Canterbury
District Health Board
Te Poari Hauora ō Waitaha

CORPORATE OFFICE

Level 1
32 Oxford Terrace
Christchurch Central
CHRISTCHURCH 8011

Telephone: 0064 3 364 4160
Fax: 0064 3 364 4165
Ralph.lasalle@cdhb.health.nz

4 May 2021

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RE Official Information Act request CDHB 10587

I refer to your email dated 10 April 2021 requesting the following information under the Official Information Act from Canterbury DHB. Specifically:

1. The earliest Annual Plan that appears to be available on the CDHB website is for 2008/09. I presume that there are also earlier plans which date from the founding of the CDHB'. **Would you please provide me with copies of those up to and including 2007/2008, either electronically or by hard copy mailed to my home address at 9 White Street Rangiora 7400.**

The earlier Canterbury DHB Annual Plans are attached electronically including the following years:

- **2001/2002 - Pages 1 – 72**
- **2002/2003 - Pages 73 – 162**
- **2003/2004 - Pages 163 - 258**
- **2004/2005 - Pages 259 - 382**
- **2005/2006 - Pages 383 - 496**
- **2006/2007 - Pages 497 - 571**
- **2007/2008 - Pages 572 - 671**

The Canterbury DHB's Annual Plan for 2019/20 (the Annual Plan for 2020/21 is not yet publicly available) states on page 1 that the Annual Plan "has been prepared to meet the requirements of the New Zealand Public Health and Disability Act, Crown Entities Act, Public Finance Act, and the expectations of the Minister of Health."

2(a) Please provide specific details of the sections and/or subsections of the three Acts which require DHBs to prepare Annual Plans.
2(b) Please provide specific details which give the Minister of Health the right to state what his or her expectations are of the CDHB - what is the legislative basis for such expectations?

We are declining a specific response to these questions pursuant to section 18(d) of the Official Information Act *i.e. "…. The information requested is publicly available."*

There are multiple sections and/or subsections that relate to the preparation and content of the DHB's Annual Plan and Statement of Performance Expectations. The online documents are searchable and all available publicly from www.legislation.govt.nz.

I trust this satisfies your interest in this matter.

You may, under section 28(3) of the Official Information Act, seek a review of our decision to withhold information by the Ombudsman. Information about how to make a complaint is available at www.ombudsman.parliament.nz; or Freephone 0800 802 602.

Please note that this response, or an edited version of this response, may be published on the Canterbury DHB website after your receipt of this response.

Yours sincerely

Ralph La Salle
Acting Executive Director
Planning, Funding & Decision Support

Canterbury DHB
District Health Board
Te Poari Hauora o Waitaha

ANNUAL PLAN

2001 – 2002

Table of Contents

1. Executive Summary

This is the Canterbury District Health Board‟s inaugural annual plan. It outlines the key activities of the Canterbury DHB in the next 12 months.

The plan has been written without the assistance of a strategic plan, which will be completed in 2002, but outlines the timetable for the development of the strategic plan – the development of which is one of the key tasks for the Canterbury DHB in the 2001/2002 financial year. This strategic plan will set future priorities for the Canterbury DHB.

The strategic planning process will give the Canterbury DHB the opportunity to plan for the health and disability needs of the Canterbury community in a more inclusive and comprehensive way than ever before.

The strategic planning process will include increased consultation and input from the community in determining what services are provided and will lead to a closer working relationship with other health providers.

A key focus of the strategic planning process, and for the DHB in general, will be better health outcomes for Maori, pacific peoples, refugee communities, rural communities and the elderly.

This process will pay particular regard to the Crown‟s obligations under the Treaty of Waitangi and will be helped by the work of our Kaumatua, Taua and Maori Health Manager.

Integration with other health care providers, including primary, and community groups will continue to be a key theme for the Canterbury DHB in the 2001/2002 financial year.

As with all the Canterbury DHB‟s work, integration projects will help ensure the Canterbury DHB delivers improved health outcomes and disability services to the Canterbury community.

The annual plan will establish the Canterbury DHB‟s role as a funder as we move towards a greater focus on funding services which will be outcome focused and grounded in continuous quality improvement.

Discretionary funds have not been identified for the 2001/2002 financial year. Future opportunities for discretionary funding will result from savings made through efficiencies.

The key business of the Canterbury DHB in the 2001/2002 financial year will be:

- An assessment of the health status of the Canterbury Population;
- Preparation of a 5-10 year Strategic Plan, based on the above Needs Assessment (aligned with the priorities of the NZ Health Strategy, NZ Disability Strategy, Maori Strategy (Draft April 2001) and other health strategies);
- Building capacity including prioritisation of health needs. This and other aspects of the DHB"s work will involve consultation with the community
- Provision of health services as agreed from the Crown Funding Agreement between the Ministry of Health and the Canterbury DHB. These services will cover Personal Health, Mental Health and Maori Health Services in those areas where the responsibility has been, or will be, devolved to the DHB.

By concentrating on these key areas the Canterbury DHB is working to ensure the Government"s health and disability strategies are realised in Canterbury resulting in better health outcomes for all sectors of our community.

Jean O"Callaghan
Chief Executive Officer

Syd Bradley
Chairman

2 Introduction

2.1 Context for the Plan

The Canterbury DHB was established 1 January 2001 and operates under accountability arrangements prescribed in the New Zealand Public Health and Disability Act 2000. The Canterbury DHB Annual Plan is one of the formal accountability documents negotiated between the Canterbury DHB and the Minister of Health.

This first Annual Plan is being completed before the first Canterbury DHB 5-10 year Strategic Plan is in place. Its objectives therefore are aligned with Government objectives for District Health Boards as set out in the New Zealand Health Strategy and the New Zealand Disability Strategy, Maori (draft April 2001) and other Health Strategies(of which there are currently 43).

The Canterbury DHB is working towards linking the health needs of the Canterbury community with the above strategies to prioritise community health needs. These priorities will be outlined more clearly in future annual plans.

The Annual Plan outlines the planned performance of the Canterbury DHB for the next 12 months (July 2001 – June 2002) including funding arrangements and services provided. Targets for the following two years are also included as per the requirements of the Ministry of Health"s Operational Policy Framework.

2.2 Role and Function of the Canterbury DHB

The Canterbury DHB was created as a result of a major change in the health structure of New Zealand following the passing of the NZ Public Health and Disability Act.

Under the new structure the Canterbury DHB, and the other 20 DHBs in New Zealand, aim to promote community „wellness" and will have more control over how government money is spent on health and disability services. DHBs will also deliver services via their own hospitals and community services.

The Canterbury DHB will progressively decide how money is best spent on health and disability services in Canterbury and then enter into agreements with organisations or individuals who can best provide those services.

However, the level of Disability Support Service provided in the region will be decided by the Ministry for the forseeable future.

The Canterbury DHB will initially be responsible for funding personal health, mental health and Maori health services through providers such as GPs, Maori and Pacific groups, mental health providers and its own provider arm services, from 1 July 2001 Funding for Disability Services and Population Health Services will be devolved to the Canterbury DHB from 1 July 2002 at the earliest.

The New Zealand Public Health and Disability Act 2000 (the Act) establishes the following functions for the Canterbury DHB:

a) To ensure the provision of services for its resident population;
b) To actively investigate, facilitate, sponsor and develop co-operative and collaborative arrangements with persons in the health and disability sector or in any other sector to improve, promote and protect the health of people, and to promote the inclusion and participation in society and independence of people with disabilities;
c) To issue relevant information to the resident population and other people for the purposes of (a) and (b);
d) To establish and maintain processes to enable Maori to participate in, and contribute to, strategies for Maori health improvement;
e) To continue to foster the development of Maori capacity for participating in the health and disability sector and for providing the needs of Maori;
f) To provide relevant information to Maori for the purposes of (d) and (e);
g) To regularly investigate, assess and monitor the health status of its population, any factors that the DHB believes may adversely affect the health status and the needs of that population for services;
h) To promote the reduction of adverse social and environmental effects on the health of people and the communities;
I) To monitor the delivery and performance of services by it and by persons engaged by it to provide or arrange for the provision of services;
j) To participate, where appropriate, in the training of health professionals and other workers in the health and disability sector;

k) To provide information to the Minister for the purposes of policy development, planning, and monitoring in relation to the performance of the DHB and to the health and disability support needs of New Zealanders;

l) To provide, or arrange to provide for the provision of, services on behalf of the Crown or any Crown entity within the meaning of the Public Finance Act 1989;

m) To collaborate with pre-schools and schools within its geographical area on the fostering of health promotion and on disease prevention programmes;

n) To perform any other functions it is by or under any enactment, or authorised to perform in writing by the Minister after consultation;

2.3 Population Characteristics

2.3.1 Summary of Demographics

The Canterbury DHB is the largest DHB by population and geographical area. 20% of its population lives outside the urban Christchurch boundary. The region"s population is ageing quickly compared to other parts of the country. Data provided in this plan is from the 1996 Census as 2001 data is still provisional.

Population Statistics

Canterbury District Health Board population statistics (1996 Census Data)

Total Population:	420,532	
Population by region		percentage
Kaikoura	4,038	1.0%
Hurunui	10,113	2.4%
Waimakariri	32,226	7.7%
Selwyn	25,140	6.0%
Christchurch City	315,120	75.0%
Banks Peninsula	8,769	2.1%
Ashburton	25,128	6.0%
Population by age:		
0-14 years	84,527	20.1%
15-19 years	31,119	7.4%
20-64 years	249,375	59.3%
65-84 years	50,464	12.0%
85 plus years	5,046	1.2%
Population by Ethnic Background:		
NZ Māori	28,596	6.8%
European	357,031	84.9%
Pacific Peoples	6728	1.6%
Asian Peoples	13,877	3.3%
Other Nations	14,298	3.4%

Birth Rate:
In 1996, 5500 babies were born
In 2006, it is projected that 4992 babies will be born.

Birth Place:
81% of people who live in Canterbury were born in New Zealand

Future Population (2021):

Total Population expected	495,500 (based on medium fertility, medium mortality and medium migration)	
Increasing by around 2775 people per year		
0-14 years	76,307	15.4%
15-64 years	322,571	65.1%
64-84 years	8,704	17.7%
85 plus years	8,919	1.8%

Households with One/ More Superannuants:	24.8%
Households with Two or More People in the Labour Force:	43.5%
Households with Children Aged Less than 5 Years:	13.4%
Households with at Least One Sole Parent Family:	11.1%

Personal Income of People Aged 15-64[1] Years:

Less than $30,000	53.3%
$30,000 - $50,000	11.3%
$50,001 - $100,000	3.4%
$100,001 +	0.8%

1 Percentages do not add to 100 as they are the percentage of the total population, not just of the population aged 15-64.

Beneficial Support Payments[2]:

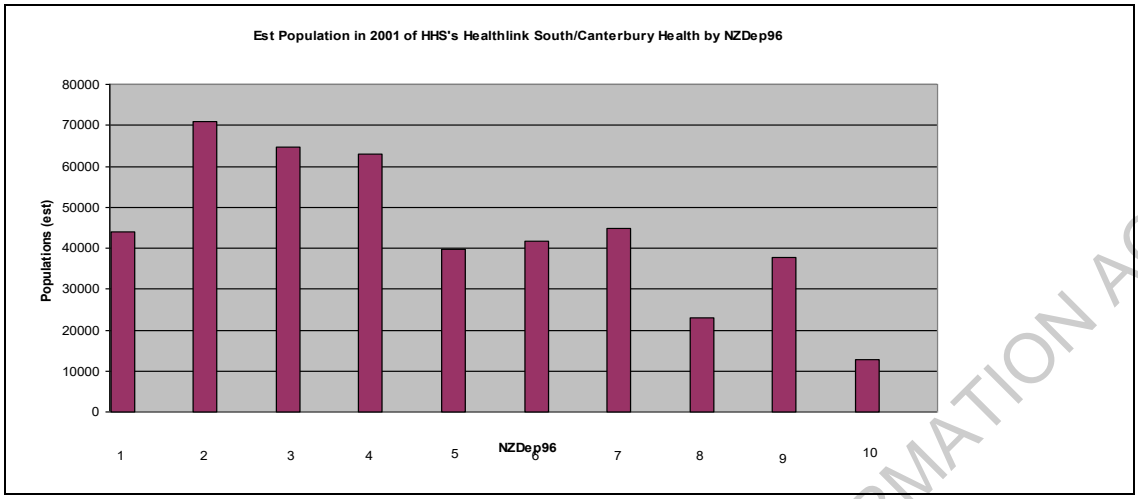
National Superannuation	13.8%
Unemployment Benefits	5.5%
Domestic Purposes Benefit	2.4%
Sickness, Invalids Benefit	3.3%
ACC regular payments	2.1%

Percentages do not add to 100 as they are the percentage of the total population, not just of the population receiving a benefit.

Provisional Results from the 2001 Census

The 2001 Census indicates Canterbury's population has increased to about 435,300, and that the districts around Christchurch are growing rapidly: 13% increase in Waimakariri and 9.9% in Selwyn. Kaikoura is one of the fastest-growing territorial authorities in New Zealand.

Deprivation Index Data (1996)



The above graph shows the Christchurch population by deprivation score (1 is least deprived and 10 most deprived), projected from work done by the Ministry Of Health in 1999. Research has shown that populations with high deprivation scores are likely to have high health needs and poor health status.

"NZDep96 is a measure of socio-economic deprivation. It is a score for a geographic community which summarises several indicators of social or economic deprivation in that community. Specifically, the indicators used are measures of unemployment, single parent families, marital status, households with no cars, rental housing, low income, education and income support."

2.3.2 Overview of Health Status

A Needs Assessment Project is underway to assess the health status of the Canterbury population as these relate to the health objectives within the New Zealand Health Strategy, the New Zealand Disability Strategy, the Maori Health Strategy and Pacific Health and Disability Action Plan (both in draft) as part of the strategic planning process. The Needs Assessment will also be cognisant of issues raised in community consultation and will link the health needs of the Canterbury community with Government health strategies and others such as The Primary Care and Positive Ageing Strategy to prioritise the district"s health needs.

The Needs Assessment Project is likely to take 2-3 years to complete to a fine level of detail.

The following is an overview of the key health status areas for the Canterbury DHB population based on data from the 1996 Census and other sources.

Smoking

Number of people who smoke tobacco regularly		65,833
Average Tobacco Smoking	Canterbury	New Zealand
Rates per 1000 population		
Females	21.0	25.8
Males	23.5	26.8
Maori	35.6	40.0
Non-Maori	21.2	23.4

Smoking rates are highest among young Maori women – 50 per 1000 population in Canterbury (57 per 1000 population nationally).

In general, smoking rates in Canterbury are slightly lower in most categories than for the rest of New Zealand. Recent Christchurch studies show that people in disadvantaged areas tend to smoke more, supporting a strong link between smoking and socio-economic disadvantage.

Diabetes

Diabetes, in particular Type 2 or non-insulin dependent diabetes, is a growing health problem internationally, and in New Zealand. In the Canterbury-West Coast region, it is estimated that about 14,000 people have known diabetes, with possibly another 5000 undiagnosed.

Type 2 diabetes has multiple effects on health, and mainly affects people as they age. New Zealand‟s ageing population means that increased pressure will be put on health services as more people develop diabetes and its accompanying complications. Type 2 diabetes is of particular concern to the Māori population.

The prevalence of known diabetes in Maori adults over 15 years was 8.3% in the most recent New Zealand health survey. The prevalence of known and unknown diabetes in a working population of Maori aged over 40 was 9.1%. The prevalence of diabetes (known and undetected) in Maori adults is likely to range as high as 15-20%. (HFA 2000).

In 1996 age standardised Maori mortality from diabetes was over six times that for non-Maori. Mortality also occurred at younger age groups when compared with non-Maori. In particular, in the ages from 45-60, age specific Maori mortality for diabetes ranged between 12-15 times that of non-Maori in the same age group. Maori deaths due to diabetes constitute 22% of all diabetes deaths. (HFA 2000).

Diabetes is also a serious concern for Pacific peoples, who are more than twice as likely to be diagnosed with diabetes than non-Pacific people, and who develop the condition at a younger age.

Hearing
In 1999 the percentage of children failing the school entry hearing test (with or without correction) was 13.8% Maori, 13.9% Pacific Peoples; 5.3% NZ European and other.

Analysis of hospitalisation data (1995/96) for otitis media (suppurative and non-suppurative finds Maori children under 5 years have over double the rates of admission compared to non-Maori.

When deprivation is taken into account, Maori children in the lowest deprivation group were much less likely to be admitted for grommets than non/Maori, non-Pacific children of the same age and level of deprivation. It is likely that Maori and Pacific children do not have the same access to specialist services as non-Maori/non-Pacific.

Infant Mortality
Until the mid 1990s, New Zealand had a high rate of cot death, or Sudden Infant Death Syndrome (SIDS) which reduced dramatically through an intensive public education programme. The numbers of deaths due to SIDS has now levelled off, but for all parts of the country, remain highest for Maori and Pacific infants. Pacific peoples" infants in Canterbury are particularly at risk.

Suicide
Suicide is a major public and mental health problem. From 1989 to1998, 658 people in Canterbury committed suicide. During 1998, the most recent year for which there are figures, 64 people died by suicide. Most of these people were of European ancestry, and the majority were male. The single group at highest risk of suicide are males aged 20-29 years. Regional comparisons of suicide rates in New Zealand are problematic because of small numbers. Canterbury is not among the regions with the highest suicide rates.

Communicable Diseases
The rates for diseases such as campylobacter, salmonellosis, Hepatitis C, and pertussis are slightly higher in Canterbury than in other parts of NZ.

Canterbury has fewer new cases of tuberculosis and meningococcal disease than other regions of NZ.

Disease	1999 Canterbury rate per 1000 people	1999 New Zealand rate per 1000 people
Campylobacter	3.00	2.22
Salmonellosis	0.64	0.56
Hepatitis C	0.09	0.03
Measles	0.03	0.03
Tuberculosis – new cases	0.05	0.11
Meningococcal Disease	0.08	0.14
Pertussis	0.50	0.28

Causes of Death (1996 – 1998)
Heart disease is the main cause of death for males and females in Canterbury.

For males, the second and third leading causes were lung cancer, and motor vehicle crash injuries (Maori), and cerebrovascular disease and cancer of the lung (non-Maori). For Maori females, the second and third leading causes of death were diabetes, and cancer of the uterus and cervix. Other cancers were also important contributors to death.

For non-Maori females, cerebrovascular disease, pneumonia, and cancers of the breast and large bowel were the main causes of mortality.

The main causes of death vary with age: Children"s deaths were due mainly to cancer and motor vehicle crashes. In the years from 1990 - 1998, teenagers and young adults died mainly due to motor vehicle crashes and suicide (although the number of suicides has since dropped.) During mid-adult life, the main causes of mortality were cancer and car crashes, as well as suicide. For older adults, the main causes of death were heart disease and cancer.

Hospitalisations, 2000
The most common causes of admissions to hospital for females were pregnancy and birth, injuries, digestive problems, circulatory disorders, gynaecological disorders and musculoskeletal disorders. For males, the most common causes of admission were cardiovascular problems, injuries, digestive problems, musculoskeletal disorders, respiratory problems, and ear, nose and throat disorders.

First hospital admissions were higher for residents of mid-Canterbury, and for people living in disadvantaged areas.

Acute admissions to hospital are currently growing at 5% per year.

Road crashes (1997)
In 1997, Canterbury had a higher rate of road crashes per 10,000 population than the national rate (27.4 vs 25.3). There were 44 fatalities.

2.4 Environment

2.4.1 Policy Expectations

The New Zealand Health and Disability Act 2000 established 11 objectives for DHBs which are:

1) To improve, promote and protect the health of the people and the communities;
2) To promote the integration of health services, especially primary and secondary health services;

3) To promote effective care or support for those in need of personal health services or disability support services;
4) To promote the inclusion and participation in society and independence of people with disabilities;
5) To reduce health disparities by improving health outcomes for Maori and other population groups;
6) To reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders;
7) To exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges provision of services;
8) To foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services;
9) To uphold the ethical and quality standards commonly expected of providers of services and of public sector organisations;
10) To exhibit a sense of environmental responsibility by having regard to the environmental implications of its operations;
11) To be a good employer.

The New Zealand Health Strategy outlines 13 population health objectives selected as short to medium term priorities:

1) To reduce the incidence and impact of violence in interpersonal relationships, families, schools and communities.
2) To reduce smoking
3) To improve nutrition
4) To reduce obesity
5) To increase the level of physical activity
6) To minimise harm caused by alcohol, illicit, or other drug use, to individuals and the community
7) To improve the health status of people with severe mental illness
8) To reduce the rate of suicide and suicide attempts
9) To reduce the incidence and impact of cancer
10) To reduce the incidence and impact of cardiovascular disease
11) To reduce the incidence and impact of diabetes
12) To improve oral health
13) To ensure access to appropriate child care services including well child and family health care and immunisation services

2.4.2. Sector Characteristics

Primary Health Services
Primary health care includes services such as visits to GPs, screening for disease, well-child services, mental health diagnosis and treatment, sexual and reproductive health services, care coordination, pharmacy and laboratory services and maternity services. General Practitioners and practice nurses are the largest group providing primary care, but there are others such as a small number of Maori and Pacific providers.

Primary health services also include personal health education services (such as nutrition counselling, advice on exercise, stress management), health camps, support services (Plunketline and Healthline telephone health advice), and mental health promotion.

The health education and promotion component of primary care is focused on the person and family/whānau, as opposed to the population health initiatives of public health agencies.

General Practice
There are about 350 General Practitioners in the Canterbury area. In Christchurch approximately 230 of these are part of the Pegasus Health Independent Practitioners" Association (IPA). Another 80 Canterbury GPs are affiliated with South Link Health IPA (based in Dunedin, with members in rural areas throughout the southern region).

Maternity
Pregnancy and parenting courses are provided by four providers in nine locations around Canterbury. All antenatal care and education, and services for delivery either at home, in a hospital (public or private), or other birth facility, are free. As well, post-natal services for mother and baby and family/whānau are provided free of charge until the baby is 6 weeks old. Lead Maternity Care is provided by midwives and GPs.

There are nine primary labour and birth facilities in the region. Rural communities are concerned about maternity cover as rural GP numbers decline and/or GPs cease their involvement in obstetrics. The rate of medical intervention in deliveries continues to increase in line with international trends. (See also the description of Women"s Health Division of Canterbury DHB, section 4.11.2).

Oral Health
There were 198 dentists in Canterbury in 2000, which is a rate of 49.7 per 100,000 of the population (aged 14+). Around New Zealand, the number of dentists per 100,000 of the population (aged 14+) ranges from a high of 55.0 (Auckland) to 23.8 (West Coast).

In Canterbury, the enrolment rate in the school dental service is high (95%, vs 89% nationally). Children at greater risk of having poor dental health include Maori and Pacific children, and children from lower socio-economic areas.

It is now apparent that there are significant inequalities in oral health status between different population groups. In particular, Maori and Pacific children and adolescents have worse oral health than non-Maori and non-Pacific children. For example, separate dental caries data for Maori children have been reported for some New Zealand regions. These indicate that Year 8 Maori children had, on average, 60% more decayed and filled teeth than non-Maori.

In Canterbury, for the six months ending 31 December 2000, of all 5 year olds from whom data was collected, 2% of Maori, 0.3% of Pacific peoples and 43% of Other Ethnicity were caries free. Similarly, for all Year 8 children from whom data was collected, 2% of Maori, 0.3% of Pacific peoples and 33% of Other Ethnicity were caries free. (School Dental Services).

Free dental services are provided to pre-school, primary school, and intermediate school children, as well as adolescents up to age 17 years who are in full time study. The oral health service also provides free emergency dental care to low-income adults, and in some cases, subsidised emergency dental services are available for holders of community services cards.

Pharmaceutical and Laboratory Services

Primary health care includes the provision and dispensing of medicines and other therapeutic devices and supplies. Pharmaceuticals are prescribed by GPs, specialists, midwives, and dentists, and dispensed by community or hospital pharmacies. Historically, Christchurch has had a comparatively high amount spent on pharmaceuticals, which has been influenced by particular patterns of GP prescribing, and by the presence of hospital specialists and a medical school.

Laboratory services are provided by hospital or community laboratories. The main hospital laboratory is on the Christchurch hospital site, with a smaller laboratory at Ashburton Hospital. There are two community laboratories with facilities in Christchurch.

Work undertaken by Independent Practitioners Association around types and numbers of laboratory tests ordered and prescription patterns has reduced Pharmaceutical and Laboratory Services expenditure in recent years.

Community Health Services
A wide range of community health services such as palliative care, domiciliary nursing, Meals on Wheels, District Nursing, emergency transport, and other community services are provided free of charge or at subsidised prices. In Canterbury, the bulk of these services are provided by non-hospital providers, which brings the benefits of choice, but the complexities of fragmentation to this very complex area. The cost and demand for these services is growing at 10% per year.

Secondary and Tertiary Services
Canterbury has a number of hospitals and community services which provide more specialised secondary and tertiary care. The provider arm of Canterbury District Health Board incorporates some hospitals and other secondary services around Canterbury (see section 4.3.1 for a full description of the Canterbury DHB"s hospitals). Other hospitals are privately-owned, and specialise in care of the elderly, maternity, day surgery, or particular elective procedures.
Some publicly-funded services are provided by private hospitals, mostly around maternity care (labour, birth including elective caesarian sections, and postnatal stay).

Mental Health
Service levels for mental health in Canterbury reach 2.2% for adults and 1.6% for child and youth compared to the Mental Health Commission Blueprint benchmarks of 3%. Priority areas remain child and youth, Maori, and workforce development.

Within Canterbury the needs of mental health consumers are met by the DHB provider and a range of NGO providers. 25% of the total mental health revenue is contracted to 60 Non Government Organisations whose services are used by the majority of mental health consumers. Inpatient bed numbers are at benchmark levels, however, there are insufficient supervised accommodation options in the district.
At present it is not known whether the prevalence of mental illness for Maori is higher or lower than the rest of the population (DHB 2001). However it is known that Maori hospital admission rates are 40% higher than for non-Maori, Maori have higher rates of presentation to crisis, acute and forensic services and are more likely than non-Maori to suffer from alcohol and drug disorders (MHC 1998).

A recent review of Forensic Services found that of 189 inpatients in Forensic Services at that time 50% were Maori and overall Maori represented 15% of all persons receiving treatment (MoH 2001).

The prevalence of mental illness amongst Pacific peoples is not clear. This is because the only reliable data that is available is based on inpatient admissions. However it is known that many people experiencing mental health problems in Pacific communities never access mainstream services (DHB 2001).

2.4.3 Regional Issues – Canterbury

Rural Health Care

The Canterbury DHB catchment area covers rural communities from Kekerengu in the North, Rangitata in the South and Arthur"s Pass in the West. Indicative health status information for populations in rural areas of Canterbury indicate their health status is considered good compared to other populations, except in a few areas where there are high numbers of low-income elderly people.

People scattered over a wide area in rural Canterbury do not have easy access to health services. Access to transport is a frequently mentioned concern. While there are problems in many rural areas throughout New Zealand recruiting and retaining GPs in rural Canterbury there has been stability in rural GP numbers and personnel for many years with the exception of Hanmer Springs. The key issues are locum coverage and fears by current rural GPs about selling their practices when they retire. Rural Canterbury also has nine hospitals that are administered by the Canterbury DHB:

- Kaikoura
- Waikari
- Oxford
- Rangiora
- Darfield
- Ellesmere
- Lincoln
- Akaroa
- Ashburton

In addition, a range of home support, palliative care, population health, oral health and other community services are funded. Pharmacies operate in some smaller centres, eg Kaikoura, Waikari.

Maori

Maori make up 28,500 ((6.8%) of the population living in Canterbury (1996 figures). By population the Canterbury district has the ninth largest number of Maori inhabitants of the 21 DHBs. Most are under 30 years of age. Ngai Tahu are manawhenua and make up about 25% of Maori in the Canterbury DHB region. Seven Ngai Tahu runaka are in the Canterbury DHB area. Other Maori in Canterbury come from tribal regions throughout New Zealand.

The available health statistics indicate that Maori in Canterbury have a similar health profile to national statistics. Available local ethnicity data does not confirm that Maori are high users of Secondary Services or under utilise Primary Services, but nationally this is so. „Maori for Maori" providers provide a range of public, primary and community health services, and some bicultural services are provided by mainstream providers.

Pacific Peoples
There are about 8000 Pacific people in Christchurch, based on Statistics NZ 1999 projections, a mixture of Island born and New Zealand born people. The Canterbury DHB has very few dedicated services for Pacific peoples. An initial needs assessment has indicated Pacific peoples are difficult to reach due to communication and cultural difficulties and over utilise secondary services rather than primary and community services.

Chronic diseases such as diabetes, asthma etc are prevalent amongst this population. The majority of the Pacific peoples are aged under 25 years.

Migrant and Refugee Communities
Christchurch has been a resettlement point for refugees especially during the past 10 years. Screening programmes for refugees have been established, however, migrant and refugee populations have particular needs in the areas of child health, mental health, primary health care and oral health.

Training and Research
The Canterbury DHB continues to foster a positive relationship with a range of health workforce trainers including the Christchurch Polytechnic, University of Canterbury and others. The training of nurses, allied health professionals and scientists by these institutions is vital in ensuring a well trained workforce.

The Canterbury community benefits from the Canterbury DHB"s close and positive professional relationship with Otago University"s Christchurch School of Medicine and Health Sciences. This relationship results in improved research and clinical services.

Christchurch Hospital is one of the leading teaching hospitals in the country and the School of Health Sciences building has been part of the hospital complex since 1972. Many Canterbury DHB staff in other health services in Christchurch also have a teaching or research role at the school.

Waiting Lists
Demand for acute medical services continues to grow at rates in excess of demographic growth. However, waiting times and numbers of patients waiting for first specialist assessments and elective surgery here reduced significantly over the past 4 years due to increased funding which is no longer available.

Ageing Population
Canterbury has a higher than New Zealand average of people over 65 and over 85 years of age. Consequently, in coming years disability support, medical and surgical services are going to be under increased pressure.

Interagency Collaboration
There are some collaborative programmes in Canterbury, such as Strengthening Families and Early Start which work across various health, education, and welfare agencies to improve health status. The Heartland initiative is now being explored by this group.

The Canterbury DHB is also involved in the *"Healthy Cities Healthy Christchurch"* initiative with the Christchurch City Council and other groups. The plan is to increase collaboration around population health initiatives.

In addition the Canterbury DHB is initiating a Needs Assessment Advisory Panel which will bring together organisations such as the Christchurch School of Medicine, Ngai Tahu Development Corporation, Crown Public Health, Pacific Trust Canterbury, Pegasus Health and Christchurch City Council to contribute expertise to the assessment of the population health status.

Workforce
The Canterbury DHB is competing in a global market place to attract medical and other health professionals to work in the region. Internationally there is a shortage of clinicians across various groups and ultimately the inability to fill positions will impact on the services that can be offered. Most recently this has occurred for radiation technologists, nurses and junior doctors.

The numbers of Maori and Pacific peoples among the health workforce is very small. Numbers of people entering health professions/social service careers, student loans, competitive pay offers overseas and service growth all contribute to the workforce numbers shortfall. A range of solutions will be needed to address this problem. It needs to include a system for collecting information on workforce numbers and categories of practice.

2.4.4 Local Issues - Canterbury

The Pegasus Health Global Contract is a unique feature to primary care services in Canterbury. Pegasus has a budget of $73 million per year, over which Pegasus has a degree of discretion to spend on the most appropriate mix of service to improve health gains which are in accord with national priorities. A key focus is to foster collaboration and cooperation between secondary and primary services.

The Canterbury DHB, by virtue of its size and infrastructure, supports smaller DHBs such as West Coast and South Canterbury with administrative and medical assistance.

GPs are located in higher numbers in affluent areas of Christchurch, than in less advantaged areas (ie, low socio-economic areas). GPs outside the city belong to other Independent Practitioner Associations outside Pegasus, in particular South Link Health which is administered from Otago.

The rural area around Christchurch is one of the fastest growing areas in the South Island. Some people living in these areas commute to Christchurch, which must be considered in health and city planning using in some cases city based health services as opposed to rural ones. This impacts on the viability of rural GP services.

Canterbury hosts a number of high risk spots/adventure operations which presents challenges to rural health services.

In Canterbury, there is a need to further improve linkages between primary care and medical/surgical services to improve patient management. It is also necessary to improve linkages between primary care and community services. Work has already been done towards this through the Elder Care Canterbury, Access Canterbury and Strengthening Families projects.

Christchurch Hospital has the busiest emergency department in Australasia, treating more than 64,000 patients a year.

Compared to other New Zealand cities, the air quality in Christchurch in the winter is poor. This winter air pollution is due to Christchurch"s geographical location and calm winter weather, which allows a temperature inversion layer to develop, trapping cold air and particulate emissions over the city. The main air sources of air pollutants in Christchurch are from industrial and commercial combustion processes, domestic heating (wood and coal fires), and motor vehicles. In 1999, the level of suspended particles in Christchurch exceeded the recommended guidelines for air pollutants on 35 days during the winter months. Air pollution at this level can cause health problems ranging from lung and eye irritation, to serious respiratory problems following long-term exposure. Christchurch residents rank air quality as one of the most important environmental issues in the city.

Fluoridation of water supplies is hotly debated in Christchurch. Water in Christchurch City is unfluoridated and in Ashburton there is a lobby to stop fluoridation there.

2.5 Treaty Partnership

The legislation governing District Health Boards provides that, in order to respect and recognise the principles of the Treaty of Waitangi and to improve health outcomes, mechanisms to enable Maori to contribute to decision-making and to participate in the delivery of health and disability services are required.

The Canterbury DHB is developing, in consultation with Maori, appropriate process to engage with the Maori community (hui, workshops etc). It is expected that this will lead to the development of measures to improve responsiveness to Maori health needs.

In particular, the Canterbury DHB is developing its relationship with the Manawhenua Health Forum, which represents the seven Ngai Tahu runaka, supported by Ngai Tahu Development Corporation. Both parties hope to agree a memorandum of understanding to express their relationship. This will form the basis for involving Maori in the Strategic planning process.

3 Strategic Directions

3.1 Vision and Values

3.1.1 Canterbury DHB Vision Statement

Our vision is :

"Working together for the best health and wellbeing
of the people of Canterbury"

3.1.2 Clarification of the Vision Statement

Working Together means the people of Canterbury, patients, Maori, Pacific peoples, other ethnic groups, community groups, health and disability providers, other DHBs, the Ministry of Health, local bodies, and other social agencies working collaboratively with the Canterbury DHB towards common goals that will deliver the best health and wellbeing of the population. (Other social agencies include education, housing, justice, youth and welfare.)

Best means the very best we can achieve within the resources available to us, and recognising that together we will have to prioritise services because demand for more services and better quality services will always outstrip the resources available.

Health and Wellbeing applies at both the individual level (for example, with treatment services) and at the community level (for example, with health promotion services). This focus continues throughout people"s lives. It includes all public health, personal health, physical and intellectual disability, chronic, and mental health areas. Achieving the best health and wellbeing relies on a range of factors, some of which are outside the health sector itself. Hence, working together to achieve this goal is essential.

The people of Canterbury are defined by the NZ Public Health & Disability Act as those living in the territorial local authorities of Kaikoura District, Hurunui District, Waimakariri District, Banks Peninsula District, Selwyn District, Christchurch City & Ashburton District. There are approximately 420,000 people living in this area. The people of Canterbury may receive some specialist services and acute services from other District Health Board areas, and similarly people from other areas may receive services provided in the Canterbury DHB area.

3.1.3 Mission

The Canterbury DHB"s mission is to improve, promote and protect the health of people in the community and foster the well-being and independence of people with disabilities and reduce disparities.

This means not only promoting good health, but preventing disease, assessing, treating and rehabilitating patients, prolonging life and providing services and support for people with disabilities.

The Canterbury DHB will work with Maori and Pacific peoples towards reducing current health disparities. It will also focus on the needs of people with disabilities and assist them to live as independently as possible while maximising their quality of life.

The Canterbury DHB will also assess and work towards a better understanding of the health and disability needs of the Canterbury population. Community consultation and involvement are important in achieving this goal.

The Canterbury DHB will work with a vast range of community health providers including GPs, mid-wives, rest home providers, home nursery, home care agencies occupational therapists, dentists, pharmacists, emergency services, organisations like Plunket and Maori and Pacific peoples" groups.

The Canterbury DHB will work to ensure that policies and systems are in place to ensure rural communities receive appropriate and accessible health services.

3.1.4 Values

The values that underpin the activities of the Canterbury District Health Board and its relationship with people who use its services, staff, providers and other stakeholders are:

- People and community focused.
- Acting with integrity.
- Openness in communications.
- Recognition and respect for Maori and the Treaty of Waitangi.
- Working inclusively.
- Fairness and honesty in our endeavours.
- Innovation encouraging each other to seek improvement.
- Flexibility and adaptability to deal with changing times.
- Taking responsibility for using the resources available in a manner to best meet individual, family and community needs.
- Respect for individuals" perspectives and contributions.

3.2 Key Strategies and Objectives of the Canterbury DHB

Strategy 1: To create a population health focus to improve, promote and protect overall health of communities.

Strategy 2: To focus on the health disparity of Maori, Pacific people and other ethnic groups and develop plans to address priority needs.

Strategy 3: To ensure the DHB is a viable organisation as a funder and a provider of services.

Strategy 4: To work with other health providers and other agencies to develop an integrated approach to plan, fund and deliver community health needs.

Strategy 5: To work with surrounding DHBs to undertake joint planning and service development.

Strategy 6: To improve the approach to quality and to plan for health improvement.

Strategy 7: To develop an open and inclusive management style.

Strategy 8: To support Research and Training that contributes to improving the health status of the Canterbury DHB population.

Strategy 9: To address key workforce issues aimed at recruiting, retaining and developing our staff.

4. DHB Performance

4.1 Canterbury DHB – Board and Major Committees

All meetings where decisions are made by the Board or any of its major committees are open to the public to attend, as observers.

Members of the community are included on the three statutory committees which report monthly to the Board. The committees are:

a) Community and Public Health Advisory Committee. To advise the Board on approaches to health improvement for people in the region and give guidance on how best to use available resources to meet the population"s needs;
b) Disability Support Services Advisory Committee. To advise on disability support needs of the region"s population in order to maximise independence of people with disabilities;
c) Hospital Advisory Committee. To advise the Board on the performance of its own hospital and community services.

In addition to the three statutory committees the Board also has the Finance Audit and Risk Committee, which includes a community representative, and the Property Committee, which advise the Board on overall financial governance and property issues respectively.

Members of the community are also invited to regular public meetings in both urban and rural areas to inform the Committees by providing the views of individuals and organisations with an interest in health and disability services in Canterbury and also provide an information sharing role with the community.

The Canterbury DHB established the Disability Support Advisory Committee in April 2001. The Committee meets monthly. The Committee comprises five board members as well as five additional community members selected after an extensive public campaign asking for n ominations. The legislation requires the Committee to give advice on the disability needs of the resident population and priorities for the use of the disability funding provided. As funding has not been devolved, the key focus of the committee in the next 12 months will be on operationalising the New Zealand Disability Strategy. Another important role for the committee will be an advocacy role in ensuring the disability needs of the community are considered before all major Board initiatives are approved.

4.2 Community Consultation

A key objective of Canterbury DHB is to facilitate increased community engagement in the assessment, planning and funding of health and disability services in its region. To achieve this, the Canterbury DHB is working to actively consult with the community, including Maori and Pacific peoples.

An initial Consultation Plan is in place has been drafted which sets out a range of different processes to be used, including:

a) Hui and other meetings with Maori and Pacific Peoples.
b) Information sharing, through newsletters, presentations, web sites, workshops, radio and television programmes, and the news media.
c) Establishing regular public meetings of both consumers and providers, for both generic issues and specific issues and services.
d) Consultation, by issuing an initial proposal, ensuring relevant information is available and listening to feedback with an open mind.

The DHB has an obligation to provide information on decisions, to make submissions available and to explain how decisions were reached. Consultation is required under the Act on the following specific matters:

a) The Strategic Plan;
b) Changes to the Annual Plan; and
c) The disposal of land.

The Consultation Plan will be updated over time to reflect the best approaches to use for this population. A specific plan is currently being developed for consultation internally and externally for the Strategic Plan.

4.3 Maori Relationships

The Canterbury DHB is developing, in consultation with Maori, appropriate processes to engage with the Maori community and Maori providers. This will assist the gathering of information regarding Maori needs, as well as the development of actions plans and measures to improve responsiveness to Maori health needs.

The Strategic Plan will incorporate a Maori Health component for the DHB which recognises the Canterbury DHB"s Treaty obligations to Maori within the framework of the NHPHD Act. It will include working with Maori on significant areas such as workforce.

4.4 Peer and Agency Relationships

The Canterbury Social Policy Interagency Network and Strengthening Families are examples of groups the Canterbury DHB is actively involved in. The Needs Assessment Advisory Panel has met and will provide more opportunity for agencies and providers to develop relationships focused on improved health care. The initial forum of this group is for information sharing on the needs of the DHB population.

4.5 South Island Shared Services Agency Limited (SISSAL)

The Canterbury DHB is one of six South Island DHBs that have formed SISSAL to provide some of the needs assessment (epidemiology), health planning and contracting functions required by the DHBs, in the most effective and cost efficient way. SISSAL has been initially established to deal with personal health and mental health services, its

capability will be expanded as further services are devolved from the Ministry of Health.

4.6 DHB Collaboration

As the major centre in the South Island providing secondary and tertiary services the Canterbury DHB is working with surrounding DHBs to undertake joint planning for:

- π locally provided services which have linkages with services provided in other districts (particularly in relation to collegial support, training, and transient patient populations);
- π services provided by single regional providers across many districts;
- π services provided only in one district (this district or other districts) which the regional population needs to access;
- π assisting other DHBs with support functions.

In addition, the Canterbury DHB is collaborating with a number of agencies such as the Christchurch City Council, Crown Public Health, Ministry of Education, Police, School of Medicine, District Health Boards of NZ, St John Ambulance Association etc.

4.7 Planning and Funding Functions

4.7.1 Summary

The purpose of the Canterbury DHB Planning and Funding Division is to plan and allocate Vote Health resources devolved to the Canterbury DHB to improve the health and independence of people within the Canterbury DHB district.

From July 1 2001 the Canterbury DHB will begin the process of taking over responsibility for funding Maori Health, Personal and Family Health and Mental Health services. Funding for Disability Support Services and Public Health will remain with the Ministry of Health until at least July 2002.

From July 1 2001 the Board will also assume responsibility for needs analysis, health planning and prioritisation processes to inform funding decisions for which it is responsible.

The Canterbury DHB will endeavour to maximise the benefits of health promotion, early intervention, good coordination and integration of services and the participation of the community in establishing priorities consistent with the NZ Health Strategy. All services funded should:

a) meet explicit quality requirements
b) be delivered in an effective, efficient and appropriate manner
c) aim to maximise health gains

The Canterbury DHB will work towards funding the optimum mix of services to provide Canterbury communities with the maximum health gains within the resources available.

4.7.2 Needs Analysis

A major 2-3 year project is underway to assess the health status of the population. The initial analysis for the Strategic Plan will be completed in August and the Canterbury DHB is collaborating with other organisations locally such as the Christchurch City Council on this project.

4.7.3 Strategic Planning

The planning process involves needs assessment, prioritisation, community engagement work, appropriate community consultation and Board approval. A timeline has been put in place for the Strategic Plan which is due with the Minister of Health on 31 May 2002. This includes a 10 week public consultation period Jan – March 2002.

Preparation of the next Annual Plan (2002/03) will pre-date confirmation of the Strategic Plan, however, it will reflect information on the population"s health status.

