and projects that reduce the negative determinants of health. *To reduce risk factors for those most at risk of poor health and share resources and capability across the region.*	Complete a joint health profile of Christchurch City with specific emphasis on Māori consultation. Support partner agencies to use Health Impact Assessments (HIA) as a tool for implementing a health-in-all-policies approach within organisations.	City Health profile reflects the whole population and promotes collaborative programmes and shared resource. Increased number of HIA completed.
	Implement the Community Violence Reduction Project in collaboration with the Christchurch City Council and NZ Police. Ensure licensed premises comply with legislation.	90% of alcohol retailers are identified from controlled purchase operations as compliant with legislation.
	Support schools to adopt a range of sustainable initiatives, plans, policies and guidelines to improve nutrition and physical activity.	70% of priority schools provide education and environments that support healthy food choices and physical activity.
Implement smoking cessation programmes. *To reduce the harm caused by tobacco.*	Provide smokefree environments to support those making cessation attempts. Ensure tobacco retailers comply with legislation. Provide Māori smoking cessation services. Identify people's smoking status and provide smokers with brief advice on quitting smoking and the resources to support cessation using the ABC Strategy. Support primary care to establish systems which will allow collection of baseline data and record the provision of smoking cessation advice.	>65% of Year 10 students have 'never smoked'. 90% of tobacco retailers identified from controlled purchase operations are compliant with legislation. >200 people enrol with the Aukati Kaipaipa smoking cessation programme. 90% of hospitalised smokers are provided with advice and help to quit smoking. 80% of current smokers identified in primary care are provided with advice and help to quit smoking.
Implement the Healthy Eating Healthy Action (HEHA) Plan in conjunction with other agencies. *To create environments that support healthy eating, physical activity and weight reduction and empower communities to take positive action.*	Support community action to empower and enable Māori and Pacific people to achieve HEHA goals and increase HEHA capability. Coordinate the delivery of Māori Community Action projects and provide HEHA workforce development opportunities to Māori communities. Support joint planning and programme delivery through the CIPANG Steering Group and Network. Implement tailored programmes that support older people to eat well and keep healthy.	Reduction in the proportion of the population who are overweight or obese. Increased percentage of the population participates in regular physical activity. Increased fruit >62% and vegetable >70% intake. >540 people participate in Appetite for Life courses.
Establish clear plans for the management of an emergency or pandemic. *To minimise risk to the public.*	Review and update emergency and pandemic plans in conjunction with other national plans and protocols. Provide appropriate emergency situation training for people across the whole system.	Increased capacity to respond to an emergency or pandemic.

6.4 Cancer Services

By working collectively to reduce risk behaviours and improving consistent access to quality services across the whole system, we will reduce the impact of cancer and improve outcomes for our population.

Why is this important?

Cancer is the second highest cause of death and a major cause of hospitalisation in New Zealand. While cancers attributable to tobacco smoking are expected to decline (with declining tobacco consumption), cancers related to poor diet, lack of physical activity and rising obesity levels are on the increase. At least one third of cancers are preventable, and the impact and death rate of cancer can be reduced through early treatment.

How are we improving outcomes for our population?

Our Canterbury Cancer Plan was approved by the Board in October 2009, and work streams will be prioritised against the national Cancer Control Steering Group's priorities and expectations. National focus is on standardisation, building capacity for treatment and models of care and patient treatment pathways, with lung and bowel cancer being the priority tumour streams. The national Cancer Control Strategy Action Plan also identifies the continued development of regional cancer networks to enhance collaboration to improve cancer control. We support the Southern Cancer Network, which brings together key stakeholders in the South Island to better plan and deliver comprehensive and integrated cancer services and to develop patient care pathways.

"The newly installed linac is 12-20% more efficient than its predecessor… The new machines will also more accurately target cancers, limiting the level of radiation reaching surrounding tissue and reducing side effects."

IAIN WARD
Radiation Oncology Clinical Director

Our programmed upgrade of equipment and facilities is progressing. The first replacement linear accelerator (linac) became operational in May 2010, with a second replacement linac scheduled to be online by the end of the year. A decision on a fourth new linac is scheduled to be re-assessed in late 2010. The replacement linacs are part of our commitment to increase capacity in the delivery of radiation treatment and meet the Minister's expectation that everyone needing radiation treatment will have this within six weeks by the end of July 2010 and within four weeks by December 2010. In order to maintain service levels during the transition phase leading up to the commencement date for the new linac, arrangements have been made for new patients from the South Canterbury DHB to receive their cancer treatment at the Otago Cancer Centre.

A new High Dose Rate brachytherapy service, replacing the previous Low Dose Rate service, has been initiated with the installation of a High Dose Rate machine at Christchurch Women's Hospital. Brachytherapy is a type of radiation treatment in which radioactive material is placed directly into or near the cancerous tumour, thereby reducing the exposure to radiation of surrounding tissue and reducing side effects for patients. A new chemotherapy suite, new clinical rooms, waiting rooms and offices are also part of the significant upgrades taking place.

The treatment of cancer involves complex treatment pathways that cut across surgical and medical oncology services as well as radiation treatment. We are cognisant of the need to initiate changes that will drive improvements for access to surgery and chemotherapy and recognise the importance of the multidisciplinary team approach in achieving these improvements. We are developing an infrastructure that strengthens and supports this. In conjunction with the Southern Cancer Network (SCN), we will develop and adopt consistent standards and documented referral pathways for the three major tumour streams of lung, colorectal and breast cancer.

With the SCN, Canterbury Clinical Network, private providers and other DHB cancer centres, we will collaborate to achieve greater efficiencies from regionally coordinated cancer services. The public/private interface is set to develop in 2010 as new facilities in the private sector come on-stream during the year, with a new cancer centre opening at St George's Hospital. This additional private capacity is likely to further enable the DHB to reduce waiting times for radiation treatment by reducing demand on public resources. While the extent of the impact is uncertain, we will look to make the most effective use of this new local facility for the benefit of our population. A new Positron Emission Tomography (PET) scanner is also scheduled for commencement in 2010 at Southern Cross Hospital. A PET scanner is far more sensitive than CT or MRI scans in detecting cancers and helps to target treatment, saving unnecessary surgery. Currently patients referred for a PET scan need to travel to Melbourne or Wellington, and we will look to make effective use of this new local facility. The Ministry of Health has also announced funding to supplement existing DHB spending on PET scans. We will take the lead in purchasing PET scans for the South Island DHBs and coordinate a regional variance committee.

Workforce development and staff retention continue to be key areas of concern in the delivery of cancer services. Additional shifts were undertaken over the past year to reduce the waiting times for radiation treatment, and a number of the additional staff required to deliver these shifts were employed on temporary contracts. We will continue to work on

strategies to recruit and retain the appropriately qualified and experienced staff needed to operate the new equipment and technology being commissioned in 2010.

Alongside the building of capacity and patient pathways for treatment, we will continue our commitment to supporting lifestyle change to reduce the risk factors for cancers. This includes the implementation of the Human Papillomavirus (HPV) Vaccination Programme to provide young women with protection against cervical cancer in primary care, the DHB's Tobacco Control Action Plan and the Sunsmart and ABC smoking cessation programmes.

Systems that support service improvements are also needed to allow for the early diagnosis of cancer and to ultimately reduce mortality rates, including improving screening and accessible primary care-based intervention and education. We will continue to collaborate with PHOs and general practice to maintain screening levels in primary care for cervical and breast cancer and to support health promotion and the early detection of cancer.

We will also continue to develop our palliative care services and support general practice to provide end-of-life care in the community. Workforce capacity is being developed as we work towards the establishment of two Palliative Care Registrar positions which provide palliative care services across the whole of the Canterbury health system. We will also evaluate the national Liverpool Care Pathway Pilot that we are piloting in 20 sites.

Meeting the Minister's Expectations

DHBs are expected to ensure that everyone needing radiotherapy starts this within four weeks from the decision to treat by December 2010. We are committed to enhancing capacity to deliver treatment and reducing waiting times.

ACTIONS 2010/11		
OBJECTIVE	**OUTPUTS**	**IMPACTS**
What are we trying to achieve?	*What action will we take to make this happen?*	*What impact will this have?*
Support cancer prevention and screening programmes. *To reduce the incidence and impact of cancer.*	Support implementation of the national HPV Vaccination Programme and evaluate progress through participation rates for the programme. Support national breast and cervical screening programmes.	>50% of eligible young women vaccinated against cervical cancer. Canterbury screening rates remain above the national average.
Build additional capacity through investment in equipment. *To reduce waiting times for radiation treatment in line with clinical guidelines and national health targets.*	Extend current operating hours as required during replacement of the linear accelerators. Take down the oldest linear accelerator and install the second replacement linac - online October 2010. Investigate and support local and regional collaboration to increase South Island capacity.	Reduced cancer mortality rates. Reduced wait times for radiotherapy treatment to a maximum of four weeks by 31 December 2010.
Improve the Patient Journey. *To further improve response time and reduce treatment delays.*	Use value stream mapping and principles of lean thinking to determine patient flow through Oncology Services. Reduce variation in the patient journey, and support services to sustain performance in a changing demand environment. Develop (with Oncology staff) planning and capacity tools to match capacity to patient flow. Introduce a clinically led pathway for endoscopy with a single point of entry and support general practitioners to give patients clear referral advice and expectations.	Reduced wait times for cancer treatments in line with clinical guidelines. Reduced wait times for all clinically appropriate patients from first contact with Oncology Services until completion of treatment.
Support palliative care services. *To improve quality of life for cancer patients needing palliative care and their families/whānau.*	Continue to implement and evaluate the Liverpool Care Pathway pilot project. Establish additional Palliative Care Registrar positions to work across the Canterbury system.	20 residential care facilities will rollout the Liverpool Care Pathway over the two years of the pilot project.
Align strategic activity across the South Island region. *To make the most effective use of resources and workforce and ensure equity of access.*	Support SCN to develop consistent standards and documented referral pathways for major tumour streams. Support SCN and local Cancer Networks to identify local issues and regional solutions to reduce inequalities in service delivery for our populations.	Reduced cancer mortality rates. Reduced variation in treatment between South Island DHBs.

6.5 Cardiovascular Disease

Through a collaborative, integrated and consistent approach to prevention, early intervention and rehabilitation, we will reduce the onset and impact of Cardiovascular Disease (CVD).

Why is this important?

CVD includes coronary heart disease, circulation, stroke and other diseases of the heart. It is the main cause of death in Canterbury and the leading cause of hospitalisation (excluding pregnancy and childbirth). Older people, Māori and Pacific people have higher rates of CVD, which will increase as our population ages. CVD is also strongly influenced by environmental and lifestyle influences and by risk behaviours such as poor nutrition, lack of physical activity and tobacco smoking. Increasing rates of CVD will result in greater demand for more specialised care and treatment for heart attack, stroke, heart failure and other circulatory diseases.

How are we improving outcomes for our population?

Our model of care for managing long-term conditions places emphasis on the continuum of care to improve service delivery and the patient journey for those with long-term conditions such as CVD. Our approach will be to strengthen service capacity across that continuum, provide services in the most appropriate settings and support population-based strategies to maximise outcomes for our population.

We promote physical activity, good nutrition and smoking cessation to improve cardiovascular health and will continue to collaborate with primary care providers and to encourage CVD risk assessment, risk management and early intervention for high-risk patients through implementation of the *Sooner, Better, More Convenient* Business Case.

We are working collaboratively to ensure we have the capacity across the Canterbury health system to treat people within appropriate timeframes. This includes our commitment to enabling primary care access to diagnostics and specialist advice to reduce unnecessary admissions to hospital when people may be more appropriately cared for in primary or community settings, or in their own homes. Through implementation of the Business Case, we will support Integrated Family Health and Social Services Networks to improve care for our population and will support the application of the methods and lessons from the establishment of our Integrated Respiratory Service to CVD management.

We will also seek to reduce readmissions and improve the quality of people's lives after an acute event by empowering people to self-manage their conditions, with clinical input, and by identifying appropriate supports including rehabilitation programmes. Strokes (where supply of blood to the brain is interrupted) can significantly affect a person's quality of life and make it difficult to perform everyday functions such as bathing, feeding and dressing. Our Community Stroke Rehabilitation Service (for example) helps clients in the home setting perform tasks where the client feels comfortable, rather than tired and stressed from travel to hospital. These services enable the clients' 'significant others' to participate. Activities such as walking to the mall or attending community-based social groups provide clients with the benefits of community integration and participation, as well as a greater sense of empowerment. Our rehabilitation focus will be backed by increased access to home support services and respite care, allowing people to remain in their homes and improving their quality of life, and by improved discharge processes and support and increased access to rehabilitation programmes to reduce the impact of the event and prevent readmission.

Meeting the Minister's Expectations

Improving cardiovascular services is a national health target, with the aim being to increase the percentage of the eligible adult population having their CVD risk assessed in primary care (currently measured by the number of people having had a fasting lipid/glucose test in the past five years).

In line with this focus, we have supported the introduction of decision informing and patient empowering information technology tools in primary care to assist with CVD risk assessment and the diagnosis and ongoing management of CVD . PHOs are providing general practice teams with evidence-based education programmes to support individualised risk assessment and the management of CVD alongside other long-term conditions.