In addition to the district planning and funding the Canterbury DHB has joined with the other five South Island District Health Boards in the establishment of a Regional Mental Health Network.

The Regional Mental Health Network has been charged with responsibility to:

- Ensure the development of a regional plan including the provision of regional mental health services and funding direction for the region
- Foster collaborative approaches amongst DHBs to improve quality and carry out audits and reviews
- Ensure joint workforce development, recruitment and retention initiatives as appropriate
- Promote increased integration and collaboration across the whole range of services

Canterbury DHB will work with the Regional Mental Health Network to achieve these goals. Planning will be based on the requirements of the Mental Health Commission Blueprint, New Zealand Mental Health Strategy, NZ Health Strategy and others such as Youth Suicide Strategy.

The plan will indicate service provision and funding parameters within the region. The network will build on the collaboration already existing within the South Island Mental Health community especially with Non Government Organisations and the future GPs.

Consultation on this plan with consumers, Maori, families and the wider community will be with the Canterbury Mental Health Forum and other key groups.

4.7.4 Integrated Care

This will include systems to help ensure that the right clinician is in the right place with the right skills providing the right treatment at the right time.

Integration has been a key focus for health providers in Canterbury during the past 3 years. The Elder Care Canterbury Project, initiated by Canterbury Health, Healthlink South and Pegasus Health in July 1997 started a multi-sector/multi-discipline approach to addressing the challenges faced by the health sector in Canterbury.

Access Canterbury, a project initiated by Health Link South and Pegasus Health in 1999, began to address interface issues between primary and secondary care for mental health. At the same time Canterbury Health and Pegasus Health began to address primary /secondary interface issues focusing specifically on acute hospital treatment.

Further initiatives will be developed using two key principles. Firstly, involvement of the community in identifying the projects to be progressed, prioritising these and then progressing them. Secondly, ensuring a multi-sector approach is adopted. This approach will ensure that all sectors of the community - community groups, health providers, local authorities and government departments are involved in developing the solutions. This approach is in recognition that other organisations have a key role to play in determining the health outcomes of the community.

4.7.5 Civil Disaster and Emergency Planning

The DHB has in place a Civil Disaster and Emergency Plan. A copy of this has already been forwarded to the Ministry of Health.

4.7.6 Funding Pool

The funding pool for 2001/02 consists of funding for services provided by the Canterbury DHB internal provider organisation and external provider contracts devolved by the Ministry.

4.7.7 Committed and Discretionary Funding Pool

Within the funding pool available, there are a number of core health services which are critical to a safe and effective health service. These services will continue to be funded regardless of any changes in funding or contracting methods or focus on priority areas.

For 2001/02 the funding received from the Ministry of Health matches closely to the contract value for contracts devolved to the Canterbury DHB. Therefore there is limited discretionary funding for 2001/02.

4.7.8 Monitoring and Quality Improvement

The Canterbury DHB has a responsibility to ensure that the health and disability services it funds (both internal and external) are of a high quality. Quality can be improved through a number of mechanisms including:

a) an effective clinical governance structure with a focus on quality services and health outcomes;
b) the type, mix and manner in which services are funded to meet the health and disability needs of the district;
c) the quality, responsiveness and cultural appropriateness of services delivered to consumers;
d) the skills and qualifications of the workforces;
e) the coordination of service delivery;
f) collaborative funding arrangements, and
g) pre agreement audits for new services;
h) Clear service specifications of services to be delivered.

The Canterbury DHB will actively monitor and assess the quality of services provided by both the DHB in-house provider and contracted providers via service agreements. Monitoring will include appropriate procedures for reporting adverse incidents as well as routine reporting against standards (such as Health and Disability Safety Standards 2001) and processes. The Canterbury DHB will work towards developing a process to enable reporting patient outcomes. The Canterbury DHB will also develop a programme of routine quality audits, service evaluations and ad hoc or issues based audits.

4.7.9 Risk and Management of Risks

The Canterbury DHB will face a number of new potential financial and non-financial risks associated with its new funding role. The Canterbury DHB will continue to enhance systems to efficiently manage both financial and non-financial service risks.

This will include identifying and reporting material risks and action plans to address them. A comprehensive Risk Register is being developed to achieve this.

4.7.10 Priorities of Purchasing

The Canterbury DHB will be required to prioritise the health and disability needs of the community within funding constraints. The Canterbury DHB is developing a transparent decision making framework that links directly to the principles and priorities of the NZ Health Strategy. This will be outlined in the DHB Strategic Plan 2002-2007 and beyond.

4.7.11 Maori Health Service Funding

The need to improve Maori health is expressed through the principles, goals and objectives of the NZ Health Strategy.

The Canterbury DHB will work with the Maori community in the region to achieve improvements in the health of Maori. There will be a particular focus on the Government‟s eight health gain priority areas for Maori:

a) immunisation;
b) hearing;
c) smoking cessation;
d) diabetes;
e) asthma;
f) mental health;
g) oral health; and
h) injury prevention.

Any new or changing funding approaches and programmes will identify any service, coverage, access, information or provider development issues for Maori and ways to address them.
The Strategic Plan will outline how the above and other issues identified in hui and as part of the Strategic Plan consultation process will be dealt with by the CDHB together with Maori.

4.7.12 Pacific Health Plan

The Canterbury DHB is one of the seven DHBs that has been requested to pull together a plan for Pacific Health. This is underway and will be presented as part of the Strategic Planning process.

Pacific providers and community groups continue to be involved in its development. Key documents and government directions from the Ministry of Pacific Island Affairs will be covered.

4.7.13 Population Health Funding

Currently the funding for Population Health in Canterbury sits with Crown Public Health and numerous Non Government Agencies, some local and some nationally based. The timeframe for the devolvement of Population Health funding to DHBs will be advised by government later in the year.

Because of the significant population health focus of the NZ Health Strategy Crown Public Health staff are involved in preparation of the Strategic Plan.

4.7.14 Disability Support Funding

The DHB is cognisant of the Disability Support funding and provider issues within its region. It is one of the pilot sites for the Disability Support Services Pilot for those over 65 years.

There is an expectation that the money for Disability Support will devolve to the DHB on 1 July 2002 or later.

4.7.15 Primary Health Care Plan

The Canterbury DHB is progressing its planning for primary healthcare based on the Primary Health Care Strategy. This work involves engaging Primary Healthcare providers and consumers.

4.7.16 Family Violence Guidelines

Programmes such as Family Start, Early Start and Heartland continue to be supported. Through Social Policy Interagency Network (SPIN) Crown Public Health and other initiatives, violence prevention programmes have been put in place.

Canterbury DHB Provider Arm Divisions are currently developing Status Reports for the Chief Operating Officer in response to the Guidelines issued by the Ministry of Health. These will detail the establishment of Special Child Assessment Network (SCAN) Teams, Employment Assistance Programme Provision and Protocols already in place, and will be a valuable tool for the anticipated Ministry of Health audit of guideline implementation in 2002.

4.8 Capability Development for further Devolution of Funding

As more information is shared with the DHB from the Ministry of Health, our capability to manage that funding which we do have at this time will grow and processes to manage future funding will be put in place. The management and monitoring of Service Agreements role falls to the Planning and Funding team.

There are a significant number of contracts within the Personal and Mental Health areas to be managed and monitored although their dates of renewal spread over the next 2-3 years.

The policy on future provider selection is yet to be confirmed, it will be cognisant of government policy.

4.9 Corporate Services

4.9.1 Structure

The Corporate Services of the DHB has been structured to a centralised administration services while providing a separation between the "funding" and "in house provider" functions of the DHB
(where required).

Corporate Services comprise of Legal & Risk Management, Finance, Information Services & Logistics, Communications, Planning & Funding, Business Assurance & Consultancy (incorporating Internal Audit), Site Redevelopment and Chief Operating Officer.

All of the above department heads together with the Kaumatua reports to the Chief Executive Officer

4.9.2 Financial Management

Financial management of the DHB is organised into 3 sections:

Overall DHB financial management including its subsidiaries
Funding, and In House Provider

The purpose of the above separation is to provide transparency between the financial performance of the two key functions of the DHB (the funding and the in house provider) while keeping an overall view of the whole organisation and related subsidiaries.

Separate financial reports are prepared for each of the above three sections monthly to facilitate monitoring at both the management level as well as to the Finance, Audit and Risk Committee.

4.9.3 Information Management

This work will be undertaken collectively by the Planning and Funding team and the Information Services team of the Corporate part of the DHB.

Collaboration of the DHB with SISSAL, SSSG and HB in collecting, summarising and analysis of contract information is vital to the ongoing success of the DHB and the sector in providing relevant information for ongoing decision making.

4.9.4 Associated Companies

The DHB has two associate companies – New Zealand Centre for Reproductive Medicine Limited (50% shareholding) and Heart Surgery South Island Limited (50% shareholding).

The financial performance of these two companies are reflected in the annual financial statements of the DHB on an equity accounting basis.

4.10 Funding Health and Disability Services

4.10.1 Funding Responsibilities for 2001-02

From 1 July 2001 Canterbury DHB will take responsibility for funding some Maori Health, Personal and Family Health and Mental Health services. A number of contracts in these areas will only be devolved 1 October 2001 or later. Funding for Disability Support Services and Public Health will remain with the Ministry of Health until at least July 2002.

For the 2001/02 year, the Canterbury DHB will be allocated specific contracts to manage, and will receive revenue that is forecast to match the value of these contracts.

Some contracts have a fixed value, and have a term that covers the whole of the 2001-02 year. There is minimal funding risk with these contracts. A number of contracts and other funding arrangements do

not have a fixed value. The value of these contracts is dependent on the demand for the services. The funding allocated for these contracts are estimated based on historical usage and does not allow for growth in demand in 2001/02. Therefore there is a risk that the funding devolved to cover these contracts may be inadeqate.

During the 2001-02 year some contracts are due to end. These contracts will need to be renewed. This will be done using the existing national purchase framework. This will be a challenge, as some providers are likely to want to pass increased cost of delivering services to the DHB. Any price increases may have to be funded by a reduction in the range or volume of services funded.

Some providers that deliver services in several districts, including Canterbury, will be managed by other DHBs. These include GP services provided by members of Independent Practitioners Association such as South Link Health, and services delivered by national providers such as the Salvation Army. Likewise the Canterbury DHB will be managing contracts with services provided for other DHBs. The Canterbury DHB will liaise and work with the other DHBs to enable information flow to assist future years planning and funding decisions. The Ministry will retain some contracts for Maori Health, Personal and Family Health and Mental Health providers.

	Number of Contracts	**Number of contracts that expire in 2001-02**
Maori Health	6	1
Personal Health (Note 1)	207	15
Mental Health	33	11
Total	**246**	**27**
Note 1: This excludes the S51/S88 General Practitioner and other Notices type contracts and Canterbury DHB internal provider contracts.		

The additional contracts to be devolved to Canterbury DHB in October 2001 is not known.

4.10.2 Service Funding

Maori Health
Some, but not all, the Maori health contracts have been devolved. It is anticipated that all Maori health contracts will be devolved to the Canterbury DHB by 30 June 2002. The Maori health contracts will be managed by the Funding Team, in consultation with the Manager, Maori Health. Most Maori contracts are not due to expire before 1 July 2002.

Personal Health
In this year the DHB has been devolved funding contracts as of 1 July 2001 and others for 1/10/2001. There are few contracts that will be up for review in 2001-02 therefore limiting expenditure for new or more services. Due to the increased demand for some „fee for service" and primary care services, the funding for these contracts is not expected to be adequate. Therefore it is unlikely that new or additional services will be contracted for in 2001/02.

Mental Health
The Canterbury DHB"s delivery of mental health services during the 2001/2002 financial year is largely predetermined by the development plans and funding agreements established by the Mental Health Directorate of the Ministry of Health and devolved to the district as of 1st July 2001[1]. As the funding currently available for mental health service delivery in the district is already committed for at least the next 12 months, the ability of the Canterbury DHB to engage in significant initiatives for new service delivery during the 2001/2002 financial year is limited. The emphasis for the District will therefore be in maintaining (and reviewing the effectiveness of) current services in anticipation of additional funding being available from July 2002 onwards.

4.11 Providing Services

4.11.1 Canterbury DHB Provider Services: Description

The Canterbury DHB provides services mainly to the people of the North and Mid Canterbury districts. A range of secondary and tertiary services are provided to people living throughout the South Island and in some cases to people who live throughout NZ.

Inpatient and outpatient services are provided from a number of facilities and sites and by teams in the community including the following:

1 The Ministry funding agreement for the South Island were informed by 'HFA Funding Plan by Mental Health Services including Drug and Alcohol for the Southern Region of New Zealand 1998-2002' and the 'Mental Health Commission Blueprint for Mental Health Services in New Zealand'.

Christchurch Hospital services as follows, as well as teaching and research:	
Medical Services	**Surgical Services**
• General Medicine • Cardiology/Lipid Disorders • Endocrinology/Diabetes • Respiratory • Rheumatology/Immunology • Infectious Diseases • Dermatology • Gastroenterology • Oncology • Nephrology • Clinical Haematology and Bone Marrow Transplant • Neurology • Paediatrics • Paediatric Oncology • STD/Sexual Health • Hyperbaric Medicine	• General Surgery • Paediatric Surgery • Vascular • Cardiothoracic • Orthopaedics • Otolaryngology • Ophthalmology • Dental • Neurosurgery • Urology • Plastic Surgery • Cardiac Surgery

General Services	**Peri-Operative Services**
• Emergency • Investigations (day medical) • Outpatients • Anaesthesia • Intensive Care Unit	• Operating Theatres • Recovery Ward • Day Surgery

Ashburton Hospital and related Community Health Services provide the following:
• General Medicine • General Surgery • Gynaecology • Obstetrics • Healthcare of the Elderly • Diagnostic Services • Community Support Services

Burwood Hospital, provides physical rehabilitation and surgical services, and is the base for a range of community services, including wellchild services and some public health nurse services.
• Spinal Injuries Unit (tertiary care for the population from Hamilton, south) • Musculoskeletal Services • Physical Disability Service • Well Child Community Services • Cardio-respiratory step-down Unit • Rehabilitation Services • Burwood Birthing Service • Elective Orthopaedic Surgery • Some public health services

Christchurch Women's Hospital, provides the following:
• Acute and Elective Gynaecology Services • Primary, secondary, and tertiary obstetric services • Neonatal Intensive Care Services to Level 6 • Pregnancy Terminations (Lyndhurst)

Princess Margaret Hospital houses:
• Assessment, Treatment and Rehabilitation Services for Older Persons • Psychiatric Services for the Elderly • Some specialised mental health services • Meals on Wheels

The Hillmorton Hospital (formerly Sunnyside) houses:
• Forensic Services (Regional) • Acute Psychiatric Services • Alcohol & Drug Services • Child and Youth Services • Adult Specialty Services • Community Services (base for range of) • Alcohol and Drug Services • Psychiatric Services for Adults with an Intellectual Disability • Intellectual Disability Assessment Treatment and Rehabilitation

Brackenridge Estate Ltd a wholly owned subsidiary of Canterbury DHB, provides residential care services to people with intellectual disability and high dependency needs.
• Residential Services • Day Programmes

Rural Health Services Canterbury DHB also provides community focused and rural healthcare services at hospitals located in Akaroa, Darfield, Ellesmere, Kaikoura, Lincoln, Oxford, Rangiora and Waikari.
• General beds (acute, minor trauma, post-acute, post-operative, relative relief, long stay, terminal care) • Obstetrics (normal childbirth services) • Meals on wheels • Facilities for other community based healthcare providers and groups

Population Health Services - Crown Public Health Limited, a subsidiary of Canterbury DHB provides a range of population/public health services in Canterbury, South Canterbury and the West Coast
• Health protection • Health promotion • Maori health promotion • Medical Officer of Health

Other Services
These include Diagnostic and Support Services which are located primarily at the Christchurch Hospital site and include high quality diagnostic testing to support the secondary and tertiary services provided by Canterbury DHB. These Diagnostic Services are also used by a range of providers and other DHBs. Other support services are also provided from the Christchurch Hospital site.

Diagnostic Services	**Support Services**
• Pathology • Radiology • Nuclear Medicine • National hormone assay service • ECG • Respiratory laboratory services	• Clinical Pharmacology • Pharmacy • Medical Illustrations • Medical Physics and Bioengineering • Patient Appliances • Specialist Equipment Maintenance • Sterile Supply • Allied Health Services

A number of community based services and mobile teams provide mental health services (including Alcohol and Drug services) throughout Canterbury.

The School and Community Dental Service operates out of 162 dental clinics in South, Mid and North Canterbury.

4.11.2 Strategic Directions 3 – 5 years

Christchurch Hospital

Christchurch Hospital is the South Island"s largest tertiary, teaching and research hospital. The hospital provides a full range of emergency, acute, elective and outpatient services. Many of the hospital"s doctors and specialists also travel to other South Island centres to provide specialist clinics and operations.

Christchurch Hospital provides services to more than 35,000 inpatients each year. Approximately two-thirds of these patients are admitted acutely. A further 13,000 are day patients.

The number of people waiting for surgery at Christchurch Hospital has fallen rapidly in recent years due to a significant increase in the number of surgical operations being provided and active review of waiting lists. There are 16,000 theatre visits each year.

The hospital operates up to 650 beds and maintains an active liaison with the Canterbury DHB"s two rehabilitation hospitals, Burwood and The Princess Margaret Hospital, to ensure that patients are appropriately placed for acute and sub-acute care.

More than 197,000 outpatients are treated at the hospital, excluding those for radiology and laboratory services. In addition, Christchurch Hospital has the busiest emergency department in Australasia treating more than 64,000 patients a year.

Christchurch Hospital is also the largest South Island tertiary teaching hospital at which doctors receive clinical training and is one of four main teaching hospitals in New Zealand. The examination pass rates for resident medical staff is high. A range of post-graduate nursing programmes is also offered.

Overall Objectives Christchurch Hospital 3-5 years

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a) To deliver to the Canterbury Community the range and quantity of services established for Christchurch Hospital through the 2001/2 financial planning process for the CDHB.
b) To enhance Clinical Governance infrastructure during the 2001/2 year in order to provide better health outcomes to the community.

c) To develop clinical audit capability following an evaluation of a software pilot at Christchurch Women‟s Hospital to enhance outcomes for patients.
d) To expand the medical credentialling project to include the full range of surgical sub-specialties to ensure patients receive high quality and appropriate surgical services.
e) To improve Occupational Health & Safety infrastructure in anticipation that Christchurch Hospital will undergo an ACC Accredited Employer Audit in March 2002.
f) To implement a programme of quality and infrastructural improvement to prepare for an anticipated accreditation audit by Health Care Standards New Zealand in the first half of the 2002/3 financial year.
g) To develop a master plan for the future development of facilities on the Christchurch Hospital campus to ensure better facilities result in better health outcomes for the community.

Older Persons Health

The Older Person‟s Health Service is based at The Princess Margaret Hospital around the assessment, treatment and rehabilitation of people over 65 years of age and those with age related illnesses. Hospital services are delivered at The Princess Margaret Hospital in the community and homes throughout North Canterbury.

A Community Therapy team and the Psychiatric Needs Co-ordination Team are also part of this service.

Overall Objectives Older Persons Health 3-5 years

a) To develop professional leadership and clinical expertise amongst staff and empower them in the management of change.
b) To manage available resources and maintain clinical managerial accountability for them.
c) To ensure patients are provided with quality speciality health services and care that is seamless and culturally appropriate.
d) To integrate health information management throughout the Older Person‟s Health Service, the wider organisation and the health environment.
e) To develop organisational structures and teams which encourage shared values and strong partnerships.
f) To continue to influence health and social policy to ensure needs and expectations of older people remain central to service development and delivery and to promote independence, dignity, autonomy and „ageing in place‟ concepts.
g) To continue integration with primary health care providers through the Elder Care Canterbury project.

Women's Health Division
The Women"s Health Division provides gynaecological, neonatal intensive care and maternity services to the population of Canterbury and the West Coast. A few highly specialised services such as gynaecologic oncology are available.

Services include:

- Neonatal Intensive Care to Level III (Intensive Care / serious condition);
- Neonatal Outreach Services;
- Secondary and tertiary obstetric services;
- Case management midwifery;
- Secondary and tertiary gynaecology services;
- Colposcopy and cervical screening services;
- Terminations of pregnancy.

Christchurch Women"s Hospital offers these services at secondary and tertiary level and accommodates approximately 4000 deliveries per annum half of which are primary. A rural primary maternity service is also provided at Lincoln and Rangiora hospitals. (A primary birthing unit is also operated independently by Burwood Hospital).

Overall Objectives Womens Health Division 3-5 years

a) To provide services at the highest possible level of quality, effectiveness and efficiency within its allocated resources; and

b) To successfully relocate services from Christchurch Women"s Hospital to a new Women"s Hospital on the Christchurch Hospital campus during the next four years.

c) To increase focus on the cultural appropriateness of all services, particularly for Maori.

d) To minimise intervention in maternity care within the requirements of optimal outcomes.

Canterbury DHB Provider Rural Health Services
The major rural hospital is Ashburton which provides secondary level acute medical and surgical services supported by health care of the elderly, maternity and childbirth and a number of community services.

Within the communities of Akaroa, Darfield, Leeston (Ellesmere), Waikari, Lincoln, Rangiora, Oxford and Kaikoura smaller hospitals provide a range of general medical and long-term care services for patients along with maternity services. Kaikoura Hospital provides an acute service supported by General Practitioners with some diagnostic services, i.e radiology is available. The rural based services are complimented by a range of „visiting" services such as mental health, school dental health, public health nurses and visiting specialists from Christchurch.

Overall Objectives Rural Health Services 3-5 years

a) To ensure there is an infrastructure of health services to meet the needs of local people whether it be from its own providers or purchased from external providers.
b) To work with rural communities to identify their health needs.
c) To work with all providers of health services in rural areas to build on the infrastructure already in place to ensure that there is appropriate coverage and a supply of health professionals available to provide a range of services.

Burwood Hospital
The major service areas include the Burwood Spinal Unit, which is a national leader which provides care and treatment for patients with spinal injuries, vertebral fractures and spinal cord injuries/impairments. The catchment area for the Spinal Unit is the South Island and the bottom half of the North Island. The unit is a leader in research and provides medical support and direction to the Otara spinal unit.

Brain Injury Rehabilitation provides comprehensive rehabilitation for people with acquired brain injury from stroke or trauma or with neurological conditions such as Multiple Sclerosis or Huntingtons Disease.

Other services provided at Burwood Hospital include cardio/respiratory step-down care from Christchurch Hospital, pain management services for the Canterbury region and a primary birthing unit.

The Public Health Nursing Service (run by Burwood Hospital) covers the area of north and mid-Canterbury. It provides a free, mobile, accessible child health intervention, advice and support in schools, homes and the community. The area covered extends from Ashburton to Kaikoura and employs 20 Public Health Nurses, a Medical Officer and a Pacific peoples" Community Health Worker.

The key components of the service are child and family assessment and intervention and/or referral. Utilising Strengthening Families and Community development models the service aims to reduce disparity and promote safe and healthy development of children. Inter-agency collaboration is essential and integral to the service and will continue to be a focus of work in the next 3-5 years.

The Public Health Nursing Team works in close liaison with the Vision and Hearing Testing Service which provides free middle ear and vision tests in schools and early childhood centres.

Overall Objectives Burwood Hospital 3-5 years

a) To continue the development of its specialty rehabilitation and surgical services while seeking additional opportunities to relieve Christchurch Hospital of other sub-acute and chronic treatment activities.
b) To continue quality assurance activities leading to re-accreditation in 2004 and a focus on the development of clinical governance processes and the identification of further co-operative relationships with other health care providers.

Mental Health Division

The Mental Health Division provides services for the assessment and effective treatment of people who require ongoing clinical intervention and support. As required the Mental Health Division"s full Annual Plan is attached in Appendix III.

The Canterbury DHB"s Mental Health Division is the largest provider of mental health services in the South Island. Services provided cover Mid and North Canterbury (population of approximately 412,000 people) as well as services on behalf of other South Island districts especially in the areas of Forensic, Child and Youth, Alcohol and Drug, Eating Disorders and Mothers and Babies.

Mental Health Services can be separated into the following broad areas:

- General Adult Psychiatric Services;
- Rehabilitation Services;
- Alcohol and Drug Services;
- Te Korowai Atawhai Maori Mental Health Service;
- Child, Adolescent and Family Mental Health Services;
- Consumer Advisory Services;
- Director Area Mental Health Services, Management Mental Health (Compulsory Assessment and Treatment) Act 1992; statutory role to North and South Canterbury; and
- Forensic Services.

While acknowledging they have their own identity Mental Health Service also manages:

a) PSAID - Psychiatric Services for Adults with Intellectual Disability;
b) Intellectually Disabled Persons Health - Assessment Treatment and Rehabilitation Inpatient Service; and
c) Intellectually Disabled Persons Health - Community Support Team.

Overall Objectives Mental Health Service 3-5 years

The Mental Health Service will provide care for people with mental illness, striving to preserve and enhance their dignity, safety and independence.

a) To deliver psychiatric services to that part of the CDHB population which has a moderate to severe mental illness and requires ongoing clinical intervention and support.

b) To consolidate Service Activity following the introduction of the „Healthlinks" Clinical Management Information System and relocation of services to redeveloped sites after five years of facility upgrade, for example review the role and function of the Alcohol and Drug Service which is still housed in three bits of unsatisfactory accommodation. A review of this team"s role will ensure that in one location the service will be better coordinated.

c) To establish clear understanding of Canterbury DHB role in Regional Service Delivery, costs and activity.

d) To continue integration with other providers including primary health care providers and NGOs and other agencies in particular Maori, Pacific Peoples, Non Government Organisations and General Practitioners.

e) To support further initiatives to counter discrimination including expansion of consumer and family involvement in services.

f) To implementation the effective workforce plan in line with the recently completed Mental Health Division Plan and the five year National Mental Health Workforce Development Plan.

g) To continue to strengthen leadership models throughout the service.

h) To attain accreditation to the NZ Safety Standards and National Mental Health Standards.

i) To participate in national, regional and local mental health service development initiatives, such as the Mental Health Classification Project, South Island Mental Health Network, preparation of a Regional Plan and activity reviews with regard to the Mental Health Strategy and Mental Health Commission Blueprint.

j) To deliver services within resources while ensuring opportunities to expand/enhance services via „New Mason" money are evaluated and acted on appropriately.

k) To be involved in research and training activities that lead to better patient outcomes.

l) To remain a leader in Maori mental health services in partnership with Tangata Whenua.

Brackenridge Estate Limited

Brackenridge Estate Limited is a wholly owned subsidiary company of the Canterbury DHB. It was incorporated in 1998 with the objective of developing and operating a specialised residential care facility for former residents of the

Templeton Centre. Brackenridge is a 14-house mini suburb facility which commenced operation in October 1999 housing 87 people who were assessed, through a needs assessment process, as having an intellectual disability and requiring specialist residential care due to medical/physical fragility or a range of challenging behaviours.

Overall Objectives Brackenridge Estate Limited 3-5 years

a) To provide a quality service which maximises the potential, and enhances the quality of life of each resident.
b) To provide the support necessary to ensure there is a maximum level of independence and all residents have the opportunity to access the range of services required to meet their individual needs, within a culturally safe environment in keeping with national and international „best practice" standards.

School and Community Dental Service

The Community Dental Service provides school dental services including free basic dental care to enrolled pre-school, primary and intermediate school children. Dental Therapists also act as a resource to organisations such as schools and pre-school groups for dental health education. The contract is a capacity one with 65,700 children in the Canterbury and South Canterbury regions.

The service also provides a "safety net" service to high school students not enrolled with private sector dentists in the General Dental Benefit Scheme - to date uptake of this service has been minimal.

Service management and clinical oversight is also provided for the School Dental Service on the West Coast under contract to West Coast DHB. A local dentist under contract provides the School Dental Service in the Kaikoura region. The service administers the Sedation Dental Pilot Scheme and the Emergency Dental Care for Low Income Adults Scheme and is directly funded to improve access to dental care for at risk children.

Overall Objectives School and Community Dental Service 3-5 years

a) To bring about an improvement in oral health status;
b) To be comprehensive;
c) To concentrate not only on treating oral disease but also on the prevention of dental decay;
d) To promote oral health to individuals;
e) To direct services to those children who have significant oral and other health and disability problems;
f) To improve the oral health of Maori and Pacific peoples.

Crown Public Health Limited
A copy of Crown Public Health Ltd"s 2001-02 Business Plan is attached in Appendix IV.

Overall objectives Crown Public Health Limited 3-5 years

- Fiscal responsibility
- Sound Risk management
- Service Plan Provision
- Recognise and respect the principles of The Treaty of Waitangi

4.11.3 Current Intentions 2001/02

Christchurch Hospital 2001/02 Organisational Infrastructure	
Measurement	**Target**
Review the organisational service infrastructure to ensure that the development and maintenance of a multi-disciplinary team based approach to patient care is enhanced.	October 01
To ensure there are effective and comprehensive pathways for clinical input into clinical risk management processes to ensure a hospital wide overview is achieved.	October 01
To achieve the specified milestones in the Accreditation Preparation Plan.	Various
To implement clinical audit processes consistent with the clinical audit implementation plan.	June 02
To implement multi-disciplinary care planning tools, including clinical pathways in accordance with the accreditation programme.	June 02
To implement the 14 sub-projects of the Theatre Review so as to improve patient satisfaction and increase the effectiveness and efficiency of patient care.	June 02
To implement Canterbury DHB policies on integration with other providers including primary health care providers and NGOs to ensure better health outcomes for the community.	Ongoing
To enhance the interface between the acute hospital and the rehabilitation services at TPMH and Burwood Hospital through targeted project activity.	June 02

Spending Wisely

To manage expenditure consistent with the expectations of the CDHB funding allocation.

To implement a Clinical Review Panel to ensure that all new high cost therapies are assessed for evidence of patient benefit and meet agreed health economic criteria.	July 01
Implement PACS radiology to eliminate imaging duplication and lost time.	June 02

Service Delivery

i) To ensure that demand for acute non-deferrable services is met;

ii) To deliver elective surgery and First Specialist Assessments consistent with the expectations of the Ministry of Health Funding Envelope.

Measurement	Target
To work collaboratively with hospital and community providers to ensure that sufficient capacity exists to manage peaks in acute service demand, with a particular emphasis on winter.	ongoing
To monitor the achievement of certainty for patients requiring elective surgery on an ongoing basis.	July 01
To maintain an active investment in the GP Liaison initiative.	ongoing
To work collaboratively with primary care to ensure that referral guidelines for elective services are implemented.	July 01

Health Strategy Goals

To integrate the Government"s Health Goals and Priorities into service delivery.

Measurement	Target
Embed the outcomes of the Diabetes disease management project.	Ongoing
To actively participate in the Asthma Disease Management Project and implement associated evidence based guidelines.	Dec 01
To work with the MOH to implement the recommendations of the MOH national working parties in Radiation Oncology, Haematology and Medical Oncology.	Dec 01
To work with the MOH to implement the South Island Paediatric Oncology strategy.	Dec 01
To undertake a review of Child Health Services including the provider arm of CDHB to establish a comprehensive vision for the future of CDHB owned Child Health Services.	June 02

Hospital Planning

Ensure the asset infrastructure meets the projected service capability requirements over the next decade.

Measurement	Target
To undertake a comprehensive facility audit and ten year facility planning process for the campus.	June 02

OLDER PERSONS HEALTH 2001/02		
Objectives	**Measurement**	**Target**
To develop professional leadership, clinical expertise amongst staff and empower them in the management of change	Workforce plan is actioned Education/training plan includes collaborative approaches to expertise and resources Professional accountability models operate for each profession Staff competency levels are defined.	 June 2002 June 2002
To manage available resources and maintain clinical accountability for them	Total length of stay across the organisation"s sites/services is measured and information used to adapt service delivery as necessary	June 2002
To ensure patients are provided with quality health services and care that are seamless and culturally appropriate	Care pathways and length of stay are defined and managed Treatment/care plans are multidisciplinary Culturally safe care is provided and audited against an agreed framework	June 2002 June 2002 June 2002
To develop organisational structures and teams that encourage shared values and strong partnerships.	Clear decision making on professional and line management issues. Decision making structures reflect best use of the talents and resources of Older Persons Health employees.	June 2002 June 2002

To continue to influence health and social policy so that the needs and expectations of older people remain central to service development and delivery.	Health promotion and prevention programmes are supported	June 2002 and ongoing
	Strategic planning has consumer input.	June 2002 and ongoing
	Support and participate in the work of the Ministry to review and advocate for older people by participating in national health committee reviews.	June 2002 and ongoing
	Support research that enhances outcomes for older people.	June 2002 and ongoing
	Intersectorial integration is achieved. Elder Care Canterbury initiatives are encouraged and supported within resource allocation	June 2002 and ongoing

WOMEN'S HEALTH 2001/02		
OBJECTIVES	**MEASUREMENT**	**TARGET**
Implement computerised clinical audit system.	System installed.	Installation by December 2001.
Achieve compatibility with other Board hospitals of patient management system.	All services using HOMER patient management system.	Full migration by June 2002.
Review and improve all processes of information for patients regarding their treatments.	Review completed and recommendations accepted by divisional governance group.	Report completed by December 2001.
Improve cultural safety for Maori patients and clients.	Policies and guidelines in place.	Full implementation by March 2002.
Finalise user requirements for new Women"s Hospital.	Working drawings signed off by users.	100% sign off.

RURAL HEALTH SERVICES 2001/02		
OBJECTIVES	**MEASUREMENT**	**TARGET**
Complete a stocktake of rural health and social services (including facilities) available in rural communities of Canterbury	Information available on health and social services (including facilities) available throughout rural Canterbury	30 December 2001
Set up and complete consultation process to obtain the views of local authorities, communities and health providers on service issues.	Information provided and meetings with target groups	30 June 2002

SCHOOL & COMMUNITY DENTAL SERVICE 2001/02		
OBJECTIVES	**MEASUREMENT**	**TARGET**
Increase the % of children receiving diagnostic radiography	2001	15%
Increase Pre-School enrolments	2001	50%

BURWOOD HOSPITAL 2001/02		
OBJECTIVES	**MEASUREMENT**	**TARGET**
Implement recommendations from accreditation process	All recommendations implemented	100% compliance by March 2002
Implement framework for clinical governance system	Recommendations of Clinical Governances Review implemented	All processes and structure in place by April 2002.
Implement Stage 1 of facility plan	• Architects complete detailed plans. • Tender Work	100% user sign off by June 2001 Award tender by end July 2001 Stage 1A October

	• Complete works as per staged dates	2001 Stage 1B & C May 2002
Develop clinical pathways	Number of clinical pathways	10 pathways developed by June 2002
Maintain and enhance MOH/ACC revenue stream	• Value of current contracts	Increase in contract value
Review discharge planning process	• Project leader(s) identified • Project plan developed	July 2001 August 2001
Agree quality action plan from Quality Health accreditation survey and maintain quality focus	• Draft Action Plan developed • Action Plan accepted by Quality Health	Complete by August 2001

MENTAL HEALTH 2001/02		
OBJECTIVES Year 1	**MEASUREMENT**	**TARGET**
Gain advantages of Healthlinks (clinical information system.)	Percentage of documents on the system	100% Review 3/02
Begin co-ordinated workforce projects for South Island as part of delivery 4 years of National Plan.	(Projects delivered on time and within budget)	Project management
Centralise recruiting	Staff vacancy numbers Turnover in nursing numbers	Maintain budgeted FTE levels at 98%
Participate in Mental Health Classification and outcome study	Clinical buy in attained	Data integrity 100% Project completed on time and within budget 6/02
Review roles in supervised accommodation	Review recommends achievable plan for the CDHB	Review completed by 8/01

Agree and action 5 projects within Access Canterbury Agreement	Projects delivered on time within budget and to standards within agreement	Better integration with GPs
Ensure South Island Mental Health Network established	✔ Established	By 9/01
Ensure CDHB Mental Health Reference Group is established.	✔ Established	By 9/01
Pursue integration projects	Projects clearly scoped and costed	Delivered on time and within resources

BRACKENRIDGE ESTATE LIMITED 2001/02		
OBJECTIVES	**MEASUREMENT**	**TARGET**
Review current Policies & Procedures to ensure they meet current legislative standards and best practice guidelines.	Policies & Procedures are reviewed and updated.	10/01
Undertake Business Contingency Planning process.	Policies & Procedures/Plans developed and implemented.	12/01
Services provided are within financial/budgeted allocations.	Allocated budgets are adhered to.	Ongoing
Determine Brackenridge Estate"s strategic future in key areas of specialisation and access to new residents.	Consultation with key stakeholders undertaken. Strategic future determined.	10/01 12/01
Enhance Clinical Practice (for example restraint minimisation, day programme development).	Clinical Practice is in line with Best Practice Guidelines and Policies & Procedures.	Ongoing
Support and optimise residents" current pattern of living, including access to day programmes.	Lifestyle plans based upon My Goals package are in place for all residents.	12/01

Consolidate links with other community and service providers.	Effective working relationships are in situ, regular contact is maintained.	Ongoing
Strengthen current stakeholder feedback mechanisms.	Stakeholder satisfaction survey undertaken. Regular contact and consultation with residents/family/whanau /other relevant stakeholders.	03/02 Ongoing
Consolidate links with other community and service providers.	Effective working relationships are in situ, regular contact is maintained.	Ongoing
Participate in audits, e.g. Standards and Monitoring Service	Review recommendations and requirements made implementing same where appropriate and/required.	Ongoing

CROWN PUBLIC HEALTH LIMITED 2001/02
Current intentions are noted in detail from page 7 onwards of the Crown Public Health Limited Business Plan 2001/02 and relate to : • Providing Public Health Services aligned to the 13 identified New Zealand Health Strategy priorities. • Best Practice in all operating methods. • Strengthening Relationships with DHB, Independent Practitioners Association, Territorial Local Authorities, Non Government Organisations, etc. • Public Health Infrastructure

4.11.4 Financial Projections

These are incorporated in Section 5.

4.11.5 Strategies for Business Improvement

Facilities, Building and Reconfiguration

The Canterbury DHB is carrying out a number of major facility projects which will reconfigure services. These are:

New Women's Hospital & Day Surgery Unit

The new Women"s Hospital and Day Surgery Unit, which has been in planning for sometime, has progressed to the completion of conceptual design. This is a project identified through the master planning process that must proceed immediately due to the present condition of the existing Women"s Hospital.

We have recently appointed a new architect to complete the design for this project. Once approval for funding has been obtained, the project will take approximately three years to complete. We expect occupation of the Women"s Hospital and Day Surgery Unit to be early 2005.

Dental

A new Dental building on the ground floor of the existing Hospital Car park building opened in June 2001. This new facility will provide a base for the tertiary, secondary dental services, as well as the community and school dental services.

Burwood Hospital

The Burwood Hospital campus contains a mix of mostly very old and inefficient facilities and a few modern facilities. The wards in particular date back to 1915, 1943, 1946 and 1955 and do not meet today"s expected standards for patients and staff.

Burwood has grown in strategic importance in our overall health delivery plans and as a result there is a need for development. The majority of Christchurch"s population growth is occurring in the North of the city, where Burwood is located.

During 2000 a redevelopment plan for Burwood was developed to address facility problems. Stage 1 of the redevelopment will see the demolition of the Ward 3 and 4 block, which is the oldest patient area within Burwood built in 1915. A purpose built, 30 bed, rehabilitation ward will replace this, and in addition, a new main entrance encompassing patient admission and administration area will be constructed to give a focal point for the campus. The Spinal Unit will be refurbished to create en-suite bathrooms and improved facilities for patients and staff. These developments are about to be tendered with completion by mid to late 2002.

The Stage One projects were chosen on the basis they would be unaffected by decisions on the long-term future of elective surgery at Burwood.

Stage 1 represents the first step in a modular master plan for the campus. Development beyond Stage 1 will be closely related to the overall Master Plan process being undertaken and the Strategic Plan being developed for the DHB.

The Princess Margaret Hospital and Hillmorton Hospital
A $44 million site redevelopment project, which encompasses both The Princess Margaret Hospital and Hillmorton Hospital (formerly Sunnyside Hospital) is virtually complete, with only minor work still left to finish. This redevelopment has significantly improved outdated facilities for patients, their families and staff. These improved facilities provide enhanced quality patient care and improve patient privacy and safety.

The new Hillmorton facilities will assist in the destigmatisation associated with Mental Health services on this site.

Integration
Integration initiatives over the 3-5 year will focus on the following:

a) maximising the benefits to patients and providers from existing integration initiatives, ie Access Canterbury, The Elder Care Canterbury Project, acute hospital/ primary care initiatives;
b) progressing a number of smaller projects where changes can be made quickly with immediate benefits to patient care, ie a multi-sector, multi-discipline, winter strategy and a review of dietetic (dietary) services throughout Canterbury; and
c) pursuing medium and longer term projects that require changes in clinical practice or contracting or funding arrangements.

The initiatives will focus on maximising benefits to patients, eliminating duplication and ensuring a continuum of care based on two key principles:

- π involvement of the community in identifying the projects to be progressed, prioritising these and then progressing them.
- π ensuring a multi-sector approach is adopted.

Collaboration with other DHBs in South Island
The Provider arm of the DHB will work with surrounding DHBs to undertake joint planning for:

- Locally provided services which have linkages with services provided in other districts (particularly in relation to collegial support, training, and transient patient populations).
- Services provided by single regional providers across many districts.
- Services provided only in one district (this district or other districts) which the regional population needs to access.

Rural Health
The Canterbury DHB will continue to review and improve systems and processes, in consultation with the rural community to improve access and quality of services and improve workforce issues in the rural community in line with the direction provided by the NZ Health Strategy and NZ Disability Strategy.

Consultation is underway by the Planning and Funding Division with the provider arm of the DHB, other rural health providers and communities in preparation for a Rural Health Strategy to form a key part of the Strategic Plan.

Waiting Lists
In line with the NZ Health Strategy the Canterbury DHB will work towards a system that will manage waiting times for elective (non emergency) surgery.

The strategy includes four key objectives for reduced waiting times:

a) National equity of access to elective services so patients have similar access regardless of where they live;
b) A maximum waiting time of six months for the first specialist appointment;
c) A maximum waiting time for surgery of six months for patients who are offered publicly funded treatment;
d) Delivery of a level publicly funded service which is sufficient to ensure access to elective surgery before patients reach a state of unreasonable distress, ill health and or incapacity;

The seven strategies for achieving these objectives outlined in the NZ Health Strategy are:

a) Nationally consistent clinical assessment;
b) Increasing the supply of elective services;
c) Giving patients certainty;
d) Improving the capacity of public hospitals;
e) Better liaison between primary and secondary sectors;
f) Actively managing sector performance; and
g) Building public confidence.

The Canterbury DHB will be implementing systems to ensure the maximum contribution to improved health and reduced inequalities from its investment in elective services.

The strategy outlines three key initiatives to achieve this:

a) The continuation of existing joint projects with primary care providers that are focussed on clinical situations resulting in secondary care referrals plus the expansion of these projects to other clinical areas

b) Ensuring that patients with the greatest need and ability to benefit are offered treatment first;
c) Providing a smooth and timely pathway through to treatment; and
d) Ensuring that the best care and support available is provided to patients seeking elective surgery.

Teaching & Research
The Canterbury DHB will continue to foster its relationship with providers of teaching and research. It sees as one of its key roles a provider of clinical placements for under graduate and post graduate students.

The Canterbury DHB will resolve outstanding issues associated with clinical placements for health professionals over the next six months. It will also work with its clinicians to increase the amount of Clinical Training Agency revenue available to the DHB.

The Canterbury DHB will continue to support the Christchurch School of Medicine Research Office and support clinicians and multi-disciplinary teams to carry out relevant and approved research within its institutions and services.

New Management Style
The Canterbury DHB will develop a management style that is more open, inclusive and transparent and that fosters a true partnership between staff, and between staff and management.

There is the need to devolve greater responsibility and accountability for resources, planning and delivery of quality health services and adopt clinical governance process.

This process has already been initiated through the distribution of the consultation document:

“Proposal for Change – Canterbury DHB Provider Structure”.

The goals of this process include continued commitment to high quality care and higher productivity, improved patient satisfaction and development of a partnership model between management and clinicians.

Disability Action Plan
To ensure the objectives of the NZ Disability Strategy are implemented, an Action Plan has been drawn up to cover employment, facilities and inclusive behaviours. This has been adopted by the Canterbury DHB. The DHB Provider Arm and other providers will be monitored against agreed tasks.

Maori Health
The Kaumatua, Taua and Mental Health Manager are working to identify key issues for action to feed into the Maori Health Strategy for the provider arm. These include workforce development, ethnicity data collection issues and staff training.

Elective Services

It is the intention of Canterbury DHB to retain current levels of elective service and run a deficit as a consequence.

The DHB"s Elective Services Business Plan 2001/02 outlines referral management policy, key strategies and targets and includes guidelines for primary – secondary interface.

The Canterbury DHB"s aim is to achieve 100% compliance with the 6 month maximum waiting time. Canterbury acknowledges that it is committed to working to achieve 100% compliance but the parties acknowledge that in calculating whether the DHB has achieved the target set for this measure, there are certain acceptable exclusions including whether the patient has caused the deferral or the patient did not attend the appointment, a deferral because the patient is temporarily medically unfit. When reporting against the quantitative targets that have been set for 2001/02, the DHB will also provide advice on progress it is making towards the 100% requirement including:

- baseline information at the commencement and end of the period
- movement since this time and during 2001/02 in relation to the target
- analysis of gaps from target and factors influencing this proposed strategy to address gaps with timeline for movement to target

Merger with Health Link south

Implications of the merger of Canterbury Health with Health Link South include implementation of a new Management structure and enhanced clinical co-operation between the specialities of General Medicine and Older Person"s Health.

Maternity

The CDHB Maternity Service is an active member of the NZ Maternity Managers Group, which encourages information sharing and benchmarking between similar facilities. To that end the CDHB benchmark on a quarterly basis: Average length of stay, intervention rates and staff levels with Dunedin, Waikato, and National Women's. We also benchmark on an annual basis with Wellington and Middlemore. The CDHB is also a member of the Women's Hospitals of Australasia network, which is extremely strong on benchmarking as a tool to enhance clinical and management performance.

5. Financial Projections

5.1 Consolidated Projected Statement Of Financial Performance

	2001/02 $000
Operating Revenue	
Funder Services Revenue	189,780
Provider Services Revenue	387,184
Governance and Funding Administration Revenue	2,552
Interest income	720
Other revenue	38,483
Total Revenue	618,719
Operating Expenditure	
Funder Services	191,780
Provider Services	392,464
Governance and Funding Administration	22,644
Total Operating Expenditure	606,888
Earnings before Interest, Depreciation, Capital Charge	11,831
Less:	
Interest Expense	(9,275)
Depreciation	(19,487)
SURPLUS/(DEFICIT) BEFORE CAPITAL CHARGE	(16,931)
Capital Charge Receipts	14,028
Capital Charge Payments	(17,279)
SURPLUS/(DEFICIT)	**(20,182)**

5.2 CONSOLIDATED PROJECTED STATEMENT OF FINANCIAL POSITION

	2001/2002 $000
CROWN EQUITY	**156,862**
CURRENT ASSETS:	
Cash, bank account, short term investments	
Accounts Receivables & Prepayments	42,648
Inventory	6,994
	49,642
CURRENT LIABILITIES:	
Bank overdraft, secured borrowings	(28,069)
Creditors	(34,671)
Provisions and Payables	(33,788)
	(96,528)
Net Working Capital	(46,886)
NON CURRENT ASSETS:	
Land, Buildings, Plant and Equipment	284,539
Long Term Investments	595
Trust Funds	6,429
NON CURRENT LIABILITIES:	
Borrowings & Provisions	(87,815)
NET ASSETS	**156,862**

5.3 CONSOLIDATED PROJECTED STATEMENT OF CASHFLOWS

	2001/02 $000
OPERATING CASHFLOWS	
Cash was provided from Crown Agencies and other income sources	646,288
Cash was provided to employees, suppliers and payment of interest	635,863
	10,425
INVESTING CASHFLOWS	
Cash was provided from sale of assets	
Cash was provided to purchase of assets	(31,200)
	(31,200)
FINANCING CASHFLOWS	
Cash was provided from equity support and proceeds from borrowings	23,184
Cash was provided to repayment of borrowings	(267)
	22,917
Net increase/(decrease) in cash held	2,142
Add Opening cash balance	(2,795)
CLOSING CASH BALANCE	**(653)**
Made up from:	
Balance Sheet Operating Overdraft	(653)

5.4 Capital Expenditure

Total budget for capital expenditure is $30 million of which $15 million is for Site Redevelopment, which mainly relates to the Christchurch Womens project and $15 million is for normal capital expenditure replacement.

6.0 Performance Requirements

6.1 Accountability Indicators

The CDHB, under the Funding Agreement with the Crown, is required to report against a set of quantitative and qualitative accountability indicators.

The 2001/02 accountability indicators were developed recognizing that DHBs are accountable for securing improved health status for their populations. This accountability is independent of the way in which funding for specific services, or components of service, are arranged. DHBs can influence the comprehensiveness and cohesiveness of service coverage for their population by:

- directly funding services
- influencing other funders.

Each indicator in the DHB accountability set is a means by which progress in the marshalling of resources for the fulfilment of a particular expectation can be evaluated, as well as achievement of the expectation itself. It is the former that will be the focus of the Ministry"s assessment of DHB performance, particularly with regard to the indicators that relate to services where the DHBs" ability to influence the outcome is not through direct funding of all services that may impact on the outcome.

To this end DHBs have been asked to agree targets for all indicators in the accountability set. The actions taken by the DHB to influence the direction of performance in relation to specified targets will be the paramount consideration in assessment of performance, rather than the match between actual performance and the indicator itself.

Listed below are the quantitative measures that exist. For each of these measures actual results for the CDHB are stated, together with the national average and the targets set for the 2001/02 year. The setting of those targets has been based on:

- expectations expressed by the Ministry of Health
- the latest national data
- the latest CDHB specific data

The intent of this section is to recognise that CDHB does not have funding for some, in some instances, but should be looking at the health of the DHB irrespective. The aim is to get DHBs to look at progress towards increasing the health status of their population.

Qualitative Accountability Indicators

Governance			
Indicator No	**Title**	**Objective**	**Frequency**
GOV-01	Responding to and resolving service coverage issues	Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of the ability to pay, and a high performing system in which people have confidence. CDHB will respond to issues and constraints in meeting service coverage issues.	Quarterly
GOV-02	Effective Health Needs Assessment	A comprehensive health needs assessment report is produced for the DHB population. CDHB has produced the preliminary needs assessment and an indication of the ongoing process to progress	1 November 2001
GOV-03	Prioritisation	The CDHB will be prioritising the needs of the DHB"s community in terms of the directions set by the NZ Health and Disability Strategies within available service funding. Implementation will not be progressed until feedback is taken into account and the process is finalised along with the Strategic Plan.	31 May 2002
GOV-04	Local Iwi/Mäori are engaged and participate in DHB decision making and the development of strategic and plans for Mäori health gain.	Processes for participation, engagement and input by Iwi/Maori are in place in respect to: • Health Needs Assessment • Prioritisation • Planning • Service Delivery • Monitoring • Evaluation of Services	Annual
GOV-05	Progress in the development of Mäori workforce and Mäori providers	Progress is in developing the DHB Maori workforce; promote workforce development among contracted mainstream providers and in the development of Maori providers. CDHB will report on progress towards this indicator	Annual

GOV-06	Pacific people are engaged and participate in DHB decision making and the development of strategies and plans for Pacific health gain.	CDHB will report on progress towards this indicator	Annual
GOV-07	Progress in the development of Pacific workforce and Pacific providers	CDHB will report on progress towards this indicator	Annual

Quality Systems

Indicator No	Title	Objective	Frequency
QUA-01	Quality systems	The quality of services including cultural appropriateness provided and funded by the DHB is maximised through effective monitoring and audit and the promotion of an organisational culture, which is supportive of quality initiatives. CDHB will forward our proposed audit plan and report on progress towards meeting this indicator.	Annual
QUA-02	***Mental Health quality measures***	Mental health services are delivered in accordance with the Government"s service coverage expectations and to meet the New Zealand Health Strategy"s priority for mental health services: • Improving the health status of people with severe mental illness. • A high-performing system in which people have confidence; and • Active involvement of consumers and communities at all levels.	***Annual***
QUA-03	Nationally consistent clinical assessment – Elective Services	Nationally consistent clinical assessment is achieved. CDHB will report on progress towards achieving nationally consistent clinical assessments.	Quarterly

Nursing Practice and Development

Ind No	Title	Objective	Frequency
NUR-01	Nursing practice and development	Maximise the contribution of nurses to quality care by ensuring the consistent organisational support of clinical career pathways, professional development, on-going education, and an infrastructure, which allows for nursing input into decision making at all levels. CDHB will report on what processes are in place to involve nursing staff in decision making.	Quarterly

Child Health

Ensure access to appropriate child health care services including well child and family health care and immunisation

Ind No	Title	Objective	Frequency
CHIQ-02	***Progress in implementing the Baby Friendly Hospital Initiative in maternity facilities***	***Progress in implementing the BFHI in maternity facilities. CDHB will report on issues, constraints, and progress towards meeting this indicator as agreed in the monitoring framework.***	***Annual***

Diabetes
Reduce the incidence and impact of Diabetes

Ind No	Title	Objective	Frequency
DIA-07	Implementation of the minimum diabetes dataset	Reduce the incidence and impact of diabetes in New Zealand. CDHB will ensure that the local diabetes teams currently provide the required information direct to the Ministry of Health	Annual

Primary Care			
Ind No	**Title**	**Objective**	**Frequency**
PRI-01	***Progress towards implementing the Primary Health Care Strategy***	***CDHB will advise on progress towards implementing the Primary Health care Strategy as indicated in the framework***	***Annual***
PRI-02	Progress in developing the capacity of primary care providers to impact on suicide prevention	CDHB will report issues and constraints, and progress towards capacity development.	Annual
Elective Surgery Reducing waiting times for public hospital elective services			
Ind No	**Title**	**Objective**	**Frequency**
ELE –01	Level of publicly funded service delivered is sufficient to ensure access to elective surgery for all patients before they reach a state of unreasonable distress, ill health or incapacity.	Delivery of a level of publicly funded service which is sufficient to ensure access to elective surgery before patients reach a state of unreasonable distress, ill health or incapacity. CDHB will report on issues, constraints, and progress towards meeting the indicator targets set.	Quarterly

Mental Health			
Ind No	**Title**	**Objective**	**Frequency**
MEN-01	Progress towards improving Mäori mental health	Progress is made towards improving Maori access to Mental Health services, the effectiveness of mainstream services for Maori and availability and capability of Kaupapa Maori services through the implementation of the Maori Mental Health Strategy. These will be covered within CDHB Maori Health Plan Strategic Directions.	Annual
MEN-02	Comprehensive and timely data is provided to MHINC	CDHB will comply with MHINC reporting requirements.	Quarterly

Quantitative Accountability Indicators

Accountability Indicator		Total	Maori	Pacific Peoples	Other
CHI-01 % of Children Fully Vaccinated at 2nd Birthday	CDHB Target	Same target of 75% for all DHBs and all ethnic groups			
CHI-06 % of Children Passing School Entry Hearing Screening Test	CDHB Target	94.3	90.1	86.1	95.1
CHI-08 % Repeat Admissions for Asthma in Children Under 5	CDHB Target	6.3	9.1	6.3	5.6
CHI-09 % Repeat Admissions for Asthma in Children Aged 5 to 14	CDHB Target	5.8	5.6	10.0	5.5
CHI-13 % Babies Born in Public Hospital with Low Birth Weight	CDHB Target	6.2	7.2	4.9	6.1
CHI-15 Full Breastfeeding Rate at Six Weeks	CDHB Target	67.4	63.7	60.1	68.3
CHI-16 Full Breastfeeding Rate at 3 Months	CDHB Target	55.0	43.9	52.5	56.3
ORA-04 Mean MF Score at Form 2 (Year 8)	CDHB Target	1.6	-	-	-
ORA-01 Caries Free at Age 5	CDHB Target	53.6	-	-	-
CAR-10 Repeat Admissions for Acute Rheumatic Fever in People < 30	CDHB Target	29.3	-	-	-

In regards to the oral health targets (ORA series) it should be noted that there is no fluoridation of all public water supplies. Any changes effected now or in the near future will not show through in the MF rate of Form 2 children for another seven to twelve years at the earliest. CDHB will endeavour to meet the target subject to the above constraint.

PRI-03 % of New or Renewed Agreements for General Practice Services that use the national service agreement framework for primary care.

CDHB will report on issues, constraints, and progress towards meeting the indicator targets set.

PRI-04 Number of Contracted Providers of General Practice Services with a Maori Health Plan that has been agreed with the funder. CDHB will report on issues, constraints, and progress towards meeting the indicator targets set:

CDHB Target: 100%

ELE-02 100% of Patients do not wait longer than 6 months for first specialist assessment.

CDHB Target:

Quarter 2 Ended 31/12/2002	**80%**
Quarter 3 Ended 31/03/2002	**90%**
Quarter 4 Ended 30/06/2002	**100%**

ELE-03 100% of Patients who have been offered publicly funded treatment do not wait longer than 6 months.

CDHB Target: 100%

In relation to elective services (ELE series) the DHB"s aim is to achieve 100% compliance with the 6 month maximum waiting time. Canterbury acknowledges that it is committed to working to achieve 100% compliance but the parties acknowledge that in calculating whether the DHB has achieved the target set for this measure, there are certain acceptable exclusions including whether the patient has caused the deferral or the patient did not attend the appointment, a deferral because the patient is temporarily medically unfit. When reporting against the quantitative targets that have been set for 2001/02, the DHB will also provide advice on progress it is making towards the 100% requirement including:

- baseline information at the commencement and end of the period
- movement since this time and during 2001/02 in relation to the target
- analysis of gaps from target and factors influencing this proposed strategy to address gaps with timeline for movement to target

CAR-03 Number of people waiting CABG (< than 6 months)

CDHB will report on issues, constraints, and progress towards meeting the indicator target set at zero people waiting for all DHB"s and all ethnic groups.

CAR-05 Number of people for angioplasty

CDHB will report on issues, constraints, and progress towards meeting the indicator target set at zero people waiting for all DHB"s and all ethnic groups.

CAN-01 Waiting times for radiotherapy

Target for all DHBs to be zero people waiting outside best practise times at 30 June 2002.

DIA-01 Diabetes Case Detection Rate

Current rate plus 20% for all DHBs and all ethnic groups

DIA-02 Diabetes Case Management

Target set at 5% reduction in proportion of people on register with HBA1c blood test >8% for all DHBs and all ethnic groups

DIA-04 **Retinal Screening of People with Diabetes in the Last 2 Years**
Same target of 80% for all DHBs and all ethnic groups

In respect of the diabetes targets (DIA Series) the target is a progress target that CDHB will endeavour to meet. CDHB will produce a report detailing an update on status and progress towards target. Minimum coverage within the report to include

· Baseline information at the commencement and end of the period (if available)
· Progress during „01/02 in relation to the target
· Analysis of gaps from target and factors influencing this.
· Proposed strategy to address gaps with timeline for movement to target.
· Involvement of other funders to achieve target (i.e. Public Health) and process of engagement

Performance To Annual Plan

FIN-01	Actual financial performance compared to the approved District Annual Plan of the Funder, Provider and Governance	CDHB will report on variance to the Business Plan.
FIN-02	The percentage of the DHBs total expenditure on services provided by Maori providers compared to the percentage of the DHBs total expenditure on services provided by Maori providers at 1 July 2001	CDHB will report on this indicator.

Hospital And Related Services

HMD0-01/02/03	Performance to Contract Percentage Eligible Day Case Surgery Emergency Triage Times	CDHB will report on these indicators.
HMD-04	90% for in-house provider only	90% for in-house provider only.

Canterbury

District Health Board

Te Poari Hauora ō Waitaha

ANNUAL PLAN

2002 – 2003

December 2002

Annual Plan 2002 - 2003

Produced by
Canterbury District Health Board
PO Box 1600 Christchurch
December 2002

Telephone (03) 364 4160

www.cdhb.govt.nz

ISSN: 1176 1296

SIGNATORIES

AGREEMENT DATED THIS 7th DAY February OF ~~2002~~ 2003

(Made under Section 39 (1) of the New Zealand Public Health and Disability Act 2000)

BETWEEN

Honourable Annette King
Minister of Health

Chairman (or CEO) of the
Canterbury District Health Board

Table of Contents

1.0 EXECUTIVE SUMMARY

1.1 Statement from DHB Chair and CEO

This is the Canterbury District Health Board's Annual Plan for the 2002/2003 financial year. It outlines the key activities of the Canterbury DHB to 30 June 2003.

Key Canterbury DHB priority areas are child and youth health, primary health, Māori health, mental health, disease prevention and management and diabetes and cancer.

Through our role as both a funder and provider of health services we will be able to make progress on a more integrated and seamless approach to the prevention and treatment of health issues affecting these priority areas.

The Canterbury DHB began this process last year with a review of Canterbury Child Health Services, provided by the Canterbury DHB and other providers, and the issues surrounding the health of Canterbury children. This review will lead to a child health strategy for Canterbury.

Strategies for Māori Health, Primary Care, Pacific peoples and Rural Health have been developed.

The Canterbury DHB recognises and respects the principles of the Treaty of Waitangi: partnership, participation, and protection.

We are committed to reducing disparities and improving health outcomes for Māori and ensuring Māori involvement in planning for these and that commitment is reflected in this annual plan.

In this plan the Canterbury DHB has identified challenges during the next 12 months which include:

- Working within the resources we have to fund and deliver the best possible health and disability services and outcomes for Canterbury people
- Working effectively as a funder of health services and towards a population based funding approach
- Ongoing development of our relationships with health workers in our hospitals and in community health services to build a workforce appropriate to our needs.
- Improving public understanding of our role and community participation in our processes

- Developing enhanced relationships with the community, health providers and social agencies
- Developing better information systems that ensure providers can more efficiently communicate and monitor patient care
- Demonstrating capability to the Ministry of Health
- Working with other South Island DHBs on areas of common need and interest.
- Preparation for the new primary care environment and the establishment of primary health care organisations
- Completion of the Older Person's Health Lead DHB project and implementation of the Pacific People's Health and Disability Action Plan
- Managing demand for acute medical services
- Developing action plans for the agreed health gain areas for the Canterbury District.

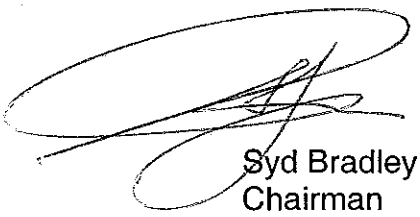
The Canterbury DHB provider arm will be implementing its proposal to devolve budget control to clinical partnerships to ensure budgets are managed by those delivering services.

We will be working to help ensure the Canterbury community understands there are not sufficient resources to deliver all health services to the level the community might like and that decisions must be made about priorities.

This annual plan will continue to establish the Canterbury DHB's role as a funder as we continue to move towards a greater focus on funding services which will be outcome focused and grounded in continuous quality improvement.

By concentrating on these key areas the Canterbury DHB is working to ensure these Health and Disability strategies are realised in Canterbury resulting in better health outcomes for all sectors of our community.

Jean O'Callaghan
Chief Executive



Syd Bradley
Chairman

2.0 INTRODUCTION

Our Purpose

"To improve the health and wellbeing of people living in Canterbury"

Who We Are

- We are the health organisation responsible for funding most health services in Canterbury. We are funded by Government, but it is up to us to work together with Canterbury people, to decide what health services we need and how to best use our funding, noting Government policies.

What We Do

- Fund most mental health, Māori health and personal and family health services in Canterbury (We are planning for monies for disabilities support and public health to be devolved in July 2003).

- Run Canterbury's 14 public hospitals and provide mental health, disability support, alcohol and drug and community health services within the provider arm.

- Promote community health and well-being through population health programmes such as health promotion and protection.

- Encourage all health and disability support providers in Canterbury to work together to streamline health care and make care more efficient and effective.

This Plan's objectives are aligned with Government objectives for District Health Boards as set out in the New Zealand Health Strategy and the New Zealand Disability Strategy, Māori, and other Health Strategies as well as directions in the current Canterbury DHB Strategic Plan.

The Annual Plan outlines the planned performance of the Canterbury DHB for the period 1 July 2002 – 30 June 2003 including funding arrangements and services provided.

2.1 Population Profile

The Canterbury DHB catchment area covers rural communities from Kekerengu in the North, Rangitata in the South and Arthur's Pass in the West. 16% of the population live in rural towns (eg Kaikoura), rural centres (eg Rakaia) and wider area (eg Malvern). The Canterbury DHB is the largest DHB by population and geographical area. Canterbury has the ninth largest Māori population.

Canterbury District Health Board population statistics

Usually resident population by region: (2001 data)

	Number	% of CDHB population	% Who identify as Māori
Kaikoura	3,483	0.8%	15%
Hurunui	9,882	2.3%	5.4%
Waimakariri	36,900	8.6%	6.8%
Selwyn	27,312	6.4%	5.9%
Christchurch City	316,224	74.0%	7.1%
Banks Peninsula	7,833	1.8%	7.6%
Ashburton	25,443	6.0%	4.7%
Total	**427,077**	**100.0%**	**6.9%**

Population by Age: (1996 data)

0-14 years	84,527	20.1%
15-19 years	31,119	7.4%
20-64 years	249,374	59.3%
65-84 years	50,464	12.0%
85 plus years	5,046	1.2%
Total:	**420,530**	**100.0%**

Population by Ethnic Background: (1996 data)

NZ Māori	28,596	6.8%
European	357,031	84.9%
Pacific Peoples	6,728	1.6%
Asian Peoples	13,877	3.3%
Other Nations	14,298	3.4%
Total	**420,530**	**100.0%**

Birth Rate:
In 1996, 5500 babies were born
In 2006, it is projected that 4992 babies will be born.

Birth Place:
81% of people who live in Canterbury were born in New Zealand

Future Population (2021):

Total Population expected	495,500 (based on medium fertility, medium mortality and medium migration)	
Increasing by around 2,775 people per year		
0-14 years	76,307	15.4%
15-64 years	322,571	65.1%
64-84 years	87,704	17.7%
85 plus years	8,919	1.8%
Total	**495,681**	**100.0%**

Households with One/ More Superannuants:	24.8%
Households with Two or More People in the Labour Force:	43.5%

Households with Children Aged Less than 5 Years:	13.4%
Households with at Least One Sole Parent Family:	11.1%

Personal Income of People Aged 15-64[1] Years:

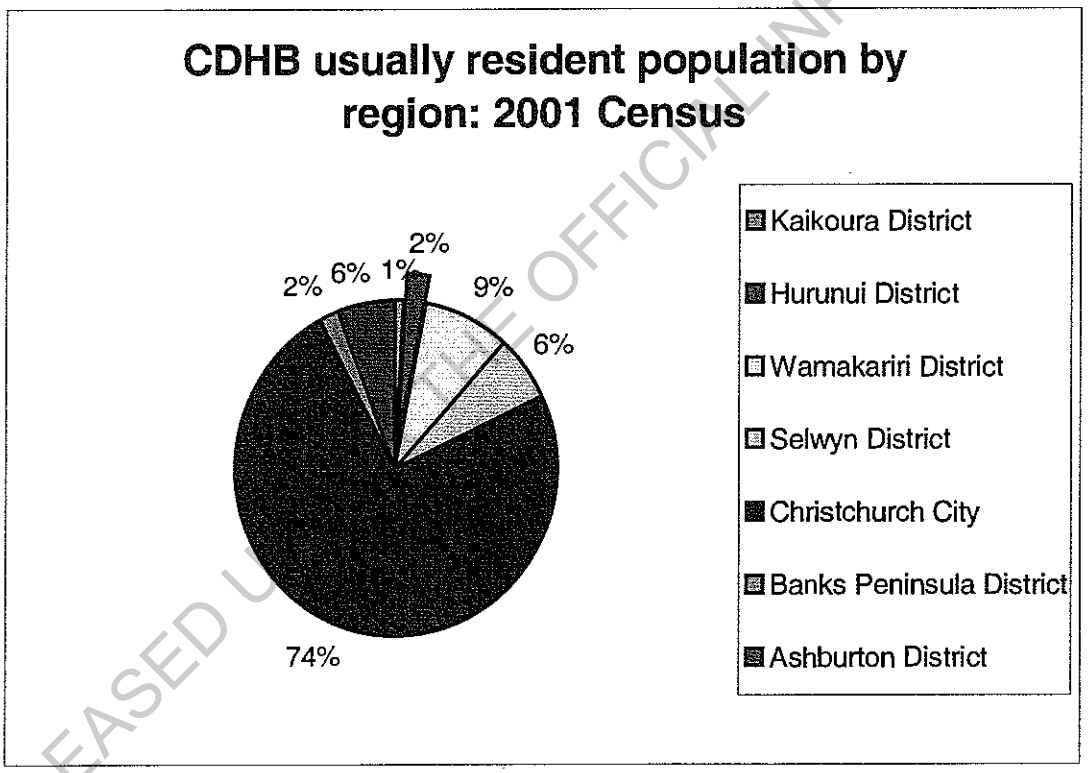
Less than $30,000	53.3%
$30,000 - $50,000	11.3%
$50,001 - $100,000	3.4%
$100,001 +	0.8%

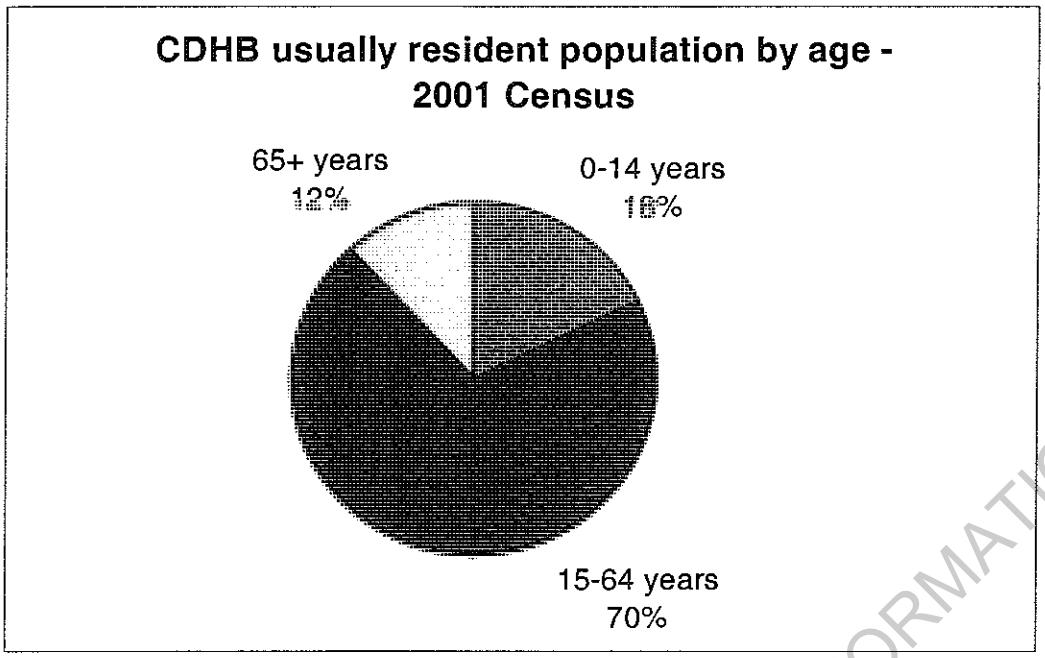
1 Percentages do not add to 100 as they are the percentage of the total population, not just of the population aged 15-64.

Beneficial Support Payments[2]:

National Superannuation	13.8%
Unemployment Benefits	5.5%
Domestic Purposes Benefit	2.4%
Sickness, Invalids Benefit	3.3%
ACC regular payments	2.1%

2 Percentages do not add to 100 as they are percentage of the total population not just of the population receiving a benefit.





2.2 Key Issues for Canterbury

An initial Needs Assessment Project was completed in October 2001. It aimed to assess the health status of the Canterbury population as these relate to the health objectives within the New Zealand Health Strategy, the New Zealand Disability Strategy, the Māori Health Strategy (in draft) and Pacific Health and Disability Action Plan as part of the strategic planning process. The Needs Assessment also covered issues raised in community consultation and linked the health needs of the Canterbury community with Government health strategies and others such as The Primary Care and Positive Ageing Strategy to prioritise the district's health needs.

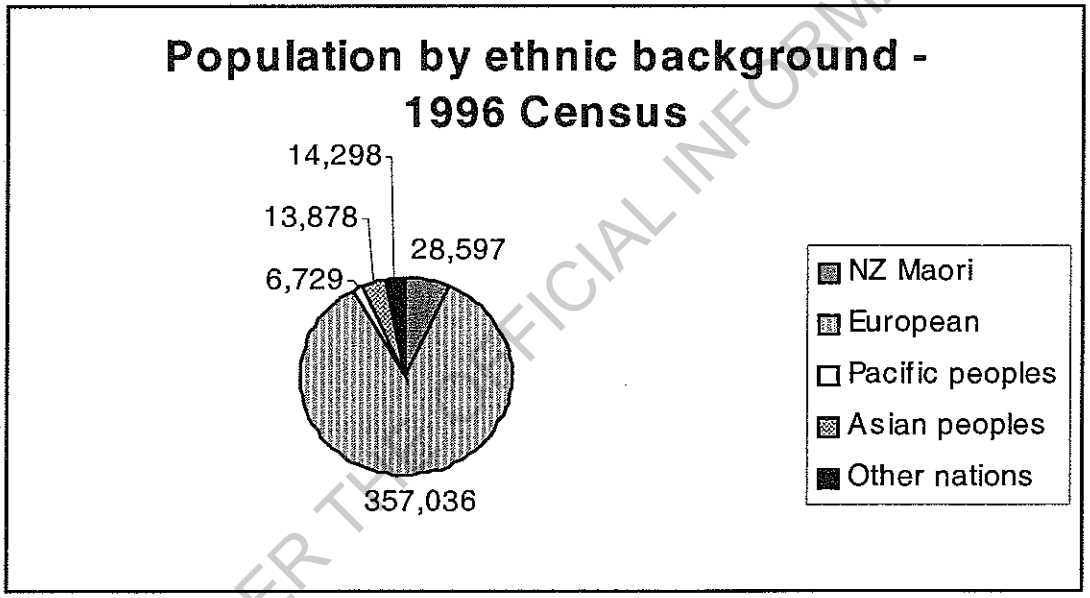
A fuller Needs Assessment for the Canterbury DHB population will be completed in June 2004. Current documentation is available on the Canterbury DHB website.
Key population trends for the Canterbury DHB population are:

- **Ageing Population**
  Canterbury's population is ageing quickly compared to other parts of the country. The percentage of the population who are 65 or older will increase from 12% in 2001 to 20% in 2021. Both Māori and Pacific people aged 65 and over are projected to increase each of their share of the DHB's population from 3% to 7% by 2021. This has implications not only for the relative size of the population of working age to support the older people, but also for health as older people particularly those over 75 years, consume a significant amount of health resources.

- **Decreasing Child Population**
  The population aged 0-14 will decrease to 15% of the Canterbury DHB population by 2021 compared to 18% in 2001.

- **Relatively Large Youth/Young People Population**
  Currently around 20% of New Zealand's population are in the age group 12-24 years. This is relatively large compared to the size of the rest of the population. The Canterbury figure is estimated to be similar.

- **Changing Ethnicity of the Canterbury DHB Population**
  An increasing number of the Canterbury DHB child and young people population are non-European, principally Māori, Pacific and Asian.



- **Māori**
  Most are under 30 years of age. Kai Tahu are manawhenua and make up about 25% of Māori in the Canterbury DHB region. Seven Kai Tahu runaka are in the Canterbury DHB area. Other Māori in Canterbury come from tribal regions throughout New Zealand.

  The available health statistics indicate that Māori in Canterbury have a similar health profile to national statistics. Available local ethnicity data does not confirm that Māori are high users of Secondary Services or under utilise Primary Services, but nationally this is so. 'Māori for Māori' providers provide a range of public, primary and community health services, and some bicultural services are provided by mainstream providers.

- **Pacific Peoples**
  There are about 8000 Pacific people in Christchurch, based on Statistics NZ 1999 figures, a mixture of Island born and New Zealand born people. The Canterbury DHB has very few dedicated services for Pacific peoples. An initial needs assessment has indicated Pacific peoples are difficult to reach due to communication and cultural difficulties and over utilise secondary services rather than primary and community services. Canterbury is one of the 7 Pacific priority DHBs with particular responsibilities for funding Pacific health services.

  Chronic diseases such as diabetes, asthma etc are prevalent amongst this population. The majority of the Pacific peoples are aged under 25 years. A significant proportion of these individuals are also part-Māori.

- **Migrant and Refugee Communities**
  Christchurch has been a resettlement point for refugees especially during the past 10 years. Exact figures are not available but it is likely this population exceeds 4000. Screening programmes for refugees have been established, however, migrant and refugee populations have particular needs in the areas of child health, mental health, primary health care and aged care.

- **Asian Population**
  The Asian population in Canterbury DHB is 3%. This population is steadily growing although at a slower rate than the Māori and Pacific peoples' populations. Many Asian-born individuals living in New Zealand are now ageing and the numbers of New Zealand born Asian children and youth populations are increasing.

2.2 Key Issues for Canterbury DHB

- Finalisation of the Canterbury DHB Strategic Plan and Directions 2006, in particular, the proposed values, the proposed directions, the five health gain areas (child health, cardiovascular disease, diabetes, primary care and Māori health) and ongoing important work (in areas such as public health, older persons health, mental health, cancer, nutrition, Pacific peoples health).

- Post-consultation confirmation of, or alterations to, the proposed prioritisation principles.

- Working within the resources available, to fund and deliver the best possible health and disability services and outcomes for Canterbury people. There is not enough money to do everything. We must prioritise and choose how to best use the resources available.

- Working effectively as the new funder of most mental health, Māori health and personal and family health services in Canterbury in a changing environment of Government health funding. From 2003 the funding that Government gives

the Canterbury DHB will be based on a formula linked to our population. We will have to prioritise the needs of people within our available funds and develop new ways of funding.

- ❒ Ongoing development of our relationships with health workers in hospitals and in community health and disability services to build a workforce that meets the health and disability needs of the community now and in the future. This includes addressing challenges such as staff shortages in some areas and staff needs for ongoing career development and participation in decision-making.

- ❒ Improving public understanding of the DHB's role and community participation in DHB processes. Many Canterbury people still do not have a clear understanding of what the Canterbury DHB's role is and what it can reasonably achieve within the resources available.

- ❒ Demonstrating capability so the Ministry of Health devolves to CDHB the funder role for public health services and some disability services.

- ❒ Developing enhanced relationships with the community, health providers and social agencies such as Age Concern, Child Youth and Family, Ngai Tahu Development Corporation and the Christchurch City Council.

- ❒ Developing better information systems that ensure providers can more effectively communicate and monitor patient care and provide better information for planning and funding purposes.

- ❒ Preparation for the new Primary Care environment and establishment of Primary Health Care organisations. The Canterbury DHB is working on determining what form proposed Primary Health Care Organisations would take in this district. There is a wide range of views on the benefits, costs, funding for, structure and effectiveness of Primary Health Care Organisations within the district and work needs to be done to identify a way forward. Some rural communities have ideas about how PHOs may benefit their areas.

- ❒ Completion of Ministry of Health required Canterbury DHB projects in the areas of Older Persons Health (the Lead DHB Project) and implementation of the Pacific Peoples Health and Disability Action Plan.

- ❒ Managing demand for acute medical services in coming years, disability support, medical and surgical services are going to be under increased pressure from the demands of more people in the older age range. Waiting times and numbers of patients waiting for first specialist assessments and elective surgery have reduced over the past 4 years due to increased funding, however, these improvements may not be sustained, and we must develop new initiatives.

- Working within the wider policy framework (the NZ Health and Disability Strategies).

2.3 Treaty of Waitangi

The Canterbury DHB recognises and respects the principles of the Treaty of Waitangi: partnership, participation and protection. We also acknowledge the expectations of the New Zealand Public Health and Disability Act 2000 and the Crown Funding Agreement. We are committed to reducing disparities and improving health outcomes for Māori and to ensuring Māori involvement in planning for these.

The Canterbury DHB regularly meets with Kai Tahu as manawhenua of the district, through the Manawhenua Health Group ki Waitaha, which comprises the seven Kai Tahu runaka supported by the Ngai Tahu Development Corporation. We also meet with nga Maata Waka representatives and Māori communities in formal and informal settings. Quarterly Māori community consultation meetings are held to provide forums for learning about Māori issues and providing an update on Canterbury DHB activities.

The Canterbury DHB has established Te Kahui Taumata, a group of senior Canterbury DHB staff led by the Chief Executive, Kaumatua, and Taua. This group will ensure that the Canterbury DHB recognises and respects the principles of the Treaty of Waitangi and actively works to improve the health of Māori.

3.0 STRATEGIC DIRECTIONS

3.1 Vision Statement

Our vision is :

"To promote, enhance and facilitate the health and wellbeing of the Canterbury District"

Ki te whakapakai, whakamaanawa me te whakahaere i te hauora
Mo te orakapai o ka takata o te rohe o Waitaha

3.2 Values and Ways of Working

These are:

Manaaki me te kotua i etahi	*Care and respect for others*
Hapai i a matou mahi katoa i ruka i te	*Integrity in all we do*
Kaiwhakarite i ka hua	*Responsibility for outcomes*
Arotahi atu ki ka takata me ka iwi whanui	*Be people and community focused*
Whakaatu whakaaro hihiko	*Demonstrate innovation*
Tuu atu ki ka uru (ratou ka takata me ka roopu e parekareka ana mai ki a tatou mahi)	*Engage with our stakeholders (those individuals and groups with an interest in our work)*

3.3 Directions and Objectives for the Canterbury DHB

The proposed directions for the Canterbury DHB over the next 5-10 years are:

Direction 1:	Improving the Health Status of our Community.
Direction 2:	Finding Better Ways of Working
Direction 3:	Working Together: Innovative Models of Service Integration
Direction 4:	Developing Canterbury's Health Care Workforce
Direction 5:	Being a Leader in Hospital and Health Care Services

Listed over the page are the key objectives for 2002/2003 for Canterbury DHB.

3.3.1 Improving the Health Status of our Community

DIRECTION 1: IMPROVING THE HEALTH STATUS OF OUR COMMUNITY		
Objectives	**Activities**	**Milestones**
1. Delivering on local and national health priorities for our population	• Progressively develop Action Plans for Health Gain Areas starting with the priorities once finalised in the Strategic Plan	
The proposed priorities are: • Child and Youth Health		Child Status Report complete/ Youth due December 2003
• Primary Health		
• Māori Health		
• Mental Health		
• Disease Prevention and Management - Cardiovascular disease - Diabetes - Cancer		
	• Develop Pacific Peoples Action Plan[1]	Complete
	• Establish Advisory Mechanisms for each health priority area	As relevant
	• Finalise Prioritisation Framework	December 2002 (Review each December)
2. Information and Systems to Monitor Health Status	• Health indicators in funding agreements inform Needs Assessment process (this will provide information to align contracted services with priorities and will inform future evaluation processes)	From December 2002
3. Robust health needs assessment in place	• Use this process to inform Annual Plan process and review Strategic Plan	Annually
4. Strategic Review of Process	• Executive Management Team to monitor quarterly implementation of the Strategic Plan • Check activities progressed as part of Canterbury DHB Disability Strategy Implementation Action Plan	Quarterly March and September each year

[1] Pacific Peoples Action Plan is attached as Attachment B. It outlines the Canterbury DHB's approach to reducing health inequalities and improving health of Pacific peoples.

3.3.2 Finding Better Ways of Working: Effective Policy and Funding Frameworks

DIRECTION 2: FINDING BETTER WAYS OF WORKING: EFFECTIVE POLICY AND FUNDING FRAMEWORKS		
Objectives	**Activities**	**Milestones**
1. Increased cooperation between providers and agencies	• Complete final draft Canterbury DHB Regional Information Strategy	February 2003
2. Stocktake and review services based on sound information	• Stocktake review current health services funded by DHB	December 2002
	• Stocktake review current health services funded by Vote Health and other non-health agencies	June 2003
3. Implementing Policy and frameworks	• Implement prioritisation framework and have clear funding principles and processes	December 2003
	• Work with providers to implement re-prioritised funding (including Transitional Strategy)	June 2003 and ongoing
	• Work with other agencies to implement mutual funding directions in one area based on Action Plan	June 2003 and ongoing
	• Ensure Health Promotion Programmes link with priority areas	Annually
	• Communicate via regular forums with staff, the health sector and the community to help ensure they are informed about our aims, challenges and achievements and have the opportunity to have their say.	Quarterly (staff) 6 monthly (community and providers)
	• Develop a partnership for decision-making in our hospitals between doctors, nurses and management and between hospital and community services	August 2002

DIRECTION 2: FINDING BETTER WAYS OF WORKING: EFFECTIVE POLICY AND FUNDING FRAMEWORKS CONT'D...		
Objectives	**Activities**	**Milestones**
4. Systems Management and Support	• Continually review processes to ensure best practice standards are met; incorporate expert advice from groups such as Cochrane Collaboration, Health Technology Assessment Unit etc	From March 2003
	• Scope regional administration service to be provided by CDHB to others and vice versa	December 2002
	• Explore the development of an Information Systems Bureau to support Canterbury DHB, community, IT/IS infrastructure	November 2002

3.3.3 Working Together: Innovative Models of Service Integration

DIRECTION 3: WORKING TOGETHER: INNOVATIVE MODELS OF SERVICE INTEGRATION		
Objectives	**Activities**	**Milestones**
1. Communication Research and Evaluation	• Develop Community Provider Advisory Group	November 2002
	• Research and analyse best practice models, processes of implementation of integration	July 2002
	• Identify issues/areas where planning adds value	February 2003
2. Rural Action Plan	• Implement Recommendations from CDHB Rural Health Action Plan; including short term options to support access to GPs in rural areas	June 2003
	• Establish community based Steering Group to develop options for development of PHOs	December 2002
3. Integration Services in Mental Health	• Convene stakeholders to develop a common vision	August 2002
	• Progressively implement models via contracts	December 2002

4. Continuum of Care of Older People	• **Undertake Lead DHB Project to prepare for devolvement of DSS money** • **Develop a contracting model and determine resource implications for Continuum of Care** • **Demonstrate capability**	June 2003 April 2003 February 2003
5. Healthy Christchurch Project	• **Develop a Charter of common purposes for agencies** • **Identify key projects to initiate under Charter**	December 2002 February 2002
6. Primary Health Care Strategy	• Develop Canterbury DHB Action Plan	October 2002

3.3.4 **Developing Canterbury's Health Care Workforce** (more details of specific within the in-house provider are in Sections 4 and 5)

DIRECTION 4: DEVELOPING CANTERBURY'S HEALTH CARE WORKFORCE		
1. Leading professionals	• Ensure professional advice is available directly to CEO and EMT	July 2002
2. Learning and Growing People	• Develop and offer management training programmes • Implement strategies for greater participation by Māori and Pacific people in health care workforce including - developing skills and knowledge of current staff - obtaining accurate ethnicity data • Improve links with secondary and tertiary education providers to influence curriculum and source graduates	July 2002 Plan October 2002 Ongoing Ongoing
3 Develop initiatives that ensure CDHB has the workforce to support a changing health environment.	• Develop retention strategies that acknowledge ageing workforce • Evaluate current system performance review	June 2003 February 2003

4. Recruitment and Retention Strategies to attract the workforce, with particular emphasis on areas facing shortages.	• Improve efficiency of recruitment advertising and the profile of CDHB as a health employer of choice. • Implement exit interview processes to assist in identification of targeted strategies.	Ongoing December 2002
5. Employee Development Strategies (continued)	• Collaborate with other DHBs and NGOs on career pathways and training • Organisational training needs developed and delivered • Develop information processes to improve collection of HR information CDHB wide	February 2003 Ongoing February 2003 (as part of Regional IS Plan)
6. Support/Participate in Government Initiatives to address workforce issues	• Ensure input to CTA Advisory Group process • Participate in DHBNZ workforce development work including forming a national view on student debt	October 2002 Ongoing
7. Work jointly with other DHBs on workforce issues.	• Participate with other DHBs in consistent approach to collective negotiations. • Participate with other DHBs to achieve a consistent approach to the analysis and sharing of workforce data.	Ongoing Ongoing
8. Working with unions	• Establish working parties with unions on key issues affecting staff. • Work together with unions on key issues. • Ensure a "no surprises" approach with unions on issues of mutual interest.	July 2002 Ongoing Ongoing
9. HR policies which support devolvement	• Review and development of HR policies which support flexibility and devolvement of decision making.	Ongoing

10. Occupational Health & Safety	• Establish a strategic direction for OSH which provides recognised best practice and consistency of approach across the CDHB. • Begin implementation of OSH strategic directions. • Identify options for an ACC partnership approach.	November 2002 December 2002 November 2002

3.3.5 Being a Leader in Hospital and Health Care Services

DIRECTION 5: BEING A LEADER IN HOSPITAL AND HEALTH CARE SERVICES		
Objectives	**Activities**	**Milestones**
1. Maintain and develop appropriate centre of excellence/regional services in Canterbury DHB	• Develop Regional Services Plan for two services working with other DHBs.	March 2003
2. Community Services	• Develop and support services/ programmes in line with chosen health priorities	March 2003 and ongoing
3. Research	• Support research in line with selected health priorities such as lipids, diabetes - Continue funding support to Research Office at Christchurch School of Medicine - Support Health Research Council developments	Ongoing Annually Annually

3.4 Treaty of Waitangi

The Canterbury DHB will implement the requirements of the New Zealand Public Health and Disability Act 2000.