ACTIONS 2010/11		
OBJECTIVE	**OUTPUTS**	**IMPACTS**
What are we trying to achieve?	*What action will we take to make this happen?*	*What impact will this have?*
Improve the identification of people 'at risk' of CVD. *To improve access to appropriate intervention and support improved self management of CVD.*	Support the implementation of a Diabetes/CVD screening programme to improve early detection of at risk urban and rural Māori. Support the implementation of a Diabetes/CVD screening programme to improve early detection of at risk urban and rural Pacific people.	73% of the eligible population will have had their CVD risk assessed every five years – via lipid/fasting glucose test. 62.9% of the eligible Māori population will have had their CVD risk assessed every five years -via lipid/fasting glucose test. 60.1% of the eligible Pacific population will have had their CVD risk assessed every five years -via lipid/fasting glucose test.
Ensure people receive the right care in the right setting. *To support improved access to resources, information and support to enable people to modify lifestyles, self manage their condition and stay well.*	Expand the range of patient pathways agreed between general practice and hospital specialists to include cardiology to improve the integrated management of CVD. Support the implementation of text-to-remind programmes in general practices and pharmacies to support recalls and medicines reminders. Support the integration of health promotion/wellness plans, including clinical education/cross-sector referrals. Support the design and implementation of clinical/patient education and tools for self management of long-term conditions. Provide general practitioners with access to specialist advice and diagnostics without the need for a hospital appointment.	Reduction in CVD readmission rates. CVD pathways available online via HealthPathways website accessible from GP desktops. 80% of the eligible population will have received a CVD risk assessment in primary care. 80% of smokers attending primary care will be provided with advice and help to quit smoking.
Support Rehabilitation Programmes. *To reduce the likelihood of a subsequent CVD event and to support people to optimise recovery.*	Continue to support the referral of people to cardiac and stroke rehabilitation programmes after acute events. Provide a broader range of stroke rehabilitation services to complement existing services. Provide a broader range of specialised rehabilitation and support services for people who need more advanced care.	>34% of people access cardiac rehabilitation after an acute event. >68% of people access stroke rehabilitation after an acute event.

6.6 Diabetes

We will deliver a diabetes service for Canterbury residents where the right service is provided for the right person at the right time in the right place as part of a seamless, truly integrated service that provides expertise and is supported by clinical governance and evidence-based best practice.

Why is this important?

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

Type II diabetes, most frequently diagnosed in adults and now being diagnosed in Canterbury's children and young people, is strongly linked to poor nutrition and other lifestyle factors and is therefore amenable to prevention.

How are we improving outcomes for our population?

Diabetes remains a priority area for the Canterbury DHB, and we will continue the work the Canterbury Initiative began in 2009/10, using a collaborative model between hospital specialists, general practitioners, nurses, dieticians, podiatrists and ophthalmologists to design patient pathways and provide integrated packages of care around patients. The work will to be supported through the implementation of the *Sooner, Better, More Convenient* Business Case.

A mixture of population initiatives and individual lifestyle changes will help to reduce the prevalence of diabetes amongst our population. We will continue to promote and support healthy lifestyles, including physical activity, good nutrition and smoking cessation, to decrease the risk factors that contribute to and exacerbate diabetes.

The effective management of diabetes relies on a whole of system approach to raising awareness and improving education, intervention, self management and the quality of care being provided to people with diabetes. The proportion of those people who have diabetes that have good diabetes control can be used to indicate the quality or effectiveness of the care being provided and is one of the national health targets. In Canterbury, while the proportion of people with good diabetes control is relatively high, we appear to be well below the national average in terms of the number of annual diabetes reviews being delivered to our population.

Collaborative research undertaken with our Local Diabetes Team found that there was strong awareness of diabetes annual reviews, which were seen as one part of good monitoring throughout the year. However, the annual review did not necessarily result in a management plan produced in partnership with people's general practitioners, to ensure that they managed their condition and had ongoing routine assessments and reviews. Feedback from primary care suggests that the number of annual checks being reported is not reflective of the number of general practitioners who work with their patients throughout the year to monitor and manage their patients' diabetes care, and a number do not claim (or report) this care as a one-off diabetes annual check.

We have made a commitment to work in partnership with our primary care partners and with community providers and Māori and Pacific communities to support better diabetes education, earlier intervention and better care planning and to improve the monitoring and review of our population identified with diabetes. In doing so, we will accurately record and recognise all those people who receive a diabetes annual review and all those people who received the components of an annual review as part of ongoing diabetes management throughout the year. With a clear understanding of the gaps, we will work to support targeted improvements and to deliver against both national health targets for diabetes – maintaining the proportion of our population with good diabetes control at 79% and increasing the proportion who are receiving an annual review of their condition to 52%.

Because diabetes also affects eyesight and blood circulation (resulting in increased foot problems), we will improve access to community-based services that help to improve quality of life for people identified with diabetes, including retinal (eye) screening and podiatry services. We will also support primary and community providers with timely support and advice from specialist services and promote the development of diabetes management guidelines and an integrated referral pathway across the whole system, to reduce unnecessary hospital admissions and the longer-term complications from diabetes such as blindness, amputations and renal failure.

To ensure the most cost-effective use of limited resources, we will target populations with the highest risk and where the long-term benefit is greatest, including Māori and Pacific populations and during childhood, adolescence and pregnancy. We will also focus on peer support programmes and empowering the self management of diabetes as a more effective use of resource. Traditionally, the self management tasks required when people with Type II diabetes move onto insulin

injections have been taught by diabetes educators on a one-to-one basis. Recognising that the number of Type II patients needing insulin is increasing rapidly, the Christchurch Diabetes Centre has developed a new group model of education. This programme enables patients who have just commenced on insulin to help those who have yet to start. Audit of the first 50 patients participating demonstrated classes were as effective as traditional one-on-one education, while allowing patients to benefit from mutual support and discussion with others with the same condition.

Meeting the Minister's Expectations

Provision of free diabetes annual checks and improvements in the management of diabetes are national health targets. We believe that our results could be more reflective of the positive support for people with diabetes taking place in Canterbury and that we can do more to better integrate services across the whole system.

We have already started to work with our largest PHO to identify where the management of diabetes has not been reflected in diabetes annual check data. Practices where good diabetes management is taking place will be identified, and our data capture will be aligned to more accurately reflect the Canterbury situation. As part of this process, practices where diabetes management is less well managed will be supported to better monitor and support people with diabetes. The combination of this work will result in a real understanding and significant improvement in Canterbury's contribution to the national health target.

ACTIONS 2010/11		
OBJECTIVE	**OUTPUTS**	**IMPACTS**
What are we trying to achieve?	*What action will we take to make this happen?*	*What impact will this have?*
Improve the identification of people 'at risk' of diabetes. *To improve access to appropriate intervention and support the improved self management of diabetes.*	Support primary care to provide increased evidence of diabetes reviews undertaken with improved reporting to positively impact on the health target. Align data capture methods to accurately measure diabetes management activity. Support primary care to provide education and training to improve diabetes management in practices where additional support is needed.	An increase in the proportion of the total population with diabetes receiving a diabetes annual review from 38% to 44%.
Ensure people receive the right care in the right setting. *To support improved access to resources, information and support to enable people to modify lifestyles, self manage their condition and stay well.*	Expand the range of patient pathways agreed between general practice and hospital specialists to include diabetes to improve integrated management of diabetes. Support primary care to provide increased evidence of diabetes review utilisation with improved reporting to positively impact on the national health target. Support the implementation of a Diabetes/CVD screening programme to improve early detection of at risk Māori. Support the implementation of text-to-remind programmes in general practices and pharmacies to support recalls and medicines reminders. Support the integration of health promotion/wellness plans including clinical education and cross-sector referral. Support the implementation of a Pacific Diabetes/CVD screening programme. Support the design and implementation of clinical/patient education and tools for self management of diabetes. Free up hospital specialist services to focus on patients with complex needs and provide responsive and flexible specialist support to general practice teams. Invest in improving access to appropriate diabetes services in the community (retinal screening and podiatry services).	Reduced growth in ED and acute hospital admissions. Agreed diabetes pathways available online through HealthPathways. 52% of the total expected population with diabetes have their diabetes systemically monitored. 44% of the expected Māori population with diabetes have their diabetes systemically monitored. 40% of the expected Pacific population with diabetes have their diabetes systemically monitored. 79% of the total population with diabetes have improved diabetes management (HbA1c>=8%). 70% of the Māori population with diabetes have improved diabetes management (HbA1c>=8%). 56% of the Pacific population with diabetes have improved diabetes management (HbA1c>=8%).

6.7 Respiratory Disease – Canterbury's Integrated Respiratory Service

We will deliver a respiratory service for Canterbury residents where the right service is provided for the right person at the right time in the right place as part of a seamless, truly integrated service that provides expertise and is supported by clinical governance and evidence-based best practice.

Why is this important?

Respiratory disease is recognised as one of the key developing long-term disease burdens associated with rising obesity and an ageing population. Up to 100,000 people in Canterbury may be affected by respiratory issues, including chronic obstructive pulmonary disease (COPD), asthma and sleep disorders. Many of the risk factors associated with respiratory disease, such as smoking, poor nutrition and poor housing, heating and air quality, are seen as preventable.

The impact of respiratory disease in terms of illness and the cost to the health sector is significant, and Māori have disproportionately higher rates of respiratory disease. Improved respiratory services provide a major opportunity to improve Māori health outcomes and health status.

How are we improving outcomes for our population?

Over a year ago we committed to integrating respiratory services in our region and making services available in the community so that respiratory diseases could be quickly identified and people could have effective management plans in place to avoid unnecessary hospital admissions and adverse longer-term health outcomes.

Significant progress has been made and with the guidance and support of the clinically led Integrated Respiratory Service Development Group (IRSDG), stronger professional links have been established between primary and secondary services. Whole of system networks and relationships are being nurtured and developed to ensure the sustainable change required to achieve a truly integrated Respiratory Service. In just the first twelve months of the Integrated Respiratory Service model having been established in Canterbury:

- Patients have more choice regarding the location of their intervention and no longer have to travel to hospital for spirometry, sleep assessment or overnight oximetry. Patients can now access these diagnostic services in general practice settings across Canterbury. In total, there are six approved provider practices of spirometry testing and 20 approved provider practices of sleep assessments; all in addition to the mobile team which has also been established. These practices are attracting referrals from neighbouring general practices and are forming a basis for integrated family health and social service networks. 657 spirometry tests and 392 sleep assessments have already been delivered in the community;
- Rural patients are better served due to the strong uptake of services from rural general practice, with Kaikoura, Cheviot, Akaroa, Amberley, Rangiora and Ashburton practices becoming approved providers with the expertise to serve their patient populations;
- Patients can now also partake in pulmonary rehabilitation in community locations in Rangiora, Aranui and Kaikoura, and planning is underway for programmes in Ashburton and Hornby. Exercise classes have started in Rangiora and Amberley. The aim is to double the number of people receiving pulmonary rehabilitation in Canterbury;
- Patients can be assessed in their community anywhere across Canterbury by the community Respiratory Physician. Over 140 patient assessments have already been delivered, along with practice education;
- Patients can be assured of consistent quality of care across secondary and primary care through the development of IT systems, education programmes and quality frameworks that are being embedded in patient pathways;
- The sharing of workforce and other resources across the system has commenced to ensure high productivity, value for money and improved access for patients, and as a natural outcome of the whole of sector relationships; and
- General Practice-based diagnostic testing and community-based pulmonary rehabilitation programmes now provide the platform, skills and capacity for delivering *better, sooner, more convenient* respiratory services and have the ability to impact positively on referral and admission rates to hospital.

We will continue to support this momentum to improve our response to acute and long-term needs, improve the appropriateness of referrals and admissions to secondary care, enable a more flexible secondary care response and make the best use of specialist expertise. The Integrated Respiratory Services model will be evaluated based on reduced unnecessary hospital admissions for respiratory conditions, improved access for high-risk groups and increased patient quality of life and satisfaction.

The understanding and knowledge gained from establishing this integrated service will be shared as we look to integrate other services for long-term conditions in a similar way, with cardiovascular and diabetes a focus for the coming year.

ACTIONS 2010/11		
OBJECTIVE	**OUTPUTS**	**IMPACTS**
What are we trying to achieve?	*What action will we take to make this happen?*	*What impact will this have?*
Improve the identification of people 'at risk' of respiratory disease. *To improve access to appropriate intervention and support long-term strategies and prevent admissions.*	Support the provision of COPD screening alongside screening for other long-term conditions. Explore telehealth and other technologies and more flexible options for long-term conditions management.	An increased number of people access screening for COPD.
Ensure people receive the right care in the right setting. *To support seamless patient care and improved access to resources, information and support to enable people to modify lifestyles, self manage their condition and stay well.*	Expand the range of patient pathways agreed between general practice and hospital specialists to include COPD, chronic cough, dyspnoea, haemoptysis, sleep disorders, spirometry and asthma. Expand general practice capacity and skills to enable general practice-based diagnostic testing and community-based pulmonary rehabilitation. Free up hospital specialist services to focus on patients with complex needs and provide responsive and flexible specialist support to general practice teams. Provide multidisciplinary services for obstructive sleep apnoea (OSA), with community-based services supporting patients with low complexity OSA integrated with hospital specialist services for those patients with more complex needs. Introduce a transparent single gateway and triage of specialist referrals to ensure equity of access. Enhance services for patients in remote and rural communities. Design services and models of care that support the development of Integrated Family Health and Social Service Networks.	Equitable access to timely diagnosis, assessment and care plans, with more services available closer to home. Simplified assessment and case coordination. Sustainable services in local communities; familiar faces throughout the patient journey. 20 provider education forums provided for extended general practice teams. 1,320 spirometry assessments completed in the community. 1,020 sleep assessments completed in the community. A reduction in the proportion of HSS respiratory out-patient appointments that are follow-ups. Reduced COPD readmission rates. Reduced acute admissions for COPD.
Apply the available Canterbury health workforce in different ways and promote education and support for clinical staff and patients. *To support a rehabilitation focus and enable seamless patient care to meet future needs within available resources.*	Support the involvement of practice nurses and community physiotherapists in pulmonary rehabilitation programmes. Develop a skills and knowledge framework for pulmonary rehabilitation, spirometry and OSA screening to be delivered in the community. Support the Cardio-Respiratory Outreach (CRO) Service and Canterbury Initiative Support Organisation to work as one team. Extend the respiratory education focus to support GP teams to provide care in the community. Provide patients with self management material for minimising their disease progression.	Patients have the right information to manage their health needs and are supported to manage their conditions. Increased number of community pulmonary rehabilitation programmes delivered within current funding levels to 12 programmes. 150 patients access community-based pulmonary rehabilitation programmes. 20 provider education forums provided for extended GP teams.

7 Additional Focus - Meeting Government and Community Expectations

Like all DHBs, Canterbury has a number of obligations and responsibilities under the New Zealand Public Health and Disability Act, through our Crown Funding Agreement with the Ministry and as part of national health strategies and the Minister of Health's ongoing expectations and priorities.

This section addresses the specific expectations that fall outside of our identified Transformational and Strategic Priorities, but reflect ongoing work which is of particular interest to the Minister, the Ministry and our community.

The areas of additional focus are:

- Elective Services Delivery;
- Workforce; and
- Maternity Services.

7.1 Elective Services

Elective Services are non-urgent procedures and operations that improve people's quality of life. We will make the best use of the resources we have available, provide equity of access and certainty of care and keep waiting times under six months.

Why is this important?

The Canterbury DHB's population is growing and ageing, and the burden of long-term conditions is increasing. These trends result in increasing demand for elective surgical procedures. It is important for the wellbeing of our population that we meet as much of this elective demand as possible, ensure our population receives equitable access to services and minimise the demand for acute (emergency) services.

How are we improving outcomes for our population?

Our ability to meet our population's increasing demand for elective services is often compromised by increasing acute demand, but also by increased demand from other DHBs for the more specialised services we are able to provide. To achieve our objective of increasing elective surgical discharges, we will continue to work collaboratively with our regional DHB colleagues through the South Island Regional Elective Services Plan. By taking a more collaborative approach, we can improve the delivery of elective services not only to our own population, but also that of the wider South Island. By making formal clinical arrangements around the delivery of services, we can better plan capacity and workforce needs and improve regional outcomes, without putting delivery of services to our own population at risk.

In developing the Regional Elective Services Plan, we recognise that the capacity of the public health system to efficiently provide elective surgery to meet demand is governed by a number of crucial and often competing factors including: the demand for beds; availability of surgeons, anaesthetists and nursing staff; theatre capacity; scheduling and management practices; admission and discharge planning; and the existence of systematic and agreed patient pathways. The focus of the Regional Electives Services Plan is to deliver:

- Certainty of timing and access to elective surgery (minimising waiting times);
- Equitable access across the South Island through improved clinical threshold management;
- A structured, consistent and sustainable approach to managing elective surgery;
- Efficient use of workforce and physical resources across the regions (accounting for travel distances and cost);
- Improved partnerships and referral management between clinicians and between districts; and
- Services designed and delivered in a way that is responsive to patient need and reflective of clinical best practice.

Within the context of supporting a regional approach to service delivery and in line with our vision, we will ensure patients receive care as close to their home as practical. This means that in developing capacity to meet the future need of our population, we will support the development of models that ensure both local and regional service sustainability. In developing any additional capacity, we will explicitly recognise the need to provide complex services for residents of other DHBs and that other DHB facilities/staffing may be utilised to ensure equitable access for all of our collective populations.

"In the first six months of 2009/10 we delivered 7,915 elective discharges (excluding elective cardiology and dental procedures) and we are on track to meet the health target of 14,369 discharges - 1,129 more than the previous year."

RUTH BARCLAY
GM CHRISTCHURCH HOSPITAL

Over the past year we have introduced a number of initiatives that have improved the delivery of elective services and enabled us to increase capacity. Full daily elective production plans for all surgical services have been implemented. Quarterly service reviews with Clinical Directors, Service Managers and our Business Development Unit enable collective learning on the effectiveness of the production plan and what changes need to be accounted for going forward. Value Metrix has also begun, with general surgery elective theatre as the pilot area. The focus is improving turn-around time for surgical patients, improving patient and staff safety and removing duplication and waste from theatre practice.

In the short term, we are likely to continue to utilise private capacity in some areas of elective surgical services such as Ophthalmology and Orthopaedics in order to support delivery of appropriate levels of service to our population. However, we will take a proactive approach to planning and contracting for these services and reducing our reactive reliance on private capacity to deliver electives.

In Canterbury we have also made a number of clinical changes to traditional practices that might be seen to negatively affect the delivery of elective volumes, but which provide for better patient outcomes.

- When appropriate for the condition of the patient, the following elective procedures will be performed acutely: cholecystectomy, prostatectomy and removal of kidney stones to reduce repeat acute admissions and general practice presentations and improve the service for patients;
- Patients who present to ED and require a TURP (transurethral resection of prostate) will be assessed immediately and either admitted acutely for surgery or booked for arranged surgery admission (within 7 days). This will replace the current process, where patients wait on the electives list for one to three months and typically have a least one more acute readmission before their surgery;
- Similarly, acute renal colic patients will be assessed on presentation to the ED, and those who require surgery will either be placed on the acute surgery list or booked for arranged surgery (within 7 days). The current pathway for renal colic patients results in multiple admissions for acute pain management while the patient is waiting for elective surgery. This new pathway will avoid repeat admissions and resolve the patient's condition promptly; and
- Our Women's Health Services are moving away from surgical intervention for the management of miscarriage and termination of pregnancy and delivering more day case medication management and ambulatory care services. This change in model of care reduces the risk for women through less general anaesthetics and surgical intervention, as well as making more resources available for other elective surgery.

Meeting the Minister's Expectations

Elective services have been identified as a national Health Target for all DHBs, and we will contribute to the national goal of increasing the volume of elective services being delivered across the country. In line with the Minister's expectations, we will increase our elective services delivery to 15,478 discharges in 2010/11 - 1,109 more than planned for 2009/10.[34]

We will also continue to deliver against the national Elective Services Patient Flow Indicators (ESPIs) which measure clarity, timeliness and fairness. Canterbury is currently achieving better than the national targets for ESPI 2 and ESPI 5 and we have set higher targets for ourselves against these two measures, to reflect our commitment to continued reductions in waiting times for our population.

ACTIONS 2010/11		
OBJECTIVE	**OUTPUTS**	**IMPACTS**
What are we trying to achieve?	*What action will we take to make this happen?*	*What impact will this have?*
Increase current production capability. *To deliver the elective surgical discharges planned in 2010/11.*	Establish whole of DHB production plans providing a clear operational basis for delivery. Maintain a pool of low complexity 'list fillers' who can come earlier for surgery at short notice. Deliver clinically appropriate elective procedures in acute settings where outcomes are more beneficial for the patient. Work in partnership with other South Island DHBs to agree a regional production plan and action plan by August 2010 to identify capacity available in the region and collectively ensure equitable access to elective services. Re-direct appropriate IDF inflows to other DHBs, to increase the capacity available to our residents in our facilities. Utilise other DHBs' facilities to deliver care to our residents where possible and appropriate. Utilise other DHB staff resources to deliver planned additional sessions in our facilities. Re-negotiate agreements with private providers to ensure service delivery occurs within the national pricing framework.	Hospital outputs are delivered to within 3% of overall plan. 15,478 elective services discharges delivered in Canterbury facilities. Improved utilisation of theatre sessions. Continued compliance with ESPIs. Increased volume of elective services delivered across the South Island, with >1,288 additional discharges delivered in 2010/11.

[34] *Elective surgical discharges exclude elective cardiology and dental procedures.*

Identify additional and future service capacity required. *To enable the DHB to meet future needs within available resources.*	Use production planning to identify and feed new requirements, including theatres, into the facilities master planning process. Identify the need for annual private capacity prior to commencement of the new financial year and contract in advance accordingly. Empower the Clinical Services Reference Group to ensure new facilities capture opportunities around the co-location of services.	Increased capacity to deliver additional volumes for local and regional populations in out-years. Actual hospital outputs are delivered to within 3% of overall plan.
Complete unmet need analysis. *To better identify the areas of unmet need and anticipate future service requirements.*	Undertake further analysis of intervention rate data to better understand the areas of unmet need relative to other DHBs. Launch the Electronic Referral Management Service (ERMS). Provide statistical reporting around referrals not accepted by the DHB through the ERMS.	Increases in elective surgical delivery are able to be matched to the unmet need in our community. Reduced variation in standardised discharge ratios and intervention rates across the South Island.
Continually Improve Performance. *To improve service quality and capacity within our hospital and specialist services and reduce waiting times for our population.*	Implement lean thinking principles and processes, including production planning to identify and remove the bottlenecks in current capacity, improver patient flow and reduce waiting times. Support surgical teams to establish performance benchmarks and monitor time wastage in theatre to improve overall utilisation. Adopt a suite of nationally agreed theatre utilisation measures to monitor performance. Develop improved clinical frameworks for managing ICU beds to enable a greater flexibility to match the supply of ICU beds to demand. Refine acute theatre models of care to reduce the impact of variation in acute demand on the delivery of elective surgery. Implement redesigned cardiology service model including extended operating days and a 7 day a week service model to reduce waiting times. Support a culture that ensures, wherever clinically appropriate, day surgery and day of surgery admissions are normal practice including: ▪ Supporting a move towards day case medication management and ambulatory care services for gynaecology surgical services.	Hospital outputs are delivered to within 3% of plan. 60% of elective and arranged surgeries are day surgeries. 90% of elective and arranged day surgeries are day of surgery admissions. Improved utilisation of theatre sessions.[35] Increased percentage of acute patients received surgery within 24 hours >85%. Elective and arranged inpatient average length of stay maintained at 4.02 days. Acute inpatient length of stay maintained at 4.01 days. 30 day mortality rates maintained ≤1.62.

[35] *The Canterbury DHB will implement the nationally agreed theatre utilisation measures with targets to be agreed before Q1 2010/11.*

7.2 Health Workforce

We will engage the best possible talent available and unlock their potential to improve the health of our community.

Why is this important?

As the global community recovers from recession over the next three years, the strategic workforce challenges associated with strong competition for skills, expectations of younger employees, implementation of new technology and shifting demographics will be exacerbated as our workforce regains confidence and becomes more mobile.

We need to be positioned to attract and retain a workforce that is skilled and values-aligned so that the best and most efficient forms of care can be delivered to the communities we serve in a sustained way.

How are we improving outcomes for our population?

Canterbury DHB is a large systems organisation where subtle change will have an enduring impact. It is critical to our success that clinicians become responsible for shaping and running clinical services in conjunction with their non-clinical colleagues. This requires the establishment and development of workforce practices that target leadership (culture, capability and commitment), organisational learning and quality. As part of implementing our plan, over the last 12 months we have:

- Developed a health-specific capability (behaviour, knowledge, skills) framework. This framework is based on current global research and has considered the strengths and pitfalls of similar models used in health systems internationally. The framework will inform all of our people-related work;
- Commenced leadership assessment programmes, which will result in senior leaders having structured development plans in place – a key initiative in improving clinical leadership. Further initiatives around talent, succession planning and critical role identification will greatly improve leadership and quality within the DHB;
- Commissioned an integrated organisational/patient safety and employee engagement survey that will identify key areas for focus in relation to organisational culture and employee engagement;
- Established a Learning and Development Council that includes primary and secondary clinical representation, as well as leaders from neighbouring DHBs, to provide organisational direction. The purpose of this Council is to establish how organisational learning can be developed and embedded across the whole system;
- Embedded existing arrangements with the University of Canterbury, University of Otago and Canterbury Polytechnic for the training and development of junior doctors, nurses, midwives, allied health professionals and management. These arrangements include joint clinical appointments, stipend arrangements, the Nurse Entry to Practice (NETP) programme and clinical placements;
- Continued training of clinicians and non-clinicians in lean thinking techniques through the XcelR8 programme, with over 300 people (doctors, nurses, allied health, managers) having already participated in training and subsequent work-based projects. The community version, Paticip8, will launch mid 2010 with over 600 people already registered;
- Refocused the orientation and front line management training programmes so that these are relevant to our working environment and support our efforts to engage and retain employees, as well as building skills, particularly for front line leaders. These programmes will accommodate and support on-the-job initiatives;
- Intensified our efforts to develop leadership skills in a joint programme involving around 50 primary and secondary care leaders per annum in gaining practical leadership skills;
- Continued to foster diversity in our workforce through our rural and Māori health workforce scholarships for students and through broader Māori development programmes supported within the community;
- Continued to support our voluntary workforce, including those who provide support with feeding patients and Meals on Wheels, night sitters who attend terminally ill patients while the carers are resting and Red Cross volunteers who attend people's homes with the District Nurses at night and get the DHB vehicle ready for visits; and
- Established an HR Shared Services function to support both the Canterbury and West Coast DHBs covering: payroll, HR information systems, training and development, health and safety, industrial relations, HR administration and recruitment. This initiative will deliver a reduction in operating costs across both DHBs while improving quality, efficiency and customer service.

ACTIONS 2010/11		
OBJECTIVE	**OUTPUTS**	**IMPACTS**
What are we trying to achieve?	*What action will we take to make this happen?*	*What impact will this have?*
Develop leadership. *To make capability the foundation for all people-related work.*	Undertake executive assessment. Implement talent processes. Identify potential. Implement development plans for all Level 2/3 Managers.	Identification of next generation leaders. Acceptance by clinical and non-clinical groups.
Support an improved organisational/patient culture. *To develop a culture supportive of organisation vision and values.*	Develop action plans for each cluster area. Standardise policies and practices.	Positive outcomes shown in improvement plans. Implementation of redesigned and standardised people practices.
Promote employee engagement. *To improve the way managers manage and leaders lead.*	Recognise clinicians and managers for their leadership and management ability.	Improved results in snap surveys. Implementation of performance management/development process.
Support clinical retention. *To reduce turnover in critical employee work groups.*	Promote the use of data and metrics for management by line managers.	Increased clinical retention rate per annum. Increased length of service rates for clinicians. Reduced employee turnover rates.
Improve workforce systems. *To ensure systems provide simple relevant tools for clinicians and managers.*	Standardise practices. Digitise Workforce process/systems.	Simple, practical process available for all Workforce areas. 50% of Workforce practices integrated/digitised. Capability system embedded in technology platform.
Improve workforce sourcing. *To ensure that there are enough of the right people with the right skills in the right place at the right time.*	Integrate workforce planning/budget model. Implement succession planning. Undertake critical role analysis. Improve strategic sourcing.	An agreed sourcing plan addressing critical gaps. Succession plans in place for L1/4 roles. End-to-end strategic recruitment plan in place.
Support regional initiatives. *To ensure DHB makes the best use of regional resources and experience and can meet future needs within available resources.*	Establish regional payroll and HRIS. Collaborate with the WCDHB. Improve collaboration with other SI DHBs.	Single Payroll and HRIS for South Island DHBs. Full service Shared Services HR function with West Coast DHB. Product portfolio made available to other DHBs.