We will work to:

- reduce health disparities by improving health outcomes for Māori and other population groups
- establish and maintain processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement
- continue to foster the development of Māori capacity for participating in the health and disability sector and for providing for the needs of Māori
- provide relevant information to Māori for the purposes set out above

The Canterbury DHB will work with Māori at both governance and operational levels. In doing so we will seek guidance from iwi and other Māori.

The Canterbury DHB will be guided by the New Zealand Health Strategy, the New Zealand Disability Strategy, the Māori Health Strategy: He Korowai Oranga, Guidelines for DHBs Establishing and Maintaining Relationships with Māori, and Whaia te ora mo te iwi.

The Canterbury DHB will recognise the Treaty of Waitangi principles as follows:

Partnership
Working together with iwi, hāpu, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services.

Participation
Involving Māori at all levels of the sector in planning, development and delivery of health and disability services.

Protection
Ensuring Māori enjoy at least the same level of health as non-Māori and safeguarding Māori cultural concepts, values and practices.

To link with the Crown Funding Agreement the Canterbury DHB will also:

a) ensure that processes for participation, engagement and input by iwi/Māori are in place in respect to:
   - health needs assessments
   - prioritisation
   - planning
   - service delivery
   - monitoring
   - evaluation of services

b) make progress in developing its Māori workforce, promote workforce development amongst its contracted mainstream providers by ensuring that mainstream services are culturally effective, and promote the development of Māori providers

c) participate fully with other government agencies in implementing the Government's objective of strengthening coordination of Māori social services and improving health outcomes for Māori

d) recognise the importance of the land to Māori by ensuring that surplus land is disposed of in accordance with the provisions of c43 of Schedule 3 of the New Zealand Public Health and Disability Act 2000

e) ensure that complete and high quality ethnicity information is included, where relevant, in the information provided to their Treaty based partnerships and other Māori to enable them to participate in the health sector and in the development of strategies to improve health outcomes for Māori.

Māori Health has been proposed as a Strategic priority for the Canterbury DHB. The draft Canterbury DHB Māori Health Plan is an inclusive pathway to Māori health and wellbeing. This work involves participation of iwi and other Māori.

This goal runs through the proposed Directions for the Canterbury DHB.

In particular the objective in the 2002/03 year is "Māori Health is aimed at improving health status, contributing to decision making and participation in health services delivery".

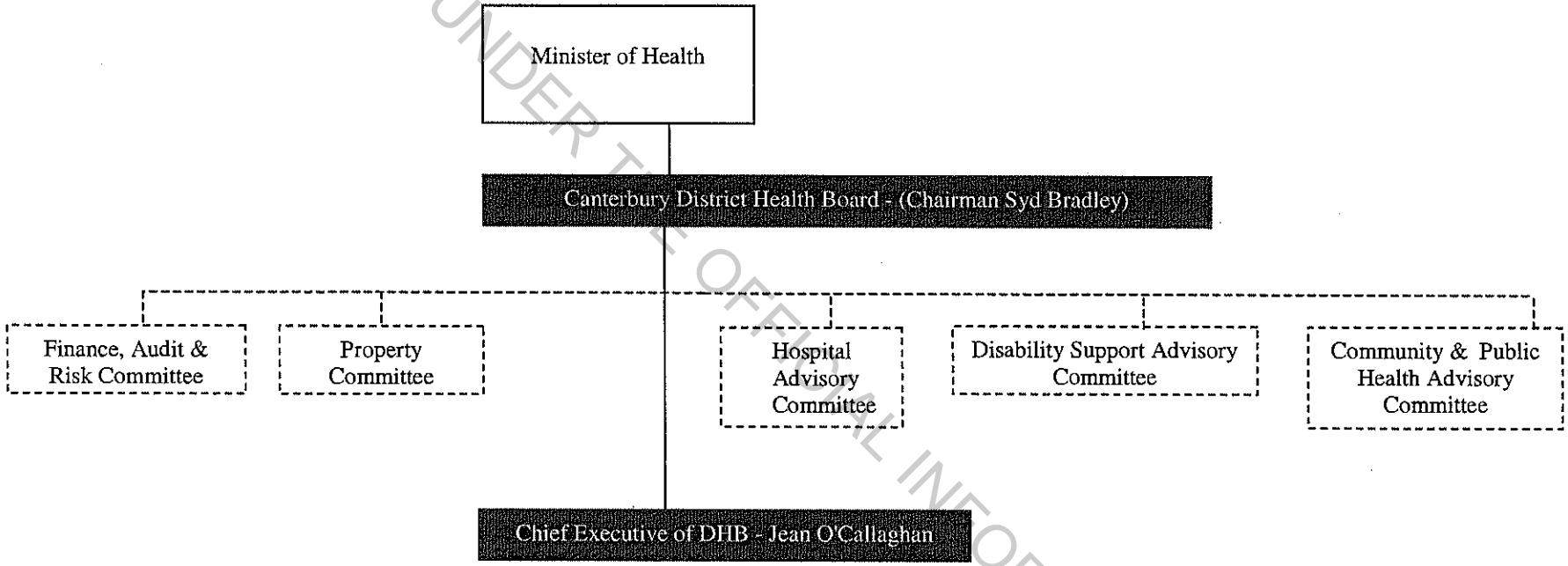
This will be measured by:

- improving accessibility and appropriateness of services
- consultation with Māori on funding decisions affecting Māori Health
- Improving Māori participation in the workforce

4.0 DHB PERFORMANCE

4.1 Ownership and Governance

4.1.1 Organisational Structure (as at December 2002)



4.1.2 Ownership Interests

The Canterbury DHB has three fully owned subsidiaries, Canterbury Laundry Services Limited, Burwood Rehabilitation Limited and Brackenridge Estate Limited which it intends to keep operating in the medium term. It also has a 50% shareholding in NZ Centre for Reproductive Medicine Limited.

The assets and liabilities of Community and Public Health (formerly Crown Public Health) were officially transferred to the Canterbury DHB in November 2002.

4.1.3 Financial Management

Financial management of the DHB is organised into 3 sections:

- Overall DHB financial management including its subsidiaries
- Funding; and
- In House Provider

The purpose of the above separation is to provide transparency between the financial performance of the two key functions of the DHB (the funding and the in house provider) while keeping an overall view of the whole organisation and related subsidiaries.

Separate financial reports are prepared for each of the above three sections monthly to facilitate monitoring at both the management level as well as to the Finance, Audit and Risk Committee.

4.1.4 Organisational Capability

The Canterbury DHB uses the office of the South Island Shared Services Agency (SISSAL) to undertake work that has relevance to other South Island DHBs and/or support its own processes thereby avoiding duplication.

The purpose of the Canterbury DHB Planning and Funding Division is to plan and allocate Vote Health resources devolved to the Canterbury DHB to improve the health and independence of people within the Canterbury DHB district. Personnel from this area are involved with the Lead DHB Project (to establish and fund a Continuum of Care for Older Persons). When the Canterbury DHB can demonstrate it meets the Ministry of Health DSS capability and criteria in this area, it will lead to the devolution of DSS monies for this district. This is expected to be on or before 1 July 2003.

The Canterbury DHB will endeavour to maximise the benefits of health promotion, early intervention, good coordination and integration of services and the participation of the community in establishing priorities consistent with the NZ Health Strategy. All services funded should:

a) meet explicit quality requirements
b) be delivered in an effective, efficient and appropriate manner
c) aim to maximise health gains.

The Canterbury DHB continues to work towards funding the optimum mix of services to provide Canterbury communities with the maximum health gains within the resources available.

Initiatives outlined in the HR Strategy, Appendix 6, aim to make Canterbury the preferred DHB to work in. Specific activities for 2002/03 are covered in the directions section 3.3 and 4.3.

The collection of ethnicity data for use of health services and staff is seen as a critical area of need and initiatives are being undertaken in the provider arm to achieve this. This requirement will be tied in with the funding agreements with Canterbury DHB providers over time.

In response to the NZ Disability Strategy, a Disability Strategy Action Plan covering five years was agreed by the Board in August 2001 (Appendix 1). This covers employment, facilities and inclusive behaviours including how Government and the Canterbury DHB expectations will be worked into all provider's contractual obligations. This has been implemented by the Canterbury DHB Provider Arm.

4.1.5 Nationwide Consistency

The Canterbury DHB will ensure that, where appropriate, the nationwide Service Framework will be applied when entering into service agreements. This includes utilising the nationally consistent service specifications and/or prices.

4.1.6 Risk and Management of Risks

A comprehensive Risk Register is being developed to identify the financial and non-financial risks for both the DHB in-house provider and contractual providers. The Canterbury DHB has an infrastructure to address these risks and will continue to enhance systems to efficiently manage both financial and non-financial service risks.

Lack of oversight and strategic direction for OSH is an identified risk that has been addressed by the appointment of a Corporate OSH Manager.

4.1.7 Cooperative Agreements

The Canterbury DHB is aware of the obligations under Section 24 of the New Zealand Public Health and Disability Act 2000 to seek authority for cooperative agreements and comply with issue guidelines.

4.1.8 Monitoring and Quality Improvement

The Canterbury DHB has a responsibility to ensure that the health and disability services it funds (both internal and external) are of a high quality. Quality can be improved through a number of mechanisms including:

a) an effective clinical governance structure with a focus on quality services and health outcomes;
b) ensuring the type, mix and manner in which services are funded meet the health and disability needs of the district;
c) providing responsive and culturally appropriate services to consumers;
d) education and training;
e) the coordination of service delivery;
f) collaborative funding arrangements, and
g) pre agreement audits for new services;
h) clear service specifications of services to be delivered;
i) development, implementation and monitoring adherence to standards;
j) development and implementation of quality systems such as clinical audit and credentialling;
k) achievement of Quality Health New Zealand accreditation for the DHB in-house provider and adherence to the Health & Disability Sector Standards for contracted providers. This will include ensuring all mental health providers are compliant with the National Mental Health Standards, through the contractual process.

The Canterbury DHB will actively monitor and assess the quality of services provided by both the DHB in-house provider and contracted providers via service agreements. Monitoring will include appropriate procedures for reporting adverse incidents as well as routine reporting against standards (such as Health and Disability Safety Standards 2001) and processes. The Canterbury DHB will work towards developing a process to enable reporting patient outcomes. The Canterbury DHB will also develop a programme of routine quality audits, service evaluations and ad hoc or issues based audits.

4.1.9 Information Management

Canterbury DHB is developing an Information Management Plan at present which will encapsulate:

1. Adherence to the objectives and priorities outlined in the WAVE report
2. Partnerships with regional health delivery organisations within Canterbury
3. Appropriate partnerships with other South Island DHBs.

Canterbury DHB's Information Management Plan is intended to reflect the contents of the DHB's Strategic Plan and the plans of Canterbury DHB's patient care units that

are currently under development. The plan will flex as these documents are published.

It is acknowledged that Canterbury DHB's ethnicity data collection methods require attention. Alongside the efforts being made to educate in-house provider staff and other providers on procedures and skills for data collection, further systems adjustments required will be done. Information associated with health and disability issues for Māori is also being sought from other organisations such as the Ngai Tahu Development Corporation and Christchurch City Council. This is being fed into the Needs Assessment process.

The Mental Health Information National Collection (MHINC) dataset extract has been established at Canterbury DHB for the last few months. Its accuracy will be monitored using MHINC report feedback via a newly set up MHINC monitoring group. The group will drive the business process changes required to steadily improve MHINC data quality.

Data collection will be undertaken collectively by the Planning and Funding team and the Information Services team of the Corporate part of the DHB.

Collaboration of the DHB with South Island Shared Services Agency Limited (SISSAL), Shared Support Services Group (SSSG) and Health Benefits (HB) in collecting, summarising and analysis of contract information is vital to the ongoing success of the DHB and the sector in providing relevant information for ongoing decision making.

4.1.10 Corporate Services

The Corporate Services of the DHB provides centralised administration services while providing a separation between the "funding" and "in house provider" functions of the DHB (where required).

Corporate Services comprise Legal and Risk Management; Finance, Information Services and Logistics; Communications; Business Assurance and Consultancy (incorporating Internal Audit) and Site Redevelopment.

These departments together with the Kaumatua, General Manager Planning and Funding and General Manager Community and Public Health currently form part of the Executive Management Team.

Relationship Management

4.1.11 Community Participation: Engagement and Consultation Processes

A key objective of Canterbury DHB is to facilitate increased community participation in the assessment, planning and funding of health and disability services in its district. Community is defined as all people in the district. Depending on the matter at hand, the 'community' will sometimes be a regional one (e.g. for the South Island mental

health plan). Community may also be defined at times as a community of interest, for instance where CDHB staff engage in the development of a proposal relation to allocation of service resources.

The CDHB recognises that some individuals and groups have special needs such as disabilities or language barriers for which their participation may require particular supports. People with disability-related needs are included, for example, by offering meetings in accessible venues with relevant supports, such as interpreters. People with cultural needs and language barriers are also catered for based on removing barriers to and encouraging participation (eg, by meeting in mutually agreed premises). We recognise that some members of the community have particular interests such as being service users, staff of the CDHB, contracted providers and others interested in the performance of the health sector in Canterbury. Where appropriate these groups are provided with flexible opportunities to have their say.

Examples of interested groups are:

- people with disabilities
- local government
- rural Mayors
- provider liaison (eg, Pegasus Health/Nurse Maude)
- community providers
- Māori
- Pacific peoples
- Government departments

Efforts to increase participation fall into two main categories: engagement and consultation. Engagement consists of the ongoing, proactive formal and informal ways in which the CDHB facilitates the participation of stakeholders in planning processes and in informing decisions about health and disability services, funding, etc. Exemplifying of engagement is the inclusion of key stakeholders in project work such as the Rural Health Strategy development and in planning meetings relating to Directions 2006. Holding Board and Committee meetings in public also allows for greater transparency and provides opportunities for the public to witness and/or engage in CDHB processes.

The other category is consultation, which is the formal process of making members of the community aware of a proposal such as the draft Strategic Plan or a proposal for the sale of land, giving them sufficient time and opportunities to consider and make submissions on the proposal. The hallmark of authentic consultation is that the feedback of the community is considered before final decisions about the proposal are made. Consultation is required under the Act on the following specific matters:

a) The Strategic Plan;
b) Changes to the Annual Plan; and
c) The disposal of land.

The Canterbury DHB is working to engage and consult actively with the community, including Māori and Pacific peoples.

An initial Community Engagement and Consultation Policy is in place which sets out a range of different processes to be used, including:

a) Hui and other meetings with Māori and Pacific peoples
b) Information sharing, through newsletters, presentations, web sites, workshops, radio and television programmes, and the news media
c) Establishing regular engagement processes with consumers and providers, for both generic and specific issues and services
d) Formal consultation as relevant

The Community Engagement and Consultation Policy will be updated over time to reflect the best approaches to use for this population.

4.1.12 Relationship with Māori

The Canterbury DHB's response to the Treaty of Waitangi will be critical to the success of its activities in relation to Māori. In addition, using a Treaty of Waitangi Framework will ensure that Canterbury DHB activities have a sound basis from which to develop.

The Canterbury DHB wants to engage in an effective manner with Kai Tahu as manawhenua of Waitaha/Canterbury, as well as with Māori of other affiliations living in Canterbury. Regular meetings are held with the Manawhenua Health Group ki Waitaha, which comprises the seven Canterbury runaka and Ngai Tahu Development Corporation. A Memorandum of Understanding is being discussed, and while it will require time to work through the parties' issues, it is regarded as a high priority activity by both parties.

The Canterbury DHB also holds quarterly Māori community consultation hui. These provide a forum for issues to be gathered from the community, and for Canterbury DHB planning to be shared. The meetings are widely advertised within the Māori community, and meeting notes are freely distributed.

The Canterbury DHB continues to enact, in consultation with Māori, appropriate processes to engage with the Māori community and Māori providers. This assists the gathering of information regarding Māori needs, as well as the development of actions and measures that improve Canterbury DHB's responsiveness to Māori health needs.

Canterbury DHB will have a Māori Health Plan which recognises the Canterbury DHB's Treaty obligations to Māori within the framework of the NZ Public Health and Disability Act 2000, and is consistent with the national directions outlined in the Korowai Oranga Māori Health Strategy and its associated Action and Implementation Plans.

4.1.13 Māori Health

The Canterbury DHB has developed a Māori Health Plan. This plan is built up from an overview of Māori Health in Canterbury/Waitaha noting the key accountability requirements. This plan is in line with the selection of Māori Health as a strategic priority of the Canterbury DHB.

The directions and projects in this plan revolve around relationships with Māori, a Canterbury DHB Māori Health Policy Framework, Quality Frameworks, Monitoring, Māori Service issues, Māori Provider Development, Workforce Development, Holistic, intersectoral approaches and accountability. These have been refined through discussion, consultation and needs assessment processes with the Canterbury DHB and are consistent with the Korowai Oranga.

The Canterbury DHB has incorporated the roles of Taua and Kaumatua into the wider organisation's structure. These roles existed within the Mental Health division, and their extension to the entire Canterbury DHB challenges the DHB to commit itself to Māori health gain and to uphold and respect the mana of these positions.

The Kaumatua, Taua and Chief Executive, lead Te Kahui Taumata, a senior management group responsible for ensuring that the Canterbury DHB recognises and respects the principles of the Treaty of Waitangi and actively works to improve the health status of Māori.

The Kaumatua, Taua and Manager, Māori Health play prominent roles in the development of effective relationships between the Canterbury DHB and the Māori communities, including the Manawhenua Health Group ki Waitaha and within the Canterbury DHB between Māori and non-Māori staff, and most importantly, promoting whanau agatanga for Māori staff and promoting cultural leadership mentoring and support.

4.1.14 National and Regional Services

The Canterbury DHB is one of six South Island DHBs that have formed a shared services agency, known as SISSAL (South Island Support Services Agency) to provide some of the needs assessment (epidemiology), health planning and contract management functions required by the DHBs. This agency may also assist to facilitate on matters that have regional and/or national implications, such as the Regional Mental Health Plan for the South Island and national primary care agreements.

As the major centre in the South Island the Canterbury DHB provides secondary and tertiary services to other DHBs (listed in Appendix 2) via a number of historical arrangements. It is also working with surrounding DHBs to undertake joint planning for:

- locally provided services which have linkages with services provided in other districts (particularly in relation to collegial support, training, and transient patient populations)
- services provided by single regional providers across many districts
- services provided only in one district (this district or other districts) which the regional population needs to access
- assisting other DHBs with support functions.

Where Canterbury DHB is the lead DHB for national contracts, we will continue to engage with the affected DHBs and/or providers, as appropriate on matters related to these contracts.

4.1.15 Sector Change Processes

The Canterbury DHB will involve itself in sector change processes through established forums such as Social Policy Interagency Network, Strengthening Families and Healthy Christchurch.

The Canterbury DHB sees collaboration as vital to its future and will create forums with relevant sectors to progress issues, eg with Local Territory Authorities regarding Rural Health.

4.1.16 Intersectoral Collaboration

Forming and streamlining services across agencies such as Accident Compensation Corporation and the Christchurch City Council is a key focus of "Better Ways of Working".

The Canterbury Social Policy Interagency Network and Strengthening Families are examples of groups the Canterbury DHB is actively involved in. The Needs Assessment Advisory Panel has met and will provide more opportunity for agencies and providers to develop relationships focused on improved health care. The initial forum of this group is for information sharing on the needs of the DHB population.

In addition, the Canterbury DHB collaborates with a number of agencies such as the Christchurch City Council, Crown Public Health, Ministry of Education, Police, District Health Boards of NZ, St John Ambulance Association etc.

Canterbury DHB has always had a close and positive professional relationship with Otago University's Christchurch School of Medicine and Health Sciences. Christchurch Hospital is one of the leading teaching hospitals in the country and the School and Health Sciences building has been part of the same complex since 1972. Many Canterbury DHB staff in other hospitals in Christchurch also have a teaching or research role at the School.

In total over 250 Canterbury DHB provider clinicians and consultants and other health professionals play a vital role in New Zealand's health education through their

teaching at the School. DHB staff are an important part of the School's research and development role in the region at graduate and post-graduate levels.

Canterbury DHB clinicians and health professionals are also involved in leading-edge biomedical research through the School. The Canterbury DHB continues to jointly support the University of Otago Research Office and has provided additional funds for research in the area of nursing in particular in the 2002 year.

The Canterbury DHB will continue to foster a positive relationship with a range of other trainees of the medical workforce including the Christchurch Polytechnic, University of Canterbury and others. The training of nurses, allied health professionals and scientists by these institutions is vital in ensuring a well trained workforce and the Canterbury DHB will continue to work constructively with these institutions.

4.1.17 Interface with Accident Compensation Corporation

The main interface with ACC occurs in relation to provider activity. Funder issues generally concern the complex boundary between ACC funded and health funded services. These issues are usually dealt with at a local level.

The range and volume of services funded by ACC has grown substantially over the past four of five years from a very small base to now represent a significant component of provider arm services. Meeting ACC needs for information and individual patient invoicing is a substantial challenge for hospital systems not designed for this application. The management of this now complex and growing relationship provides a considerable challenge.

Canterbury DHB currently has current plans to invest in IT infrastructure to resolve the identified problems. Development needs will be covered in the Information Services Strategic Plan.

Canterbury DHB recognises that ACC has become a major purchaser of health services, and that this role may expand in the coming year and beyond. In recognition of this, Canterbury DHB currently represents all South Island DHBs on the ACC/DHB Liaison Group. The aim of this group is to promote and maintain an overview of service expectations and strategies of shared interest between ACC and DHBs.

4.1.18 Governance Practices

The Canterbury DHB has a commitment to best practice in governance. All board members have received training in governance. The Canterbury DHB has formal public meetings as well as information sharing workshops and training sessions for Board members on such matters as Governance issues and the Treaty of Waitangi.

4.1.19 Arrangements (Board, sub-committees)

All meetings where decisions are made by the Board or any of its major committees are open to the public to attend, as observers. Details of Board meetings (agendas, minutes, attendees are all held on the Canterbury DHB website, www.cdhb.govt.nz).

Members of the community are included on the three statutory committees which report six weekly to the Board. The committees are:

a) Community and Public Health Advisory Committee
To advise the Board on approaches to health improvement for people in the region and give guidance on how best to use available resources to meet the population's needs;

b) Disability Support Services Advisory Committee
To advise on disability support needs of the region's population in order to maximise independence of people with disabilities; (Appendix 4)

c) Hospital Advisory Committee
To advise the Board on the performance of its own hospital and community services.

In addition to the three statutory committees the Board also has the Finance Audit and Risk Committee, which includes a community representative, and the Property Committee, which advise the Board on overall financial governance and property issues respectively.

All these committees continue to meet six weekly or more often as required.

4.2 Allocation of Funds

4.2.1 Needs Analysis

The Needs Assessment has raised the health issues listed below for the Canterbury DHB. In addition to the population trends outlined in section 2 the Needs Assessment shows the following:

- **Māori and Pacific People's Health**
Māori and Pacific peoples have poorer health status then other groups in New Zealand. Māori and Pacific people aged 0 – 74 have much higher rates of avoidable deaths than European/Others: in 1996-97 the Māori avoidable death rate was 2.5 times and the Pacific rate 1.9 times that of European/Others.

Both Māori and Pacific peoples have clearly identifiable health problems, many of which are potentially preventable (for example, smoking status and resultant associated diseases, obesity) or are amenable to early intervention and ongoing

management (such as diabetes, high blood pressure, cardiovascular disease and screenable cancers.

Māori and Pacific people tend to have reduced access to primary health care so that when they do present at the GP or hospital they are sicker, more likely to experience complications and more likely to die.

Both the Māori and Pacific people populations are young – at the present time 34% of the Māori and 33% of the Pacific peoples population in the CDHB area is under 15 and 52% of both populations is aged between 15 and 44. Thus provision needs to be made for culturally appropriate child health and maternity services will have to be made.

In addition, these populations are growing and are likely to live longer in the future (by 2021 for both Māori and Pacific peoples those aged over 64 are projected to make up 7% of the CDHB population, up from 3% at present). Thus there will be more Māori and Pacific people overall subject to diseases that people are more prone to get as they age, such as cancer and diabetes. The CDHB needs to enhance appropriate access to preventive care for all.

- **Smoking**

Not only is smoking an issue for Māori and Pacific peoples health, it is an issue for the Canterbury population: about 21% of all adults smoke regularly and a high number of many teenagers (especially females) are taking up smoking.

- **Cardiovascular Disease**

Cardiovascular disease is the leading cause of death and occurrence of disease in New Zealand. If those most at risk can be detected early and early treatment intervention through primary care can be provided, the incidence and impact of cardiovascular disease should be reduced.

- **Diabetes**

Diabetes is of epidemic proportions in New Zealand: Both type 1 and type 2 diabetes are increasing in incidence across New Zealand but it is the increase in type 2 diabetes that is of greatest concern, particularly among Māori and Pacific people. In the next 20 years, Māori are facing at least a 90% increase in prevalence (rising to approximately 47,000 people); Pacific people are facing at least a 109% increase in prevalence (approximately 18,000) people while Europeans are facing at least a 39% increase in prevalence (approximately 101,00 people).

New Zealand is also facing an obesity epidemic and as diabetes is linked with obesity it is likely that the above forecasts are underestimated.

- **Adult Cancer Rates**

Cancer is the second leading cause of death and a major cause of hospitalisation in New Zealand. Canterbury's cancer rates are similar to the rest of New Zealand. There is evidence much can be done to reduce the cancer burden and improve outcomes through prevention, early diagnosis and good care management. Lifestyle changes, such as improving nutrition, stopping smoking and increasing the level of physical activity will reduce the incidence of cancer.

- **Child Health**

Achieving good child health is vital for later adult health as the risk factors for many adult diseases and the opportunities for preventing these diseases arise in childhood. Poor child health and development also have an adverse impact on broader social outcomes including sexual and reproductive health, mental health, violence, crime and unemployment.

Overall, child health statistics for Canterbury show relatively high rates of childhood illness. Immunisation plays a key role in the prevention of disease. Data on the immunisation rates across the region is fragmented. The Canterbury rate is thought to be over 80%. The most accurate database of children (5-12 years) in place currently in Canterbury is the one held by the School Dental Service.

- **Rural Service Delivery**

Indicative health status information for populations in rural areas of Canterbury shows their health status is considered good compared to other populations, except in a few areas where there are high numbers of low-income elderly people.

About 70,000 of Canterbury's 420,000 people live in smaller rural areas. Access to transport is a frequently mentioned concern.

There are problems recruiting and retaining GPs in rural Canterbury, and although not as severe as elsewhere in New Zealand, this is becoming more of an issue. The key issues are locum coverage and fears by GPs and other health professionals about selling their businesses when they retire. Canterbury also has nine hospitals that are administered by the Canterbury DHB – Kaikoura, Waikari, Oxford, Rangiora, Darfield, Ellesmere, Lincoln, Akaroa and Ashburton.

In addition, a range of home support, palliative care, population health, oral health and other community services are funded. Pharmacies operate in some smaller centres, eg Kaikoura, Waikari. Pharmacists and other health professions face similar succession issues as the General Practitioners.

- **Primary Health Care**

Improved access to primary health care is vital for the achievement of many of the health gain priorities. One of the major barriers to accessing primary health care is cost - both fees and prescriptions, particularly for those in the lower socioeconomic groups.

Other barriers also exist:

- the services provided may be culturally inappropriate
- there may be language barriers
- it may be difficult to get to the service
- it may be difficult to get appointment times after work.

All of these factors contribute to a potential lack of continuity of care so a different health worker is seen each time.

It is believed that if services were organised around the needs of the Māori and Pacific consumers for example, then access would be improved. Services could be delivered through community initiatives and on appropriate sites such as marae, kohanga reo, churches, Māori and Pacific workplaces, sports clubs, and so on.

- **Mental Health**

Around 3% of the NZ population has a serious, ongoing, and disabling mental illness which requires specialist care and treatment. Service levels in Canterbury reach 2.2% for adults and 1.6% for child and youth compared to the 3% benchmark and is therefore required to continue consolidation and investment in mental health.

Research is underway to indicate prevalence of mental illness at a regional or city level in NZ. There is a need to know more about who uses mental health services, which people rely on the services most heavily, and which services are effective in terms of improving the quality of life of the service users. Developments in Primary Care indicate that more can be done in this setting for those with a mild to moderate mental illness.

- **People with Disabilities**

Results from the 2001 New Zealand Disability Survey are only available for New Zealand as a whole. However there is unlikely to be significant regional variation: the results of the 1996/97 survey showed little difference between the four Regional Health Authority areas and the results of the 2001 survey are comparable with those from the 1996/97 survey.

The results from the 2001 survey show that:

- One in five New Zealanders has a disability. The rate for Māori is the same but the rate for Pacific peoples is only one in seven.
- A total of 743,800 people reported some level of disability, an increase of 41,800 since 1996/97. While the overall disability rate is unchanged this 6% increase in the population of disabled people will have consequent effects on service provision for this group.
- Disability increases with age. 11% of children (0 -14 years) have a disability, compared with 13% of young people/adults aged 15 - 44years and 25% of adults

aged 45 – 64 years. 54% of people aged 65 years and over reported having a disability.

- 33% of Māori aged 45 – 64 reported a disability compared with 25% of the total population aged 45 – 64. 61% of Māori aged 65 and above reported a disability compared with only 51% of the total population in this age group. The disability rate for Māori children is also higher (15%) than the national rate for children (11%)
- Little accurate information exists for the rates of Pacific peoples with a disability in Canterbury
- The majority of disabled people have more than one disability.
- Physical disabilities are most common (66%)
- The number of people with mild disabilities has decreased and the number with moderate disabilities has increased
- The number of people with disabilities living in intellectual disability units and mental health facilities has decreased

- **Oral Health and Fluoridation**

Water fluoridation contributes to equity of health outcomes as the benefit of preventing decay is greater for those in lower socio-economic groups, children and Māori and Pacific peoples.

Less than 3% of the CDHB population receives fluoridated water. Using 1996 data extracted from the Wellington and Canterbury Hospitals and Health Services databases for children aged 4 to 13, it was found that for both deciduous and permanent teeth, children living in fluoridated areas had fewer fillings than children living in non-fluoridated areas.

75% of Māori and 84% of Pacific peoples children at age 12 have fillings whereas only 51% of 12 year olds of other ethnicities have fillings.

At least 95% of Canterbury children to the age of 12 are enrolled with the School Dental Service and the remaining 5% is largely composed of people who do not consent to having their child enrolled.

- **Infectious Diseases**

For most of the infectious diseases monitored by Community and Public Health, the Canterbury DHB area is similar to the rest of New Zealand. However mid and north Canterbury have high rates of campylobacteriosis and have had for the last 20 years. Ashburton District in particular has rates for this which are higher than the rest of the DHB area. Ashburton District also has high rates of salmonellosis, leptospirosis, cryptosporidosis and giardiasis – the latter three being diseases which are passed from animals to humans.

- **Waiting times for First Specialist Assessment and Surgical Procedures**

The NZ Health Strategy says 'a key priority for the Government is reducing waiting times for elective (non-emergency) hospital surgery and treatment'. Providing

elective surgery for those people who would benefit the most from treatment helps to improve health outcomes and reduce health disparities.

Canterbury DHB now ranks in the middle of the 21 DHBs in terms of reducing waiting lists. As a percent of throughput, we have about 9% of patients waiting more than six months for first specialist assessment. The range for all DHBs is 0.6% to 26%.

- **Asthma**

Christchurch is one of the urban areas which have been found to have the highest age and ethnic standardised prevalence rates in New Zealand and as such asthma is a serious problem for the Canterbury DHB.

Asthma is the most common cause of child admissions to hospital. Canterbury rates for repeat admissions for asthma for children under 5 are higher overall (6.3 per 100 discharges) compared to the rest of New Zealand (5.8 per 100 discharges), especially for Māori and Pacific peoples children, (9.1 and 6.3 per 100 discharges for Canterbury respectively versus 5.9 and 5.5 for New Zealand as a whole). In part this is a result of barriers to accessing appropriate care, such as cost of doctors visits, costs of pharmaceuticals and culturally inappropriate care which reduce the ability of individuals to self manage and control their asthma.

- **Young People/Youth**

New Zealand mortality statistics show 10-20 year olds to be the only age group not to have had a significant reduction in death rates since 1960. Currently New Zealand's young people have rates of drug and alcohol abuse, suicide/self-harm and adolescent pregnancy that are higher than most other developed countries. The major causes of death and hospitalisation in New Zealand's young people are injury, including motor vehicle crashes and suicide which accounts for 80% of deaths in the 16-24 year olds.

There are sub groups of young people at greater risk, for example young men have significantly higher rates of injury, accidental and intentional, than young women. Access barriers have been identified by youth as being cost of doctors' visits/prescriptions, concerns about confidentiality, embarrassment, distance to travel, inconvenient times, and lack of cultural appropriateness.

There are a number of school based health clinics and youth focus services in the Canterbury district as well as health promotion activities in cooperation with other agencies, in some cases targeting such issues such as sexual health in Pacific peoples, drink driving, mental health, street kids.

4.2.2 Needs Analysis System

The Canterbury DHB's process of Health Needs Assessment (HNA) is an iterative one. Given the tight timeframes for the preparation of the first Strategic Plan, the first HNA was necessarily limited. The goal is to deliver a comprehensive HNA by June 2004. It will include more analysis on issues faced by Māori, Pacific peoples and other groups.

The first HNA contributed to the prioritisation of health priority areas listed by Canterbury DHB in its Strategic Plan. These areas were chosen because of their potential for health gain for the whole population.

In order to develop more comprehensive information sources, and involve other sectors of the community with the HNA process, a Needs Assessment Advisory Panel has been established as noted under 4.1.18. This Panel will advise the Canterbury DHB on the adequacy and relevance of the HNA process as well as provide details on information in the priority health gain areas such as diabetes.

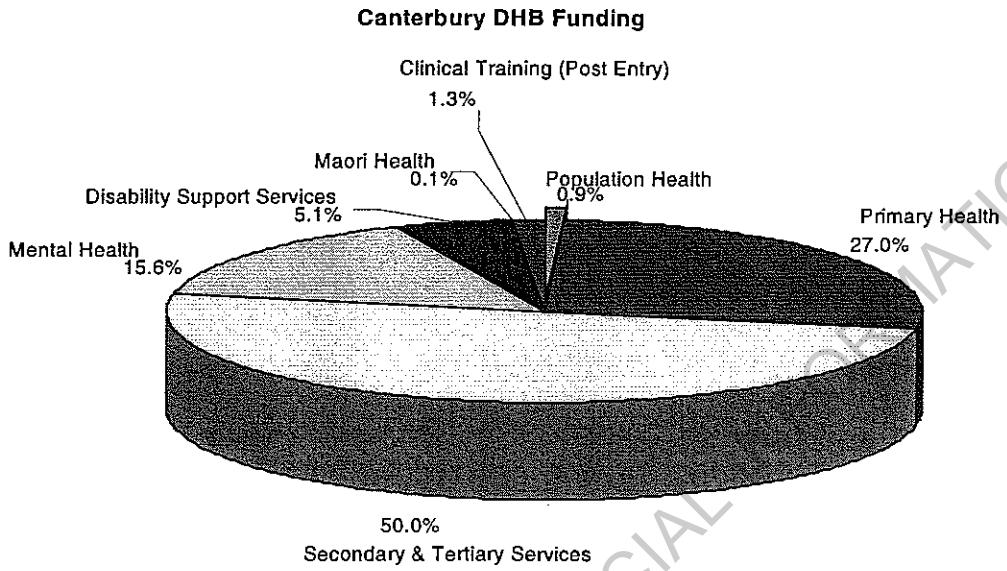
Needs analysis for the Regional Mental Health Plan was shared with South Island Shared Services Agency Limited, in consultation with the Regional Mental Health Network.

In order to improve our analytic capability associated with HNA, we are investigating the option of sharing a health economist with the Department of Public Health and General Practice at the Christchurch School of Medicine.

Over the next two years work will be done to plug the information gaps which currently exist in the HNA. Demographic data will be updated using data from the 2001 Census, further local and national utilisation data will be sought and service gap analysis will be undertaken in the priority areas. This will enable the Canterbury DHB to progress work on the priority areas and determine where changes in health service delivery may occur to achieve the greatest health gains. Links with other agencies such as the Christchurch City Council, Environment Canterbury, Ministry of Pacific Island Affairs and Department of Work and Income will continue to be forged.

4.2.3 Additional Funding Responsibilities

The Canterbury DHB has undertaken a detailed stock-take of the contracts devolved by the Ministry of Health in 2001/02 and is matching these against the key Government and proposed Canterbury DHB health priorities. The following diagram indicates how current funding is allocated in the Canterbury DHB.



Note 1: Includes Brackenridge
Note 2: Excludes funding spent by mainstream services on Māori Health Services
Note 3: Excludes revenue recovered from other parties by provider arm, capability funding.

For 2002/03, the Canterbury DHB will be funding a range of health services which is similar to that of 2001/02 while working towards service re-configuration to ensure that the many key health objectives are achieved.

The only significant change to services funded is the increased elective cardiac surgical procedures in line with recent Government announced increased volumes for the South Island.

The volume schedules for services to be purchased in 2002/03 are attached in Appendix 3.

The Canterbury DHB will continue the process to review existing Māori health services currently being funded in Canterbury and to identify gaps and/or duplication. Canterbury DHB has been working closely with the Ministry of Health Māori staff to ensure smooth hand-over of these contracts. The focus in 2002/03 will be on consolidation and development. The Māori health funding will remain as now and in the future linked to its Strategic Planning process.

The Canterbury DHB will continue to work with the Ministry of Health to access other funds in Māori Health such as those available under the Māori Development Fund.

In 2001/02 and 2002/03 a joint management process has occurred with Māori and Pacific providers to ensure the success of a joint process. The Ministry of Health participated in joint decision-making processes relating to Māori and Pacific Provider Development funding.

Canterbury DHB will continue to liaise with the Ministry of Health and DHBNZ work groups to review the service specifications for these services to ensure that they align to the objective of achieving improved health status for these population groups.

Canterbury DHB is part of the South Island Mental Health Network. The draft South Island Regional Mental Health Plan has been presented to the Ministry of Health for comment before it is signed off by the six South Island DHBs (Appendix 5).

The plan forms the framework for achieving the Ministry of Health's Mental Health Strategy and Mental Health consumers' aims, including further developing the Blueprint benchmarks.

At a regional level the key mental health work areas for 2002/03 are:

1. Regional review of Alcohol and Drug Services.
2. Stocktake of Māori Mental Health Services
3. Implement Regional Forensic Framework
4. Workforce Development
5. Review arrangements for Regional Services provided to other SI DHBs.

Only a limited amount of additional funding is available for additional mental health services in Canterbury in 2002/03. This limited additional funding has been targeted at 2 FTE Clinical Coordinators in Child Services, 2 FTE Māori Community Support Workers and support liaison between secondary services and primary care.

Although some mental health service reconfigurations are required to ensure the Blueprint gaps are closed, Canterbury DHB will be working to maintain existing mental health funding for mental health services.

Workforce Development funding will flow to Canterbury DHB providers, consumers and families following confirmation of a South Island wide approach. This will be based on regional needs identified in the regional strategy, Canterbury DHB HR Strategy and Canterbury DHB Strategic documents.

In preparation for the proposed devolution of Public Health monies from the Ministry of Health, a Memorandum of Understanding has been agreed between the Public Health Directorate and the Canterbury DHB, setting out how the partners will work together to put in place/support, initiatives in Public Health Services that are in line with the Canterbury DHB's vision and proposed Strategic Plan priorities.

The Canterbury DHB is preparing for the devolution of Disability Support Services monies via the Lead DHB project. This will involve meeting the Ministry of Health Capability Criteria for devolution of Disability Support Services monies. If any support service changes are planned by the Ministry's Disability Issues Directorate or Canterbury DHB, not related to the Lead DHB pilot, the Planning and Funding team will engage with the Directorate nationally or locally as relevant to undertake this planning together.

4.2.4 Prioritisation Process

The Canterbury DHB has proposed a set of principles to assist choices about the future funding of health services within the wider context of set Government health and disability policy and health gain areas. The principles are being consulted on as part of the Canterbury DHB draft Strategic Plan. When making decisions about which services to provide and at what level the Canterbury DHB proposes to consider the following decision-making principles:

Effectiveness
The extent to which health and disability services improve (benefit) quality of life, such as:

- The reduction in pain
- The maintenance of current activities (lifestyle)
- The promotion of independence
- The prevention of premature death

The services which produce the most benefit are likely to be of a greater priority. The level of benefit takes into account both the benefit per person and also the number of people benefiting from the service.

Cost
The total costs of services are compared to the effectiveness of those services. This is done to ensure available funding is used to achieve the maximum possible gain.

Equity
The effectiveness of the service in improving the health of disadvantaged groups of people is considered. Disadvantaged groups include those on low incomes, Māori, Pacific peoples and refugee communities.

Māori Health
In making funding decisions, the Canterbury DHB acknowledges the Treaty of Waitangi, and encourages Māori participation in providing and using services. We want to ensure that services are appropriate and accessible to Māori.