7.3 Maternity Services

We will make the best use of the resources we have available to provide maternity services that meet the needs of women, their babies and their families.

Why is this important?

High quality maternity services provide a key foundation for ensuring healthy families and children. In particular, ensuring new mothers can establish breastfeeding and increasing confidence levels in their ability to parent when discharged home provides a positive start to life for children.

Over the last few years, there has been a significant growth in the number of births in our facilities, increasing from 6,004 births in 2006 to 6,323 births in 2009 - representing a 5.4% increase. This places pressure on our maternity services. While the majority of our births (80%) occur at Christchurch Women's Hospital, primary maternity services are provided by ten different level facilities across the Canterbury region.

How are we improving outcomes for our population?

Over the past year, we have worked with the maternity facility providers in Canterbury (public and private) to plan how we can collectively offer longer stays for women who have a clinical need. This was a key expectation of the Minister of Health last year, and the $616,000 made available to implement this expectation has been invested in increasing capacity at Christchurch Women's Hospital and our primary birthing units to support longer lengths of stay. We are identifying women with a clinical need and offering this service across the region to further assist women in establishing breastfeeding and caring for themselves and their new baby.

We will continue to promote birth as a normal life event and work to ensure that women can access maternity care in a place and manner that will meet their needs and the needs of their family and whānau. In order to deliver this, we will provide a positive working environment and work with external agencies, such as NZ College of Midwives and relevant training agencies, to support the training and ongoing professional development of Lead Maternity Carers (LMCs) to ensure that there will be sufficient maternity workforce in Canterbury in the future.

Supporting women to be well mentally, physically and spiritually during their pregnancy and after childbirth, and to raise healthy children, is not just a focus for our hospital and specialist maternity services, but for the whole of the health system. The DHB does not employ the significant majority of LMCs providing maternity services in Canterbury, and a partnership based around the clinical needs of women and their babies is vital to improving the maternity journey for women. Part of our focus in the coming year will be the implementation of a national demonstration project for linking pregnant women with high needs, their LMC and their general practitioner to improve continuity of care throughout the pregnancy. Canterbury is one of two pilot sites in the country.

Geographically, we are the largest DHB in New Zealand, and ensuring that women have appropriate access to services that meet their needs as close to home as possible is a key focus. Over the past year, we have successfully collaborated with local health providers and professionals to re-establish maternity services in Kaikoura and provide women in this rural district with a choice to receive locally delivered antenatal education, birthing services and postnatal services. We will continue to evaluate the future needs of our population and will identify future capacity requirements in our Facilities Master Plan.

A number of community-based breastfeeding initiatives have been delivered over the past year to support mothers to breastfeed their babies, including peer support programmes, a successful collaborative breastfeeding Hui, the appointment of community-based lactation consultants and the establishment of a breastfeeding Advocacy Service. We will continue to promote and extend the breastfeeding services available across the Canterbury health system, provide breastfeeding education and support the development of environments that encourage breastfeeding. We will also work closely with the West Coast DHB to learn from systems established there and to improve breastfeeding rates across both of our populations.

Meeting the Minister's Expectations

In recognition of the increasing demand for maternity services and the need to provide increased choice to new mothers, we developed a draft Maternity Strategy that sets the direction for maternity services in Canterbury. This Strategy was put on hold pending the release of the Ministry's national Maternity Action Plan. Clear direction has now been provided with immediate actions and timeframes for the next 18 months, which centre on improving the quality and safety of maternity services, revising referral guidelines, improving maternity information systems and analysing and improving communication and transfer of care between health professionals. We will support the achievement of national actions.

ACTIONS 2010/11		
OBJECTIVE	**OUTPUTS**	**IMPACTS**
What are we trying to achieve?	*What action will we take to make this happen?*	*What impact will this have?*
Improve continuity of care for pregnant women with high needs. *To improve the health of pregnant women who have medical, mental health or other lifestyle issues.*	Implement (by May 2010) the national demonstration project to provide pregnant women with non-obstetric health issues with access to free GP consultations. Enable LMC to attend consultations when required and support closer collaboration between GPs and LMCs. Remove concerns related to payment for consultation during a high needs pregnancy.	10% of pregnant women who meet the criteria will have accessed this service by 1 May 2011.
Implement our Breastfeeding Action Plan. *To improve breastfeeding confidence and support mothers to care for themselves and their babies when they return home.*	Provide education and breastfeeding professional development opportunities for LMCs, practitioners and social service providers to ensure that they have up-to-date knowledge on all aspects of breastfeeding to pass on to women and their family/whānau. Provide lactation classes for pregnant women to promote and teach the art of breastfeeding. Support increased LMC input into educating, encouraging and supporting women to breastfeed at the birthing unit and at home. Increase services available to support mothers to breastfeed, particularly in rural areas, including peer support programmes and lactation services. Strengthen stakeholder alliances through joint planning and coordination of the Breastfeeding Interest Group and through joint projects and promotion of available services. Support environments (i.e. community facilities or workplaces) to encourage women to breastfeed.	68.5% of children in Canterbury are fully or exclusively breast fed at 6 weeks, with rates above 62.2% for Māori children and 65.7% for Pacific children. >57% of all children in Canterbury are fully or exclusively breastfeed at 3 months. >27% of all children in Canterbury are fully or exclusively breastfeed at and at 6 months. A reduction in unnecessary hospital admissions for children 0-4 years to <108.
Establish future infrastructure and workforce requirements for both capacity and capability. *To provide pregnant women with access to maternity care that meets their needs and expectations and to enable the DHB to meet future needs within available resources.*	Complete stakeholder and interest group consultation on the Canterbury Maternity Strategy. Begin the implementation of the Maternity Strategy and signal infrastructure needs in our facilities plan. Review and re-establish the working group looking at maternity workforce needs. Carry out a stock-take of our maternity workforce, including LMC workforce (midwives, GPs and obstetricians) to assist with planning future need. Provide appropriate placements and support training for midwifery/medical students within Canterbury birthing units. Promote a 'normal birth' to women, family, whānau and maternity service providers and encourage the use of local primary birthing units.	Increased proportion of women birthing in local primary birthing units. 100% of women who meet the clinical criteria are offered longer post-natal stays.
Promote Smoking Cessation. *To reduced smoking rates amongst pregnant women and new mothers.*	Identify women who smoke and offer advice and support to quit smoking. Record all discussions and interventions in midwifery notes/clinical records to improve communication of smoking status.	90% of hospitalised smokers identified and provided with advice and help to quit smoking.

8 Meeting the Demands on Our Financial Resources

8.1 Financial Outlook 2010/11

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

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

- Early payment is retained.
- Normal operations will occur, without additional costs or disruptions associated with H1N1 or any other pandemic.
- There will be minimal impact from any revaluation of land and buildings occurring in 2009/10.[36]
- The impact of any legislative changes, sector reorganisation or funding devolvement will be cost neutral.
- Fair prices will be received for services provided for other DHBs and the Crown.
- Investment to meet increased demand is prioritised and approved by the CEO and EMT in line with the Board's strategy. This will include any devolvement of additional mental health funding by the Ministry, as this funding may be at the expense of funds urgently required for investment in personal health or health of older persons.
- Employee cost increases for expired wage agreements are settled on fiscally sustainable terms, inclusive of step increases and the impact of accumulated leave revaluation.
- External provider increases will be within available funding received, after allowance for committed and uncontrollable funding, and will support the transformation of the Canterbury health system.
- Transformation processes and programmes to reduce duplication, variation and waste in the system are not delayed due to sector changes.

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

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

8.2 Key Fiscal Challenges

The word-wide economic recession has resulted in the Government having fewer funds available for health spending. While the health sector continues to receive the largest share of Government's new funding, the whole of the health sector can expect to face significant financial challenges. In facing these challenges, we will be disciplined and will work in

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

partnership with our clinical leaders to ensure that funding and resource allocation decisions result in the highest possible healthcare return for our investment. Our major fiscal challenges include:

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

8.3 Action Plan for Dealing with Fiscal Challenges

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

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

8.4 Out-years Scenario

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

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

8.5 Asset Planning and Sustainable Investment

Business Cases

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

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

Capital Expenditure

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

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

8.6 Debt and Equity

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

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

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

The accounting policies adopted are consistent with those in the prior year. A full statement of accounting policies is an appendix to our 2010/13 Statement of Intent which can be found on our website www.cdhb.govt.nz.

8.7.1 FORECAST GROUP STATEMENT OF COMPREHENSIVE INCOME

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

8.7.2 SUMMARY OF REVENUE AND EXPENSES BY ARM

Funding Arm

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

Governance & Funder Admin

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

Provider Arm

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

In House Elimination

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

Consolidated

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

8.7.3 FORECAST GROUP STATEMENT FINANCIAL POSITION

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

8.7.4 FORECAST GROUP STATEMENT OF CHANGES IN EQUITY

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

8.7.5 FORECAST GROUP STATEMENT CASHFLOW

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

9 Appendices

The Canterbury DHB has a number of key documents that have been referenced throughout this District Annual Plan. These documents can be accessed via the DHB's website, www.cdhb.govt.nz, (under communications; publications) or by contacting the DHB's Planning and Funding Division on (03) 364 4160.

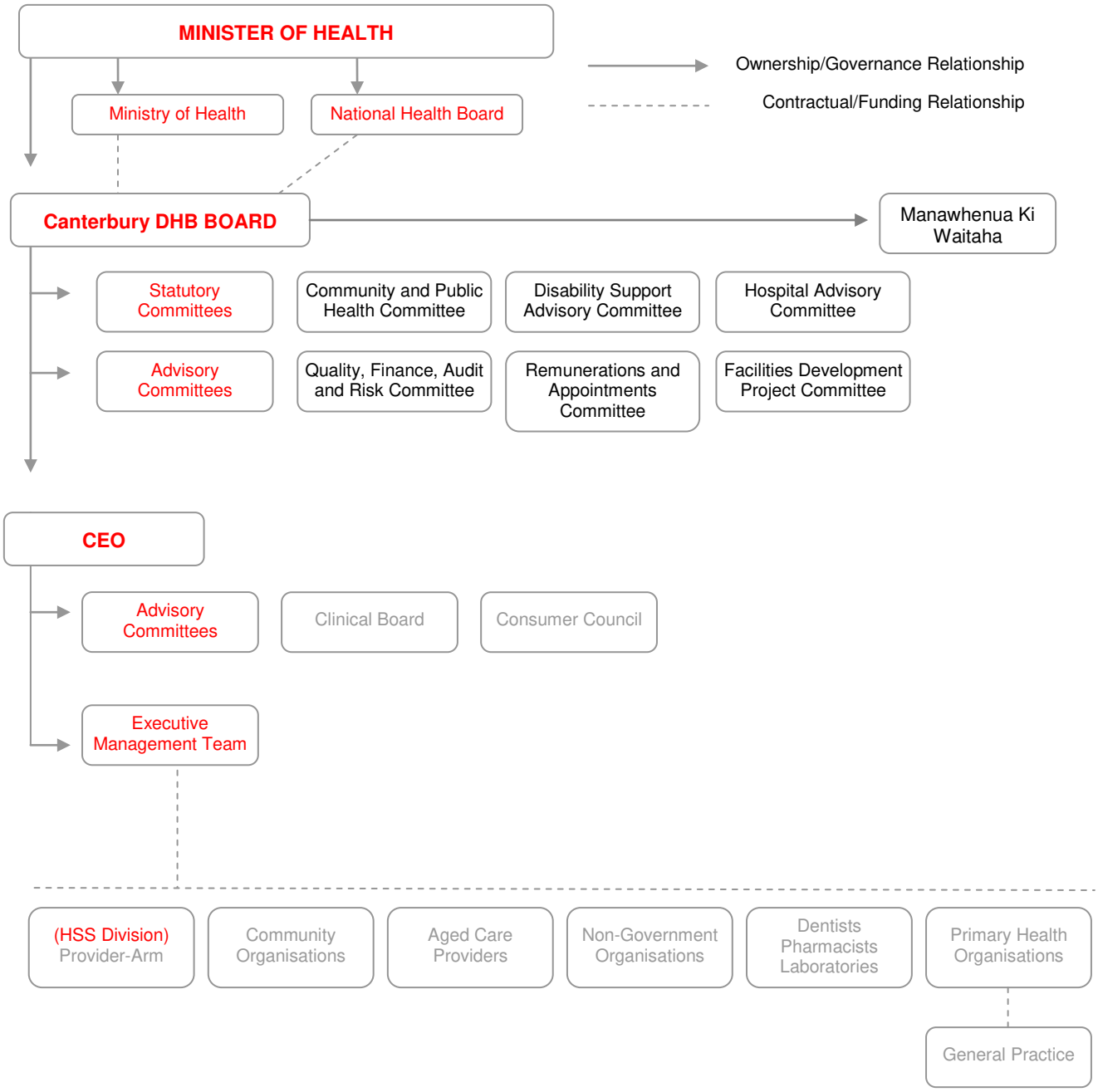
All Ministry strategies referenced in this document are available on the Ministry's website (www.moh.govt.nz).

Appendices

Appendix 1.	Canterbury DHB - Organisational Chart
Appendix 2.	Hospital and Specialist Services Division - Overview of Services
Appendix 3.	Regional Direction - Collaborative Agreements and Activity
Appendix 4.	Indicators of DHB Performance
Appendix 5.	Canterbury DHB Performance Improvement Actions
Appendix 6.	Canterbury DHB Information Service Strategic Plan Summary.
Appendix 7.	Glossary of Terms

Appendix 1.

9.1 Canterbury DHB - Organisational Chart



9.2 Hospital and Specialist Services Division - Overview of Services

HOSPITAL SUPPORT AND LABORATORY SERVICES DIVISION

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

MEDICAL AND SURGICAL SERVICES DIVISION

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

MENTAL HEALTH SERVICES DIVISION

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

OLDER PERSONS SPECIALIST HEALTH AND REHABILITATION SERVICES DIVISION

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

ASHBURTON AND RURAL HEALTH SERVICES DIVISION

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

WOMEN AND CHILDREN'S HEALTH SERVICES DIVISION

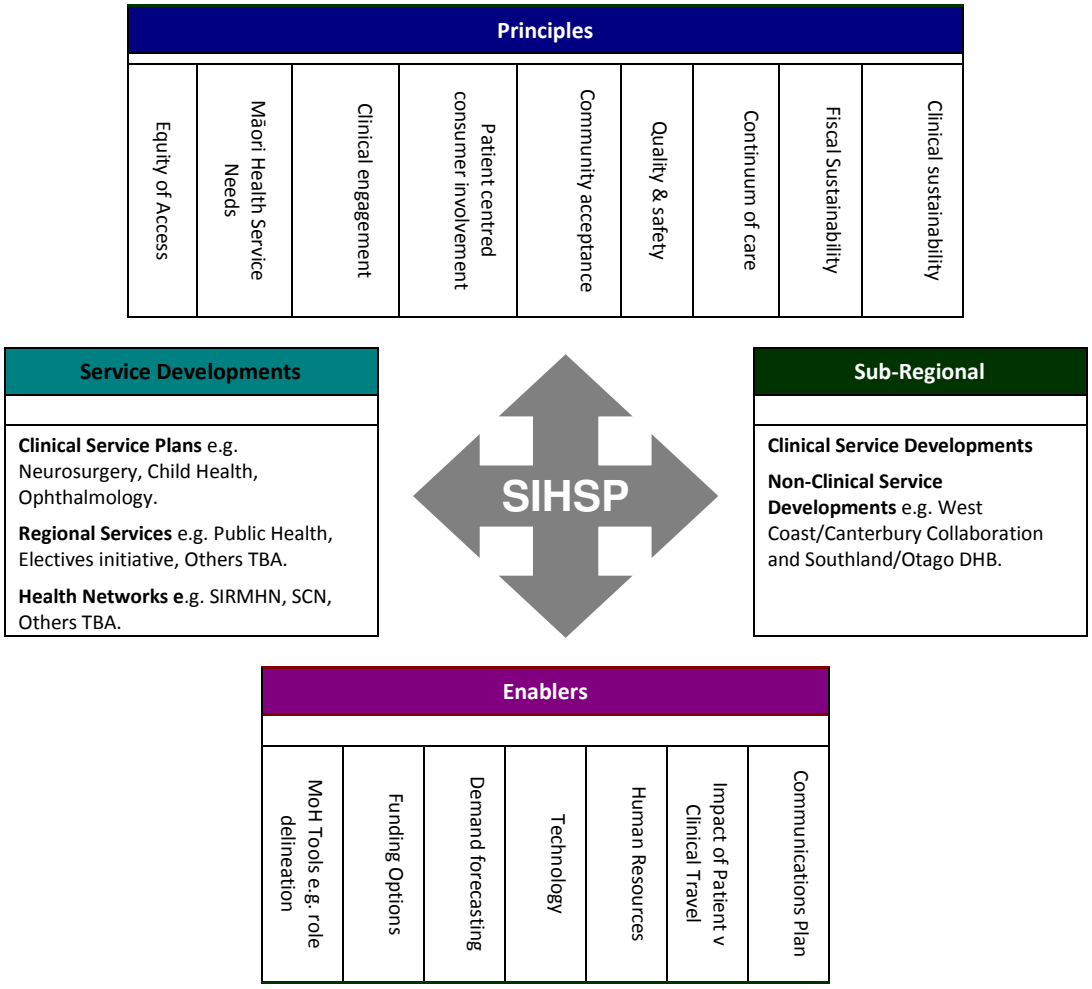
Covers acute and elective gynaecology services, primary, secondary and tertiary obstetric services, neonatal intensive care services at Christchurch Women's Hospital, first trimester pregnancy terminations at Lyndhurst Hospital and primary maternity services at Lincoln Maternity, Rangiora Hospital and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

South Island Health Services Plan – DAP Statement

The South Island DHBs have agreed to the development of a South Island Health Services Plan which links to the Health Futures Framework goals of improving system performance and strengthening clinical and fiscal sustainability. The concept of provision as close to the patient/clients home as possible is an underlying principle to be aspired to in undertaking South Island Health Service Planning, while recognising that some services, particularly lower volume and more specialised levels of care, will not be able to be undertaken at all locations. The vision of the South Island Health Services Plan (SIHSP) is to:

- reduce inequalities in access to health services across the South Island;
- enhance the quality of health services across the South Island;
- enhance the sustainability of all health services appropriately delivered in the South Island for our combined population; and
- engage with key stakeholders to ensure understanding and acceptability of South Island Health Services

SIHSP – Whole of Health Service Planning



DHB Participation

Each South Island DHB has committed to the development of the SIHSP. The Steering Group has a member from each DHB who provides a linkage to the local DHB and to their professional group across the South Island. The SIHSP Steering Group does not have decision making responsibility. Recommendations on South Island health services plans will be referred to the SI Chief Executive Group for decision and adoption. The SI DHB CE Group are the Programme Executive as such act as champions for the

Programme, and are accountable for the delivery of planned benefits associated with the Programme. The Steering Group includes other key stakeholders including Ministry of Health and Union representation.

The SIHSP provides a framework for regional and sub-regional, clinical and non-clinical developments, each of which forms part of the programme of work. Work streams are based around clinical services, e.g. developing long-term viable services and chronic care, while others consider enablers that will support different models of care and ways of delivering services. Each work stream includes participation from relevant stakeholders including DHB clinicians and managers. SISSAL provides administrative, project and programme management resource.

The SIHSP programme includes a Communication Plan that supports keeping stakeholders informed and involved in the process.

2010 -2011 Priorities

Aim	Develop a stage one South Island Regional Clinical Services Plan.
Actions	Develop a stage one Regional Clinical Services Plan that identifies: ▪ The regional and sub-regional work undertaken in 2009/10; ▪ The regional and sub-regional activities for 2010/11; and ▪ The gaps and potential future collaborative work streams and activity to meet these.
Outputs	Development of a stage one Regional Clinical Services Plan that includes the minimum content as required by the Ministry of Health and covers: ▪ Vulnerable Services; ▪ Services related to capital investment proposals that are expected in the next three years; and ▪ Configuration changes that will contribute to financial viability.
Measure	South Island Regional Clinical Services Plan completed by 30 September 2010.

Aim	Develop regional service plans for identified services to support viable health and disability services for the South Island population.
Actions	Regional service planning of prioritised services as identified in stocktake undertaken in 2008/09 or subsequently, including neurosurgery, child health, ophthalmology and public health. Establish working groups of stakeholders from relevant South Island DHBs and across the continuum. These groups will be clinically led and involve management and key stakeholders.
Outputs	Business case development to support service delivery changes as appropriate. Ongoing review and support of regional service developments. Health networks established where appropriate to support ongoing service delivery.
Measure	A reduction in service failure across the South Island through or sub-regional approaches. Regional collaboration to support equitable access to services.

Aim	Develop a plan from each enabler work stream that will support viable service delivery within the South Island
Actions	Develop work streams to consider opportunities within technology, employment and transport & accommodation that will support alternative service delivery models across the continuum of care. Involve stakeholders from across the South Island DHBs.
Outputs	Work stream plans. Business case development to support recommendations as appropriate.
Measure	Implementation of changed models of service delivery supported by changes through enabler work streams.

Aim	Implement a South Island Elective Services Plan that supports efficient, effective and sustainable management of elective surgical services for the future, in compliance with national policy and standards.
Actions	Over the next three years the South Island will: ▪ Provide a framework for the development and implementation of a collective approach for the delivery of elective surgical services across the South Island to ensure equitable access for all population groups; ▪ Improve equity of, and access to, surgical services that contribute to the health outcomes for the people of

	the South Island; ▪ Ensure southern region DHBs have the capacity to deliver the required levels of service to deliver increasing elective volumes; and ▪ Ensure southern region DHBs provide efficient and effective delivery of services.
Outputs	▪ Elective service outputs delivered as required by MoH, meeting elective services targets, ESPI compliance, case weighted discharge volumes and discharge targets. ▪ Clinical leaders supporting and involved with changing elective services approach. ▪ The development of agreed patient focused outcome measurements. ▪ Improved understanding of need (including unmet need). ▪ Development and implementation of an integrated South Island operational production planning, management and booking systems for patients requiring elective surgery. ▪ Development of a regional production/action plan based on capacity available within the region. ▪ Regional employment of medical staff (surgeons and anaesthetists etc), registered nurses, anaesthetic technicians and other identified health professionals. ▪ Shared South Island accommodation and travel policy for patients and /or staff being transported out of their deciled district for treatment. ▪ Regional planning for establishment of new theatre facilities. ▪ Establishment of outcome measurements to monitor and evaluate the benefits of the regional elective surgical service delivery. ▪ Monitoring and evaluation of the delivery of elective surgical services and establish region wide mechanisms to manage variance from expected performance.
Measure	A regional production/action plan delivered by August 2010. Elective service outputs delivered with SI collective responsibility. Decrease in variance across SI service Standardised Discharge Ratios. Increased utilisation of public resources.

To date most of the regional work has been within DHBs in order to better understand, and where possible, increase internal elective capacity. The areas of focussed attention have been similar to that outlined in the *Delivery Plan for Shorter Stays in Emergency Departments* without the condensed time frames for systems response that generally apply in coordinating quality acute care, and in this case that of quality elective patient flow: i.e. pre load or outpatients capacity; contractility or theatre utilisation; and after load or resourced bed capacity along with outpatient capacity repeated at the close of the patient journey.

The regional work to date has achieved success improving theatre capacity, resourced bed numbers and expanded utilisation and all/most DHBs are meeting the current elective services targets; including ongoing ESPI compliance requirements, case weighted volumes and discharge targets. This achievement has also relied upon accessing local private capacity where possible.

In 2010/11 active clinical leadership is key to achieving the next phase of achievement including robust regional plan that detail who, when, where, how publically funded hospital and specialist services may share their electives patient groups with regional and/or neighbour DHB so that improved access to elective services is achieved either procedure by procedure or by specialty.

The South Island DHBs have developed a Regional Elective Services Plan which includes development of a regional production plan based on capacity available within the region and agreed an implementation action plan will be confirmed by August 2010.

There are a numbers of questions that remain unanswered or will have to be adequately explored in order to understand what options the South Island DHBs have to maximise regional collaboration to achieve forecasted elective services demand in the coming years. A subject of topical discussion is patient willingness to travel to another centre, not traditionally named as their secondary care facility.

The increases in elective surgical discharge targets for 2010/11 are shown in the *South Island DHB Elective Surgical Discharges* table below. The targeted funding increases for joints, cataracts and cardiac procedures for the South Island DHBs are outlined in the second table *Joints, Cataracts and Cardiac Targeted Funding Increases*.

South Island DHB Elective Surgical Discharges. [37]

DHB	2009/10 health target	2010/11 health target	Variation from 2009/10
Canterbury	14,369	15,478	1,109
Nelson Marlborough	5,968	6,029	61
West Coast	1,571	1,592	21
South Canterbury	2,597	2,622	25
Southern	9,630	9,955	325
Total	34,135	35,676	1,541

Joints, Cataracts and Cardiac Targeted Funding Increases.

	Joints		Cataract		Cardiac		
DHB	Total required	Minimum to be Funded under EI	Total required	Minimum to be Funded under EI	Total required	Minimum to be Funded under EI	Minimum total CWD required for cardiac
Canterbury	920	470	1305	528	312	40	2652
Nelson Marlborough	346	69	413	25	111	24	944
West Coast	79	0	94	26	24	5	204
South Canterbury	148	38	168	0	44	22	374
Southern	671	182	804	116	189	0	1607
Total	2164	759	2784	695	680	91	5780

Note: Case weighted Discharged (CWD) are in WIES NZ09. Base CWD will be adjusted in accordance with any change resulting under WIES NZ10.

[37] *Elective surgical discharges exclude elective cardiology and dental procedures.*

South Island Health of Older People - DAP Statement

Health of Older People (HOP) is a service development priority area for all South Island DHBs. It is also an area of high clinical and financial risk. The rapidly increasing numbers of those aged over 65 years in the region necessitates new paradigms to address the following.

- The associated increase in health service demand;
- Current and evolving service gaps; and
- Financial sustainability of the health sector and current issues with quality and workforce.

The South Island Regional HOP Network was formally established in October 2009, in response to the demands and issues identified above. Its purpose is:

- To provide effective regional HOP service planning and funding advice and recommendations to the South Island Regional General Managers Network;
- To promote effective and appropriate sharing of information that supports a regional perspective on HOP services; and
- To develop, prioritise, implement and monitor regional activities which contain prioritised goals and allocated resources for each financial year that deliver outputs which will have an overall strategic aim for regional development.

South Island HOP teams are now working regionally in order to ensure consistent service responses and equity of access for South Island residents. It is anticipated that this will maximise returns through combined effort and the sharing of personnel and expertise to champion and address areas of common interest. A draft regional work plan has been established that builds on the work that South Island DHBs already have underway. Current and future work as identified in the work plan, supports the national Ageing in Place Strategy.

Aim	Maximise financial sustainability and cost-effectiveness.
Actions	▪ Standardise the eligibility criteria and processes for entry to HOP services. ▪ Work collaboratively to roll out InterRAI. ▪ Develop a common service specification and contracting/pricing mechanism for a restorative package of care model for Home Based Support Services. ▪ Build and maintain a regional dataset.
Outputs	▪ Reliable detailed data for funding and planning decisions. ▪ Purchasing of cost-effective service mix and configuration. ▪ Consistent approach to service allocation to ensure services are targeted appropriately to needs. ▪ Reduced demand on residential services over time.
Measure	InterRAI has been implemented in all South Island DHBs. A common service specification for Home Based Support Services is in place for all South Island DHBs. A break-even result for HOP budgets at year-end.