Acceptability
The Canterbury DHB will ensure the expectations and values of New Zealanders are considered when making prioritisation decisions.

4.2.5 Service Monitoring

Service monitoring will be in line with individual contractual arrangements. New requirements coming from the Crown Funding Agreement, Service Coverage Document and Operational Policy Framework will be worked into new contracts over time.

4.2.6 Service Outcomes

The Canterbury District Health Board will facilitate timely and equitable access to appropriate health services in accordance with Crown Funding Agreement requirements, through consultation, education, funding, support, and contract management.

In planning, contracting and delivering of services, Canterbury DHB will ensure that the health service outcomes as outlined in the New Zealand Health Strategy and Disability Strategy will be taken into consideration. This includes working with Māori and Pacific communities.

Public (Population) Health Service planning will be done collaboratively with the Ministry of Health Public Health Directorate and Community and Public Health using as its basis the Public Health Services Handbook, noting the responsibility of the Canterbury DHB on statutory issues.

4.2.7 Service Coverage

The Canterbury District Health Board will be funding a range of services similar to 2001/02 and will work towards ensuring that the service coverage requirements of the Operational Performance Framework and Service Coverage Schedule requirement are met within its available funding. Canterbury DHB is also developing processes to:

- Identify gaps and over provision in service coverage, key risks areas, and
- Facilitate the resolution of issues that constrain optimum service coverage.

Canterbury DHB will be maintaining existing mental health funding for mental health services.

4.2.8 Initiatives

New initiatives will be in line with service development plans. These are likely to be in the key health gain areas in the first instance. Ensuring Health Promotion activities are aligned with these is a key goal.

A key expectation is that of improving mainstream services responsiveness to Māori. This will include developing focus in recruitment processes (as in the HR Strategy

Appendix 6), expectations stated at corporate orientation, inclusion of mainstream responsiveness in divisional and provider arm work plans as well as contracts with community providers. In addition an increased focus on this in audit and review processes. This will take time.

The Canterbury DHB is one of the 7 DHBs in New Zealand which has met its requirements to complete a plan on Pacific peoples Health. This was tabled at the May Board Meeting having already gone through Board sub-committees.

The Ministry of Health's Public Health Directorate, Pacific Branch, is coordinating the Pacific Provider Development initiative. The initiative has four key aims:

- To support Pacific provider development consistent with the local DHB's strategy for Pacific health
- To consolidate existing Pacific provider structures
- To support Pacific providers to effectively deliver health services, and
- To build a highly skilled Pacific health and disability workforce

The Canterbury DHB has three providers who have been assessed as eligible to access the Pacific Provider Development Fund in 2001-02, by a panel comprising the Ministry of Health, Ministry of Pacific Island Affairs and the Canterbury DHB. Negotiations will commence with these providers in April to enable implementation of the Fund to proceed.

The initiatives outlined in the Canterbury DHB's Pacific Health Action Plan come under the following headings:

- Support Pacific people as health providers, including increasing the number of Pacific people in the health workforce
- Involve Pacific peoples in health service development
- Accurately collect ethnicity data
- Service development opportunities in Pacific health priority areas
- Establish a Pacific peoples' primary health service
- Help to increase collaboration between Pacific providers
- Pacific information and research initiatives.

These initiatives and associated planned activities are consistent with the directions of the New Zealand Health Strategy and New Zealand Disability Strategy and Pacific Health and Disability Action Plan 2002. The Needs Assessment Project was also used in bringing forward issues for Pacific peoples.

Smaller initiatives are underway in all areas, for example, the Women's Health Division are preparing for the audit of services to be accredited as a Baby Friendly Hospital and local rural community groups are working on initiatives to retain and improve access to health services in rural areas.

4.2.9 Service Reconfigurations

Canterbury DHB will ensure that any changes to services are carried out in an evolutionary process and that appropriate engagement and consultation are undertaken.

In addition to the initiatives around the Primary Care Strategy, Primary Health Organisations and the key health priorities of Child, Diabetes, Cardiovascular Disease, Māori Health, signalled in the Strategic Plan, the other major areas which Canterbury DHB intends to review and/or make changes to in 2002/03 include:

1. Regional review of Alcohol and Drug Services.
2. Home-based support services – secondary and primary referred
3. Mental Health long-term residential services currently provided
4. Palliative Care providers.

The provider arm in particular is implementing service reviews in cancer and orthopaedics.

4.2.10 Efficiency and Technology Gains

There are a number of challenges for CDHB in Information Technology over the next 3 to 5 years. The need for population health information to help funding decisions is new to CDHB. In addition the Provider arm has a number of systems which although functional are fast approaching technical obsolescence (vendors indicating their intention to discontinue support). There are also a number of disparate information systems and related infrastructure that needs to be rationalised. The amalgamation of Canterbury Health and Healthlink South has brought this issue sharply into focus.

In addition increasing number of clinical applications are being computerised and entering into the digital age. An example is the stage 1 implementation of the Digital Radiology Application, commonly known as PACS in Christchurch Hospital Emergency Department. Other clinical systems requiring investment include clinical audit systems, electronic patient referral system, and electronic medical records.

There will continue to be investigation of greater use of telemedicine. Providing email system to rural hospitals is also planned.

CDHB has to make investment decisions in information technology in the context of the wider role as a funder and provider role. Any investment decision needs to be in the context of a regional Information System Strategic Plan (ISSP) which will need to look at better integration of patient records and access by multiple providers in the region. The development of a regional ISSP will require buy in from major stakeholders and the process is underway.

4.3 Providing Services

4.3.1 Introduction

The Canterbury DHB District Annual Plan incorporates planning work in relation to the DHB's Strategic Plan. Directions identified in this document are the focus for the in-house provider in the coming year and beyond.

4.3.2 Provider Objectives

The in-house provider objective is consistent with the Canterbury DHB Vision

"To promote, enhance and facilitate the health and wellbeing of people living in the Canterbury area"

The Canterbury DHB in-house will implement the proposed Canterbury DHB Directions as follows:

Direction 1: Improving the Health Status of our Community we plan to:

- Continue to share key information about the health of the Canterbury population to enable service planning linked to health needs within available resources
- Work with rural communities to improve access to health services
- Implement relevant parts of the Canterbury DHB's Disability Strategy Action Plan
- Contribute to planning the Canterbury DHB in the agreed priority areas and areas of other ongoing important work
- Work to improve information collecting systems that will contribute to prioritisation.

Direction 2: Finding Better Ways of Working: Effective Policy and Funding Frameworks

- Contribute to plans and activities that develop and strengthen relationships with key agencies.
- Ensure health promotion programmes link with priority health gain areas.
- Communicate with staff and community to ensure they are informed about the in-house providers aims, challenges, resources and achievements and they have an opportunity to have input.
- Develop a partnership for decision making in the services between staff
- Implement checks to help ensure elimination of waste and avoid duplication of effort.
- Continually review processes to ensure standards are met and streamline infrastructures.
- Implement a concept of devolution of responsibility, increasing the power of staff to make decisions about their work within agreed parameters and boundaries.

Direction 3: Working Together: Innovative Models of Service Integration

- Continue to work with other health providers to ensure the right health services are provided at the right time and in the right place to meet the health needs of the people of Canterbury
- Continue to work on joint projects which involve other health care funders and providers, community groups, social agencies and local authorities towards improving the health of the people of Canterbury, eg the Healthy Christchurch programme and the Elder Care Canterbury project
- Implement relevant recommendations from the Canterbury DHB Rural Action Plan and other Action Plans that arise from Strategic Plan work
- Continue to work with tertiary education providers and researchers, such as the University of Otago's Christchurch School of Medicine, the University of Canterbury and the Christchurch Polytechnic, on projects which will benefit the training of the health workforce and the health in-house provider workforce and the health of the people of Canterbury.

Direction 4: Developing Canterbury's Health Care Workforce we plan to:

- Work with the workforce and health sector unions in a partnership to address significant issues affecting staff and the way we work
- Continue to provide ongoing planning and development programmes to enhance career pathways for staff and provide leadership opportunities, particularly Nurse Practitioners and second tier nurses
- Continue to work towards providing the right number and mix of skilled staff to provide quality health services; this includes the development of new health professional workforce groups
- Implement strategies for greater participation by Māori and Pacific peoples in the health workforce through recruitment and development initiatives within hospital and community services
- Increase training for DHB in-house provider staff in Māori health issues
- Improved links with secondary and tertiary education training providers to influence curriculum and source graduates
- Implement innovative strategies to attract and better retain staff
- Ensure Clinical Training Agency education funds are accessed and utilised fully each funding period by October for in-house provider staff
- Create a family friendly workplace; investigate another staff creche by June 2003
- Implement workforce strategies which acknowledge an ageing staff
- Support and participate in Government initiatives to address workforce issues
- Continue to develop information systems to improve the collection on information on the workforce
- Target areas with critical shortages of staff
- Ensure staff are familiar with occupational safety and health protocols.

Direction 5: Being a Leader in Hospital and Health Care Services

- Develop service plans that integrate community and hospital services in particular so that we continue to improve patient care
- Compete a comprehensive facilities plan based on service plans for other individual service areas by December 2003
- Work with other South Island District Health Boards to further develop specialist hospital and community services available to patients throughout the South Island
- Work to ensure waiting lists are managed to meet Government objectives for waiting times so the people of Canterbury receive surgery within an appropriate period
- Continue to work with health care training providers on developing programmes to make Canterbury a leading health workforce training and employment centre
- Develop a flexible approach to retain skilled staff within our hospitals
- Work at a national, regional and local level to find solutions to service pressures eg access to radiation oncology.

4.3.3 Provider Resources

Canterbury DHB has recently developed a Strategic Direction document for Human Resources (Appendix 6).

Key to this is developing a management style that is more open, inclusive and transparent and that fosters a true partnership between staff, and between staff and management.

The strategy for Canterbury DHB includes developing and growing the total health care workforce, working closely with unions and staff, improving relationships with community and tertiary education and training providers and implementing strategies for greater participation by Māori and Pacific peoples in the health workforce. Specific strategies which have been identified to meet these constraints and issues include:

Strategy 1:	Leading professionals
Strategy 2:	Learning & Growing People
Strategy 3:	Develop initiatives that ensure CDHB and providers have the workforce(s) to support a changing health environment.
Strategy 4:	Develop innovative recruitment strategies to attract workforce
Strategy 5:	Employee Development strategies
Strategy 6:	Support and participate in Government initiatives to address workforce issues
Strategy 7:	Work jointly with other DHBs on workforce issues
Strategy 8:	Working with unions and staff
Strategy 9:	HR Policies which support devolvement
Strategy 10:	Occupational Health and Safety

Increasing the participation of Māori and Pacific Peoples in the workforce are key focuses of the DHB Pacific Peoples Action Plan and Māori Health Strategy.

Initiatives following a difficult industrial round to improve relationships between the employer and employees involve a Chief Executive's communication group and annual culture survey.

4.3.4 Planned Financial Performance

The three year financial performance takes CDHB from an operating loss of $11.5M in 2002/03 to a breakeven position in 2004/05. The ability of CDHB to keep to the budgeted operating result over the three years is based on a number of key assumptions affecting revenue, operating expenditure and efficiency initiatives.

Revenue is based on the three year funding package received from the Ministry of health and adjusted for a further $1M in 2002/03 for finalisation of 2001/02 risk pool funding.

Increasing pressure on expenditure is assumed and is offset in part by efficiency that needs to be met to achieved to budgeted operating results. Efficiency initiatives will focus on both In House Provider expenditure as well as payments to External Providers. See section 4.2.10 for further comments on efficiency initiatives.

With the bulk of available capital expenditure targeted for the Christchurch Women's Hospital and Day Surgery Unit other replacement investments in hospital assets building, equipment, plant and information systems) will be a major challenge. Replacements of hospital assets will be assessed in the light of any changes to service provision. Once the need to replace has been confirmed, options of funding these assets replacement will need to be explored.

4.3.5 Planned Investment

a) **New Women's Hospital & Day Surgery Unit**
The new Women's Hospital and Day Surgery Unit, which has been in planning for sometime, has now started construction.

The project remains within programme for March 2005 occupation.

b) Facility Master Planning

A Facility Master Plan for the Canterbury DHB's hospitals is currently being developed. The Facility Master Plan will link with the strategic plan for the Canterbury DHB. The first stage of this Facility Master Plan, which included the identification of the existing data and details about each hospital has been completed. Stage Two will involve a clinical review of all hospital services, which will identify the future direction of the service along with any areas of improvement or change. Stage Three will identify areas of redevelopment and an action plan will be put in place to deal with the priority projects identified after appropriate consultation with staff and the wider community. This process involves an overview of service needs across the DHB involving NGO and other providers. The Child Health Report is an example of this.

c) Burwood Hospital

The majority of urban population growth is occurring in the north of the city, where Burwood Hospital is located. Burwood has grown in strategic importance in overall health delivery plans and as a result there is a need for further development.

The Burwood Hospital campus contains a mix of mostly very old and inefficient facilities and a few modern facilities. The old wards do not meet today's expected standards for patients and staff.

During 2000 a redevelopment plan for Burwood was developed to address the facility problems. Stage 1 of the redevelopment has seen the demolition of the oldest patient area within Burwood built in 1915. A purpose built, 30 bed, rehabilitation ward has replaced this, and in addition, a new main entrance encompassing patient admission and administration area has been constructed to give a focal point for the campus. The Spinal Unit is being refurbished to create en-suite bathrooms and improved facilities for patients and staff.

The Stage One projects were chosen on the basis they would be unaffected by decisions on the long-term future of elective surgery at Burwood Stage 1 represents the first step in a modular master plan for the campus.

d) The Princess Margaret Hospital and Hillmorton Hospital

A $45 million site redevelopment project, which encompasses both The Princess Margaret Hospital and Hillmorton Hospital (formerly Sunnyside Hospital) has been completed. This redevelopment has significantly improved outdated facilities for patients, their families and staff. These improved facilities provide enhanced quality patient care and improve patient privacy and safety. The new Hillmorton facilities will assist in the destigmatisation associated with Mental Health services on this site, especially once the old Grey Building is demolished.

e) Relocation of Alcohol and Drug Services

Alcohol and Drug Services are spread over a number of new sites. As part of wider facilities planning, future site options are being looked at with a view to bringing parts of the service together.

f) Workforce Development

The Canterbury DHB HR Strategy (Appendix 6) as noted above includes details on key projects in the in-house provider.

The Canterbury DHB Pacific Peoples Action Plan and Māori Health Strategy include workforce actions to involve Māori and Pacific peoples as well as increase capability. The in-house provider, through the South Island Mental Health Network, will undertake activities associated with the Mental Health Workforce Development Strategy and funds.

g) Information

The emphasis on information provision over the past five years has been on providing clinical staff with data on service performance. This is centred on monthly reports on throughput volumes and costs at specialty level. The process of actively reviewing this information is now being improved both at department and hospital level. A Clinical Leaders Forum has been introduced which brings together clinical directors, charge nurses and department heads on a monthly basis to examine and discuss performance measures for the hospital.

A significant information activity has been the provision to general practitioners of admission, treatment and discharge information for their patients on a daily basis.

Information systems identified for acquisition in 2002/2003 include a standardised multidisciplinary clinical audit package, an enhanced nursing dependency system and greater access to hospital databases for general practitioners.

The introduction of the Healthlinks Information System and various Discharge Planning projects has assisted both Older Persons Health and Mental Health in meeting both internal and external reporting and system requirements.

Women's Health Division intends to "Review and improve all processes of information for patients regarding their treatment" and will work towards achieving this within the next financial year. They recognise the need for community clinicians and hospital staff to also have information so they are better informed when talking with patients. Efforts to improve current

practice in this area are underway.

4.3.6 Service Planning

4.3.6.1 Overview of Services

The Canterbury DHB provides services (In-house Provider Organisation Chart Appendix 7) mainly to the people of the North and Mid Canterbury districts. A range of secondary and tertiary services (see Appendix 2) are provided to people living throughout the South Island and in some cases to people who live throughout NZ. Inpatient and outpatient services are provided from a number of facilities and sites and by teams in the community including the following:

Christchurch Hospital services as follows, as well as teaching and research:	
Medical Services	**Surgical Services**
• General Medicine • Cardiology/Lipid Disorders • Endocrinology/Diabetes • Respiratory • Rheumatology/Immunology • Infectious Diseases • Dermatology • Gastroenterology • Oncology • Nephrology • Clinical Haematology and Bone Marrow Transplant • Neurology • Paediatrics • Paediatric Oncology • STD/Sexual Health • Hyperbaric Medicine	• General Surgery • Paediatric Surgery • Vascular • Cardiothoracic • Orthopaedics • Otolaryngology • Ophthalmology • Dental • Neurosurgery • Urology • Plastic Surgery • Cardiac Surgery

General Services	**Peri-Operative Services**
• Emergency • Investigations (day medical) • Outpatients • Anaesthesia • Intensive Care Unit	• Operating Theatres • Recovery Ward • Day Surgery

Princess Margaret Hospital – Older Persons Health
• Assessment, Treatment and Rehabilitation Services for Older Persons (includes inpatient, outpatient and community) • Psychiatric Services for the Elderly (community and inpatient) • Some specialised mental health services • Meals on Wheels • Community Therapy Services • Needs Assessment/Service Co-ordination

Womens Health
• Acute and Elective Gynaecology Services • Primary, Secondary and Tertiary Obstetric services • Neonatal Intensive Care Services to Level 6 • Pregnancy Terminations (Lyndhurst) • Primary Maternity Services: Lincoln Maternity, Rangiora Hospital and Burwood Birthing Unit

Burwood Hospital, provides physical rehabilitation and surgical services, and is the base for a range of community services, including wellchild services and public health nurse services.
• Spinal Injuries Unit (tertiary care for the population from Hamilton, south) • Musculoskeletal Services • Brain Injury Rehabilitation Services • Well Child Community Services • Cardio-respiratory rehabilitation • Orthopaedic Rehabilitation Services • Burwood Birthing Service • Elective Orthopaedic Surgery • Public health services

Princess Margaret Hospital – Mental Health
• Assessment, Treatment and Rehabilitation Services for Older Persons • Psychiatric Services for the Elderly • Meals on Wheels • Child and Youth Services • Adult Specialty Services • Mental Health Community Services (based for range of) Mental Health Rehabilitation

The Hillmorton Hospital – Mental Health

- Forensic Services (Regional)
- Acute Psychiatric Services
- Alcohol & Drug Services
- Long Term Care Unit
- Assessment, Treatment and Rehabilitation Unit
- Psychiatric Services for Adults with an Intellectual Disability
- Intellectual Disability Assessment Treatment and Rehabilitation

A number of community based services and mobile teams provide mental health services (including Alcohol and Drug services) throughout Canterbury.

Ashburton Hospital and Community Services

- General Medicine, including palliative care
- General Surgery
- Maternity Services
- Assessment Treatment and Rehab Services for the Elderly
- Long-Term Care for the Elderly including specialised dementia care.
- Diagnostic Services
- Community Support Services :
- Day care services
- District Nursing
- Home Support
- Meals on Wheels
- Clinical Nurse Specialist in Respiratory, Cardiac Education, Stoma Therapy

Rural Hospitals at Akaroa, Darfield, Ellesmere, Kaikoura, Oxford, and Waikari provide the following services :

- General Beds (acute minor trauma, post-acute, post operative, relative relief, long-stay and palliative care)
- Maternity Services (normal childbirth services)
- Meals on Wheels
- Facilities for other community based health care providers and groups

Other Services

These include Diagnostic and Support Services which are located primarily at the Christchurch Hospital site and include high quality diagnostic testing to support the secondary and tertiary services provided by the in-house provider. These Diagnostic Services are also used by a range of providers and other DHBs. Other support services are also provided from the Christchurch Hospital site.

Diagnostic Services	Support Services
• Pathology • Radiology • Nuclear Medicine • National hormone assay service • ECG • Respiratory laboratory services	• Clinical Pharmacology • Pharmacy • Medical Illustrations • Medical Physics and Bioengineering • Patient Appliances • Specialist Equipment Maintenance • Sterile Supply • Allied Health Services

The School and Community Dental Service operates out of 162 dental clinics in South, Mid and North Canterbury.

4.3.6.2 Planning Objectives for 2002/03

CHRISTCHURCH HOSPITAL		
Objective	**Measurement**	**Target**
Organisational infrastructure To implement an organisational structure that supports the principles of: - clinical governance; - effective risk management; - aligning accountability with responsibility; - devolved decision-making; - adding value through multi-disciplinary teamwork; - responsiveness to patient's needs; To embed organisational processes that support these principles.	Review the organisational service infrastructure to ensure that the development and maintenance of a multi-disciplinary team based approach to patient care is enhanced. To achieve the specified milestones in the Accreditation Preparation Plan. To implement clinical audit processes consistent with the clinical audit implementation plan. To implement the 14 sub-projects of the Theatre Review so as to improve patient satisfaction and increase the effectiveness and efficiency of patient care. To implement Canterbury DHB policies on integration with other providers including primary health care providers and NGOs to ensure better health outcomes for the community.	Implement review recommendations Various Dates Ongoing from June 2002 June 2002 Ongoing
Service Delivery To ensure that demand for acute non-deferrable services is met. To deliver elective surgery and First Specialist Assessments consistent with the expectations of the Ministry of Health (See section 6) Improve access of Māori and Pacific Island children to Public Health nursing	To work collaboratively with hospital and community providers to ensure that sufficient capacity exists to manage peaks in acute service demand, with a particular emphasis on winter such as Working for Winter group. Appointment of a joint Pacific Island/DHB worker Appointment of a Māori Public Health Nurse	Ongoing July 2002 December 2002

CHRISTCHURCH HOSPITAL		
Objective	**Measurement**	**Target**
Health Strategy Goals To integrate the NZ Health Strategy NZ Disability Strategy and others into service delivery.	To actively participate in the Asthma Disease Management Project and implement associated evidence based guidelines.	December 02
	To work with the MoH to implement the recommendations of the MoH national working parties in Radiation Oncology, Haematology and Medical Oncology.	Ongoing
	Implement relevant recommendations from Canterbury DHB Child Health Report, Māori Health and Pacific Peoples Action Plan and subsequent CDHB Strategies.	Depends on recommendations
	To develop a Clinical Services Plan for Oncology	October 2002
	To develop a Clinical Services Plan for Orthopaedics	October 2002
Hospital Planning Ensure the asset infrastructure meets the projected service capability requirements over the next decade.	To undertake a comprehensive facility audit and ten year facility planning process for the campus.	Complete December 2002
	Implement PACS radiology to eliminate imaging duplication and lost time.	Stage 1 complete

THE PRINCESS MARGARET HOSPITAL (OLDER PERSONS HEALTH)		
Objective	**Measurement**	**Target**
To develop professional leadership and clinical expertise amongst staff whilst ensuring ongoing recruitment and retention of skilled staff	Workforce plan developed	August 02
	Project groups developed; • Education/training plan includes collaborative approaches to expertise and resources	November 02
	• Succession Planning strategy identified	February 03
	• Collaborative recruitment and retention strategies exist regionally with some national initiatives in place.	June 03
	Professional accountability models operate for each profession	July 02
	• Staff competency levels are defined.	June 03
	Credentialling completed	December 02
To manage available resources and maintain clinical accountability for them	Maintain and enhance MOH/ACC Revenue stream	ongoing
	Total length of stay across the organisation's sites/services is measured and information used to adapt service delivery as necessary	June 03
To ensure patients are provided with quality health services and care that are seamless and culturally appropriate	Review quality framework in preparation for achieving Accreditation	August 02
	Implement Clinical Audit System	June 03
	Implement Healthlinks Computer System	June 03
	Treatment/care plans are multidisciplinary and incorporate focused goals	Ongoing
	Improve delivery of culturally safe care for Māori and Pacific Island patients	June 2003 and ongoing

THE PRINCESS MARGARET HOSPITAL (OLDER PERSONS HEALTH) CONT....		
Objective	**Measurement**	**Target**
	Discharge planning project implemented and action plan developed	June 03
To develop organisational structures and teams that encourage shared values and strong partnerships	Clear decision making on professional and line management issues. Decision making structures reflect best use of the talents and resources of Older Persons Health employees.	Review August 02 Review December 02
To continue to influence health and social policy so that the needs and expectations of older people remain central to service development and delivery.	Health promotion and prevention programmes are supported Seasonal planning includes all providers and the wider community Strategic planning has consumer input. Support and participate in the work of the Ministry to review and advocate for older people by participating in national health committee reviews. Support research that enhances outcomes for older people. Elder Care Canterbury Lead DHB initiatives are encouraged and supported within resource allocation.	Ongoing Annually Ongoing review Ongoing Review annually
To continue with integration with Primary Health Care providers through Elder Care Canterbury project	Contribute to LinkAGE project for the Continuum of Care of elderly people	Initial project complete June 2003

WOMEN'S HEALTH		
OBJECTIVES	**MEASUREMENT**	**TARGET**
Review quality framework in preparation for accreditation process.	Review completed.	October 2002
Review of clinical services particularly in regard to sub-speciality mix.	Review completed including plan for future direction of clinical services.	December 2002
Implement computerised clinical audit system.	System installed.	Installation by June 2003
Develop Clinical Director role leading to an effective system of clinical governance.	Consultation with medical staff, development of appropriate CD job description, identification and actioning of training and support needed. Key elements central to clinical governance implemented.	June 2003
Preparation for Site relocation	Work completed as per staged dates.	Ongoing
Review quality and appropriateness of information provided to WHD patients	Work progressing on implementing recommendations.	June 2003
To increase focus on the cultural appropriateness of all services particularly for Māori.	Work progressing on implementing guidelines contained within document: Māori Policy Register.	Positive feedback at Annual Hui (February 2003).
Strengthen links to Pacific People and refugee and migrant people representatives.	Staff attendance at forums focussing on cultural awareness as part of overall provision of health services.	June 2003.
To identify synergies with other providers which will improve service delivery and enhance the continuum of care.	Implementation of opportunities identified by the review underway.	June 2003.
To achieve Baby Friendly Hospital Initiative (BFHI) status.	Pass survey first time.	Achieve BFHI status by December 2002.

BURWOOD HOSPITAL		
OBJECTIVES	**MEASUREMENT**	**TARGET**
Implement recommendations from accreditation process	A process to be in place to address all recommendations	100% compliance by September 2002
Implement framework for clinical governance system	Recommendations of Clinical Governances Review implemented	All processes and structure in place by December 2002.
Implement Stage 1 of facility plan	Complete works as per staged dates	October 2002
Maintain and enhance MOH/ACC revenue stream	Value of current contracts	Increase in contract value
Review discharge planning process	Project leader(s) identified Project plan developed Project completed	October 2002 March 2003 December 2003
Workforce Planning To review Workforce Development Plan for Māori staff	Project group set up to analyse and report	Projections and recommendations reviewed by March 2003
Enhance patient and family knowledge of the rehabilitation process	Access to Allan Bean Centre resources measured	Review June 2003
Implement Māori Quality Plan	As per plan linked to Canterbury DHB Māori Plan	As per plan

SCHOOL AND COMMUNITY DENTAL SERVICE		
Objective	**Measurement**	**Target**
Increase the % of children receiving diagnostic radiography		20%
Increase Pre-School enrolment In relation to pre-school population		65%

MENTAL HEALTH SERVICE		
Objective	**Measurement**	**Target**
Gain advantages of Healthlinks (clinical information system.)	Percentage of documents on the system.	100% Review December 2002
Begin co-ordinated workforce projects for South Island as part of Mental Health Workforce Development Plan.	Projects delivered on time and within budget.	Project management
Centralise recruiting	Staff vacancy numbers Turnover in nursing numbers	Maintain budgeted FTE levels at 96%
Review Service in terms of CDHB Provider Arms responsibility as specialist service	Review completed on time and involves NGO and other sectors.	Understand what specialist services provider arm should provide by December 2002
Review roles in supervised accommodation	Review recommends achievable plan for the CDHB	Review completed by July 2002. Implement any reconfiguration of services as relevant
Agree and action projects within Access Canterbury Agreement	Better integration with GPs	Projects delivered on time within budget and to standards within agreement

ASHBURTON HOSPITAL AND COMMUNITY SERVICES		
Objective	**Measurement**	**Target**
Rural Health Provide input into rural health plan	Rural health plan contains measures by which provider arm can support. eg. support for GP practice, specialist and allied health outreach services	December 2002
Health Service Accreditation	Successful re-accreditation of Ashburton Health Services (Ashburton Hospital and Tuarangi Home)	July 2002
Development of clinical service plans for services of Ashburton	Plans developed that provide direction for service development over next 5-10 years	December 2002
Develop draft Health Plan for clinical services and facilities at Ashburton	Follows on from clinical service planning	June 2003
Complete transfer of Oxford and Kaikoura Hospitals to ACHS Division	Administrative functions, budgets and management strategies finalised	September 2002
Commence development of clinical service plans for 'rural' hospitals	Clinical service plans in draft form prepared for Akaroa, Darfield, Ellesmere, Kaikoura and Waikari Hospitals services and relevant community services. NB Kaikoura may accelerate	June 2003
Health Service Accreditation	Successful re-accreditation of Akaroa, Darfield, Ellesmere and Waikari Hospital. Successful first Accreditation of Kaikoura and Oxford Hospitals.	December 2003
Finalise Clinical Plans for Rural Hospitals	Finalise clinical service plans with final approval for Akaroa, Darfield, Ellesmere, Kaikoura, Oxford and Waikari Hospitals.	December 2003
Develop Health Plans for clinical services and facilities at Rural Hospitals	Health Plan finished and developed for hospitals and associated services at Akaroa, Darfield, Ellesmere, Kaikoura, Oxford and Waikari Hospitals	December 2003

4.3.6.3 Service Changes

The following areas of child health, cardiovascular (heart) disease, diabetes and Māori health represent where service developments in these areas will occur in in-house provider in line with service reconfigurations/expansions will generate significant potential for gains in health and wellbeing. The following tables outline the issues and what we propose to achieve in these health areas.

Child Health

- Implement an action plan from recommendations of the Child Health Strategy Report. This includes working to ensure child health services are culturally appropriate.
- Continue to work with other child health providers and other agencies to provide services that are centred on supporting children and their families
- Continue to promote healthy lifestyles for children including healthy eating and physical activity programmes
- Facilitate opportunities for the continued development of Māori and Pacific.

Cardiovascular Disease

- Work with other providers who promote health messages related to physical activity, healthy eating, obesity and smoking cessation
- Support programmes that support prevention, early intervention and ongoing uptake of services
- Contribute to a review of cardiovascular services and implement relevant parts of the resultant action plan to ensure they best meet the needs of the people living in Canterbury noting:
  - use of guidelines for cardiovascular disease and cardiac rehabilitation guidelines
  - interfaces between primary and secondary care
  - services for Māori and Pacific peoples and determine barriers to accessing mainstream services
  - cardiac education
- Improve coordination between Māori provider and mainstream organisations
- Link with national strategic work in the Māori Health Strategy and Pacific Peoples Health and Disability Action Plan.

Diabetes

- Following a CDHB review of the provision of diabetes services, implement the relevant aspects of the review
- As part of the above and Child Health work review secondary services for children with diabetes to ensure they have access to appropriate care
- Work to improve retinal screening provision. Reduce waiting list by half by December 2003
- Work to ensure that diabetes services are culturally appropriate

- Work with Māori and Pacific providers and communities to support prevention, early intervention and ongoing uptake of services
- Promote healthy lifestyles internally and to other providers which will lead to a decrease in the risk factors (unhealthy eating, being overweight, lack of physical exercise) which contribute to Type 2 diabetes

Māori Health

- Work closely with Kai Tahu, as manawhenua of Canterbury, as well as with Māori with other community and tribal affiliations in developing our strategies and action plans for improving Māori health
- Continue to improve Māori participation in service planning and in the health workforce
- Increase training of provider arm staff in Māori issues in 2002
- Work with Māori communities and Māori providers to support health promotion and education, early intervention and ongoing uptake of services

Community Consultation

A key objective of Canterbury DHB is to facilitate increased community participation in the assessment, planning and funding of health and disability services in its region. To achieve this, the in-house provider will work to actively consult with the community as required over service developments.

As part of the DHB, the provider arm has an obligation to provide information on decisions, to make submissions available and to explain how decisions were reached.

Integration: Working Together

Integration initiatives focus on best outcomes for patients and not on what is best for individual providers. As part of the Canterbury DHB the provider arm will work with other health care providers, including rural providers, to ensure that integrated services result in improved health outcomes for the Canterbury community. This will include systems to help ensure that the right clinician is in the right place with the right skills providing the right treatment at the right time.

The Elder Care Canterbury, Access Canterbury and other initiatives will continue. New initiatives will start associated with work in key areas.

Waiting Lists/Elective Surgery

In line with the NZ Health Strategy the Canterbury DHB will work towards a system that will reduce waiting times for elective (non emergency) surgery. To facilitate this, an Elective Services Steering Group has been set up. This group is the result of meetings between the Canterbury DHB, Independent Practitioners Association and the Ministry of Health. This is a small high level group chaired by the Chief Executive which will not be involved in operational matters rather ensuring that the appropriate groups are addressing issues and blockages in the system.

Operationally, a group of clinicians and management staff will address elective services issues and report to the Steering Group.

Four key objectives for reduced waiting times are:

a) The continuation of existing joint projects with primary care providers that are focused on clinical situations resulting in secondary care referrals plus the expansion of these projects to other clinical areas

b) Ensuring that patients with the greatest need and ability to benefit are offered treatment first

c) Providing a smooth and timely pathway through to treatment; and

d) Ensuring that the best care and support available is provided to patients seeking elective surgery.

No volume shifts are planned currently. There will be consideration to improve the overall provision in the 2002/03 year. The Canterbury DHB will use its best endeavours to reduce the length of the waiting lists and meet Government targets.

Rural Health Co-ordination

The Canterbury DHB has adopted a Rural Health Action Plan which includes actions for the provider arm associated with improving access to services by the rural community. The provider arm will work towards improving discharge planning and liaison with rural health and disability providers and people who need services.

Co-ordination within the provider arm of the Canterbury DHB is effected through various forums and communication systems. Regular inter-divisional meetings are held between professional and functional leaders eg General Managers, Directors of Nursing, Clinical Directors, Quality Managers, Human Resource Facilitators, etc. Within Christchurch Hospital a divisional management team comprising chiefs of medical services, director of nursing and heads of the major support functions, meets weekly to monitor and lead the operational aspects of the service. This group is supported by a system of medical, nursing and administrative leadership.

A review of the Christchurch Hospital management structure has recently been completed with proposals put forward will enhance the delegation of responsibility to clinical staff organised into service clusters.

It is proposed to devolve a degree of budgetary control to cluster level (Clinical Director, Nurse, Manager) to improve accountability. The exact details of delegations is yet to be confirmed.

Plans are also well advanced to introduce a system of Clinical Governance to give clinical staff the oversight of quality improvement and risk management as they relate to patient care.

Older Persons Health will continue to ensure the efficient co-ordination of services both across Hospital sites and within the wider community.

Women's Health Division is involved in several joint working parties with Pegasus aimed at improving co-ordination of services for women with gynaecological conditions.

A pilot service agreement between Pegasus and Women's Health Division is already in place for the provision of pregnancy, labour and birth and postnatal care.

The withdrawal of Ashburton based Obstetric and Gynaecology services has encouraged Women's Health Division and Ashburton to join forces to ensure women of Ashburton and surrounding rural areas are not penalised by this. Women's Health Division clinicians will regularly hold clinics in Ashburton and refer patients to Christchurch Women's Hospital for surgery.

Women's Health Division is also putting greater emphasis on understanding the needs of patients using our services and increasing liaison with community groups who represent various foci, as a way to break down barriers between the hospital and the community.

Mental Health Services will continue to involve the wider NGO sector and primary care (including alcohol and drug providers) in service developments.

4.3.7 Other Health Services Provided by Canterbury DHB

These are the Community and Public Health and Brackenridge Estate.

4.3.7.1 Community and Public Health

Community and Public Health provides a range of population/public health services in Canterbury, South Canterbury and the West Coast including:

- Health protection
- Health promotion
- Māori health promotion
- Medical Officer of Health

Crown Public Health ceased to be a company in November 2002 but the Canterbury DHB will provide services to Canterbury, South Canterbury and West Coast. Overview of their services is included in Appendix 8. The role and focus of Community and Public Health is seen as key to the workings of the DHB and as such their work has been reflected in the Directions and activities throughout earlier part of this document.

Key aspects of their plan for 2002/03 include:

Provider Objectives 2002 - 2003

1. Align services to reflect health priorities as contained in the three District Health Boards' strategy plans
2. Promoting preventative approaches to health issues within District Health Boards and their activities
3. Focus on working in a "joined up" manner with local authorities/ communities/and other social service providers (e.g. Mental Health Foundation, Pegasus, social service providers)
4. Develop enhancements of Community and Public Health infrastructure (Quality, Workforce Development, Performance Appraisal)
5. Position ourselves in the changing environment of health protection to optimise opportunities.

Funding (3 year)
Community and Public Health's core contract with the Ministry of Health continues until 30 June 2003. A small path increase is anticipated for this financial year. The level of increase has not been indicated at this stage, possibly in the region of 1%. Small extra contracts are expected to continue through until 30 June 2003.

Public Health – Participation in initiatives
The major intersectoral initiative the DHB is participating in is the development of Healthy Christchurch. This initiative involves many major government entities, local bodies, research institutes and iwi as well and approximately 120 community groups. While still in its formative stages this initiative presents a powerful vehicle for strong intersectoral approaches to health in its broadest sense into the future.

In addition to this involvement there is an ongoing involvement and support for many smaller intersectoral projects including "Stay on Your Feet" programme developed as part of Elder Care Canterbury (an umbrella intersectoral project for many collaborative initiatives).

Service Configuration
Community and Public Health will be reviewing service configuration across the three regional areas covered by Community and Public Health to ensure the best alignment with both national and regional health priority areas. The review will be carried out with both Ministry and DHB input and will tie in with contract renewal due 2003. Further details on how the review will be managed can be found in Community and Public Health 2002/03 Strategic Plan (Appendix 8).

Human Resources
Human Resources are currently static, although there is a possibility of extra funding in Smokefree and Nutrition in the next twelve months. The Collective Employment Agreement continues until 31 December 2003. There will be no percentage

increases until this time, however there are automatic step increases within the Agreement. These increases are covered through budgeting and path increases.

Physical Capacity
There is sufficient physical capacity to meet the needs of our contracts.

Financial
There is an expectation that funding will not be exceeded by expenditure.

Service Planning
The three year Service Plan is reviewed annually with the Ministry of Health. The process for this year's review has been agreed to be one of continuing projects already underway and with a collaborative approach being applied over the next twelve months to align structure/activities and contracts to reflect the priorities identified on both a national basis and the emphasis applied by the three District Health Boards over which Community and Public Health's regional services apply.

Quality Improvement Process
Community and Public Health's Organisational Quality Manual specifies processes for customer reaction to our services, along with procedures for undertaking surveys of customer awareness and effectiveness of our services.

Issues facing services are regularly reported to Management, to Community and Public Health's Board and our funder. Strategies to address these issues are negotiated and developed by Management with our funder.

Presently our Quality Management System is being audited externally and recommendations from that audit will be incorporated into our system.

4.3.7.2 Brackenridge Estate

Brackenridge Estate Ltd a wholly owned subsidiary of Canterbury DHB, provides residential care services to people with intellectual disability and high dependency needs including day programmes.

The 2002/2003 Business Plan for Brackenridge Estate focuses on the need to establish efficient systems, ensure financial viability and manage the risks associated with the changing health and disability environment while maintaining and improving an appropriate environment for all residents. It also signals increased attention to fulfilling the objectives in the NZ Disability Strategy.

All activities and initiatives within Brackenridge Estate will be measured against a clear mission statement, values and philosophies to ensure they are in tune with these fundamental principles. Such an approach highlights the need to develop strong partnerships with residents, families, staff and the wider community. Programmes need to be in place for residents that are meaningful and provide full opportunity for inclusion in society. This means working with other providers and

funders to improve opportunities for residents. In the meantime we have to ensure we do not fall into the trap of providing services and recreation at Brackenridge when the aim is to achieve inclusion for the residents in the wider society.

A number of other significant issues will need to be dealt with in the coming year. These include:

a) Finalising plans for the swimming pool complex and its ongoing running costs
b) Successful renegotiation of the Collective Employment contract for staff which expired in December 2001. This must be settled within the financial parameters the Board has set.
c) Living within resources/negotiating a sustainable contract with the Ministry of Health.
d) More clearly recognising areas of risk and managing them proactively.
e) Restructuring vehicle lease arrangements and determining whether to own or lease the fleet in the future.

While this Plan provides an overview of what can be expected from Brackenridge Estate over the next twelve months, it also establishes the longer term pathway that the Company will be following to provide a positive environment to enhance the life of each resident well into the future.

5.0 FINANCIAL FORECASTS

Canterbury DHB Group
Budgeted Financial Statements
For the Year Ending 30 June 2003, 2004 and 2005

OPERATING STATEMENT	2001/02 Actual $'000	2002/03 Forecast $'000	2003/04 Forecast $'000	2004/05 Forecast $'000
Operating Revenue				
MoH Revenue	623,078	670,944	693,256	712,724
Patient Related Revenue	22,611	20,563	20,563	20,563
Other Revenue	9,708	8,808	8,808	8,808
Total Operating Revenue	655,397	700,315	722,627	742,095
Operating Expenditure				
Employee Costs	299,748	315,066	324,360	332,353
Treatment Related Costs	83,402	82,155	82,198	81,842
External Service Providers	195,119	213,939	216,322	218,648
Other Expenses	54,244	52,872	54,325	54,768
Total Operating Expenditure	632,513	664,032	677,204	687,612
Earnings before Interest, Capital charge & Depn	22,884	36,283	45,423	54,483
Interest, Capital Charge & Depreciation				
Net Interest Expense	(7,443)	(7,896)	(8,896)	(10,896)
Capital Charge Expenditure	(16,192)	(16,400)	(17,100)	(17,100)
Depreciation	(20,892)	(23,487)	(24,987)	(26,487)
Total Interest, Capital Charge & Depreciation	(44,527)	(47,783)	(50,983)	(54,483)
Net Results	(21,643)	(11,500)	(5,560)	0

Canterbury DHB Group
Budget Statement of Financial Position
For the Years Ending 30 June 2003, 2004 & 2005

	30/06/02 Actual *$'000*	30/06/03 Forecast *$'000*	30/06/04 Forecast *$'000*	30/06/05 Forecast *$'000*
Public Equity				
Opening Equity	156,546	134,923	148,423	157,863
Equity Injection - Chch Women Hosp		25,000	15,000	
Net Result for the period	(21,623)	(11,500)	(5,560)	0
Total Public Equity	**134,923**	**148,423**	**157,863**	**157,863**
Current Assets				
Cash & Bank (OD)	(3,635)	155	114	801
MoH Debtor	36,800	36,000	36,000	36,000
Other Debtors & Other Receivables	14,779	15,000	15,000	15,000
Prepayments	1,017	1,017	1,017	1,017
Stocks	7,331	7,331	7,331	7,331
Total Current Assets	56,292	59,503	59,462	60,149
Current Liabilities				
Creditors & Accruals	55,067	45,000	45,000	45,000
Capital charge payable	7,834	4,234	3,900	3,900
GST	4,006	4,006	4,006	4,006
Provision for Income Tax	17	17	17	17
Interest Accrual	312	312	312	312
Staff Entitlement	28,661	35,000	35,000	35,000
Short Term Borrowings	27,568	120,000		
Total Current Liabilities	123,465	208,569	88,235	88,235
Working Capital	(67,173)	(149,066)	(28,773)	(28,086)
Investments	466	466	466	466
Restricted Assets - Trust Fund	7,180	7,180	7,180	7,180
Fixed Assets	277,091	295,604	313,167	330,480
Term Staff Entitlement	(3,636)	(3,636)	(3,636)	(3,636)
Deferred Tax	(69)	(69)	(69)	(69)
Minority Interest	(56)	(56)	(56)	(56)
Term Loans	(78,880)	(2,000)	(130,416)	(148,416)
Net Assets	**134,923**	**148,423**	**157,863**	**157,863**

Canterbury DHB Group
Budget Statement of Cash Flows
For the Years Ending 30 June 2003, 2004 & 2005

	2001/02 Actual $'000	2002/03 Forecast $'000	2003/04 Forecast $'000	2004/05 Forecast $'000
Cashflows from Operating Activities				
Cash provided from:				
MOH Receipts	621,518	671,744	693,256	712,724
Other Receipts	30,191	29,150	29,371	29,371
	651,709	700,894	722,627	742,095
Cash applied to:				
Employee Costs	293,724	308,727	324,360	332,353
Supplies & Expenses	311,060	359,033	352,844	355,258
Taxes Paid	(2,416)	-	-	-
	602,368	667,760	677,204	687,612
Net Cashflow from Operating Activities	**49,341**	**33,134**	**45,423**	**54,483**
Cashflows from Investing Activities				
Cash provided from:				
Sale of Assets	579	-	7,450	3,200
Interest Received	565	483	483	483
	1,144	483	7,933	3,683
Cash applied to:				
Advance to JV/Trust Investments	454	-	-	-
Purchase of Assets	19,319	42,000	50,000	47,000
	19,773	42,000	50,000	47,000
Net Cashflow from Investing Activities	**(18,629)**	**(41,517)**	**(42,067)**	**(43,317)**
Cashflows from Financing Activities				
Cash provide from:				
Equity Injection		25,000	15,000	-
Loans Raised		42,968	128,416	18,000
	-	67,968	143,416	18,000
Cash applied to:				
Loan Repayment	2,420	27,416	120,000	
Capital Charge Payments	16,356	20,000	17,434	17,100
Finance Costs	7,322	8,379	9,379	11,379
	26,098	55,795	146,813	28,479
Net Cashflow from Financing Activities	**(26,098)**	**12,173**	**(3,397)**	**(10,479)**
Overall Increase/(Decrease) in Cash Held	4,614	3,790	(41)	687
Add Opening Cash Balance	(8,249)	(3,635)	155	114
Closing Cash Balance	**(3,635)**	**155**	**114**	**801**

6.0 KEY ASSUMPTIONS

The financial forecasts in this SOI are based on a set of assumptions. The following are the key assumptions.