Aim	Ensure fairness and equity of access.
Actions	▪ Document a consistent framework for referral, assessment and care co-ordination across the HOP continuum. ▪ Work collaboratively to roll out InterRAI. ▪ A common process for reconfiguring Home Based Support Services into a restorative approach. ▪ Develop a regional booking system for respite care. ▪ Build and maintain a regional dataset.
Outputs	▪ Standard and objective access criteria for HOP services. ▪ A restorative focus for Home based support services. ▪ Effective allocation of respite care.

	▪ Reliable detailed data for funding and planning decisions. ▪ Communicate South Island access criteria to all DHBs nationally.
Measure	Agreed access criteria implemented across DHBs.

Aim	Maintain quality of care.
Actions	▪ Identify initiatives for improving quality and cost-effectiveness. ▪ Identify the workforce capability and capacity needs for the HOP continuum. ▪ Improve referral, assessment and coordination services to ensure service type and level are targeted to need (right person, right skill, right place, right time). ▪ Collaborative relationships fostered among primary, secondary and tertiary HOP. ▪ Develop a regional approach to supporting carers. ▪ Enhance primary care interface for older people. ▪ Ensure monitoring of quality is effective. ▪ Maintain a restorative focus for home based support services.
Outputs	▪ More predictable access to specialist services and better use of scarce resources. ▪ Better linkage of HOP and support services to primary health care – more proactive care of frail older people. ▪ Reliable insight into quality of services.
Measure	Reduction in issues related to quality of care for users.

South Island Regional Mental Health - DAP Statement

The South Island Regional Mental Health Network has developed the second South Island Regional Mental Health Strategic Plan (2009 – 2012). It builds on key national policies and emulates Te Tahuhu: Improving Mental Health 2005 – 2015 and Te Kokiri: The Mental Health and Addiction Action Plan 2006 – 2015.

The strategic plan outlines the ten strategic challenges identified in Te Kokiri and provides the proposed South Island DHB's strategic activities, for which a regional approach is most appropriate, to achieve these challenges. The strategic activities have informed the development of the annual work plan for last year and will continue to do so for the next two years. Within the context of a dynamic and evolving health environment, wider societal changes and expectations of Government, the strategic plan activities will be reviewed annually and an annual work plan developed to meet these changing demands.

Aim	To promote effective and appropriate sharing of information that supports a regional perspective on Mental Health Planning and Funding, influences changes, and progresses the implementation of National Mental Health Strategy.
Actions	The South Island Regional Mental Health Network continues to share information and collaborate regionally.
Outcomes	A regional perspective on mental health planning and funding improves effectiveness and reduces duplication.
Measure	Regional collaboration occurs, influences change and progresses the implementation of National Mental Health Strategy.

Aim	To implement the regional activities as defined in the second South Island Regional Mental Health strategic plan (2009 – 2012), that support the development of South Island mental health services.
Actions	An annual work plan is developed with key projects that meet the objectives defined in the second South Island Regional Mental Health strategic plan (2009 – 2012).
Outcomes	There is an improvement in mental health outcomes for the South Island population.
Measure	Annual work plan activities are regularly monitored and reported and are achieved by the end of June 2010.

Aim	To support national workforce and service development initiatives and guidelines.
Actions	Regional plans are developed that support national guidelines.
Outcomes	There is an improvement in mental health outcomes for the South Island population.
Measure	South Island mental health services reflect national guidelines.

Southern Cancer Network – DAP Statement

The Cancer Control Strategy Action Plan 2005-2010 identified a number of priorities, including the continued development of regional cancer networks to enhance co-operation and collaboration of organisations involved with/or contributing to cancer control. The structures, scope and functions of regional networks in New Zealand are evolving.

The Southern Cancer Network (SCN) brings together key stakeholders in the South Island to support the planning and delivery of comprehensive and integrated cancer services. These services are co-ordinated across patient care pathways through a multidisciplinary team approach, for the given population area (region). The SCN aims to increase access to comprehensive cancer services by promoting a collaborative approach to cancer care planning and delivery.

The SCN was formed in 2007 and the present management infrastructure established in 2008 with a steering group elected in March 2009 to provide advice and direction to the management team and associated groups. The steering group is representative of the South Island cancer continuum with members selected from each region and professional grouping. The SCN Strategic Plan was completed in August 2009 and each South Island DHB is working on or has developed a Local Cancer Plan.

Aim	Promote service improvements for lung and bowel cancer.
Actions	Collaborate with regional networks and the Ministry of Health in the development of national standards and patient management frameworks. Establish Regional South Island multi-disciplinary work groups for the management of lung and bowel cancer. Liaise with South Island Local Cancer Networks.
Outputs	Establishment of a National Working Group for the Lung and Bowel Cancer Tumour Stream. Development of National Standards for lung cancer. Development of Patient Management Framework for lung cancer and bowel.
Measure	Standards and Patient Management Frameworks are adopted by cancer service providers.

Aim	Develop a co-ordinated and seamless cancer journey for the patient.
Actions	Work with the Ministry of Health, other Cancer networks and all relevant groups to explore the national adoption of Patient Management Frameworks for lung and bowel cancer. Work with multidisciplinary teams across the region to maximise the timeliness of the lung and bowel cancer patient's access to referral, diagnosis, treatment, follow-up, surveillance and/or end of life care.
Outputs	The patient journey is 'mapped' for lung and bowel cancer in the South Island.
Measure	Reports with recommendations are produced.

Aim	Determine South Island Inequalities for Cancer patients.
Actions	Collaborate with South Island Manawhenua Groups, Iwi and other Māori Health groups to identify and address issues relating to inequalities. Promote the adoption of strategies known to reduce inequalities with respect to cancer and cancer services.
Outputs	Establishment of a SCN South Island Māori Advisory Group. Inequalities are identified with recommendations.
Measure	Action plan developed for implementing recommendations.

Aim	SCN maintains an informed position with respect to cancer service provision across the region and works with stakeholders to address issues.
Actions	Work with Local Cancer Networks Groups to monitor, co-ordinate and identify local issues and to oversee development and implementation of Local Cancer Plans. Develop data collection, monitoring systems and a range of indicators. Understand the South Island Cancer burden at a regional and district level.
Outputs	All South Island DHBs have a Local Cancer Plan that is reviewed annually. Data collection to enable the network to monitor progress against strategies over time. South Island Health Needs Assessment for Cancer.
Measure	Data and information ensures local, regional and national cancer strategies align.

9.4 Indicators of DHB Performance

The Ministry's Indicators of DHB Performance for 2010/11 follow with Canterbury DHB targets identified.

Indicator Code	Measure and Canterbury DHB Targets	Reporting Expectations
Policy Priorities Dimension		
HT1: Shorter stays in ED	1. Report the number of patient presentations to the ED with an ED length of stay less than six hours against the number of patient presentations to the ED separately for each relevant ED facility, using the Ministry template provided. 2. If any of the ED facilities do not meet the target for the quarter, provide narrative comment on the quality of the data, steps taken to meet the target and improve the quality of emergency department care and any difficulties encountered with implementation of the target. **Target – 95% of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours.**	Quarterly.
HT2: Improved access to elective surgery	Report on progress quarterly on an exception basis against the target agreed in the District Annual Plan. **Target – 15,478 elective surgery discharges will be delivered.**	Quarterly
HT3: Shorter waits for cancer treatment	1. Supply monthly templates that measure the interval between the patient's first specialist assessment and the beginning of radiation treatment, along with other related measures, from each Cancer Centre as detailed in the Ministry reporting template. 2. Provide a report confirming the DHB has reviewed the monthly wait time templates produced by the relevant Cancer Centre(s) for the quarter. Where the monthly wait time data identifies any patients domiciled in the DHB waiting more than 6 weeks due to capacity issues and/or that wait time standards were not met for patients in priority categories A and B, provide a report outlining the resolution path that has been agreed with the cancer centre. **Target – 100% of people needing radiation treatment will have this within six weeks by the end of July 2010 and within four weeks by December 2010.**	Deliverable 1 - Monthly Deliverable 2 – Quarterly.
HT4: Increased immunisation	Provide a qualitative report confirming progress is tracking toward target as planned, or provide an exception report if progress is not tracking to plan. **Target –91% of two year olds are fully immunised by July 2011.**	Quarterly.
HT5: Better help for smokers to quit	1. For hospitalised patients, provide a report confirming progress is tracking toward target as planned, or provide an exception report if progress is not tracking to plan. Local Patient Management Systems will capture data using coding information developed for 2009/10. **Target – 90% of hospitalised smokers provided with advice and help to quit by July 2011.** 2. For primary care patients, the PHO Performance Programme tobacco indicators will capture the data to report against the health target **Target – 80% of patients attending primary care provided with advice and help to quit by July 2011.**	Quarterly.
HT6: Better diabetes and CVD services	1. Report the number of people in the eligible population who have had the laboratory blood tests (lipids and glucose or HBA1c) for assessing absolute CVD risk in the last five years against the number of people in the eligible population. This target will be reported for Māori, Pacific, and Other ethnic groups. **Target - Māori 62.9%, Pacific 60.1%, Other 73.9%, Total 73.0%.** 2. Report the number of unique individuals with type I or type II diabetes on a diabetes register whose date of their free annual check is during the reporting period against the expected number of unique individuals to have type I or type II diabetes, as at the start of the reporting period. This target will be reported for Māori, Pacific, and Other ethnic groups. **Target – Māori 44%, Pacific 40%, Other 53%, Total 52%** 3. Report the number of people with type I or type II diabetes on a diabetes register that had an HbA1c of equal to or less than 8% at their free annual check during the reporting period against the number of people with type I or type II diabetes on the diabetes register whose date of their free annual check is during the reporting period. This target will be reported for Māori, Pacific, and Other ethnic groups. **Target – Māori 70%, Pacific 56%, Other 80%, Total 79%**	Quarterly.
PP1: Clinical leadership	Provide a qualitative report in the form of a self assessment identifying progress achieved; what's worked; what hasn't; planned actions for each of the following areas of focus: 1. Whether managers and clinical leaders feel valued and recognised for their leadership capability 2. Whether joint management and clinical relationships are effective 3. Whether strong and effective engagement is in place at all levels, across management and clinicians, and across disciplines 4. Whether there is shared ownership of organisational outcomes across management and clinical leadership, across disciplines.	Annually in Q4.

PP2: Implementation of BSMC primary health care	Supply a report confirming implementation of the changes to primary care service delivery models agreed in DAP and progress on implementation of the Business Case OR a report identifying why changes to primary care service delivery models agreed in DAP have not been implemented, with an associated resolution plan.	Annually in Q4.
PP3: Local Iwi/Māori engagement and participation in DHB decision-making, development of strategies and plans for Māori health gain	1. Report the percentage of PHOs with Māori Health Plans agreed by the DHB **Target – 100%** 2. Report the percentage of DHB members having Treaty of Waitangi training **Target – 100%** 3. Report on achievements against the Memorandum of Understanding between the DHB and its local Iwi/Māori relationship partner, and describe other initiatives achieved that are an outcome of engagement between the parties. Provide a copy of the Memorandum. 4. Report on how (mechanisms/frequency of engagement) local Iwi/Māori are supported by the DHB to participate in the development and implementation of the strategic agenda, service delivery planning, development, monitoring, and evaluation (include a section on PHOs). 5. Report on how Māori Health Plans are being implemented by PHOs and monitored by the DHB OR for newly established PHOs, a report on progress in the development of Māori Health Plans. 6. Describe when Treaty of Waitangi training has, or will, take place for Board members. 7. Identify at least two key milestones from your Māori Health Plan to be achieved in 2010/11. For reporting in Q2, provide a progress report on the milestones, and for reporting in Q4, provide a report against achievement of those milestones. *2.3 Working Together: Review and Update the Maori Health Plan with delivery of 'Report Card'* *4.4 Developing Our Health Workforce: Promote Health as a Career and support Kia Ora Hauora*.	Six monthly in Q2 and Q4.
PP4: Improving mainstream effectiveness	1. Provide a report describing the reviews of pathways of care (within the DHB provider-arm) that have been undertaken in the last 12 months, focused on improving Health outcomes and reducing health inequalities for Māori. Report on an example(s) of actions taken to address issues identified in the reviews.	Six monthly in Q2 and Q4.
PP5: Waiting times for chemotherapy treatment	1. Provide Chemotherapy Templates that measure the interval between the first specialist assessment and the start of first chemotherapy treatment. Templates will display results for each month within the quarter. 2. Provide qualitative comment on reasons (and management plans) for people with chemotherapy waits longer than 6 weeks. **Target 100% within 6 weeks**	Quarterly.
PP6: Improving the health status of people with severe mental illness through improved access	Report the average number of people domiciled in the DHB district, seen per year rolling every three months being reported (period lagged by three months) against the projected population of the DHB district. Provide data by age and ethnicity for the following groupings: child and youth aged 0-19, adults aged 20-64, people aged 65+. Where the rate has not been met, provide commentary/resolution plans on what is being done to address the performance failure. **Target Māori Other Total** **0-19 2 2 2** **20-64 3.6 2.5 2.5** **65+ - - 2.72**	Six monthly in Q2 and Q4.
PP7: Improving mental health services using relapse prevention planning	1. Report the number of adults (20 years plus) with enduring serious mental illness who have been in treatment* for two years or more since the first contact with any mental health service (*at least one provider arm contact every three months for two years or more.). The subset of alcohol and other drug only clients will be reported for the 20 years plus. 2. Report the number of Child/Youth (0-19 years) who have been in secondary care treatment* for one or more years (*at least one provider arm contact every three months for one year or more). 3. Report the number and percentage of long-term clients with up-to-date crisis prevention/resiliency plans (NMHSS criteria 16.4), and describe how this is assured. 4. Where the DHB did not meet targets, provide commentary/resolution plan on what it is doing to address the performance failure. 5. All reports must provide ethnicity breakdowns. Where DHBs have exceptionally high rates of Māori and Pacific Island acute bed use rates, the relevant DHBs will be notified and asked to review their treatment of these long-term consumers. **Target – 95% of all long-term clients have up-to-date plans across all age groups and ethnicities.**	Six monthly in Q2 and Q4.