2002/03 Assumptions

- Ministry of Health revenue is based on amounts notified up to 31 May 2002 plus additional funding to correct funding errors for contracts assigned in 2001/02.
- Canterbury DHB will receive it's fair share of Pharmac rebates.
- Ministry of Health will fully fund the demand driven expenditure overspend in 2001/02. Hence, there will not be any reduction in future Canterbury DHB's revenue.
- The Crown will inject a $25 million of equity during the first quarter of the financial year which will partly be used to fund the construction of the new Christchurch Women Hospital.
- Average CPI for expenditure will be between 2% and 4%.
- Efficiencies of $11 million will be generated from operational and support functions. The demonstration of achievement of efficiency gains would mean no clawback by the Ministry of Health for the at risk portion of funding.
- Canterbury DHB will reinvest $2M in new health initiatives.
- Acute medical growth will be constrained to 2% through new health initiatives.
- There will be no significant increase by New Zealand Blood Services on blood prices.
- There will not be any significant growth in other DHBs expenditure on synthetic blood products which is currently paid for by Canterbury DHB.
- Additional loan of $16.6M will be raised at average interest rate of 6.5%.

2003/04 Assumptions

- Ministry of Health revenue is based on amounts notified up to 31 May 2002 plus additional funding to correct funding errors for contracts assigned in 2001/02. The impact of any shift to population based funding is assumed to be neutral.
- Canterbury DHB will receive it's fair share of Pharmac rebates.
- The Crown will inject $15 million of equity during the first quarter of the financial year.
- Average CPI for expenditure will be between 2% and 3%.
- Acute medical growth is held at 2002/03 level through new initiatives including integration projects with primary care.

- Efficiencies of $5 million will be generated from operational and support functions. The demonstration of achievement of efficiency gains would mean no clawback by the Ministry of Health for the at risk portion of funding.
- Canterbury DHB will reinvest $1M in new health initiatives.
- Canterbury DHB will receive $7.4M from sale of surplus property.
- New loan of $129.4M will be raised at average interest rate of 7%.

2004/05 Assumptions & Risks

- Ministry of Health revenue is based on amounts notified up to 31 May 2002 plus additional funding to correct funding errors for contracts assigned in 2001/02. The impact of any shift to population based funding is assumed to be neutral.
- Canterbury DHB will receive it's fair share of Pharmac rebates.
- Average CPI for expenditure will be between 2% and 3%.
- Acute medical growth is held at 2002/03 level through new initiatives including integration projects with primary care.
- Efficiencies of $8.8 million will be generated from operational and support functions. The demonstration of achievement of efficiency gains would mean no clawback by the Ministry of Health for the at risk portion of funding.
- Canterbury DHB will reinvest $1M in new health initiatives.
- Canterbury DHB will receive $3.2M from sale of surplus property.
- Additional loan of $18M will be raised at average interest rate of 7.5%.

7.0 REPORTING INFORMATION: PERFORMANCE REQUIREMENTS

Performance Measurement, Targets and Reporting

The Canterbury DHB is committed to performance improvement, both as a funder of services and as a provider of services.

The Canterbury DHB, under the Funding Agreement with the Crown, is required to report against a set of quantitative and qualitative accountability indicators.

Accountability Indicators

The accountability indicators reflect the accountability that CDHB has for securing improved health status for its population. As responsibility for funding some services is yet to be devolved to DHB's, there are indicators where the DHBs' ability to influence the outcome is not through direct funding but through influencing other funders.

Due to the evolving nature of DHB's and their responsibility for funding, the actions taken by the CDHB to influence the direction of performance in relation to specified targets is of as much importance as the match between actual performance and the indicator itself.

Qualitative Accountability Indicators

Performance against the qualitative indicators will be measured on the basis of reporting deliverables rather than numeric targets. Performance will be assessed not only on provision of reports that meet the stated content requirements but also compliance with the reporting timeframes.

Quantitative Accountability Indicators

The majority of the quantitative indicators are aimed at measuring DHB performance in addressing cardiovascular disease, diabetes, oral health and well child services - four priority areas within the New Zealand Health Strategy.
For each of the quantitative indicators set out in this plan targets have been set for the 2002/03 year. The setting of those targets has been based on:

- Expectations expressed by the Ministry of Health
- The latest national data
- The latest CDHB specific data

It should be noted that for many indicators only one year's historical data has been available to set targets, and that for a number of indicators, historical data does not exist. Consequently there are some indicators for which a target is unable to be set at this stage. It is the intention of the CDHB to gather the required baseline data to allow for targets to be set for future plans.

It is noted that the Ministry will be using results outside 90% or 99% confidence intervals to trigger further analysis for a number of indicators.

Indicator results and targets have been stated for three population groupings, Māori, Pacific people and Other. The overall targets for the DHB reflect these ethnic specific results and the demographic characteristic of the Canterbury DHB.

The intent of this section is to recognise that Canterbury DHB does not have funding for some, in some instances, but should be looking at the health of the DHB irrespective. The aim is to get DHBs to look at progress towards increasing the health status of their population.

Quantitative Accountability Indicators

Child Health

Indicator No	Objective	Report Frequency	Canterbury DHB Target			
			Total %	Māori %	Pacific People %	Other %
CHI-08	Repeat admissions for asthma in children under 5 and in children 5-15	Six Monthly	5.8	5.9	5.5	5.3
CHI-09	Repeat admissions for asthma in children 5-15	Six Monthly	5.8	5.6	6.4	6.0
CHI-13	Percentage of babies born in public hospital with low birth weight	Six monthly	6.2	7.2	4.9	6.1
CHI 15	Full breastfeeding rate at six weeks and three months	Annually	67.4	63.7	60.1	68.3
CHI-16	Full bresatfeeding rate and three months	Annually	55.0	43.9	52.5	56.3
CHI 17	Ambulatory Sensitive Admission - Under 5	Six monthly	98.1	71.2	97.8	97.0
CHI-18	Ambulatory Sensitive Admission 5-14 years	Six monthly	18.9	15.0	28.9	19.1
CHI-19	Ambulatory Sensitive Admission 15-24 years	Six monthly	12.2	11.2	11.8	12.3
CAR 10	Repeat admissions for acute rheumatic fever in people under 30	Annually	29.3	-	-	-

Target rate per 100 discharges with a 90% confidence interval of the New Zealand rate.

Cardiac			
Indicator No.	Objective	Report Frequency	Target
CAR-03	Number of people with certainty who have been waiting for more than 6 months for a coronary artery bypass graft	Six monthly	Canterbury DHB will report on issues, constraints, and progress towards meeting the indicator target set at zero people waiting for all DHBs and all ethnic groups.
CAR-05	Number of people with certainty who been waiting for more than 6 months for angioplasty	Six Monthly	Canterbury DHB will report on issues, constraints, and progress towards meeting the indicator target set at zero people waiting for all DHBs and all ethnic groups.
Cancer			
CAN-01	Waiting times for Radiotherapy	Monthly	Target for all DHBs to be zero people waiting outside best practise times at 30 June 2002.

Elective Surgery

ELE-02	100% of patients do not wait longer than 6 months for first specialist assessment The CDHB will put in place a transition plan to achieving 100% compliance during the 02/03 year		Quarter ended 30/09/02 100% 31/12/02 100% 31/03/03 100% 30/06/03 100%
ELE-03	100% of patients who have been offered publicly funded treatment do not wait longer than 6 months		100%

In relation to elective services (ELE series) the DHB 's aim is to achieve 100% compliance with the 6 month maximum waiting time. Canterbury acknowledges that it is committed to working to achieve 100% compliance but the parties acknowledge that in calculating whether the DHB has achieved the target set for this measure, there are certain acceptable exclusions including whether the patient has caused the deferral or the patient did not attend the appointment, a deferral because the patient is temporarily medically unfit. When reporting against the quantitative targets that have been set for 2001/02, the DHB will also provide advice on progress it is making towards the 100% requirement including:

- baseline information at the commencement and end of the period
- movement since this time and during 2001/02 in relation to the target
- analysis of gaps from target and factors influencing this proposed strategy to address gaps with timeline for movement to target

PRI-04	Number of Contracted Providers of General Practice Services with a Māori Health Plan that has been agreed with the funder	Quarterly	100%

Child Health

Indicator No	Objective	Report Frequency	Canterbury DHB Target Total %	Māori %	Pacific People %	Other %
CHI-01	Children fully vaccinated by their 2nd birthday	Annually	75	75	75	75
CHI-06	Percentage of children passing school entry hearing screening test	Annually	94.3	90.1	86.1	95.1
Oral Health						
ORA-04	Mean MF score at form 2 (year 8)	Annually	1.6	-	-	-
ORA-01	Caries free at age 5	Annually	53.6	-	-	-
	In regards to the oral health targets (ORA series) it should be noted that there is no fluoridation of all public water supplies. Any changes affected now or in the near future will not show through in the MF rate of Form 2 children for another 7-12 years at the earliest. CDHB will endeavour to meet the target subject to the above constraint.					

Diabetes

			Total	Māori %	Pacific People %	Other %
DIA-01	Diabetes case detection rate (Using local Diabetes Team figures)	Annually	54	50	55	55
DIA-02	Diabetes case management	Annually	24	35	40	22
DIA-04	Retinal screening of people with diabetes in the last two years	Annually	65	N/A	N/A	N/A
	No ethnicity breakdown is available for this indicator. However, for those who had a retinal examination within the last year (1844) the breakdown is 28% Māori, 31% Pacific People, 34% other.					

Qualitative Accountability Indicators

Strategic Development – Māori and Pacific Peoples			
Indicator No	**Title**	**Objective**	**Frequency**
STR-01	Local Iwi/Māori are engaged and participate in DHB decision-making and the development of strategic and plans for Māori health gain.	Processes for participation, engagement and input by Iwi/Māori are in place in respect to: • Health Needs Assessment • Prioritisation • Planning • Service Delivery • Monitoring • Evaluation of Services	Six Monthly
STR-02	Progress in the development of Māori workforce and Māori providers	Progress is in developing the DHB Māori workforce at all levels of the organisation, promote workforce development amongst its contracted mainstream providers and in the development of Māori providers.	Annually & Quarterly
STR-03	Implementation of the Māori Health Plan	Progress achieved towards implementation of the Māori Health Plan within the DHB provider arm.	Annually
STR-04	Pacific people are engaged and participate in DHB decision-making and the development of strategies and plans for Pacific health gain.	Processes for participation, engagement and input by Pacific people are in place in respect to: • Health Needs Assessment • Prioritisation • Planning • Service Delivery • Monitoring • Evaluation of Services	Annually
STR-05	Progress in the development of Pacific workforce and Pacific providers	Progress is in developing the DHB's Pacific workforce at all levels of the organisation, promoting workforce development amongst its contracted mainstream providers and in the development of Pacific providers.	Annually

Quality Systems			
Indicator No	**Title**	**Objective**	**Frequency**
QUA-01	Quality systems	The quality of services including cultural appropriateness provided and funded by the DHB is maximised through effective monitoring and audit and the promotion of an organisational culture, which is supportive of quality initiatives.	Quarterly
Indicator No	**Title**	**Objective**	**Frequency**
QUA-02	Mental Health quality measures	Mental health services are delivered in accordance with the Government's service coverage expectations and to meet the New Zealand Health Strategy's priority for mental health services: • Improving the health status of people with severe mental illness. • A high-performing system in which people have confidence; and • Active involvement of consumers and communities at all levels.	Quarterly
QUA-03	Nationally consistent clinical assessment – Elective Services	Nationally consistent clinical assessment is achieved.	Quarterly
QUA-04	Responding to resolving service coverage issues	Ensure timely and equitable access to a comprehensive range of health & disability services, regardless of ability to pay, & a high performing system in which people have confidence.	Quarterly
QUA-05	Prioritisation	Prioritise the needs of DHB communities in terms of the directions set by the NZ Health & Disability Strategies within the available funding.	31 May 2003
Nursing Practice and Development			
NUR-01	Nursing practice and development	Maximise the contribution of nurses to quality care by ensuring the consistent organisational support of clinical career pathways, professional development, on-going education, and an infrastructure, which allows for nursing input into decision making at all levels.	Quarterly

Child Health			
Ensure access to appropriate child health care services including well child and family health care and immunisation			
CHIQ-02	Progress in implementing the Baby Friendly Hospital Initiative in maternity facilities	Progress in implementing the BFHI in maternity facilities.	Annually
Diabetes			
Reduce the incidence and impact of Diabetes			
DIA-07	Implementation of the minimum diabetes dataset	Reduce the incidence and impact of diabetes in New Zealand.	Annually
Primary Care			
PRI-01	Progress towards implementing the Primary Health Care Strategy	Progress is made towards implementing the Primary Health care Strategy.	Annually

Indicator No	Title	Objective	Frequency
PRI-02	Progress in developing the capacity of primary care providers to impact on suicide prevention	The rate of suicide and suicide attempts is reduced.	Annually
Elective Surgery			
Reducing waiting times for public hospital elective services			
ELE –01	Level of publicly funded service delivered is sufficient to ensure access to elective surgery for all patients before they reach a state of unreasonable distress, ill health or incapacity.	Delivery of a level of publicly funded service which is sufficient to ensure access to elective surgery before patients reach a state of unreasonable distress, ill health or incapacity.	Quarterly

Mental Health			
MEN-01	Progress towards improving Māori mental health	Progress is made towards improving Māori access to Mental Health services, the effectiveness of mainstream services for Māori and availability and capability of Kaupapa Māori services through the implementation of the Māori Mental Health Strategy.	Annually
MEN-02	Comprehensive accurate and timely data is provided to MHINC	Compliance with MHINC reporting requirements.	Quarterly
MEN-03	Access to Mental Health Services: The NZ Mental Health Strategy sets targets for access to treatment and support services for people of different age groups with severe mental illness	Progress is made towards improving the access to services in the following age groups: 0- 9 0.2% 10-14 0.6% 15-19 0.8% 20-64 1.0% 65+ 0.1% **Total 0.7%** **65+ not on MHNI System** **The system will not give accurate data for Māori, Pacific people or other at this time.**	Quarterly

8.0 ATTACHMENTS/APPENDICES

A. Glossary of Terms
B. Pacific Health Action Plan

1. Canterbury DHB Disability Strategy Action Plan
2. Services to other Centres Table
3. Canterbury DHB Provider Arm Funding Schedule
4. Disability Support Advisory Committee Terms of Reference and Members
5. South Island Regional Mental Health Plan
6. HR Strategy
7. List of Community and Public Health Services
8. Additional Financial Information/Explanation

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

DISTRICT ANNUAL PLAN

2003 – 2004

13 June 2003

A NOTE ABOUT THIS DOCUMENT

The Canterbury District Health Board's Annual Plan 2003-2004 sets out the directions and activities for the District Health Board over the next year.

The plan has been agreed between the Minister of Health and Canterbury District Health Board.

The Annual Plan is represented in two documents:

Document 1: Annual Plan Summary 2003-2004 (to come)
The Summary summarises the fuller Annual Plan

Document 2: The Canterbury District Health Board Annual Plan
(this document which follows the required Ministry of Health template guidelines).

TABLE OF CONTENTS

1.0 EXECUTIVE SUMMARY

1.1 Statement from DHB Chair and CEO

This is the Annual Plan for the Canterbury District Health Board (CDHB) for the 2003 / 2004 financial year. Its key purpose is to outline the activities the Board will be undertaking to the 30th of June 2004. This plan represents a further step in our continuing path towards our vision of 'promoting, enhancing and facilitating the health and wellbeing of the people of the Canterbury District'.

The Canterbury DHB is committed to strategies that clearly show our community the direction of the current and future public health services the Canterbury DHB will fund and provide and at the same time meet the expectations of the New Zealand Government's health expectations and goals. Key Canterbury health priority areas are child and youth health, primary health, Maori health, mental health, disease prevention and management of cardiovascular disease, diabetes and cancer.

Strategies for Maori health, Primary Care, Pacific People's and Rural health have been developed (as of March 2003). We are committed to reducing disparities and improving health outcomes for Maori and ensuring Maori involvement in planning for these. Our commitment is reflected in this Annual Plan.

This year, as this plan highlights, the Canterbury DHB will continue to build its capability and resources as a funder as we move forward towards a population based funding approach. We also continue to focus on working within the resources we have to fund and deliver the best possible health and disability services and outcomes for the people of Canterbury. We are preparing to function as funder, as well as provider, of services for Older People.

A high performing health service is based on the skill and endeavours of those working within the system. Our aim is to improve support for all health professionals and enhance the working conditions for staff in our public hospitals and in community health services.

The Canterbury DHB recognises the Treaty of Waitangi as the founding document of New Zealand and acknowledges our obligations as defined in the New Zealand Public Health and Disability Act. This commitment is reflected in the actions that have been developed for Maori health, primary care, Pacific peoples and rural health in this Annual Plan. We are determined to continue reducing disparities and improve health outcomes for Maori and ensure Maori are involved in the planning for these.

At a strategic level, we are also focusing on the factors that influence health as well as on providing complex treatment in high tech hospitals. Health can be affected by educational, environmental, income, housing, and nutritional factors. We have a role to play in ensuring combined action across these different sectors is developed and many of our projects also involve sectors such as local and regional councils. The Healthy Christchurch project is a good example of this and the linkages between the many agencies must be well connected to meet individual needs. Developing enhanced relationships with health providers and other DHB's also continues to be a priority.

There are continuing challenges for all District Health Boards in meeting the continuous and growing demand for health services with no increase in resources in the future. Such a demand does place fiscal risks on DHBs. Devolution of budgets to clinical areas will continue along with improved systems for monitoring expenditure. We will also be communicating with the Canterbury community to ensure greater understanding of health issues and in particular decisions about resources and funding priorities.

Canterbury DHB enters the 2003-2004 financial year with a clear view of its role in bringing health gains to the Canterbury District. It does so with the realisation that this is not going to be able to be achieved in the short term or without changing the way we do things.

Population and reduced funding levels in "real terms" will bring challenges to the services we currently provide as we adjust to the national equity of funding from 2004/5 and 2005/6.

Initial analysis undertaken by the Ministry of Health shows that Canterbury DHB is 3% over funded under the population based funding model. This means that Canterbury DHB will receive no demographic funding in 2004/05 and 2005/06.

The signalled funding adjustment is about $7M for the 2004/5 financial year and a further $7M in 2005/6. Work has started to establish what we must do to enable us to manage within our fair share of public health funding for both now and in the future. We will also work to ensure that full funding recognition is given to the Canterbury DHB in terms of providing services for other DHBs.

We need to ensure our community and health providers are aware of the challenges this scenario represents. This must be achieved as we evolve from the transitional funding formula to the new substantive formula that will apply from 2004/5 financial year onwards. This will be achieved through hospital and community based consultation and engagement to determine the appropriate solutions that best meets the needs of our community and then actioned to meet, in real terms our adjusted funding levels.

Jean O'Callaghan
Chief Executive

Syd Bradley
Chairman

1.2 Signatories – Minister/Chair/CEO

Signatories

AGREEMENT DATED THIS 21st DAY OF June 2003

(Made under Section 39 (1) of the New Zealand Public Health and Disability Act 2000)

BETWEEN

Honourable Annette King
Minister of Health

Chairman of the
Canterbury District Health Board

Chief Executive Office
Canterbury District Health Board

2.0 INTRODUCTION

2.1 Vision Statement and Values

2.1.1 Vision and Values

Our Vision - *Ta Matou Matakite*

To promote, enhance and facilitate the health and well-being of the people of the Canterbury District

Ki te whakapakari, whakamaanawa me te whakahaere i te hauora
Mo te orakapai o ka takata o te rohe o Waitaha

Our Values

Care and respect for others	*Manaaki me te kotua i etahi*
Integrity in all we do	*Hapai i a matou mahi katoa i ruka i te pono*
Responsibility for outcomes	*Kaiwhakarite i ka hua*

2.1.2 Who We Are

We are the health organisation responsible for funding most health services in Canterbury. We are funded by Government, but it is up to us to work together with Canterbury people, to decide what health services we need and how to best use our funding, noting Government policies. We:

- Fund most mental health, Māori health and personal and family health services in Canterbury. (We are planning for monies for disability support (older people) to be devolved in October 2003).
- Run Canterbury's 14 public hospitals and provide mental health, disability support, alcohol and drug and community health services within the provider arm.
- Promote community health and well-being through population health programmes such as health promotion and protection.
- Encourage all health and disability support providers in Canterbury to work together to streamline health care and make care more efficient and effective.

Our Ways of Working

Be people and community focused	*Arotahi atu ki ka takata me ka iwi whanui*
Demonstrate innovation	*Wakaba whakaaro hihiko*
Engage with our stakeholders (those individuals and groups with an interest in our work)	*Tuu atu ki ka uru (ratou ka takata me ka roopu e parekareka ana mai ki a tatou mahi)*

2.1.3 Our Strategic Directions and Top Priorities

The Canterbury DHB completed a strategic planning process in 2002/03 "Toward a Healthier Canterbury: Directions 2006" which involved community consultation. The agreed strategic directions are:

1. Improving the health status of our community
2. Finding better ways of working: Effective Policy and Funding Frameworks
3. Working together: Innovative Models of Service Integration
4. Developing Canterbury's Health Care Workforce
5. Being a Leader in Hospital and Health Care Services

In the Strategic Plan health areas were chosen for special attention based on a health needs assessment for Canterbury, consideration of key Government health strategies such as the New Zealand Health Strategy, New Zealand Primary Health Care Strategy, the Māori Health Strategy and the New Zealand Disability Strategy and feedback received in the formal consultation on the strategic plan.

Details of the health needs assessment and the summary of submissions can be found on our website: www.cdhb.govt.nz .

The priorities are:

- Child and Youth Health
- Primary Health
- Māori Health
- Mental Health
- Disease Prevention and Management
  - Cardiovascular (Heart) Disease
  - Diabetes
  - Cancer

2.1.4 The District Annual Plan 2003-2004

This Plan's objectives are aligned with Government objectives for District Health Boards as set out in the New Zealand Health Strategy and the New Zealand Disability Strategy, Māori, and other Health Strategies as well as directions in the current Canterbury DHB Strategic Plan.

The Annual Plan outlines the planned performance, funding arrangements and services provided of the Canterbury DHB for the period 1 July 2003 – 30 June 2004 noting the Ministers 'Start Here' List and emphasis on :

- He Korowai Oranga
- New Zealand Disability Strategy
- Elective Services and Radiotherapy waiting times
- Diabetes
- Inequalities
- Primary Care
- Mental Health Blueprint

2.2 Treaty of Waitangi

The Canterbury DHB recognises and respects the principles of the Treaty of Waitangi: partnership, participation and protection. We also acknowledge the expectations of the New Zealand Public Health and Disability Act 2000 and the Crown Funding Agreement. We are committed to reducing disparities and improving health outcomes for Māori and to ensuring Māori involvement in planning for these.

The Canterbury DHB has agreed a regular meeting schedule with Kai Tahu as manawhenua of the district, through the Manawhenua Health Group ki Waitaha, which comprises the seven Kai Tahu runaka supported by the Ngai Tahu Development Corporation. We also meet quarterly with Te Runanga o Nga Maata Waka representatives and the Māori community and engage in numerous other formal and informal interactions with Māori providers, services and community organisations. The outcomes of these meetings feed directly into Canterbury DHB planning processes

The Canterbury DHB has established Te Kahui Taumata, which includes the Kaumatua and Taua and senior Māori staff who provide Māori specific advice and direction to the Chief Executive. This group will ensure that the Canterbury DHB recognises and respects the principles of the Treaty of Waitangi and actively works to improve the health of Māori

2.3 Population Profile

2.3.1 Key Details

The Canterbury DHB catchment area covers rural communities from Kekerengu in the North, Rangitata in the South and Arthur's Pass in the West. 16% of the population live in rural towns (eg Kaikoura), rural centres (eg Rakaia) and wider areas (eg Malvern). The Canterbury DHB is the second largest DHB by population and largest in geographical area. Canterbury has the ninth largest Māori population. The total population is 427077; 6.9% identifying as Māori (2001 Census). Key CDHB population statistics are attached in 7L.

2.3.2 Overview Canterbury Population

An initial Needs Assessment Project was completed in October 2001and more lately a Needs Assessment for Older People. They assess the health status of the Canterbury population as these relate to the health objectives within the New Zealand Health and Disability Strategies. The Needs Assessment also covered issues raised in community consultation and linked the health needs of the Canterbury community with Government health strategies and others such as The Positive Ageing Strategy.

The Health Needs Assessment for Canterbury (October 2001) showed that the Canterbury population is similar to the NZ population as a whole in overall morbidity and mortality rates. The leading causes of death of people in Canterbury are cardiovascular disease and cancer. As yet, we do not have data which show that particular groups of people are at higher risk of dying from particular disorders. Greater emphasis on accurate collection of ethnicity data, and analysis of hospital discharges linked with NZDep2001 coding will help provide this information in coming years.

It is expected that Canterbury DHB's directions, plans and actions on major health risk areas and diseases will help decrease morbidity and mortality rates for the Canterbury population in the coming years.

People in Canterbury have the highest life expectancy at birth (77.7 years) of all DHBs. Nationally, Māori life expectancy is lower than that of other ethnic groups. In Canterbury, Māori and Pacific communities are at higher risk of diabetes and associated complications than other groups. It is hoped that Canterbury DHB's plans to address diabetes, cardiovascular disease, and cancer will improve Māori and Pacific health status, and reduce inequalities in life expectancy. In addition, Canterbury DHB's Whakamahere Hauora Māori ki Waitaha (Māori Health) Plan is designed to address high health risk areas for Māori, including smoking, obesity, and alcohol consumption, by working with Māori communities on public and personal health initiatives. Canterbury DHB's Pacific Health Action Plan is likewise aimed at reducing inequalities, and improving health outcomes for Pacific people.

Poorer health status is linked with high degree of deprivation, and Canterbury DHB has about 80,000 people living in NZDep deciles 8-9-10. Canterbury DHB health priority action plans recognise the need to provide services for hard-to-reach people who may not access primary and secondary health services. Our developing Primary Health Organisations will be working with high-need populations to try to reduce health inequalities associated with socio-economic status, in line with the DHB's health gain priority areas.

While the health status of rural Cantabrians is good, some rural areas of Canterbury do not have adequate access to primary or community-provided health services. Canterbury DHB's Rural Health Plan lists actions to improve rural access issues.

A fuller Needs Assessment for the Canterbury DHB population will be completed in June 2004. It will build on the DHB information and using data from other government departments/Territorial Local Authorities (TLAs). Current documentation is available on the Canterbury DHB website (www.cdhb.govt.nz).

Key population trends for the Canterbury DHB population include:

- **Ageing Population**

Canterbury's population is ageing quickly compared to other parts of the country. The percentage of the population who are 65 or older will increase from 12% in 2001 to 20% in 2021. Both Māori and Pacific people aged 65 and over are projected to increase each of their share of the DHB's population from 3% to 7% by 2021. This has implications not only for the relative size of the population of working age to support the older people, but also for health as older people, particularly those over 75 years, consume a significant amount of health resources.

- **Decreasing Child Population**

The population aged 0-14 will decrease to 15% of the Canterbury DHB population by 2021 compared to 18% in 2001.

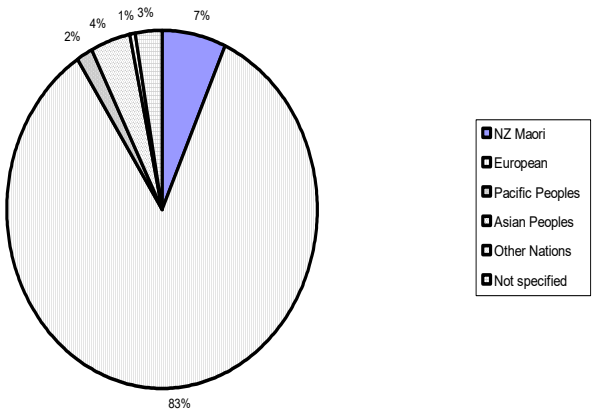
- **Relatively Large Youth/Young People Population**

Currently around 21% of New Zealand's population is in the age group 10-24 years. This is relatively large compared to the size of the rest of the population. The Canterbury figure is similar, at 20%.

- **Changing Ethnicity of the Canterbury DHB Population**

An increasing number of the Canterbury DHB child and young people population are non-European, principally Māori, Pacific and Asian.

Population by Ethnic background - 2001 census



- **Māori**

Most are under 30 years of age. Kai Tahu are manawhenua and make up about 25% of Māori in the Canterbury DHB region. Seven Kai Tahu runaka are in the Canterbury DHB area. Other Māori in Canterbury come from tribal regions throughout New Zealand.

The available health statistics indicate that Māori in Canterbury have a similar health profile to national statistics. Available local ethnicity data, because of its incompleteness, does not confirm that Māori are high users of Secondary Services or under utilise Primary Services, but nationally this is so. 'Māori for Māori' providers provide a range of public, primary and community health services, and some bicultural services are provided by mainstream providers.

- **Pacific Peoples**

There are more than 7254 Pacific people in Christchurch, based on Statistics NZ 2001 figures, 1.7% of the Canterbury population and compromising a mixture of Island born and New Zealand born people. The Canterbury DHB currently has three Pacific providers and limited Pacific service within mainstream providers. An initial needs assessment has indicated Pacific peoples are difficult to reach due to communication and cultural difficulties and over utilise secondary services rather than primary and community services.

Chronic diseases such as diabetes and asthma are prevalent amongst this population. The majority of the Pacific peoples are aged under 25 years. 25% of these individuals are also Māori through inter-marriage.

- **Migrant and Refugee Communities**

Christchurch has been a resettlement point for refugees especially during the past 10 years. Exact figures are not available but it is likely this population exceeds 4000. Screening programmes for refugees have been established, however, migrant and refugee populations have particular needs in the areas of child health, mental health, primary health care and aged care.

- **Asian Population**

The Asian population in Canterbury DHB is 4.2%. This population is steadily growing although at a slower rate than the Māori and Pacific peoples' populations. Many Asian-born individuals living in New Zealand are now ageing and the numbers of New Zealand born Asian children and youth are increasing. There has been a growth in information about the health needs of the Asian population in recent years.

2.4 Key Issues

- Reducing the deficit in line with the three year funding path while still providing the required volume and range of services.

- Preparing for and taking on the role of funding Disability Support (Older People) Services from 1 October 2003.

- Planning collectively with all stakeholders including primary care, community services and other government agencies. In particular Involving public health, primary and community care providers in service development and decision-making processes. This will help us implement the NZ Primary Care Strategy and in particular establishing three PHOs in Canterbury.

- Addressing the increasing burden of chronic diseases, such as respiratory and cardiac illnesses, and diabetes, modern epidemics of the western world. Chronic disease reduce the quality of life for sufferers, and are expensive to treat over their lifetime. They are a major issue in New Zealand and in the Canterbury DHB, yet there are opportunities for early prevention and disease management strategies.

- Working effectively as the funder within the CDHB area and with other South Island DHBs in a changing environment of Government health funding which sees the introduction of Population Based Funding (PBF) from 2003/04. We will have to prioritise the needs of people and develop new ways of contracting.

- Ongoing development of our relationships with health workers in our hospitals and in community health and disability services to build a workforce that meets the health and disability needs of the community now and in the future. This includes addressing challenges such as staff shortages in some areas, staff needs for ongoing career development and staff participation in decision-making.

- Negotiating with the major healthcare unions collective employment arrangements from June 2003 while limiting any disruption to services.

- Complying with new legislation and requirements that set standards for services and health professional activity.

- Developing enhanced relationships with the community, health providers and social agencies such as Age Concern, Child Youth and Family, Kai Tahu and the Christchurch City Council. In particular, working with Territorial Local Agencies (TLAs), planning collectively for health and social services as outlined in Local Government Act 2002.

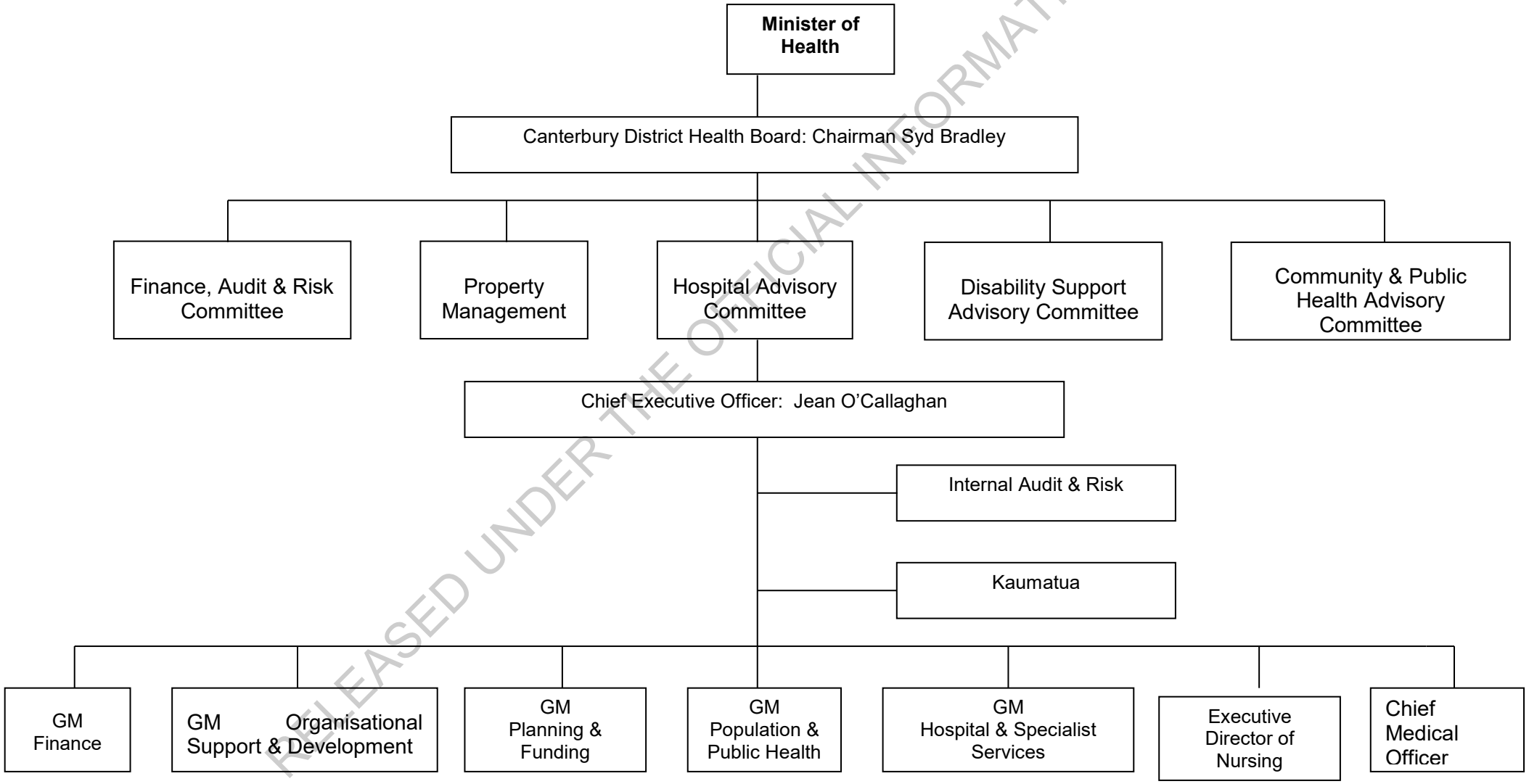
- Responding to the rapid growth in the range of new diagnostic techniques, screening services, pharmaceuticals, bio-technology, robotics and remote diagnostic educational systems. These can be used in hospital and community settings. The opportunity to apply these developments may cause ethical, cultural and funding dilemmas.

- Implementing better information systems that ensure providers can more effectively communicate and monitor patient care and provide better information for planning and funding purposes.

- Working within the wider Government and policy framework the NZ Health and Disability Strategies and delivering on key Canterbury DHB issues.

2.5 Organisational Structure (as at 12 March 2003)

District Health Board Structure – Overview



3.0 ENSURING SERVICES FOR THE CANTERBURY DHB'S POPULATION

3.1 Canterbury DHB Organisational Performance

3.1.1 Canterbury DHB Core Directions

The Canterbury DHB Board and senior management have collectively determined key strategies, actions to achieve outcomes in line with each of its Core Directions.

PLANNING TIMELINE FROM CANTERBURY DHB STRATEGIC PLAN TOP PRIORITIES FOR HEALTH GAIN	
Child Health	March 02
Youth Health	January 04
Primary Health **	September 02
Māori Health	July 02
Mental Health	May 03
Disease Prevention: - Cardiovascular Disease - Diabetes (Interim Plan only- Full plan due October 03) - Cancer	 June 03 September 02 July 03
** Community and Primary Health Care Plan	October 03

* ONGOING WORK	
Information Management	March 03
Population/Public Health Services - Reduce Smoking - Improve Nutrition +Reduce Obesity & Increase Physical Activity - Infectious Diseases	 June 03 September 03 December 03
Pacific Peoples Health	May 02
Alcohol & Other Drugs Treatment	June 03
CDHB Disability Strategy Action Plan	December 01
Elective Surgery/Waiting Lists	December 02
Family Violence Guidelines	July 03
Older Persons Health (DSS)	March 03
Oral Health	March 03
Respiratory Illness	September 03
Rural Health	March 02

DIRECTION 1: IMPROVING THE HEALTH STATUS OF OUR COMMUNITY				
Goals	**Strategies**	**Actions**	**Timelines**	**Outcomes/Measures of achievement**
1.1 Reduce health inequalities	1.1.1 Target resources to relevant populations	All plans have clearly identified intervention goals Monitoring against targets Plan for each priority area completed Ensure Health Promotion Programmes link with priority areas Plans have funding identified including cost shifts/additional $ needed	Plans have timeframes Reported on quarterly	CFA requirements met, e.g. immunisation rates Bi-annual review Disability Action Plan reflects progress to meet targets Increased investment in Māori Health Clear direction for each priority area Resource changes identified and monitored
	1.1.2 Adopt a clear Statement of Funding Strategy including sustainability	Paper to EMT by March each year	Annually	Sustainable funding achieved for services
1.2 Better understanding of Health Needs of Community	1.2.1 Standardise information collection across continuum of care	Trial/implement information exchange system between primary and secondary sectors (e.g. diagnostic results) Develop policy on ethnicity information collection and implement action plan (2 year time-frame to cover all providers) Participate in centre for evidence based practice with Christchurch School of Medicine	December 03 Audit progresses May 03 By July 03	Improved information flow and more timely treatment Improved information on numbers of Māori, Pacific Peoples and others for use in service development planning/funding and monitoring health outcomes Improved services and decision-making

DIRECTION 1: IMPROVING THE HEALTH STATUS OF OUR COMMUNITY				
Goals	**Strategies**	**Actions**	**Timelines**	**Outcomes/Measures of achievement**
1.2 Better understanding of Health Needs of Community cont…..		Collaborate with researchers to identify ethnic trends. Agree and implement a MoU with Manawhenua ki Waitaha that includes information monitoring	Ongoing By December 03	Information for Needs Assessment MoU in place
	1.2.2 Build connectivity between providers and funders in Canterbury regionally and nationally	Implement ISSP Undertake rollout of National Register eg immunisation Continue collaboration in Canterbury Local Mapping project (information partners) Produce a full Health Needs Assessment for CDHB Build two-way electronic communication between the secondary and primary sector : Establish infrastructure/ trial in Laboratory/PACs	From July 03 From September 03 From July 03 June 04 June 04	Increased Information Services between Canterbury providers Better developed databases Health Needs Assessment will give more specific Canterbury information for planning and funding purposes (re draft Strategic Plan priority areas) Reduce duplication of tests Build confidence in two-way processes.