PP8: Alcohol and drug service waiting times and waiting lists	1. Report the DHB's longest waiting time, in days, for each mental health service type for one month prior to the reporting period - by Māori and Other ethnicities. Waiting times are measured from the time of referral for treatment to the date the client is admitted to treatment, following assessment. Whilst assessment and motivational or pre-modality interventions may be therapeutic, they are not considered to be treatment. If a client is engaged in these processes, they are considered to be still waiting for treatment. 2. Report the number of clients on waiting lists for treatment at the end of the month - by Māori and Other ethnicities. 3. Supply a narrative identifying the name/location of service(s) with the longest waiting time and waiting list; explaining variances of more than 10%; explaining/identifying targets that the DHB may have for reducing waiting times and/or waiting lists.	Six monthly in Q2 and Q4.
PP9: Delivery of Te Kokiri	Provide a summary report on progress made towards Implementation of Te Kokiri: the Mental Health and Addiction Action Plan, using the template provided by the Ministry.	Annually in Q3.
PP10: Oral health – mean DMFT score at year 8	1. Report the total number of permanent teeth of year eight children, Decayed, Missing (due to caries), or Filled, and the total number of caries free children, at the commencement of dental care, at the last dental examination, before the child leaves the DHB Community Oral Health Service against the total number of children who have been examined in the year eight group, in that year. 2. Provide data by ethnicity and fluoridation status (of school area the child attends) using the Ministry template provided. DHB will provide data but has not set targets as a small percentage of children in Canterbury have access to fluoridated water currently a total of 92 children. **Decayed/Missing/Filled Target** **Māori Pacific Other Total** **2.14 2.06 1.23 1.34** **Caries Free Target** **Māori Pacific Other Total** **35% 37% 52% 50%** **Number Examined Target** **Māori Pacific Other Total** **>485 >162 >4,801 >5,448**	Annually in Q3.
PP11 : Children caries free at age 5 years	1. Report the total number of caries free children, and the number of primary teeth decayed, missing (due to caries), or filled at the first examination after the child has turned five years, but before their sixth birthday against the total number of children who have been examined in the age five group that year. 2. Provide data by ethnicity and fluoridation status (of school area the child attends) using the Ministry template provided. DHB will provide data but has not set targets as a small percentage of children in Canterbury have access to fluoridated water currently a total of 39 children. **Decayed/Missing/Filled Target** **Māori Pacific Other Total** **3.00 4.15 1.22 1.53** **Caries Free Target** **Māori Pacific Other Total** **45% 29% 69% 65%** **Number Examined Target** **Māori Pacific Other Total** **>481 >158 >3,632 >4,271**	Annually in Q3.
PP12: Utilisation of DHB funded dental services by adolescents	Report the total number of completions and non-completions under the Combined Dental Agreement for adolescent (people from year 9 up to and including age 17 years) patients plus additional adolescent examinations with other DHB funded dental services (e.g. Community Oral Health Service (COHS), Māori Health providers and other contracted providers). Provide data by ethnicity. **Target—70%.**	Annually in Q4.
PP13: Improving the number of children enrolled in DHB funded dental services	1. Report the total number of children enrolled with DHB funded dental services (COHS and other contracted providers) under age five years. Provide data by ethnicity. **Target - 20,300 (60% of children under five enrolled)** 2. Report the total number of preschool and primary school children enrolled with DHB funded dental services (COHS and other contracted providers) who have not been examined according to their planned recall period against the total number of preschool and primary school children enrolled with DHB funded dental services. Provide data by ethnicity and decile. **Target 6,900 (10% of children overdue for examination)**	Annually in Q3.

PP14: Family violence prevention	Provide a confirmation report on achievement an overall score of 70/100 in audits for child abuse and partner abuse components of VIP programme. Where an overall score of 70/100 is not achieved, identify the combined audit score and provide an exception report on specific actions taken since the audit to progress the recommendations of the audit. **Target—Overall combined score of 140/200 or above.**	Annually in Q4.
System Integration Dimension		
SI1: Ambulatory sensitive (avoidable) hospital admissions	1. Provide commentary on the DHB's latest 12 month ASH data (provided by the MoH). The report may include additional district-level data that is not captured in the national data collection and information about local initiatives that are intended to reduce ASH admissions. 2. Provide information about how health inequalities are being addressed with respect to this health target, with a particular focus on ASH admissions for Pacific and Māori 45-64 year olds. **Targets:** **Other (0-74) at or below 95** **Māori (0-74) at or below 95** **Pacific (0-74) at or below 95** **Other (45-64) at or below 95** **Māori (45-64) at or below 95** **Pacific (45-64) at or below 95** **Other (0-4) at or below 108** **Māori (0-4) at or below 95** **Pacific (0-4) at or below 95**	Six monthly in the Q2 and Q4.
SI2: Regional Service Planning	Provide a report confirming that the DHB has progressed the Regional Clinical Service Plan according to plan submitted to MoH. If the DHB cannot provide the confirmation report, it must transition to compliance no later than 6 months after non-compliance is first reported and provide to the Ministry a planned pathway to full compliance, including key milestones and timelines, no later than 3 months after non-compliance is first reported.	Six monthly in the Q2 and Q4.
SI3: Service Coverage	Report progress achieved during the past quarter towards resolution of exceptions to service coverage identified in the DAP, and not approved as long -term exceptions, and any other gaps in service coverage identified by the DHB or Ministry through: analysis of explanatory indicators, media reporting, risk reporting, formal audit outcomes, complaints mechanisms and sector intelligence.	Six monthly in the Q2 and Q4.
SI4: Elective Services Standardised Intervention Rates (SIRs)	Unless separately negotiated: ▪ For publicly funded casemix included elective discharges in a surgical DRG, a target intervention rate of at least 292 per 10,000 of population will be achieved. ▪ For major joint replacement procedures, a target intervention rate of 21.0 per 10,000 of population will be achieved. This should be comprised of the following rates: 10.5 per 10,000 of population for hip replacement and 10.5 per 10,000 of population for knee replacement. ▪ For cataract procedures, a target intervention rate of 27.0 per 10,000 of population will be achieved. ▪ For cardiac procedures a target intervention rate of at least 6.23 per 10,000 of population will be achieved. DHBs with rates of 6.23 per 10,000 or above in previous years will be required to maintain those with rates less than 6.23 per 10,000 will be required to increase the level of service to at least 6.23: 10,000. By 2011/12 all DHBs will be delivering at a rate of at least 6.5 per 10,000 of population. ▪ Cardiac surgery is defined as coronary artery bypass graft (CABG), valve replacement or repair, and CABG plus valve replacement or repair, for people aged 15 and over. ▪ The current national intervention rate for percutaneous revascularization is 10.8 per 10,000. It is expected that DHBs will maintain their current rates of this procedure in 2010/11. For any procedure where the standardised intervention rate in the 2009/10 financial year or 2010 calendar year is significantly below the target level, submit a report demonstrating EITHER: 1. what analysis the DHB has done to review the appropriateness of its rate, AND 2. whether the DHB considers the rate to be appropriate for its population; OR 3. a description of the reasons for its relative under-delivery of that procedure, AND 4. the actions being undertaken in the current year that will ensure the target rate is achieved. The analysis report (1 and 2) must cover the relationship between the secondary/primary sectors, including evidence of consultation with primary care as to the perceived level of access. The report must also provide confirmation from the relevant service clinical director that the rate being provided is appropriate for the DHB population. Unless the above information is provided, the Q1 report (3 and 4) needs to outline actions being undertaken to achieve the required rate. Q3 report needs to outline progress made against plan.	Six monthly: Q1 and Q3.

SI5: Funding for Māori Health and disability initiatives	In the template provided by the Ministry: 1. Report actual expenditure on Māori Health Providers by General Ledger code. 2. Report actual expenditure for Specific Māori Services provided within mainstream services targeted to improving Māori health by Purchase Unit. 3. Where information is available report total predicted expenditure for Māori health in the 2010/11 DAP in comparison to the actual expenditure with explanation of the variances.	Annually in Q4.
SI6: Risk management	1. Provide a report confirming: the DHB uses a formal risk management and reporting system to manage DHB risks and report them to its Board; the system meets current Australia/New Zealand Standard Requirements (including 'AS/NZS 4360:2004' and 'HB 228:2001'); how frequently the DHB submits formal risk report updates to its Board (or a Board approved sub-committee). 2. If the DHB cannot provide the confirmation report, it must transition to compliance no later than 6 months after non-compliance is first reported. Formalise and provide to the Ministry a planned pathway to full compliance, including key milestones and timelines, no later than 3 months after non-compliance is first reported.	Six monthly in Q2 and Q4.
SI7: Improving breast-feeding rates	1. Set DHB-specific breastfeeding targets with a focus on Māori, Pacific and the total population respectively to incrementally improve district breastfeeding rates to meet or exceed the National Indicator. **Target:** **6wks Māori 62.2%, Pacific 65.7%, Other 69%, Total 68.5%;** **3mths Māori 48%, Pacific 44%, Other 58%, Total 57%;** **6mths Māori 20%, Pacific 19%, Other 31%, Total >27%.** 2. Where any target has not been met, provide commentary/resolution plan on what the DHB is doing to address the performance failure. 3. Maintain appropriate planning and implementation activity to improve the rates of breastfeeding in the district. 4. Report local data from non-Plunket Well Child providers as follows: the total number of babies seen during the 12 month period that are fully breastfed in each age group and by ethnicity, Māori, Pacific and Other against the total number of babies seen during the 12 month period in each age group and by ethnicity.	Annually in Q4.
Ownership Dimension		
OS1: Staff Turnover	1. Report the number of personnel (employed by Provider Arm), divided according to the five professional groups set out in the DHB/MoH Common Chart of Accounts (medical, nursing, AHP, management and administration, and support personnel), who cease employment due to voluntary resignation during the quarter. 2. Report the total headcount of personnel (employed by Provider Arm), divided according to the five professional groups, at the beginning of the quarter. 3. From this data, calculate the staff turnover using the Ministry formula provided.	Quarterly.
OS2: Capital Expenditure to Plan	Capital Expenditure should be delivered in line with plan. Where the DHB is out of line, provide exception report establishing the reasons and including any action plans in place to address issues.	Quarterly exception reports.
OS3: Elective and arranged inpatient length of stay	Reduce average length of stay (ALOS) for elective and arranged inpatients. Where the DHB is not in line with target, provide information about any factors that are thought to be hindering achievement, and any actions being taken to gain improvements. **Target - maintain current standardised average length of stay 4.02 days**	Quarterly exception reports.
OS4: Acute inpatient length of stay	Reduce average length of stay (ALOS) for acute inpatients. Where the DHB is not in line with target, provide information about any factors that are thought to be hindering achievement, and any actions being taken to gain improvements. **Target - maintain current standardised average length of stay 4.01 days**	Quarterly exception reports.
OS5: Theatre Productivity	Submit data elements in line with nationally agreed theatre utilisation measures, using the Ministry template provided. **Targets - an improvement on current performance with targets to be agreed before Q1 2010/11.**	Quarterly.
OS6: Elective and arranged day surgery	Increase the proportion of elective and arranged surgery undertaken on a daycase basis. Where the DHB is not in line with target, provide information about any factors that are thought to be hindering achievement, and any actions being taken to gain improvements. **Target - 60%**	Quarterly exception reports.
OS7: Elective and arranged day of surgery admission	Provide 90% of elective and arranged surgery on a day of surgery admission (DOSA) basis. Where the DHB is not in line with national target, provide information about any factors that are thought to be hindering achievement, and any actions being taken to gain improvements. **Target - 90%**	Quarterly exception reports.
OS8: Acute Readmissions to Hospital	Maintain 28 day unplanned acute readmission rates at the current rate or lower. Where the DHB is not in line with target, provide information about any factors that are thought to be hindering achievement, and any actions being taken to gain improvements. **Target – maintain current standardised acute readmission rate at 9.15% or lower**	Quarterly exception reports.

OS9: 30 day mortality	Maintain 30 day mortality rate at the same level, or reduce it. Where the DHB is not in line with target, provide information about any factors that are thought to be hindering achievement, and any actions being taken to gain improvements. **Target - maintain current standardised mortality rate (1.62%) or lower**	Annually in Q4.
OS10: Improving quality of data provided to National Collections Systems	Improve the quality of data provided to national collections. Where the DHB is not in line with targets, provide explanation of improvement plans. **Targets:** **NMDS timeliness – between 2% - 5%** **NHI duplications – between 2% - 3%** **Ethnicity Not Stated or set to an alternative Residual Code in the NHI – between 2% - 4%** **Standard vs. specific descriptors – between 50% - 59%**	Quarterly exception reports.
OS11: Hospital outputs are delivered to plan	1. Submit completed Provider Arm (+Additional) price volume schedules during the 2010/11 DAP round. 2. Deliver hospital outputs to a level that is within 3% of overall planned outputs stated at the year's beginning, and within 5% of planned outputs for major areas of service delivery. 3. Where delivery is outside target, describe the factors leading to variance, and any remedial actions being taken.	Q2, Q3 and Q4 exception reports.
OS12: National Patient Satisfaction Survey	This is a placeholder measure to be confirmed by the Ministry of Health.	Quarterly

9.5 Canterbury DHB Performance Improvement Actions

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

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

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

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

9.6 Canterbury DHB - Information Services Strategic Plan Summary

Template for ISSP Information

DHB NAME: Canterbury DHB **Prepared: 22 / 02 / 2010**

Column 2: Project Ranking	Column 6: HISAC Action Zone	Column 7: Project type	Column 8: Project significance	Column 10: Project Funding Source
1: Must Do in 2010/2011	1: National Network Strategy	N: New	N: National	I: Internal (in approved DAP)
2: Should Do in 2010/2011 Probable Do in 2011/2012	2: NHI Promotion	U: Upgrade	R: Regional	M: MoH New Funding
3: Nice to Do in 2010/2011 Should Do in 2011/2012	3: HPI Implementation	R: Replacement	L: Local	P: Third Party
4: Non-urgent - Requested by Clinicians	4: ePharmacy			N: Not yet determined
5: Non-urgent - Requested by Board/Staff	5: eLabs			
6: Non-urgent-Requested by Ministry	6: Discharge Summaries			
7: Early Warning - upcoming work - probable future Rank 1	7: Clinical Care and Disease Management'			
8: Early Warning-upcoming work - probable future Rank 2	8: Electronic Referrals			
9: Early Warning-upcoming work- probable future Rank 3	9: National Outpatient Collection			
	10: National Primary Care Collection			
	11: National Systems Access			
	12: Anchoring Framework			