DIRECTION 1: IMPROVING THE HEALTH STATUS OF OUR COMMUNITY				
Goals	**Strategies**	**Actions**	**Timelines**	**Outcomes/Measures of achievement**
1.3 Integrated health planning in Canterbury	Involve all players who can contribute to and influence health programmes	Establish an Integrated Service planning framework, incorporating Disease Prevention and Management, Public Health and Primary Care Establish/identify advisory mechanisms for each priority area	July 03 Facilities Masterplan – Complete by April 04	Integrated Clinical Service Plans in place as per Strategic Plan timeline Facilities Master Plan for Canterbury hospitals reflects need Improved links with Community service providers
	1.3.2 Improve Community Consultation Processes	Audit Consultation Policy and amend as relevant	October 03	Community informed and involved
1.4 Strategic Review of Progress	1.4.1 Review Strategic Plan	Undertake review	June 04	Directions/priorities reviewed
	1.4.2 Rewrite Strategic Plan	Rewrite and consult on plan	June 07	Requirement of CFA to update 2007
	1.4.3 EMT monitor Core Directions workplan	Review progress quarterly	October January April July	Progress on actions monitored

DIRECTION 2: BETTER WAYS OF WORKING: EFFECTIVE POLICY AND FUNDING FRAMEWORKS				
Goals	**Strategies**	**Actions**	**Timelines**	**Outcomes/Measures of achievement**
2.1 Fund services that focus on outcomes	2.1.1 Fund one mental health provider by outcomes	Select providers Negotiate contract (include evaluation in contract)	Contract in place March 04	Workable funding framework that could be extended to other services Compliance with CFA requirement
2.2 CDHB funding framework for PHO's	2.2.1 Work with MoH and PHO establishment groups to put in place systems that underlie service delivery and manage risk	Continually review government funding framework and make adjustments to fit local needs	Commence July 03	Robust funding framework for CDHB/PHOs Framework identifies risks for PHOs/CDHB
2.3 Transparent planning and funding processes	2.3.1 Communicate planning and funding process to stakeholders	Develop and implement communications plan Stakeholders/community updates and newsletters.	September 03	Reporting/monitoring which is timely and accurate
	2.3.2 Prioritisation of strategic funding to align with health priorities	Allocate Strategic Investment Pool (SIP)	Annually	Investment in priority health gain areas
	2.3.3 Put in place a sustainable 3 year funding path	Establish transparent budgeting process Support service managers/GMs to monitor, analyse action budget variances	April 04	Reporting and monitoring which is timely, accurate and budget variances are appropriately identified and addressed
2.4 Simplify contract documentation where appropriate	2.4.1 Provide appropriate contract documentation for services	Review existing CDHB contract documentation/types Agree policy to enhance or improve to ensure relevancy Change contracts where appropriate	October 03 January 04 From January 04 progressively	Contracts use plain English and meet purpose

DIRECTION 2: BETTER WAYS OF WORKING: EFFECTIVE POLICY AND FUNDING FRAMEWORKS				
Goals	**Strategies**	**Actions**	**Timelines**	**Outcomes/Measures of achievement**
2.5 Developing and strengthening intersectoral relationships	2.5.1 Increase involvement and participation of key agencies 2.5.2 Determine better ways of joint planning and funding 2.5.3 Stocktake and review health services funded by Vote Health and other non health agencies	Facilitate Canterbury CEO's Forum Develop a Memorandum of Understanding with Territorial Local Agencies (TLAs) in Canterbury to reflect health responsibilities and accountabilities aligned with new Local Government Act Implement regional ISSP Work with one other agency to implement mutual funding direction in a priority health gain area Identify and scope opportunities for intersectoral collaboration to promote Pacific responsiveness Facilitate joint planning with Christchurch City Council on child health and/or older persons health	Ongoing August 03 As per Plan By June 04 March 04 Ongoing	Better communication MoU signed by 6 TLAs Information sharing CDHB/other agency project joint funding MoH proposals re Pacific Fono and Regional Forum Ministry of Pacific Island Affairs (MIPA) Senior Officials group Pilot and evaluate intersectoral contracts Joint service delivery on one area of child/older persons services
2.6 Implement checks to help ensure we eliminate waste or duplication from our services	2.6.1 Put in place savings realisation plan	Agree a plan, implement and report on progress	Plan agreed yearly in April	Savings attained as per plan Duplications eliminated Assessment of new clinical practices

DIRECTION 3: WORKING TOGETHER – INNOVATIVE MODELS OF SERVICE INTEGRATION				
Goals	**Strategies**	**Actions**	**Timelines**	**Outcomes/Measures of achievement**
3.1 Improved Coordination and integration of services for the elderly	3.1.1 Work with the wider sector to implement a continuum of care for the elderly	Pilot standardised assessment tool	Start August 03	Consistent information for service delivery and planning
		Tool evaluation commenced		
		Establish a resource service providing information on services for the elderly	Start scoping July 03	One stop shop/brokerage service providing information on services for elderly
		Establish working group to investigate for Acute Stroke and Delirium Service at Christchurch Hospital	From July 03	Improved management of stroke patients
		Implement Home Support Review recommendations	From July 03	Better coordination of Home Support Services
		Continence strategy implemented	June 04	Consistent approach to continence products
		Take part in external evaluation of COSE project	Start July 03	Future of COSE clear
		Implement cross sectoral communication strategy	Ongoing	Community informed
		Complete stocktake of and establish policy on home support workforce	January 04	Sustainable Home Support workforce
		Investigate Step-down facility	November 03	Effective Step-down care options
	3.1.2 Progressively implement new DSS contracting model for older people	Determine area to pilot new contracts and begin process (include monitoring and evaluation)	From July 03	Improved coordination

DIRECTION 3: WORKING TOGETHER – INNOVATIVE MODELS OF SERVICE INTEGRATION				
Goals	**Strategies**	**Actions**	**Timelines**	**Outcomes/Measures of achievement**
3.2 Improve child health	3.2.1 Implement CDHB's Child Health Report recommendations	As per the actions in the CDHB Child Health Report Share information/ensure consultation between Site Redevelopment and the Child Health Project Develop assessment and case management system for children with complex needs Select and action feasible measures to improve service quality and integration from those identified by the stakeholder group, eg, a collaborative approach between the CDHB and Christchurch City Council for healthy homes for children with severe asthma	From July 03	Improved health indicators as per CFA Better information for planning facilities reflect service and user needs Effective Case Management System in place Improved service quality integration for stakeholder identified groups
	3.2.2 Implement new Well Child Framework with Well Child Providers	Review contracts to ensure in line with framework Ongoing monitoring	From July 03 By June 04	All Well Child services on framework Robust information for service development
	3.2.3 Establish local systems to comply with national requirements	Implement MoH initiatives: - NIR Outreach Immunisation programme - Child & Youth Mortality Register - Mental Health Outcomes Measurement - NHI Reporting	Progressively	Meet CFA requirements

DIRECTION 3: WORKING TOGETHER – INNOVATIVE MODELS OF SERVICE INTEGRATION				
Goals	**Strategies**	**Actions**	**Timelines**	**Outcomes/Measures of achievement**
3.3 Manage medical acute demand in a cost effective way	3.3.1 Work with Primary Care providers and set up clinical pathways in respiratory and cardiology	Set up cross sectoral working group with Terms of Reference Investigate Step-up/ Step-down options and pilot Produce and implement recommendations Clarifying and setting baseline information for measurement and ongoing monitoring	From July 03	Acute medical growth in respiratory and cardiology is contained
3.4 Encourage innovation	3.4.1 Develop mechanism for evaluating, promoting, supporting and implementing innovative ideas	New ways of doing things communicated through external and internal mechanisms Present CDHB Quality Innovations Awards Trial innovative concepts where business case adds value	From August 03 Annually	Innovation encouraged, promoted and supported - new ways of service delivery trialed
3.5 Continually improve quality	3.5.1 Promote Quality	Award publicly quality focus initiatives Retain and attain Accreditation and Baby Friendly Hospital Status	From August 03 May 04 March 04 July 03 September 04 September 04 September 04 November 03	Improved quality systems and services Gain Accreditation or recertification for: Ashburton Burwood Christchurch Womens Mental Health Christchurch Princess Margaret Rural Hospitals
	3.5.2 Improve reporting on quality KPIs to organisation	Identify and report on KPIs to the Board Act on recommendations of Quality and Patient Safety Council	December 03 Ongoing	Reporting on quality KPIs improved KPIs show improvement in service quality

DIRECTION 3: WORKING TOGETHER – INNOVATIVE MODELS OF SERVICE INTEGRATION				
Goals	**Strategies**	**Actions**	**Timelines**	**Outcomes/Measures of achievement**
3.6 Manage primary referred services expenditure growth	3.6.1 Work with primary care providers to address issues	Complete review and analysis of expenditure data and key areas contributing to expenditure growth Evaluate alternatives in consultation with stakeholders Pilot a pharmacy based integration project aimed at managing growth	August 03 November 03	Expenditure growth on community referred pharmaceuticals and laboratories is effectively managed
3.7 Support Healthy Christchurch Project	3.7.1 Work with Healthy Christchurch as an active participant	Review projects, evaluate and identify new/additional work	Annually	Alignment of Healthy Christchurch and CDHB objectives
3.8 Establish improved System of Care for Mental Health	3.8.1 Implement CDHB Mental Health Strategy	Develop and begin to implement CDHB mental health service development plan which reflects NGO, Primary Care and provider arm integration	From July 03	More coordination of services Better outcomes for consumers Integrated Plan

DIRECTION 4: DEVELOPING CANTERBURY'S HEALTH CARE WORKFORCE				
Goals	**Strategies**	**Actions**	**Timelines**	**Outcomes/Measures of achievement**
4.1 Achieve a workforce which provides right skills at the right place and time for best delivery and outcomes	4.1.1 Undertake analysis of workforce needs	Collect relevant workforce information including ethnicity data Implement HR policies which provide for the recruitment and retention of appropriate staff including Māori and Pacific Island within the DHB	January 04 February 04	CDHB annual workforce profile compatible to national systems Increase in number of Māori and Pacific staff A clear understanding of workforce capacity and capability
	4.1.2 Link workforce utilisation to productivity	Develop and report on a set of productivity measures that link to workforce utilisation	February 04	Information is used to plan and match workforce to activity levels (for wider implementation 04/05 onwards)
	4.1.3 Strengthen partnerships with education providers	Memorandum of Understanding with undergraduate and post-graduate providers re industry needs	February 04	Improved level of skill sets demonstrated by graduates exiting training programmes
	4.1.4 Maintain and improve skills and capability of staff	Establish a career development ▪ Develop scope of Nurse Practitioner in Mental Health ▪ Establish Nurse Practitioner in primary care and elder care Contribute to national projects eg. DHBNZ, Health Workforce Advisory Committee (HWAC) Provide Leadership and Management programmes for clinicians Prioritise training to assessment of need	April 04 June 04 Ongoing Ongoing	Nurse Practitioner definition fits with scope of practice legislation and operational needs of DHB National projects reflect CDHB concerns Improved critical skill sets that meet the patient and organisation's needs Improved patient satisfaction

DIRECTION 4: DEVELOPING CANTERBURY'S HEALTH CARE WORKFORCE				
Goals	**Strategies**	**Actions**	**Timelines**	**Outcomes/Measures of achievement**
4.1 Achieve a workforce which provides right skills, right place, right time for best delivery and outcomes cont…..	4.1.5 Monitor skills of staff	Implement Tikaka Hauroa (Māori Mental Health) Development Programme Reach agreement with providers on compliance with Health Practitioners Competency Assurance Bill Clarify implications of Health Practitioners Competency Assurance Bill on credentialling Fully implement credentialling programmes for medical staff (Provider arm) as appropriate	August 03 Progressively	Accreditate Tikaka Hauroa on NZQA frameworks Meet College/ legislation requirements
	4.1.6 Work to ensure all contracted health and disability providers are appropriately developing their workforce	Develop HR requirements for CDHB providers collaborating with NGOs on career pathways and training	Annually	Healthcare workforce appropriately developed
	4.1.7 Improve system of performance management	Evaluate current system of performance management and implement changes	December 03	Consistent proactive approach to performance management
	4.1.8 Improve efficiency of recruitment advertising	Implement electronic recruitment system; continue to monitor usage	April 04	Increased recruitment pool Cost effective recruitment process
	4.1.9 Work to implement objectives of Primary Health Care Strategy	Respond to PHO and Ministry of Health initiatives regarding workforce development	Ongoing	Improved retention and recruitment of primary care workers

DIRECTION 4: DEVELOPING CANTERBURY'S HEALTH CARE WORKFORCE				
Goals	**Strategies**	**Actions**	**Timelines**	**Outcomes/Measures of achievement**
4.2 The CDHB is seen as preferred district for health workers in New Zealand	4.2.1 Improve work environment through involvement of staff at all levels of organisation	Promotion of teamwork	Ongoing	Adequate support for professional development
		Develop a transparent prioritisation of Training and Development needs for each workforce group	Ongoing	
		Include clinical staff in decision-making at all levels of the organisation	Ongoing	Improved Clinical Governance Complete the Devolution programme
		Continue to encourage staff to identify organisational / divisional strengths and weaknesses	Ongoing	Continue to achieve high retention rates in national benchmarking reviews
		Identify and implement manageable workloads that benefit patient care outcomes	Ongoing	Reduce the use of agency staff Reduce the vacancy rate for nursing
		Work towards improving family friendly work environment	Ongoing	
		Continue to carry out organisational culture survey to ascertain staff feelings about the work environment	October 03	Staff Culture Survey demonstrates improvement in all six key areas
		Utilise exit interview information	Ongoing	Improved retention rates
		Regular communication forums with Unions to work on key issues	Ongoing	Improved Industrial Relations
		Enter into ACC Partnership Programme	June 04	Improve workplace safety Reduce ACC levies

DIRECTION 4: DEVELOPING CANTERBURY'S HEALTH CARE WORKFORCE				
Goals	**Strategies**	**Actions**	**Timelines**	**Outcomes/Measures of achievement**
4.3 Support and participate in government initiatives to address workforce issues	4.3.1 Ensure Clinical Training Agency education funds are accessed and fully utilised each training period	Input to Clinical Training Agency Advisory Group process Link Clinical Training Agency planning process with DHB workforce planning Commit all funds	Annually October	Clinical Training Agency funding is fully utilised Available funding is accessed for organisational need
	4.3.2 Participate with other DHBs in consistent approach to collective negotiations	Collaborate with other DHBs over benchmarking data and IR strategies	Ongoing	Consistent approach achieved

CDHB Workforce Details (numbers) are in Attachment 7N.

DIRECTION 5: BEING A LEADER IN HOSPITAL AND HEALTH CARE SERVICES				
Goals	**Strategies**	**Actions**	**Timelines**	**Outcomes/Measures of achievement**
5.1 Services are responsive to user needs	5.1.1 Develop a facilities plan that reflects user needs (Refer 1.3.1)	Engage Consultants to assist with preparation of Facilities Masterplan and Business Cases Community Consultation as required Ensure all plans incorporate requirements of Disability Action Plan	Commence July 03 Master Plan complete April 04 Burwood 04 Stage II ChCh Womens 05	Two services are configured from a patient/community focus/need Facility development reflects future needs - access for targeted populations is improved - efficient use of sites to reduce duplication and gain the most cost effective use of locations - people with disabilities find sites user friendly
	5.1.2 Review outpatient services and options for improved access to diagnostic services	Complete Review Implement Review results	September 03 From January 04	Improved access to diagnostic services Reduced outpatient waiting times
	5.1.3 Delivery of rural services is integrated and sustainable	Close liaison between rural PHOs and Ashburton Community and Hospital Services Evaluation of PHO interest in greater range of rural health service delivery	ongoing February 04	Improved access/ efficient use of resources Improved service delivery to rural communities
	5.1.4 Identify services/ programmes that will achieve improvements against chosen health priorities	Implement strategy for health promoting hospitals/services/ programmes covering health gain areas (Plans for further improvements tabled for consideration and action)	December 04	All CDHB sites smokefree

DIRECTION 5: BEING A LEADER IN HOSPITAL AND HEALTH CARE SERVICES				
Goals	**Strategies**	**Actions**	**Timelines**	**Outcomes/Measures of achievement**
5.2 Support leadership in research	5.2.1 Foster research especially in health priority areas	Invest in high priority area scholarships Joint appointment of Māori Research Manager Participate in Centre for Evidence Based Practice Contribute to research in priority areas	Review September annually	Robust Needs Assessment process Improved recruitment and retention of staff Improved culture of organisation Increased CDHB credibility
5.3 Optimise management of elective services	5.3.1 Involve hospital and community clinicians in all aspects of elective service management	Consult with stakeholders Review hospital processes to ensure maximum productivity Retain data on un-met needs to utilise in needs assessment data report Look at emerging trends re elective and acute surgery Agree GP referral criteria	Ongoing Ongoing	Improved service delivery Compliance with CFA and Ministry of Health policy Clinical planning defines core business
5.4 Work with other DHBs, regionally and nationally	5.4.1 Identify where CDHB can assist regional areas to meet needs	Reach agreement on the provision of specialty services in the South Island/ agree process for determining national services (Outline inter-regional flow implications) Develop Regional Services Plan for two services working with other DHBs	March 04 June 04	Efficient use of regional resources Improved health service delivery
	5.4.2 Work with South Island Regional Mental Health Network to continue development of mental health services in South Island	Undertake regional Mental health plans in agreed areas Progress MOU with South Island DHBs re regional provision of psychiatric services via South Island Mental Health Network	As per Project Plans Get agreement December 03	Improved consistency of regional services MoU in place

3.1.2 Minister of Health's Objectives 2003-04[1]

Mandatory Strategic Objective 1: He Korowai Oranga

The Canterbury DHB adopted a Māori Health Action Plan in July 2002. The key focus of this has been implementing He Korowai Oranga. Key strategies for action on Māori health are included in the Canterbury DHB Core Directions (Section 3.1.1).

Objectives	Milestones/Actions
Develop policy on and implement Ethnicity Data Collection throughout CDHB (2 year timeframes to cover all CDHB providers))	▪ Ethnicity Data Collection Policy signed off; ▪ Ethnicity Data Collection Audit undertaken in provider arm, and quality improvement plans developed [2 services audited) ▪ Ethnicity Data Collection Audit plan developed for community providers; ▪ Māori Health Plans required from community & primary providers identify progress towards developing accurate ethnicity data at provider level, especially NHI data ▪ Training modules piloted, reviewed and implemented ▪ Information Support systems refinements are scoped and implemented to collect and report accurate ethnicity data information according to agreed standard
Workforce Development – Canterbury DHB is recognised as a leader in Māori health worker development	▪ Māori Mental Health Service Development Coordinator is working effectively to support the development Māori Mental Health community providers and agreed position milestones met, including establishment of provider network; ▪ Te Roopu WhioWhio [SI Māori Mental Health workstream] survey is completed and analysed and other 2003-04 agreed milestones are met; ▪ SI Māori Health Workforce Development Plan is drafted for consultation with SI DHBs & MOH; ▪ Māori Structures in CDHB continue to engage Māori staff and be supported by CDHB management e.g. Te Ao Marama, nga komiti; ▪ Career pathway planning for Māori staff continues ▪ Māori are attracted to health careers through national, regional and district strategies including Māori Health presence at secondary school and tertiary institution networking opportunities; ▪ cultural training for CDHB staff continues to be available at least school and tertiary institution networking opportunities ▪ Secondary South Island Māori Provider and Service Worker Hui held in Canterbury

[1] Indicators and targets are correlated with Qualitiative and Quantitative Accountability Indicators in Section 5.

He Korowai Oranga cont…..	
Support reduction in health inequalities through Service Development in priority areas e.g. Diabetes, Cancers, Cardiovascular disease, Child Health	▪ Support reduction in health inequalities through Service Development in priority areas such as Cardiovascular disease including increased resourcing across the continuum from population health to community, primary and secondary care. ▪ Final Diabetes plan shows increased links with co-morbidities for Cancers and cardiovascular disease ▪ Research project re impact on health outcomes of Māori community health worker involvement [Cardio-respiratory outreach] commences ▪ Community Nutrition & Physical Activity programme is agreed with MOH Public Health, with priority focus on Māori and Pacific ▪ Implement Well Child framework
Encourage Māori participation in all CDHB activities at all levels	▪ MOU with Manawhenua ki Waitaha agreed ▪ Quarterly meetings with Te Runanga o Nga Maata Waka held ▪ Quarterly meetings with Māori Community held ▪ Māori komiti in CDHB provider arm continues ▪ Regular meetings held with Māori providers and services ▪ Māori involvement in Needs Assessment process and CDHB planning/working group activities e.g. PHO development ▪ Māori managers across CDHB meet regularly to develop, advocate and implement consistent Māori strategic directions
Implement inter- and intra-sectoral development opportunities that support the development of Whanau Ora [e.g. CYFS, Ministry of Education, Ministry of Health [Disability & Population Health], Māori provider- primary-secondary provision	▪ Pilot joint contracts with 2 Māori providers], ▪ Ministry of Education [align Well Child/Positive Parenting contracts], ▪ Ministry of Health funded Disability [Service Development Coordinator position in post to investigate Māori disability information and needs in Canterbury; ▪ Quality improvement initiatives focused on community disability providers enhance service response to Māori consumers ▪ Referrals to Māori providers eg, Well Child, enhanced and Māori providers develop increased credibility and profile ▪ Intersectoral Māori provider hui held looking at common vision and Māori practice model in Canterbury to support vision of Whanau Ora
Approach	▪ Canterbury DHB's approach is an inclusive one, that involves Manawhenua, Māori community, Māori community providers, Māori Service workers in the development, implementation and monitoring of progress
Risks and Mitigation Strategies	▪ Risks, particularly around resourcing, human and financial ▪ Risk are mitigated through consultative engagement, inclusion in budgeting processes
Indicators and Targets	▪ These flow out of above milestones ▪ Data is captured in performance indicators in Section 5.

Mandatory Strategic Objective 2: New Zealand Disability Strategy

Canterbury DHB has developed a Disability Strategy Action Plan (DSAP, Attachment 7K) which outlines the steps it will take to implement the NZ Disability Strategy. The DHB aims to ensure it contributes to a 'non disability' society through its actions, and the action of the providers with whom it contracts. The DSAP involves disability-sensitive approaches to staff education, property development, employment, contracting and monitoring.

Annual Objective(s)	▪ Continue to promote and provide a non-disabling culture within the CDHB ▪ Progressively update information relating to disabled people and disability issues ▪ Update all provider contracts to ensure implementation of the NZ Disability Strategy occurs
Approach	▪ The CDHB will continue to utilise DSAC (Disability & Support Advisory Committee) as an advisory group. The CDHB's aim is to ensure that new facilities, workforce training and employment practices promote a non-disabling society across all providers
Milestones/actions	▪ A consultation 'round' is planned and completed to enable collection of information relating to disabled people and disability issues for Health Needs Assessment due June 2004 ▪ Needs analysis of Māori with disabilities to be undertaken as part of Health Needs Assessment ▪ Training commenced for current staff from January 2004 ▪ As HR policies updated they reflect EEO principles ▪ Provider contracts include Disability Strategy clause from July 2003
Risks and Mitigation Strategies	▪ Ongoing communication with disability community regarding activity within the CDHB with opportunities for feedback, discussion of issues and identification of potential problems ▪ Cost of staff training: look at opportunities for cost-effective delivery
Indicators and Targets	▪ Training in disability issues to commence ▪ Needs Assessment report completed by June 2004 ▪ Twice yearly monitoring of DSAP in place

Mandatory Strategic Objective 3: Elective Services and Radiotherapy Waiting Times

Meeting Demand for elective services is of concern to the CDHB. The CDHB Elective Services Steering Committee presented a plan to the February 2003 Board Meeting. The key focus is provision of services letting people know when they can expect to be seen or not and the collection of information to demonstrate demand.

Annual Objective(s)	To ensure the completion of the implementation of Ministry of Health policy and ensure processes of maintenance and monitoring are in place.
Approach	The plan for elective services will focus upon two streams of activity: Management of the referral interface and a focus upon patients remaining in the community / primary care until the optimal time for referral or treatment is reached (given limited hospital resources). Monitoring of key performance indicators within the hospital system to ensure the most effective and efficient use of elective services resources and funding. The objective of these streams of activity is to: Introduce a policy change to the classification of patients on waiting lists for surgery, in order to meet Ministry of Health requirements and to ensure accurate benchmarking of Canterbury DHB against other DHBs. Reduction and elimination of the "residual waiting list" by transferring responsibility / duty of care for patients unlikely to be treated to the primary care provider and provide GPs with transparency around "rarely seen / treated" categories or conditions. Extension of Active Review processes across all services for patients without certainty of treatment within 6 months but who are likely to deteriorate or are just below the funding threshold. To achieve this, several initiatives have been implemented or are in the process of implementation: Identification of what can be delivered by the hospital and make this transparent – GP Information Folder with "Rarely Done" lists; pre-screening processes that "turn around" referrals for services that cannot be provided. Those unlikely to be treated / seen within 6 months are monitored in the community –Active Review processes, the resourcing of GP Liaison and "screening" services. Accessing of supports in the community – community services, GP and practice nurse education / upskilling, advice services, access to diagnostic investigations and community clinics. Establishment of "screening" functions within the hospital – outpatient nurses with a special interest, GP Liaisons, booking clerks and Active Review facilitators

	Encouragement of communication between primary and secondary care – care plans for patients on elective waiting lists; referral guidelines; reassessment processes; GP Liaison; outpatient nurses with a special interest; integration forums (such as Elder Care Canterbury, Integration Design Group and the Elective Services Steering Group) Focus of hospital resources on what can be done efficiently –multi-disciplinary approach across services, cluster model, clinical governance, key performance indicators and advice and guidance to primary care. In the FY03/04 these processes will be fully implemented and a system of maintenance and monitoring established in accordance with the Ministry of Health Continuous Quality Improvement (CQI) program for elective services. This strategy also complies with the CDHB program for moving towards Quality Health NZ accreditation.
Milestones/Actions	**September 2003** – Patients clearly identified in respective categories (Certainty, Active Review, GP Care) and advised of this status. All patients in GP Care with a documented Care Plan. Ongoing process of Active Review. **December 2003** – Database of care plan information (that clearly illustrates the level of need not being met) to be reviewed to determine if level of access to elective intervention in each service is adequate and make recommendations for improvement where it is not. **March 2004** – Review financially sustainable thresholds and make recommendations to Annual Plan and budget process to address gaps in elective service delivery. **June 2004** – Confirm strategy for ongoing management of elective services within funding constraints (including review of provider arm capacity and capacity of primary care to manage the patients in the interim).
Risks and Mitigation Strategies	**Unmet promises** – number of patients for whom certainty of treatment within 6 months was promised but who are now overdue for their surgery **Provider capacity** – ability of hospital provider arms to deliver funded volumes given constraints on site, staffing (anaesthetic, nursing, SMO, RMO) and level of community supports equipped to manage patients in the interim **Level of need of patients** – where patients not being offered assessment or surgery may fall into a state of unreasonable distress, ill health or incapacity with no ability by the provider arm to increase capacity to deliver a service once the patient has deteriorated. **Reliability of assessment / CPAC tools** – where the methods used to determine national access levels to assessment or surgery are unreliable, are applied inconsistently or change, causing risk or anomaly in the financially sustainable thresholds for whether a patient can access publicly funded services or not. **Ad hoc responses to pressure or lobby groups** – where one-off increases in services are introduced without reference to an overall plan for delivery of elective services, but are introduced to satisfy public or political pressure groups, hence creating disincentives for managing a robust rationing system.
Indicators and Targets	Elective Services Performance Indicators (monthly) Internal audit reports (monthly and annually) Crown Funding Agreement reporting (quarterly) District Annual Plan reporting (quarterly)

Mandatory Strategic Objective 4: Diabetes

The Canterbury DHB signed off a Interim Diabetes Plan in 2002. Service developments included:

- additional retinal screening volumes
- reviewing retinal screening provision
- supporting Leadership Programmes for Māori and Pacific Peoples
- increased access to community podiatry

A Diabetes Steering Group has been set up to drive strategic direction alongside the Local Diabetes Team.

Annual Objective(s)	▪ To review progress on implementation of Diabetes Plan October 02 ▪ Combined action on diabetes and cardiovascular diseases and cancer as relevant ▪ Present Diabetes Strategy October 03
Approach	▪ Adopt actions to: - reduce incidence of diabetes, particularly in high risk populations - focus on early intervention, and - reduce the harm caused by diabetes to people with diabetes
Milestones/Actions	▪ Detail will be covered in the Diabetes Strategy October 03 and is likely to cover increased access to Retinal Screening ▪ Increased access to services for adolescents with diabetes ▪ Targeting Māori and Pacific Peoples populations ▪ Improving information for annual report reviews ▪ Supporting workforce initiatives, particularly those focusing on improving nursing and community support worker skills with the Christchurch Polytechnic ▪ Support the establishment of a Community Nutrition Programme for Māori and Pacific Peoples
Risks and Mitigation Strategies	Risk ▪ Resources, both financial and people Mitigation ▪ To plan an achievable work programme
Indicators and Targets	▪ As per the Interim Plan/Diabetes Strategy indicators covered in Section 5 of this document

Mandatory Strategic Objective 5: Inequalities

The Canterbury DHB is aware of the impact of socio-economic status, education and employment has on people's health. It will incorporate the equity lens in its service development planning and funding and work intersectorally through groups like Strengthening Families on inequalities.

Annual Objective(s)	▪ To reduce health inequalities
Approach	▪ Target resources to identified relevant populations ▪ Use equity lens in planning ▪ Support initiatives which develop community capital; building on the community's proposals to effect change
Milestones/Actions	▪ All health gain and clinical service plans* include health promotion ▪ continue to support Healthy Christchurch initiative
Risks and Mitigation Strategies	▪ Resources (staff and funding) not supporting this approach ▪ Mitigated by training and reorientating service plans to ensure inequalities a priority area.
Indicators and Targets	All plans have clearly identified intervention goals and monitoring against target ▪ Clear direction for each planning area ▪ Links with Public Health funding decisions locally and regionally ▪ See Section 5, Māori and Pacific Peoples indicator

* Page 16 outlines planning timeline for service, populations and disease groups.

Mandatory Strategic Objective 6: Primary Care

Canterbury DHB will implement the Primary Health Care Strategy 2001 by establishing Primary Health Organisations, and implementing a Community and Primary Health Care Plan in Canterbury. The aim is to improve population health by improving access to primary care and public health programmes designed to suit local needs.

Annual Objective(s)	▪ Complete the CDHB Community and Primary Health Care Plan ▪ Establish three Primary Health Organisations in Canterbury, one in Christchurch and two in rural Canterbury
Approach	▪ Develop integration initiatives and coordinate care across service areas ▪ Develop primary care workforce in particular opportunities for primary care nursing ▪ Develop information and quality improvement systems ▪ Work with interested communities and provider groups to develop Primary Health Organisations
Milestones/Actions	Community and Primary Health Care Plan Development of Steering Group ▪ Project plan for primary care developed by October 2003 and approved by Board ▪ Links made with other plans, including Cardiovascular, Diabetes, Child Health Primary Health Organisations ▪ Communities and provider groups including Maori who are interested in PHO development identified and supported ▪ Funding for rural workforce retention and recruitment allocated ▪ PHO establishment funding applied for ▪ Work with developing PHOs to promote enrolment of populations ▪ Work with developing PHOs to plan primary health nursing roles in the PHO ▪ PHOs approved and 'go live' ▪ First quarter review of PHO's progress ▪ Inclusion of PHOs in scoping work in future of rural hospitals and health centres
Risks and Mitigation Strategies	Community and Primary Health Care Plan ▪ Plan is not agreed on by stakeholders ▪ Close consultation with stakeholders and adequate information about resources Primary Health Organisations ▪ Primary Health Organisations do not establish, because of funding problems, lack of practitioner buy-in, or lack of community involvement ▪ Support PHO establishment committees, advocate for adequate funding, encourage participation of all primary providers and community representatives in an area ▪ PHOs experience technical problems associated with IT systems, which disrupts quarterly payments. ▪ Work closely with MoH and PHO to ensure IT systems are adequate and there are experts on hand to help as problems arise
Indicators and Targets	▪ PHOs must meet Canterbury DHB/Ministry of Health minimum criteria ▪ As per Section 5 PRI-04, PRI-01, PRI-02

Mandatory Strategic Objective 7: Mental Health Blueprint

Canterbury DHB planning and service development for mental health services is in line with the Ministry of Health's expectations for working towards the Blueprint benchmarks over the next two years. The South Island is unlikely to receive significant additional money in the future. (Draft Regional Mental Health Work Plan 2003/04 is Attachment 7D).

Annual Objective(s)	Establish: ▪ Improved System of Care for CDHB Mental Health Services ▪ Work with South Island Mental Health Network to continue development of Mental Health Services in South Island ▪ Spend mental health money on mental health services
Approach	▪ Implement CDHB Mental Health Plan (expected to be presented to Board July 2003) ▪ Implement aspects of South Island Mental Health projects as relevant for Canterbury ▪ Involve all stakeholders in mental health sector in service development ▪ Improve MHINC data collection
Milestones/Actions	▪ Trial outcome measurement as a basis for contracting with one mental health provider in 2003-04 ▪ Implement recommendations of Residential Accommodation Respite Care, Needs Assessment Service Coordination, South Island Alcohol and Other Drug reviews ▪ Continue to progress clinical governance of South Island Forensic Services ▪ Progress to a System of Care via contracts and working together for CDHB mental health providers ▪ Implement GP Link programme with WINZ ▪ Monitor mental health spend by providers ▪ Undertake activity in regional mental health plan 2003/04.
Risks and Mitigation Strategies	Risk ▪ Sector resistant to change Mitigation ▪ Involve stakeholders in service development planning
Indicators and Targets	▪ More coordination of services and better outcomes for consumers ▪ Improve consistency of regional services ▪ See Section 5

3.1.3 Additional CDHB Objectives for 2003-04

CDHB Strategic Objective 1: Pacific Peoples

The Canterbury DHB adopted Pacific Peoples Health Action Plan in May 2002. Its focus is:

a) Support Pacific People as health providers, including increasing the number of Pacific people in the health workforce
b) Involve Pacific Peoples in health service development
c) Accurately collect ethnicity data
d) Establish a Pacific People's primary health service
e) Help to increase collaboration between Pacific providers

Annual Objective(s)	▪ Incorporate Pacific focus in all CDHB planning and inter-sectoral activities ▪ Pacific Provider Development, including development and quality improvement plans ▪ Pacific Provider Development Fund fully expended according to agreed Plan ▪ Pacific Workforce Development ▪ Pacific participation – ensuring regular and robust involvement of Pacific communities and providers ▪ Ethnicity Data Collection [as with Māori] ▪ Pacific Disability – proposal to MOH for Pacific Disability Needs Analysis Project ▪ LinkAGE project incorporates focus on Pacific elderly ▪ Pacific Primary Clinic operational
Approach	▪ Canterbury DHB's approach is an inclusive, consultative one, that involves Pacific communities community providers, service workers in the development, implementation and monitoring of progress
Milestones/Actions	▪ CDHB consultation and engagement activities incorporate Pacific focus ▪ Implement PPDF to support agreed development plans for 3 Pacific providers, to ensure sustainable, quality development, according to plan agreed with providers and MOH ▪ Pacific Primary Clinic commences and progress monitored ▪ Pacific Community Health Worker position at Union & Community Health Centre implemented effectively in conjunction with Pacific Community Nursing Project ▪ Focused Pacific milestones are included in all CDHB plans to improve Pacific Health outcomes, including resourcing and targets ▪ A Pacific focus is included in intersectoral development activities e.g. CYFS, Ministry of Education, Ministry of Health [Public Health & Disability] ▪ LinkAGE project identifies activities to improve service access for Pacific elderly ▪ Workforce development – Provider arm staff meetings continue; Canterbury is seen as a positive environment for recruitment and retention of Pacific staff; Pacific career development pathways and mentoring of Pacific staff occurs [clinical, management, cultural]; CDHB actively participates in MOH Pacific Branch Workforce Development project
Risks and Mitigation Strategies	▪ Risks particularly around human and financial resources ▪ Mitigation of above through consultative engagement and inclusion in budgeting processes
Indicators and Targets	▪ As attached in Section 5 ▪ Achievement of and progress on above milestones/actions

CDHB Strategic Objective 2: Health of Older People

Canterbury is a Lead DHB in relation to older people's health services. In March 2003 a Discussion Document relating to the integrated Continuum of Care has been circulated to key stakeholders for their feedback. The DHB works closely with the integration project, Elder Care Canterbury, and has developed a system of integrated care.

Annual Objective(s)	▪ Begin to progress coordination and integration to ensure provision of seamless, appropriate services for the Elderly – right service(s), right place, right time – proactive prevention, early intervention, management through implementation of LinkAGE project work.(see Direction 3.1 pg 22)
Approach	▪ Standardised health needs assessment tool agreed and pilot started in conjunction with the Ministry of Health, throughout Canterbury. ▪ Develop and start implementation of Integrated Continuum of Care throughout Canterbury ▪ Develop cross sectoral information sharing system noting services available; policy protocols, procedures ▪ Develop and implement communication strategy – cross sectoral, public ▪ Undertake workforce development for agreed philosophy and integrated Continuum of Care Model ▪ Undertake health promotion and maintenance for older people
Milestones/Actions	▪ Comprehensive health needs assessment tool pilot started in 2003-04 ▪ Continue to support working group investigating Acute Stroke Unit at Christchurch Hospital ▪ Undertake workforce development for agreed philosophy and Integrated Continuum of Care model ▪ Start implementation of Home Support Review recommendations and ensure contracting strategies in place ▪ Develop Continence Strategy Scope ▪ COSE (Co-ordinator of Services for the Elderly) model evaluation commenced. ▪ Working through Healthy Christchurch to link with joint Christchurch City Council/CDHB activities on older people ▪ Quarterly LinkAGE newsletters ▪ Reports to Elder Care Canterbury Project Forum bi-monthly meetings ▪ Reports to monthly Community Stakeholder Group meetings ▪ HealthLine and Health First and Stakeholder News articles regular contributions ▪ Stocktake of home support workforce; establish policy on home support workforce ▪ Investigate Step-down facility ▪ Establish a resource service providing information on services for the elderly ▪ Continue to consult and respond to concerns of Maori and Pacific Peoples
Risks and Mitigation Strategies	▪ The Ministry of Health does not devolve sufficient funding to service contracts and/or meet predicted growth in demand for services through increased numbers of older people who are also living longer. Need to continue to work closely with the Ministry to ensure understanding of sector and contracts that will be devolved. ▪ There has been a loss of expertise in the Ministry of Health during the lead up to devolution – DHB needs to ensure that sufficient experienced staff are part of the Ministry's devolution package. ▪ Risk that the delayed devolution will reduce the perceived importance of the LinkAGE project which is a significant part of implementing the Health of Older People Strategy. There is pressure from the community, particularly via the Elder Care Canterbury Project to make significant progress during this financial year.
Indicators and Targets	▪ As per milestones above

CDHB Strategic Objective 3: Child Health

The Child Health Project is based on the "Child Health Strategy Report" (May, 2002). Its overall goal is to achieve a seamless, coordinated child health service spanning all areas of child health from illness prevention through tertiary services including mental health and disability support services, Māori and Pacific Health. Work undertaken in 2002/03 included implementing a Communications Plan; identifying the vision for Child Health with stakeholders; appointing a Child Health Project Manager; and completing a review of our Child Health contracts as well as understanding other Child Health funding arrangements. The objectives below build on work to date.

Annual Objective(s)	▪ Continue to implement CDHB's "Child Health Strategy Report" including - exploring web based child health services directory and parent held child health record; action plan for Māori; Pacific service development - Establish case management system for children with complex needs such as severe disabilities and behavioural needs - Select feasible measures that can be taken now to improve service quality and integration from those identified by the stakeholder group. - Contract and monitor Well Child providers in line with the Well Child Framework. ▪ Establish systems that comply with national systems (eg, National Immunisation Register and Kidslink).
Approach	▪ Led by CDHB in a project format. ▪ Identify short, medium and long-term actions and implement. ▪ Work together with other child health funders. ▪ Keep stakeholders informed and involved.
Milestones/Actions	▪ Information Strategy developed to support implementation of Nationally specified and local systems. ▪ Site redevelopments reflect support of Child Health Strategy (eg, Standards for the Wellbeing of Children in Healthcare; Family Centred Care). ▪ Review of contracts and any associated change management plan completed and implemented. ▪ Implement Family Violence Guidelines
Risks and Mitigation Strategies	Risk ▪ Resource limitations ▪ Failure to incentivise behavioural change. Mitigation strategy ▪ Identify actions that can be taken now within existing resources. ▪ Reprioritise resources to support actions.
Indicators and Targets	▪ Improve health indicators as per CFA (Section 5) ▪ All Well Child services on new framework by end June 2004. ▪ Meet CFA requirements for national information systems. ▪ Service providers/other sectors report better access to information to support service provision and resource allocation. ▪ Facilities reflect service and service user/family needs. ▪ Case management system in place June 2004. ▪ Measures identified by stakeholder group agreed and implemented in a timely manner. ▪ Early Start Program supported

CDHB Strategic Objective 4: Cardiovascular Disease

As part of preparing a plan on Cardiovascular Disease for Canterbury DHB work in 2002/03 on Cardiovascular has included:

- Meeting on public health issues in Cardiovascular disease
- Evaluation of a 24 hour angioplasty proposal
- Review of Literature
- Bringing together of a Cardiovascular Steering Group representing providers and users
- Building on national work

Annual Objective(s)	▪ Develop a Cardiovascular Action Plan for Canterbury, (present to Board July) covering the continuum from health promotion, disease prevention, treatment, rehabilitation and palliative care.
Approach	▪ Work with key stakeholders (Steering Group) to develop plan, and ensure that the plan is compatible with national guidelines. The plan will be consistent with other CDHB plans and contracts, with links in particular to Māori, Pacific and diabetes actions plans. The plan should build on Canterbury primary providers' and public health plans.
Milestones/Actions	▪ Preliminary discussions with key stakeholders and establishment of Steering Group ▪ Economic evaluation of 24 hour angioplasty proposal ▪ CDHB Board adopts Cardiovascular Disease Strategy July 2003 ▪ Implementation Plan developed and implemented.
Risks and Mitigation Strategies	Risk: ▪ Increasing incidence of cardiovascular disease due to ageing population and lifestyle choices ▪ Resource limitations Mitigation: ▪ Work closely with other sectors to encourage Canterbury people of all ages to adopt 'healthy lifestyle' ▪ Work with Primary Health Organisations to focus health promotion activities on reduction in cardiovascular and related diseases ▪ Identify best use of funds now available for secondary and tertiary treatment
Indicators and Targets	▪ As per milestones above ▪ See Section 5

CDHB Strategic Objective 5: Cancer/Palliative Care

The CDHB Cancer Strategy will build on national policies as well as noting issues raised in its Palliative Care Strategy presented to the Canterbury DHB Board May 2003 and review of Oncology Services (November 2002).
Key policy documents are:

- Cancer Control Strategy for New Zealand
- NZ Health Strategy
- Canterbury DHB Strategic Plan 2002-06
- The NZ Palliative Care Strategy
- Healthy Eating: Health Action (February 2003)

Annual Objective(s)	▪ Maintain current levels of public education regarding healthy lifestyle and its contribution to cancer prevention. ▪ Complete a comprehensive clinical planning process (following publication of the NZ Cancer control strategy) to address service integration, facility planning and capacity needs. ▪ Eliminate fragmentation and variable access criteria within local Palliative care services. ▪ Improve access to local Palliative Care Services within the Canterbury district.
Approach	▪ Continue to support programmes focusing on improving nutrition, smoke free lifestyles, limiting alcohol intake, increasing exercise and sun protection campaigns. ▪ Utilise the NZ Cancer control strategy and evidence from Needs Analysis to form the basis of a planning process for the district. ▪ Establish a CDHB Community based local Palliative Care Service and consolidate funding streams. ▪ Establish a working group to determine consistent access criteria and clarify patient flow within local Palliative Care services. ▪ Develop a plan for establishment of a Specialist Palliative Care Service. ▪ Work with neighbouring DHBs to ensure that the terms of national cancer screening contracts are met for the region
Milestones/Actions	▪ Board adopt CDHB Cancer Strategy September 2003. ▪ Current level of health education maintained. ▪ Planning process is undertaken and completed by June 2004. ▪ Contract in place for community based local Palliative Care Service. ▪ Palliative care access criteria defined and utilised. ▪ Review national screening contracts annually to ensure the region's population is accessing all screening services
Risks and Mitigation Strategies	▪ Risk: Sign-off of the NZ Cancer control strategy is delayed. ▪ Risk: focus of Palliative Care planning needs to be broader to include those patients with non-cancer diseases. Ensure representation from these groups is included in all service delivery planning.
Indicators and Targets	▪ Section 5 CAN-01 ▪ As per CDHB Cancer and Palliative Care Strategies.

CDHB Strategic Objective 6: Oral Health

The Oral Health Strategy (due to go to Board in May 2003) has been developed to identify those aspects of oral health care that are publicly funded and to identify activities, noted below, that will provide benefit to the population of Canterbury. (20% of oral health treatment is publicly funded).