1	2	3	4	5	6	7	8	9	10	11	12
Project Name	**Project rank priority**	**DHB Project Ref #**	**Planned Start (Mth/Yr)**	**Expected Completion (Mth/Yr)**	**HIS-NZ Action Zone #**	**Project Type**	**Significance National? Regional? Local?**	**Approx Capital Cost ($000)**	**Funding Source**	**Identify Project reference in DAP.**	**Brief Project Description: 1) effect of change on DHB operation 2) the measures of DHB, Regional or National Benefit to be achieved**
TestSafe South	1	IS 449	07/2008	10/2010	5	N	R,L	$201k	I	Section 5.6 – Quality & Patient Safety	Creation of a Regional Results Repository – initially with results from CDHB, NMDHB, SCDHB (including Primary Care)
Storage Area Network Replacement	1	IS 54	07/2009	10/2010	12	R	R,L	$ 950K	I	Section 5.6 – Quality & Patient Safety	Replaces core storage Improves system performance for frontline services
Major Upgrade of Concerto	1	IS 107	07/2009	03/2011	6,7,8,12	U	L	$ 62k	I	Section 5.6 – Quality & Patient Safety	Upgrades concerto to latest release
Healthlink Enterprise Server	3	IS 1053	07/2009	10/2010	12	N	L	$ 25k	I	Section 5.6 – Quality & Patient Safety	Provides infrastructure for improved DHB to GP messaging
e-Referrals	1	IS 111	06/2010	06/2011 (ongoing)	8	N	R, L	$ 132k	I	Section 5.2 – Delivering *Better, Sooner, More Convenient* Health Services and Section 5.6 – Quality & Patient Safety	Implements hospital end of the Canterbury Initiative e-Referrals
Major Éclair Upgrade	2	IS 1061	07/2009	02/2011	5	U	R, L	$ 27k	I	Section 5.6 – Quality & Patient Safety	Upgrades Éclair to latest release. Provides capability to pilot e-Orders for labs Improves system performance for frontline services
Exchange 2010	2		07/2009	02/2011	12	U	L		I	Section 5.6 – Quality & Patient Safety	Upgrades Exchange to latest release
InterRAI National Hosting	1		03/2009	06/2011	12	N	N	TBA	M	Section 5.3 – Older Persons' Health Services	Provides hosting services for national InterRAI implementation
CoreDocs	2		06/2010	07/2011	7, 12	N	L	$180k	I	Section 5.6 – Quality & Patient Safety	Improves system performance for frontline services
Patient Admin System Replacement (approval pending)	1		08/2010	2013/14	7,12	R	R,L	TBA	1	Section 5.1 Making Our Hospital Work	Replacement of end of life Patient Administration System (e.g. HOMER)

Appendix 7.

9.7 Glossary of Terms

GLOSSARY OF TERMS USED IN THIS DOCUMENT		
ACC	Accident Compensation Corporation	Crown Entity set up to provide comprehensive, 24hour, no-fault personal accident cover for all New Zealanders.
	Acute Care	The provision of appropriate, timely, acceptable and effective management of conditions with sudden onset and rapid progression that require attention.
ASH	Ambulatory Sensitive Hospital Admissions	Hospitalisation or death due to causes which could have been avoided by preventive or therapeutic programme
ALOS	Average Length of Stay	ALOS is the sum of bed days for patients discharged in the period (i.e. lengths of stay) divided by the number of discharges for the period.
	Blueprint Funding	Blueprint funding is allocated by Government to work to ensure the development of mental health services for the 3% of the total NZ population with moderate to severe mental illness. Service development is based on the service levels set out in the Mental Health Commission's Blueprint for Mental Health Services in New Zealand: How Things Need to Be (1998).
CAPEX	Capital Expenditure	Spending on land, buildings and larger items of equipment.
COPD	Chronic Obstructive Pulmonary Disease	A progressive disease process that most commonly results from smoking. Chronic obstructive pulmonary disease is characterised by difficulty breathing, wheezing and a chronic cough.
	Crown Entities	A generic term for a diverse range of entities referred to in the Crown Entities Act 2004. Crown entities are legally separate from the Crown and operate at arms length from the responsible or shareholding Minister; they are included in the annual financial statements of the Government.
CE Act	Crown Entities Act	The Act which governs Crown Entities set out in 2004.
CTA	Clinical Training Agency	The CTA provides funding for Post Entry Clinical Training programmes, are nationally recognised by the profession and/or health sector and meet a national health service skill requirement rather than a local employer need.
	Continuum of Care	Exists when a person can access responsive services matched to their level of need at any time throughout their illness or recovery.
CWD	Case Weighted Discharge	Relative measure of a patient's utilisation of resources
CFA	Crown Funding Agreement	This is an agreement by the Crown to provide funding in return for the provision of, or arranging the provision of, specified services.
CVD	Cardiovascular Disease	Cardiovascular diseases are diseases affecting the heart and circulatory system. They include ischaemic heart disease, rheumatic heart disease, cerebrovascular disease and other forms of vascular and heart disease.
DOSA	Day of Surgery Admission	DOSA is a patient who is admitted on the same day on which they are scheduled to have their elective surgery. The admission can be as either a day case or an inpatient.
	Determinants of Health	The range of personal, social, economic and environmental factors that determine the health status of individuals or populations.
DSS	Disability Support Services	Services provided for people who have been identified as having a disability, which is likely to continue for a minimum of six months and results in a reduction of independent function to the extent that ongoing support is required.
DRG	Diagnostic Related Group	The grouping of patients in accordance with their diagnosis.
DAP	District Annual Plan	This document sets out what the DHB intends to do over the year to advance the outcomes set out in the District Strategic Plan, the funding proposed for these outputs, the expected performance of the DHB provider arm and the expected capital investment and financial and performance forecasts.
DHBNZ	District Health Board NZ	National representative body for all twenty-one DHBs.
DSP	District Strategic Plan	The DSP document identifies how the DHB will fulfil its objectives and functions over the next five to ten years by: identifying the significant internal and external issues that impact on the DHB and affect its ability to fulfil its mandate and purpose, acknowledging societal outcomes and identifying appropriate system outcomes as they relate to DHB population outcomes and outlining major planning and capability building
ESPIs	Elective Services Patient flow Indicators	The ESPIs have been developed by the Ministry to assess whether or not DHBs are on the right track with the Government policies on elective services.

FSA	First Specialist Assessment	(Outpatients only) First time a patient is seen by a doctor for a consultation in that speciality, this does not include procedures, nurse or diagnostic appointments or pre-admission visits.
	Follow-ups	Further assessments by hospital specialists.
FTE	Full Time Equivalent	An Employee who works an average minimum of 40 ordinary hours per week on an ongoing basis.
HbA1c	Haemoglobin A1c	The level of HbA1c reflects the average blood glucose level over the past 3 months. Also known as glycated haemoglobin.
HEAT	Heat Equity Assessment Tool	The HEAT Tool provides questions to assist people working in the health sector to consider how particular inequalities in health have come about, and where the effective intervention points are to tackle them.
HIS-NZ	Health Information Strategy– New Zealand	The Government's Health Information Strategy for all DHBs.
HNA	Health Needs Assessment	A process designed to establish the health requirements of a particular population
	Health Outcomes	A change in the health status of an individual, group or population which is attributable to a planned programme or series of programmes, regardless of whether such a programme was intended to change health status.
HPI	Health Practitioner Index	The HPI will be a comprehensive source of trusted information about health practitioners for the NZ health and disability sector. The HPI will uniquely identify health providers and organisations. This will allow health providers who manage health information electronically to do so with greater security. It will help our health sector to find better and more secure ways to access and transfer health-related information.
HEHA	Healthy Eating Healthy Action 'Strategy'	HEHA is the Ministry's strategic approach to improving nutrition, increasing physical activity and achieving healthy weight for all New Zealanders.
HSS	Hospital and Specialist Services Division	The Provider-arm of the Canterbury DHB.
IPJ	Improving the Patient Journey	The Improving the Patient Journey Programme has been established by the DHB to encourage participants to positively influence the effectiveness and efficiency of the organisation and to improve patient outcomes. The overarching goals are to: reduce unnecessary waits and delays within the patient continuum of care and embed innovation tools, techniques and learning into services and other organisations. The involvement and leadership of frontline staff in the review of the system underpinning patient care is key to the success of the Programme.
	Integration	'Combine into a whole' or 'complete by addition of parts'.
ISSP	Information Services Strategic Plan	The Canterbury DHB's Plan for information services – in line with the national Health Information Strategy.
IDFs	Inter-District Flows	An IDF is a service provided by a DHB to a patient whose 'place of residence' falls under the region of another DHB. Under PBF each DHB is funded on the basis of its resident population therefore the DHB providing the IDF will recover the costs of that IDF from the DHB who was funded for that patient.
InterRAI	International Resident Assessment Instrument	Comprehensive geriatric assessment tool.
KPP	Knowing the People Planning Project.	The Programme identifies those people with enduring mental illness and tracks their progress against ten elements of recovery from employment status through to use of hospital services.
LOS	Length of Stay	LOS is the time from admission to discharge, less any time spent on leave. It is normal to exclude boarder patients when calculating length of stay.
MoU	Memorandum of Understanding	An agreement of cooperation between organisations defining the roles and responsibilities of each organisation in relation to the other or others with respects to an issue over which the organisations have concurrent jurisdiction.
MHINC	Mental Health Information National Collection	The national database of mental health information held by the NZ Health Information Service to support policy formation, monitoring and research.
	Morbidity	Illness, sickness.
	Mortality	Death.
NHI	National Health Index	The NHI number is a unique identifier that is assigned to every person who uses health and disability support services in NZ. A person's NHI number is stored on the NHI along with that person's demographic details. The NHI and associated NHI numbers are used to help with the planning, co-ordination and provision of health and disability support services across NZ.
NIR	National Immunisation Register	The NIR is a computerised information system that has been developed to hold immunisation details of NZ children and assist to improve immunisation rates.

NZHIS	New Zealand Health Information Service	A group within the Ministry responsible for the collection and dissemination of health-related data. NZHIS has as its foundation the goal of making accurate information readily available and accessible in a timely manner throughout the health sector.
NGO	Non-Government Organisations	There are many ways of defining NGOs. In the context of the relationship between the Health and Disability NGOs and the Canterbury DHB, NGOs include independent community and iwi/Māori organisations operating on a not-for-profit basis, which bring a value to society that is distinct from both Government and the market. In reality this will mean that any profits are put back into the organisation, rather than distributed to shareholders.
OPF	Operational Performance Framework	The OPF is one of a set of documents known as the 'Policy Component of the DHB Planning Package' which sets out the accountabilities of DHBs. The OPF is endorsed by the Minister of Health and comprises the operational level accountabilities that all DHBs must comply with, given effect through the Crown Funding Agreements between the Minister and the DHB.
PMS	Patient Management System	PMS (secondary-care), or Practice Management System (primary-care) used to keep track of patients. In secondary care the focus is usually on tracking the admissions, discharges or transfers of patients, in primary care, the focus is on maintenance of the register.
PHARMAC	Pharmaceutical Management Agency	Government Agency which secures the best health outcomes that are reasonably achievable from pharmaceutical treatment and from within the amount of funding provided.
PBF	Population Based Funding	Involves using a formula to allocate each DHB a fair share of the available resources so that each Board has an equal opportunity to meet the health and disability needs of its population.
	Primary Care	Primary Care means essential health care based on practical, scientifically sound, culturally appropriate and socially acceptable methods. It is universally accessible to people in their communities, involves community participation, is integral to, and a central function of, the country's health system, and is the first level of contact with the health system.
PHO	Primary Health Organisation	A new development in service delivery PHOs encompass the range of primary care and practitioners and are funded by DHBs to provide of a set of essential primary health care services to those people who are enrolled in that PHO.
	Public Health	The science and art of preventing disease, prolonging life and promoting health and efficiency through organised community effort. A collective effort to identify and address the unacceptable realities that result in preventable and avoidable health outcomes, and it is the composite of efforts and activities that are carried out by people committed to these ends.
QIC	Quality Improvement Committee	The Quality Improvement Committee is a statutory committee established under the NZ Public Health and Disability Act 2000. Appointed and accountable to the Minister of Health it provides independent advice on quality improvement in the health sector.
	Secondary Care	Specialist care that is typically provided in a hospital setting
SISSAL	South Island Shared Services Agency Ltd	SISSAL provides a consultancy service to the South Island DHBs, and works in partnership with them on health planning and funding issues. SISSAL is funded by the DHBs on an annual budget basis to provide these services including contract and provider management, audit, strategy and service development, analysis, and project and change management.
SOI	Statement of Intent	The Statement of Intent covers three years and is the DHB's key accountability document to Parliament. It is a statutory obligation under the Public Finance Act and has a high level focus of key financial and non-financial objectives and targets, similar to an executive summary.
	STAT Dispensing	STAT Dispensing refers to all-at-once dispensing by pharmacies.
SDR	Standardised Discharge Ratio	The SDR measures the intervention rates for a selected group of procedures and compares them with the national average. If all DHBs were providing services at the same level, they would all be at 1. Intervention analysis does not necessarily indicate what the right rate might be, but compares DHBs with the national mean, taking board population demographics into account.
TLA	Territorial Local Authority	Local Council also known as: Regional Councils; District Councils; Territorial Local Authorities; Unitary Authorities; City Councils; Councils
	Tertiary Care	Very specialised care often only provided in a smaller number of locations
	Xcerlr8	Xcelr8 is a learning and development programme established by the DHB with the specific objectives of: achieving more with what we already have; equipping the DHB for future challenges; supporting participants to achieve; and bringing the DHB further together by refreshing the basics and providing a memorable and fun learning experience.
YTD	Year to Date	The 12 month period immediately prior to the date given.

A DAY IN THE LIFE OF THE CANTERBURY DHB

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