Annual Objective(s)	▪ Incorporate Oral Health focus in provision of existing health promotion work ▪ Develop and communicate a position on water fluoridation ▪ Clarify position on School Dental Service Delivery ▪ Develop robust information regarding Oral Health status ▪ Maintain appropriate workforce
Approach	▪ To use relevant CDHB Action plans and contracts to ensure that Oral Health education is incorporated and promoted along with other 'healthy lifestyle' messages. Agreeing a CDHB position statement on Fluoridation will help further discussion around this. ▪ The Dental Clinic review recommendations regarding School Dental facilities provide impetus for work around future integrated service delivery structures. ▪ Work to ensure good data collection to help develop an accurate assessment of oral health status and service delivery performance.
Milestones/Actions	▪ Participation by representatives of all Oral Health teams in any oral health service reviews and Community and Public Health Programme planning ▪ CDHB stated position on water fluoridation October 03 ▪ Completed action plan for School and Community dental service facilities and staffing structure November 03 ▪ Scope information systems in CDHB provider arm Oral Health Services and determine a way forward by July 04 ▪ Working relationship with the University to support recruitment to training ▪ Comprehensive review of service delivery and contract issues for Hospital Dental Service
Risks and Mitigation Strategies	▪ Fluoridation: a recent decision to cease fluoridation of Ashburton's water supply indicated poor support for fluoridation. A communication programme in relation to a statement on this subject is required ▪ Raised awareness of oral health may increase demand for services increasing the waiting list for CDHB who is the key provider for people on low income. This requires monitoring.
Indicators and Targets	▪ Section 5 (ORA-04 and ORA-01) ▪ As per Oral Health Strategy

CDHB Strategic Objective 7: Information Management

The Information Management Plan focuses on managing/analysing information and processes in order to facilitate the provision of health services. The emphasis is on providing clinical support and business solutions, rather than technology. Key aspects of health information and processes work are:

- improve information management and analysis, providing support for clinical management
- work with clinical and management areas in identifying and adopting best practises
- integration with primary and community care
- deliver information to the point of care

In approaching Information management, the CDHB works closely with stakeholders to implement solutions which satisfy their requirements.

Annual Objective(s)	IS Strategic Framework Document
	• Establish Clinical Information Systems (CIS) Plan
	• Implement the first steps of Clinical Information Systems as directed by the CIS Plan.
	• Begin a collaborative project with Canterbury primary sector on diagnostic results reporting
	WAVE Project
	• Establish Electronic Discharge Summaries
	• Inter DHB Collaboration
	  • Support the Hawkes Bay implementation of the Labs Information System into the CDHB. Nelson Marlborough DHB, Taranaki DHB multilab organisation
	  • Support the implementation of any other DHBs into the multilab organisation

Approach	▪ All IS projects signed off by the IS Advisory Group ▪ All projects controlled through normal project management processes established at CDHB ▪ Project governance groups established and will contain representatives from secondary and primary sectors as required ▪ Projects impacting primary sector will involve a full consultation with interested primary sector parties. ▪ Other DHBs will be approached and their knowledge and products used as much as possible to solve CDHB implementations
Milestones/actions	▪ Clinical Information Systems Plan activities scheduled for 2003 / 04 year completed as per plan ▪ District diagnostics results reporting project scoped and begun December 03 ▪ Electronic discharge summaries project pilot completed July 03 ▪ Roll out process as per project plan June 04 ▪ Phase II of HBDHB changes complete January 04
Risks and Mitigation Strategies	▪ Funds are made available to complete the strategic work. Mitigated by early involvement of DHB financial managers and Board to agree funds for the projects. Also the use of already developed products in use by other DHBs to minimise implementation costs ▪ Human resources availability from both primary and secondary sectors/mitigated by setting a realistic implementation plan
Indicators and Targets	▪ As per project plans flowing from the above projects ▪ Compliance with national MIS requirements.

Information associated with health and disability issues for Māori is being sought from other organisations such as the Ngai Tahu Development Corporation and Christchurch City Council. This is being fed into the Needs Assessment process.

The Mental Health Information National Collection (MHINC) dataset extract has been implemented in Canterbury DHB. There are concerns with its accuracy. This is being progressed with the National MHINC monitoring group.

3.1.4 Population Health

The timeline and planning approach to NZHS and CDHB Strategic plan priorities not yet outlined is covered under Direction 1 (Section 3.1). Opportunities however for action will still be taken without formal plans in 2003/04. Working in 2003/04 towards making the Canterbury DHB Hospital sites smokefree and implementing the Family Violence Guidelines are examples of this. This will be in association with MoH Public Health Directorate, CDHB public health services, other public health and primary care stakeholders.

The current Ministry of Health Population Health Directorate RFP process for a Community Nutrition Programme is another example of a population approach to food and exercise for Maori/Pacific Peoples' families in Canterbury. Fundamental to all this work is linking initiatives that concentrate on reducing obesity, improving nutrition, increasing exercise and reducing smoking in targeted groups.

Work to reduce suicide per se will be incorporated in Youth Strategy (due January 2004) and Mental Health Strategy (due July 2003).

3.1.5 Consultation/Community Participation

The *New Zealand Public Health and Disability Act 2000*, specifies consultation in relation to the following matters:

a) The Strategic Plan;
b) Changes to the Annual Plan; and
c) The disposal of land.

A number of the initiatives indicated in the Canterbury Annual Plans may warrant formal consultation such as reconfiguration of services The Canterbury DHB will identify consultation needs in each instance and meet its obligations in this regard.

One of our key objectives is to continue facilitating increased community participation in the assessment, planning and funding of health and disability services in Canterbury. Our *Community Engagement and Consultation Plan* will be updated by October 2003 to ensure our policies and practices are up to date and supportive of this objective.

We continue to use the following principles to guide our efforts to engage and consult with the people of our District:

Whilst consultation will be carried out for the areas specified in the legislation, there will be other instances where consultation methods such as focus groups, discussion documents and other processes will be used.

Community is defined as all people in the district. Depending on the issue or question, the 'community' will sometimes be defined as a regional one (e.g. for the South Island mental health plan). Community may also be defined as a community of interest, or a group or groups of people who should be heard from because they have particular knowledge of or interest in services or issues relating to them (eg, Māori).

People with disability-related needs and/or language barriers are, wherever appropriate and possible, included in our consultation and engagement processes. This occurs, for example, by offering meetings in accessible, appropriate venues with supports, such as interpreters.

As a part of its ongoing work, the Canterbury DHB continues to engage and consult actively with the community, including Māori and Pacific peoples.

A key focus of the CDHB Rural Plan is working with Territorial Local Authorities (LTAs) and community health groups to sustain access to health care services in rural Canterbury. This approach has helped advance the establishment of PHOs.

3.1.6 Quality and Safety

The Canterbury DHB has established a Quality and Patient Safety Council. The purpose of the Canterbury DHB Quality Council is to provide advice to the CEO on quality matters and a forum for the wider DHB (community providers and operating division) to discuss quality issues. It will facilitate on-going improvement of the quality of health delivered to the population served by the Canterbury DHB (Terms of Reference as Attachment 7F) and progress development of a strategic quality plan.

The CDHB will establish a Credentialling Board to put in place a CDHB policy and system on credentialling that both meets the needs of the organisation and health professional regulation bodies. This will also provide a forum to clarify the implications of the Health Professionals Competency Assurance Bill.

The Canterbury DHB has a responsibility to ensure that the health and disability services it funds (both internal and external) are of a high quality. In addition to the above work quality can be improved through a number of mechanisms including:

a) an effective clinical governance structure with a focus on quality services and health outcomes;
b) ensuring the type, mix and manner in which services are funded meet the health and disability needs of the district;
c) providing responsive and culturally appropriate services to consumers;
d) education and training;
e) the coordination of service delivery;
f) collaborative funding arrangements,
g) pre agreement audits for new services;
h) clear service specifications of services to be delivered;
i) development, implementation and monitoring adherence to standards;
j) development and implementation of quality systems such as clinical audit

k) achievement of Quality Health New Zealand accreditation for the DHB in-house provider and adherence to the Health & Disability Sector Standards for contracted providers. This will include ensuring all mental health providers are compliant with the National Mental Health Standards, through the contractual process.

Key actions in 2003/04 are covered in Direction 3 Working Together and Direction 4 Workforce (Section 3.1).

3.1.7 Research and Teaching

The Canterbury DHB has established a Canterbury DHB research group with the School of Medicine and will continue to allocate money to health gain area research in 2003/2004. A key development is the joint establishment of a Centre for Evidence Based Medicine between the Christchurch School of Medicine and DHB. It will look at practical ways of solving common problems and evaluating innovations for the total Canterbury DHB health sector. (Encouraging and supporting research is covered in 3.1 Direction 5).

The intersectoral Local Mapping Exercise being coordinated locally by the Christchurch City Council and Child Youth & Family has Canterbury DHB involvement and contribute to research on health need and social service solutions. The Ministry of Social Development have a research project on collaborative planning for youth in place involving the Social Policy Interagency Network (SPIN). Canterbury DHB is involved in this work. An aim is to identify meaningful health/lifestyle indicators for service development. These will include youth suicide and suicide attempts.

Canterbury DHB has always had a close and positive professional relationship with Otago University's Christchurch School of Medicine and Health Sciences. Christchurch Hospital is one of the leading teaching hospitals in the country. Many Canterbury DHB staff in other hospitals in Christchurch also have a teaching or research role at the Christchurch School of Medicine.

The Canterbury DHB will continue to foster a positive relationship with a range of other trainees of the medical workforce including the Christchurch Polytechnic Institute of Technology, University of Canterbury and others. The training of nurses, allied health professionals and scientists by these institutions is vital in ensuring a well trained workforce and the Canterbury DHB will continue to work constructively with these institutions.

3.1.8 National and Regional Services

The Canterbury DHB works with the other five South Island DHBs on joint issues through a shared services agency, 'SISSAL' (South Island Support Services Agency). It provides some of health planning and contract management functions required by the DHBs. This agency also assists to facilitate matters that have regional and/or national implications, such as projects for the South Island Mental Health Network and contracts in primary care.

The CDHB sees it has a clear role to be a lead DHB in regional and national development. It will continue to provide administrative support and clinical expertise to other DHBs. Future provision will need to include the implications of inter district flows and introduction of Population Based Funding (PBF).

As the major centre in the South Island the Canterbury DHB provides secondary and tertiary services to other DHBs (listed in Appendix 7E) often via a number of historical arrangements. CDHB sends some patients out of the South Island for specialist treatment eg paediatric heart surgery.

In 2003/04 the financial risk to DHBs of inter district flows will be limited to personal health case weighted discharges (ie acute and elective inpatient services). All DHBs will continue to provide full acute coverage for each others' residents, and elective service coverage in line with historical practices.

CDHB holds a number of regional and national service contracts. As part of contract negotiation and monitoring we will continue to engage with the affected DHBs and/or providers.

It is also expecting to work with surrounding DHBs to undertake joint planning for DSS devolution and continue to work with other South Island DHBs over PHO establishment and Public health services funding.

The CDHB also has a role to work nationally and will contribute to the DHBNZ joint work plan in areas such as negotiating a contract with the New Zealand Blood Service.

The CDHB supports DHB collaborative initiatives via DHBNZ. Three DHB collaborative initiatives have been supported by the DHB CEOs Group for attention during the 2003/04 year.

1 Smokefree DHB Workplaces and Sites

All DHB workplaces and sites will be smokefree by 31st May 2004. The CDHB will be part way through the process due to complete 31 December 04. Expectations for smokefree workplaces and sites will be included in DHB contracts with health providers at every re-negotiation opportunity. DHBNZ will support the process and assist DHBs to share best practice processes and tools.

2 Quality Use of Medicines in Hospitals

Develop a best practice system/model to reduce error in medicine management in hospitals. Work will include a stocktake of existing processes and assessment of systems that are working. Preferred model will be rolled out and implemented across all DHBs in the 2003/04 year. DHBNZ will support the process and assist DHBs to share best practice processes and tools.

3 Best Practice Sourcing of Supplies

Improve DHB performance in procurement of supplies. Each region will identify five procurement areas they will focus on for 2003/04. These areas will be included in District Annual Plans for all DHBs in the Group. DHBNZ will profile the total picture to the Minister and central agencies, and assess any common issues for national attention.

Further collaborative initiatives for action by DHBNZ and the CEO Group include:

- ***Health Sector Work Plan*** – Develop a single workplan for key projects across the sector, including Ministry policy activity, DHBNZ activity and regional DHB activity.
- ***Inter-sectoral activity*** - DHBNZ to co-ordinate and seek further inter-sectoral information from the Ministry;
- ***Ministry – CEO Forum*** – Develop an effective forum between DHB CEOs and the Ministry on policy and regulatory issues;
- ***Information Technology*** – Describe DHB information needs and seek alignment of Ministry activity in information systems and implementation of WAVE;
- ***Service Changes*** - Each region to share their best set of guidelines /rules for service change affecting more than one DHB. Large service changes to be considered by the DHB CEO – Ministry Group;
- ***Senior Medical Officer (SMO) Employment Relations*** – The CDHB will support a collective process and strategy for SMO negotiations for a national agreement;
- ***DHB Policies*** – DHBs to share policies through DHBNZ to avoid duplication

The CDHB supports District Health Boards New Zealand and will continue to participate in DHBNZ activities. DHBNZ exists to support DHBs and provide coordination of activity at the national level. DHBNZ maintains links with central agencies and works to confirm sector priorities through the Health Sector Workplan and the DHBNZ Annual Plan. DHBNZ is active in a range of areas including: Primary Health; Workforce Development; Industrial Relations; Funding and Accountability; Devolution (Health for Older People, Public Health); Service Frameworks, Pricing and prioritisation tools; and Information (WAVE).

3.1.9 Prioritisation Framework

The Canterbury DHB has agreed a set of principles to assist choices about the future funding of health services within the wider context of set Government health and disability policy and health gain areas. When making decisions about which services to provide and at what level the Canterbury DHB proposes to consider the following decision-making principles:

Effectiveness
The extent to which health and disability services improve (benefit) quality of life, such as:

- The reduction in pain
- The maintenance of current activities (lifestyle)
- The promotion of independence
- The prevention of premature death

The services which produce the most benefit are likely to be of a greater priority. The level of benefit takes into account both the benefit per person and also the number of people benefiting from the service.

Cost
The total costs of services are compared to the effectiveness of those services. This is done to ensure available funding is used to achieve the maximum possible gain.

Equity
The effectiveness of the service in improving the health of disadvantaged groups of people is considered. Disadvantaged groups include those on low incomes, Māori, Pacific peoples and refugee communities.

Māori Health
In making funding decisions, the Canterbury DHB acknowledges the Treaty of Waitangi, and encourages Māori participation in providing and using services. We want to ensure that services are appropriate and accessible to Māori.

Acceptability
The Canterbury DHB will ensure the expectations and values of New Zealanders are considered when making prioritisation decisions.

3.1.10 Relationship with Māori

The Canterbury DHB's response to the Treaty of Waitangi will be critical to the success of its activities in relation to Māori. In addition, using a Treaty of Waitangi Framework will ensure that Canterbury DHB activities have a sound basis from which to develop.

The Canterbury DHB has agreed to engage in an effective manner with Kai Tahu as manawhenua of Waitaha/Canterbury, as well as with Māori of other affiliations living in Canterbury. Monthly meetings are held with the Manawhenua Health Group ki Waitaha, which comprises the seven Canterbury runaka and Ngai Tahu Development Corporation. A Memorandum of Understanding at governance level is under discussion, as are the operational relationships that will ensue.

Quarterly hui are held with Te Runanga o Nga Maata Waka, and valuable information and feedback is conveyed and gained from the quarterly Māori community consultation hui. The meetings are widely advertised within the Māori community, and meeting notes are freely distributed.

The Canterbury DHB continues to enact, in consultation with Māori, appropriate processes to engage with the Māori community and Māori providers. This assists the gathering of information regarding Māori needs, as well as the development of actions and measures that improve Canterbury DHB's responsiveness to Māori health needs. In addition, strong relationships exist between and with Māori staff working in the Canterbury DHB services, and with Māori community providers.

Canterbury DHB has a Māori Health Plan [*Whakamahere Hauora Māori ki Waitaha]* which recognises the Canterbury DHB's Treaty obligations to Māori within the framework of the NZ Public Health and Disability Act 2000, and is consistent with the national directions outlined in *He Korowai Oranga* and *Whakatataka.* Our Māori Health Plan is currently in its implementation phase.

3.2 Funding Health Services

3.2.1 Service Coverage

The Canterbury DHB ensures that, where appropriate, the Nationwide Service Framework is applied when entering into service agreements. This includes utilising the nationally consistent service specifications and/or prices.

Canterbury DHB service development and funding works to ensure that the health service outcomes as outlined in the New Zealand Health Strategy and Disability Strategy are taken into consideration. This includes working with Māori and Pacific communities.

The Canterbury DHB facilitates timely and equitable access to appropriate health services in accordance with Crown Funding Agreement requirements, through consultation, education, funding, support, and contract management. The Canterbury DHB will work towards ensuring that the service coverage requirements of the Operational Performance Framework and Service Coverage Schedule requirement are met within its available funding (see Attachment 7B).

Canterbury DHB will fund in 2003/04 a range of services similar to 2002/03 and, upon devolution from the Ministry of Health, will also fund Services for Older People. The move to population based funding and adjustments to our financials mean we have to work to manage within our share of public health funding now and in the future. Therefore the CDHB continues to identify gaps and over provision in service coverage, key risks areas, and facilitate the resolution of issues.

Canterbury DHB will ring fence mental health funding for mental health services. It will maintain disability support money for disability support services when this is devolved from 1 October 2003.

The Canterbury DHB is working to foster the development of Maori capacity for providing the needs of Maori. As with other DHBs Maori Health and Disability Services are provided via a mixture of mental health and explicit Maori health funding and funding allocated to mainstream services. The areas for investment over the next three years have not been fully scoped but a process is underway under the oversight of Te Kahui Taumata (a group comprising the CEO and senior managers). The Canterbury DHB are currently working with a range of stakeholders which will help with identification. The Canterbury DHB will give the Ministry of Health preliminary indication of progress in September 2003 and full details by end of the year.

The CDHB and MoH Public Health Directorate have a shared decision model set up to undertake collaborative Public (Population) Health Service planning. CDHB Community and Public Health is also involved as are other DHBs as relevant. This uses the Public Health Services Handbook as a base, noting the responsibility of the Canterbury DHB on statutory issues.

3.2.2 Service Delivery

Volume Schedules for services to be purchased in 2003/04 are attached in 7A.

3.2.3 Service Monitoring and Evaluation

Financial management of the DHB is organised into 3 sections:

- Overall DHB financial management including its subsidiaries
- Funding and
- In House Provider

The purpose of the above separation is to provide transparency between the financial performance of the two key functions of the DHB (the funding and the in house provider) while keeping an overall view of the whole organisation and related subsidiaries.

Separate financial reports are prepared for each of the above three sections monthly to facilitate monitoring at both the management level as well as to the Finance, Audit and Risk Committee.

A comprehensive Risk Register has been developed to identify the financial and non-financial risks for both the DHB in-house provider and contractual providers. The Canterbury DHB has an infrastructure to address these risks and will continue to enhance systems to efficiently manage both financial and non-financial service risks.

Canterbury DHB will active monitors and assesses the quality of services provided by both the DHB in-house provider and contracted providers via service agreements. Monitoring includes appropriate procedures for reporting adverse incidents as well as routine reporting against standards (such as Health and Disability Safety Standards 2001) and processes.

Canterbury DHB will work towards developing a process to enable reporting patient outcomes initially in the mental health and older persons areas. The DHB has a programme of routine quality audits, service evaluations and ad hoc or issues based audits.

It is acknowledged that Canterbury DHB's ethnicity data collection methods require attention hence policy and implementation work noted earlier in this document.

Collaboration of the DHB with South Island Shared Services Agency Limited (SISSAL), and Health Payments Agreements and Compliance (HealthPAC) in collecting, summarising and analysis of contract information is vital to the ongoing success of the DHB and the sector in providing relevant information for ongoing decision making.

The Canterbury DHB will collaborate with national and South Island arrangements regarding the handling of Inter-regional District Flows (IDF). Work associated with the regional support this DHB gives other South Island DHBs will consider the funding impact.(See section 3.1.1 Goal 5.4).

Service monitoring is in line with individual contractual arrangements. New requirements coming from the Crown Funding Agreement, Service Coverage Document and Operational Policy Framework will be worked into new contracts over time. There are areas of service coverage which will continue to challenge the CDHB in light of the move to population based funding.

As agreements with contractual providers are renegotiated, indicative volumes are agreed against key performance indicators, so that regular monitoring of provider performance can be undertaken, utilising the "Target Monitoring" system developed in conjunction with HealthPAC and SISSAL.

The Canterbury DHB is adopting National Service Specifications, a key requirement of which is the collection of the NHI number. As provider contracts are renegotiated we are working with organisations to improve their collection methods and reporting of their NHI number (as a key element in the basic client record).

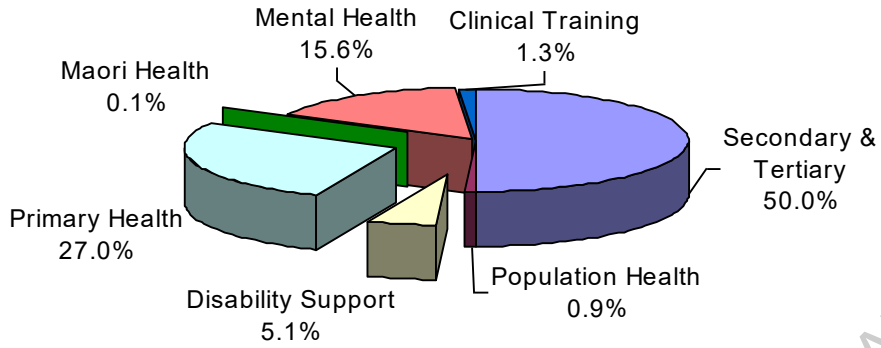
3.2.4 Additional Funding Responsibilities

The Associate Ministry of Health announced in February 2003 that funding for Disability Support Services (DSS) for older people will be transferred from the Ministry of Health to DHBs from 1 October 2003. Before the funding is transferred each DHB has to demonstrate that it can implement services integrated around older people's often changing needs and that it has robust reporting and monitoring systems in place.

Canterbury DHB has been involved in the Lead DHB Project (to establish and fund a Continuum of Care for Older Persons). We expect to be in a position where we can meet the capability criteria set by the Ministry of Health prior to October 2003, so that this funding can be devolved to the DHB at that time. An establishment plan has been provided as requested to MoH 9 May 2003 (Attachment 7H)

The following diagram indicates how current funding is allocated in the Canterbury DHB.

Canterbury DHB Funding



Note 1: Includes Brackenridge
Note 2: Excludes funding spent by mainstream services on Māori Health Services
Note 3: Excludes revenue recovered from other parties by provider arm, capability funding.

For 2003/04, the Canterbury DHB will be funding a range of health services which is similar to that of 2002/03, but will also include the Disability Support Services for older people and rural retention funding.

The Canterbury DHB will continue the process to review existing Māori health services currently being funded in Canterbury and to identify gaps and/or duplication. The focus in 2003/04 will be on consolidation and development.

Māori Health service development co-ordinators are working in the Mental Health and Disability areas to support Māori Services' development and sectoral collaboration. The Disability co-ordinator will also focus on developing a robust information set about Māori with disabilities in Canterbury.

Total expenditure on Maori services has been calculated and the Maori Health plan signals that targets need to be established to increase expenditure on Maori Health linked to Strategic Planning processes (details on Māori health expenditure are in Section 7J.

The Canterbury DHB will continue to work with the Ministry of Health to access other funds in Māori Health and Pacific Peoples health such as those available under the Māori and Pacific Peoples Development Funds. The Canterbury DHB will continue to liaise with the Ministry of Health and DHBNZ work groups to review the service specifications for these services to help ensure they align with improving health status for population groups who face inequalities.

Canterbury DHB is part of the South Island Mental Health Network. The South Island Regional Mental Health Strategic Plan was adopted by South Island DHBs and Ministry of Health in 2002. The draft work plan for 2003-2004 is underpinned by the Strategic Plan and is attached as 7D.

The plan forms the framework for achieving the Ministry of Health's Mental Health Strategy and Mental Health consumers' aims, including further developing the Blueprint benchmarks.

In a climate of limited funding growth, it is recognised that the focus of service development in the southern region will be primarily on 'better' rather than 'more' services. In practice this means that further growth in the quality and quantity of services provided, within funding parameters, will continue to occur principally by:

a) A re-configuration of existing services
b) Collaboration with the primary health sector
c) Collaboration with sectors outside health, such as, Justice and Welfare
d) Improvements in the quality of service delivery

Key strategic themes for 2003/04 are:

- Implementation of Service Development Planning, in particular:
  - Regional review of Alcohol and Drug Services.
  - Stocktake of Māori Mental Health Services
  - Implement Regional Forensic Framework
  - Review arrangements for Regional Services provided to other South Island DHBs
  - Introduction Outcome Measurement
  - Review of Needs Assessment Service Coordination
- Workforce Development
- Quality Audit and Evaluation
- Linkages with Primary Health Care
- Infrastructure Development

Only a limited amount of additional funding is available for additional mental health services in Canterbury in 2002/03. This limited additional funding has been targeted at Pacific People , services for older persons and GP liaison/integration ($220K applied for in total).

Although some mental health service reconfigurations are required to ensure the Blueprint gaps are lessened, Canterbury DHB will be working to maintain existing mental health funding for mental health services.

3.2.5 Service Reconfigurations 2003-04

As a result of work in 2002/03 the Canterbury DHB will reconfigure services in the following areas:

Areas	Key recommendations
Home Support/ District Nursing Services	Attachment 7P
Mental Health Needs Assessment Service Coordination	(Attachment 7Q draft key changes)
Alcohol and Other Drug Services	Attachment 7R
Primary Care (in line with PHO establishment)	Covered in 3.1.2 Primary Care
Mental Health Residential Accommodation/Respite	Attachment 7S

Care Services	
Diabetic Retinal Screening provision	Attachment 7T
Bone Health Services	Attachment 7U
Rural Health	Attachment 7V
Orthopaedic Services	Attachment 7W
Cancer/Oncology/Palliative Care Services	Covered in 3.1.3 Cancer
Facilities Review	Attachment 7X
Continence Services	Attachment 7Y
School Dental Clinics	Covered in 3.1.1 Oral Health

Service Configurations that will be further investigated in 2003/04 include:

Referred Radiology, Labs (referred services management)	Covered in 3.1
Child Health	Covered in 3.1.3
Older Persons Health	Covered in 3.1.3
Mental Health	Covered in 3.1.2
Outpatient Services and location of same	

The Board has approved that the Canterbury DHB's 50% shareholding in the New Zealand Centre for Reproduction be sold, this approval has received the Minister's approval. The Canterbury DHB will be working through a process with the University of Otago to progress this sale.

The introduction of population based funding means the Canterbury DHB is considered to be over funded by 2-3%. Over a period of time Government will move district health boards to equity which means the Canterbury DHB will receive less funding in future years.

This is a matter not well understood by the community and Health and Disability providers in Canterbury. Its resolution cannot wait until the 2004/05 year for planning prioritisation and implementation. This work must start now if we are to live within our budget in future years.

As a result of this other areas may be added to the list of service reconfigurations planned in 2003/04 listed above. This will be achieved by working with and consulting our clinicians in the primary, community and secondary areas that we fund. It will involve hospital and community based consultation and engagement to determine the appropriate solutions that best meets the needs of our community and then actioned to meet, in real terms our adjusted funding levels.

In all cases processes of consultation with key stakeholders have been undertaken or are planned. The Canterbury DHB is aware of implications of Ministry of Health letter of expectation regarding contracting out of services and will deal with these as appropriate.

3.3 Providing Health and Disability Services

3.3.1 Introduction

The Canterbury DHB has three fully owned subsidiaries, Canterbury Laundry Services Limited, Burwood Rehabilitation Limited and Brackenridge Estate Limited which it intends to keep operating in the medium term. It also currently has a 50% shareholding in New Zealand Centre for Reproductive Medicine Limited.

The Canterbury DHB provides services mainly to the people of the north and mid Canterbury districts. A range of secondary and tertiary services are provided to people living throughout the South Island and in some cases to some people who live throughout New Zealand. Population/public health services in Canterbury, South Canterbury and West Coast include health protection, health promotion, Māori health promotion and the Medical Officer of Health. Laboratory Services support is provided to five other DHBs in North and South Islands.

Inpatient and outpatient services are provided from a number of facilities and sites and by teams working in the community. The major hospitals include Christchurch, Burwood, Christchurch Womens, Ashburton, Hillmorton and The Princess Margaret as well as a number of hospitals in rural areas.

An organisation chart of the In-house provider an details of services provided by the Canterbury DHB are found in Attachment 7E.

Members of the DHB In-house provider have been involved in drawing up strategies and actions for the Canterbury DHB Core Directions (Section 3.1.1), the Minister's objectives (Section 3.1.2) and Canterbury DHB Objectives (Section 3.1.3).

3.3.2 Ashburton and Community Health Services

Annual Objectives		Approach	Milestones	Indicators / Targets
1. HE KOROWAI ORANGA				
1.1	**To: Ensure Māori participation and input into policy and service development**	▪ Māori Health Advisor included in relevant activities	▪ Policies reviewed with Māori Health Advisor input by December 2003	▪ 100% of policies reviewed with Māori Health Advisor input ▪ Clinical Service Plan development has agreed input
1.2	**To: Improve ethnicity data collection throughout the service**	▪ Participate in draft ethnicity data collection policy consultation process ▪ Participate in ethnicity data collection baseline review	▪ from July 2003	▪ Ethnicity data updated in each admission ▪ Review completed
2. DIABETES				
2.1	**To: Expand the Nutrition programme at Ashburton**	▪ Develop a proposal for increased funding	▪ Proposal approved July 2003 ▪ Proposal implemented December 2003	▪ Number of programmes delivered
2.2	**Establish nutrition clinics at Akaroa, Darfield, Ellesmere, Kaikoura, Oxford and Waikari**	▪ Develop a proposal for clinic establishment	▪ Proposal approved July 2003 ▪ Proposal implemented December 2003	▪ Number of programmes delivered
3. GENERAL SURGERY				
3.1	**To: Comply with guidelines for waiting time for patients on the general surgical waiting list**	▪ Review waiting lists as per CDHB processes	▪ September 2003	▪ Completed waiting list review September 2003 ▪ % of patients receiving surgery within 6 months
4. WORKFORCE				
4.1	**To: Develop a Divisional Training Plan**	▪ Undertake needs analysis ▪ Plan developed	▪ July 2003 ▪ December 2003	▪ Training meets needs
4.2	**To: Develop a Nurse Practitioner role**	▪ Develop Scope of Practice (Elder Care)	▪ June 04	▪ Scope of Practice implemented

OTHER PROJECTS		INDICATORS/TARGETS
1	Driver Assessment Service	▪ Proposal approved by CDHB ▪ Service established by Dec 2003
2	Hospital Accreditation	▪ Completed accreditation surveys for all hospitals Dec 2003 ▪ Kaikoura and Oxford Hospitals accredited November 03 ▪ Re-accreditation for Akaroa, Darfield, Ellesmere and Waikari Hospitals
3.	Clinical Service planning	▪ Completed Service plans for each service July 2003
4	Facilities	▪ Established building and equipment forecast July 2003 ▪ Completed facilities plan December 2003
5	Rural Maternity Services	▪ Completed Maternity services review and plan October 2003.

3.3.3 Burwood Hospital

Annual Objectives		Approach	Milestones	Indicators / Targets
1. 1. HE KOROWAI ORANGA				
1.1	**To: Increase staff cultural awareness.**	▪ Support staff attendance at training ▪ Raise profile of Komiti Kai Whakaharere	▪ Komiti to lead/support Māori at Burwood Hospital	▪ June 04 50% of staff have attended cultural training ▪ Komiti responds to Māori staff issues and Māori general issues.
1.2	**Improve information for Māori patients**	▪ Māori language component in Patient Information brochure	August 2003	▪ Improve communication ▪ STR 02
1.3	**To: Improve ethnicity data collection throughout the hospital**	▪ Participate in draft ethnicity data collection policy consultation process ▪ Participate in ethnicity data collection baseline review	▪ July 2003	▪ Ethnicity data updated in each admission ▪ Review completed
2. DISABILITY				
2.1	**To: Provide timely service for children with a disability requiring therapy**	▪ Approach Ministry of Health for funding to address extended waiting time	▪ Secure funding by July 03	▪ Waiting list reduced by June 2004 by 25%

2.2	**Provide appropriate rehabilitation services for people with a brain injury**	▪ Negotiate with DSS to increase funding to support patient demand and decrease unacceptable patient waiting times both in inpatient and outpatient	▪ Funding commences July 2003	▪ Clinically appropriate waiting time which meets contract requirement by June 2004.
3. WORKFORCE				
3.1	**To: Develop individual development plan for all Managers**	▪ Plan developed ▪ Evaluation	▪ August 2003 ▪ August 2004	▪ Managers personal plan developed, implemented and reviewed .
3.2	**Increase staff recognition activities**	▪ Formal recognition of long service (p.m. tea and certificate) ▪ Develop annual process for staff awards in relevant categories	▪ Implement July 2003 December 2003	▪ Improve staff morale
3.3	**Focus on staff health and safety**	▪ To develop and implement a safe handling policy ▪ Staff Wellness Committee ▪ Prepare organisation for ACC Workplace Safety Audit	▪ Appoint Safe Handling Co-ordinator ▪ Training December 2003. ▪ Activity Plan developed by June 2003 ▪ Plan developed to work to audit by June 2003	▪ Reduce lost time hours by 50% by June 2004 ▪ Active participation in staff wellness day. ▪ Achieve ACC Workplace Safety Audit by June 2004.
3.4	**Ensure staff retention**	▪ Staff recognition ▪ Communication forums ▪ Review support for conference attendance and relevant tertiary study	▪ Establish process for staff recognition ▪ Schedule regular staff forums ▪ Guidelines reviewed and circulated to staff	▪ Staff awards presentation December 2003. ▪ Staff turnover less than 10% ▪ Staff attendance at forums ▪ Utilisation of support by staff (in hours and $)
4. LINKAGE / ELDER CARE CANTERBURY				
4.1	**To: Improve elder friendliness at Burwood Hospital**	▪ Implement Elder Friendly Guidelines.	▪ Implementation plan by July 2003	▪ Completed by June 2004.

OTHER PROJECTS		INDICATORS/TARGETS
1	ACC Co-ordination Project	▪ Improved communication with DHB and with ACC ▪ Increase revenue income by $500,000.
2	Orthopaedic Review	▪ Participate in implementation of orthopaedic review action plan
3.	Accreditation	▪ Burwood Hospital to be re-accredited and certified in March 2004.
4	Organisation Review	▪ Establish organisational structure for Burwood Hospital by July 2003.
5	Consumer Participation	▪ Increase consumer participation at Burwood Hospital. 1 pilot project implemented by June 2004.

3.3.4 Christchurch Hospital

Annual Objectives		Approach	Milestones	Indicators / Targets
1. HE KOROWAI ORANGA				
1.1	**To: Improve ethnicity data collection throughout the hospital**	▪ Participate in draft ethnicity data collection policy consultation process ▪ Participate in ethnicity data collection baseline review ▪ Pilot staff training modules for data collection	▪ July 2003 ▪ June 2004	▪ Ethnicity data updated in each admission ▪ Review completed
1.2	**To: Ensure CDHB is recognised as a leader in Māori health worker development**	▪ Implement Māori Service development proposal ▪ Māori staff to attend Te Ao Marama and Te Komiti Whakarite ▪ Complete staff performance reviews as per policy ▪ All staff to attend cultural training	▪ December 2002 ▪ Ongoing ▪ Ongoing ▪ Ongoing	▪ Plan implemented ▪ Number of meetings attended ▪ Number of performance reviews completed ▪ Number of staff attending cultural training.
1.3	**To: Reduce health inequalities**	▪ Support reduction in inequality through service development in priority areas by: - Staff participation in service and clinical planning activities to reduce inequalities - Support Cardio-Respiratory outreach proposal - Support research on Māori Health outcomes	▪ Ongoing	
1.4	**To: Include Māori staff in all CDHB activities**	▪ Staff attendance at To Ao Marama, Te Komiti Whakarite and community consultation hui. ▪ Māori staff participation in evaluation of research proposals	▪ Ongoing	▪ Number of meetings attended

2. PRIMARY CARE INTEGRATION				
2.1	**To:** **Continue the development of strong links with primary care providers**	▪ Participate in the Acute demand project ▪ Participate in the Elective services management project	▪ As per project plan ▪ As per project plan	
3. OPERATIONAL MANAGEMENT				
3.1	**To:** **Improve operational efficiency**	▪ Implement the recommendations of the Efficiency and best practice group	▪ Ongoing	
3.2	**Improve occupational safety and health**	▪ Implement a Safe Manual Handling program ▪ Review accident reporting processes ▪ Establish Staff Health Unit	▪ December 2003 ▪ December 2003 ▪ June 2004	▪ Programme implemented ▪ Recommendations implemented ▪ Unit open
4. DIABETES				
4.1	**To:** **Deliver the Primary Health Care Strategy**	- Work collaboratively with the Primary Care sector to: - Ensure early detection - Undertake health promotion activities - Increase access to podiatry - Consider the evaluation and pilot of the Pacific Peoples and Māori Leadership pilot and implement changes	Ongoing As per Diabetes Plan July 03	▪ Admission rates for patients with diabetic ketoacidosis ▪ Presentation rates to Emergency dept. with hypoglycaemia

4.2	**To:** **Continue to develop the Diabetes service to meet the objectives of the Diabetes Interim plan and future plans**	▪ Utilise information system to identify all inpatients with Diabetes ▪ Continue to review and define service delivery and processes (Service provision framework) ▪ Participate in the Local Diabetes Team and Diabetes Sector meetings	▪ September 2003 ▪ December 2003 ▪ Monthly	▪ Reports available ▪ Service Provision Framework complete
5. OLDER PERSONS HEALTH				
5.1	**To:** **Improve the services and environment available for elderly people within Christchurch Hospital**	▪ Engage the assistance of Māori and Pacific providers ▪ Work jointly with LinkAGE, Elder Care Canterbury, the Primary sector and Community Providers to facilitate: - Early Discharge co-ordinator pilot - Care planning and documentation - Explore Units for Acute Stroke and delirium - Elder Friendly guidelines for the Emergency Dept and hospital wide	From July 03	▪ Reduction in complaints from the Elderly ▪ Decreased average length of stay for >65 yrs ▪ Reduced incidence of adverse events in the >65 yrs age group in the hospital
6. CHILD HEALTH				
6.1	**To:** **Progress with the implementation of the Child Health Strategy Report 2002**	▪ Participate in the planning of the implementation of the Child Health Strategy Report	▪ As per Project Plan	▪ Implementation Plan completed and agreed ▪ Formal and informal networks and good communication processes in place

6.2	**To:** **Ensure planning and construction of appropriate facilities for children and their families is followed through at Christchurch Hospital**	▪ Complete planning for short term alterations to address urgent requirements ▪ Begin planning for a child health facility within the overall plan for Christchurch Hospital, using a collaborative approach	▪ Planning for interim improvements completed ▪ Board sign off obtained October 04 ▪ From July 03	▪ Short term improvements in place by June 2004 ▪ Long term plans available for review
6.3	**To:** **Assist in implementing the Family Violence Intervention Guidelines**	▪ To work collaboratively within the hospital and community to assist in implementing the guidelines	▪ As per CDHB Project Plan	▪ Ministry of Health Guidelines implemented within resources
6.4	**To:** **Implement the Child and Youth Mortality Review processes**	▪ Respond to directions/ recommendations of National Child and Youth Mortality Register Committee ▪ Prepare a plan for actions and funding	▪ March 2004 ▪ June 2004	▪ Christchurch Hospital staff involved in meetings and implementation ▪ Funding requirements identified and documented

OTHER PROJECTS		**INDICATORS/TARGETS**
1	New premises planning - Diabetes	▪ Completion of needs identification ▪ Planning underway by April 2004
2	Attain accreditation	▪ Work underway – first survey September 2004
3	Outpatient Services Review	▪ Link to efficiency and focus on elder friendly services
4	Patient Flow Project implementation	▪ Focus on efficient users of resources
5	Step-down phase of care	▪ Evaluation complete

3.3.5 Christchurch Womens Hospital

Annual Objectives		Approach	Milestones	Indicators / Targets
1. HE KOROWAI ORANGA				
1.1	**To: Progress implementation and embedding of the Cultural Policy.**	▪ Support staff attendance at training ▪ Involvement of Māori in all key appointments.	▪ Provision of staff training ▪ Appointment of 1.0 FTE WHD Māori Health Worker January 03.	▪ June 04 50% of staff have attended cultural training.
1.2	**To: Improve ethnicity data collection throughout the hospital**	▪ Participate in draft ethnicity data collection policy consultation process ▪ Participate in ethnicity data collection baseline review	▪ July 2003	▪ Ethnicity data updated in each admission ▪ Review completed
2. DISABILITY				
2.1	**To: Implement the CDHB Disability Action Plan**	▪ Staff to attend disability awareness training ▪ Audit of facilities signage	▪ Staff attendance at training December 2003 ▪ Audit completed July 2003	▪ 10% of staff have attended training ▪ Positive audit outcome with action plan in place to implement any recommendations arising from audit.
3. INEQUALITIES				
3.1	**Implement strategies to reduce inequalities in health status**	▪ Identification of disadvantaged strategies	▪ Establishment of High needs midwifery team July 2003 ▪ Promotional plan for rehydration service at Rangiora Hospital	▪ Number of women with High needs service LMC ▪ Plan implemented, women using service, LMC and GP's aware of it.

4. WORKFORCE				
4.1	To: **Develop Canterbury Health's workforce and recognise staffs contribution to positive patient outcomes**	▪ Allied Health Professional Advisers participating directly to WHD Divisional Management team ▪ Continue to implement 5 year strategic plan for Midwifery and Nursing	▪ July 2003 ▪ Ongoing	▪ Attendance of Professional Advisers at Divisional Management and Combined Management Meetings on a quarterly basis. ▪ Implementation of plan in a timely manner.
5. CANCER				
5.1	To: **Reduce the death rate from Cervical cancer**	▪ Appoint a WHD Liaison General Practitioner ▪ Annual Hui to discuss Women's Health issues ▪ Extension of Cervical screening suitcase clinics	▪ March 2003 ▪ February 2004 ▪ June 2004	▪ .3 FTE employed ▪ Hui completed ▪ Number of additional clinics held 03/04.

OTHER PROJECTS		**INDICATORS/TARGETS**
1	New Christchurch Women's and Day Surgery Hospital	▪ Project meets construction milestones ▪ Project completed March 2005
2	Information system transfer (CARESYS to HOMER)	▪ Transfer complete ▪ Staff trained and utilising the system
3	Baby Friendly	▪ Retain status
4	Neonatal Services with other DHBs The Neonatal service has been involved in discussions with other DHB also providing tertiary Neonatal services and Ministry of Health officials. These discussions are aimed at identifying key factors which lead to high levels of transports/retrievals and seeking to reduce, minimise or eliminate these factors.	▪ The aim is to progress discussions on the availability of resourced cots nationally. A key issue appears to be containing transports. ▪ The Women's Health Division Neonatal service plan reflects a commitment to staff recruitment, retention and education in appropriate numbers, continuing support for current cot numbers and a proposal for a regional paediatric service to better manage referrals at source. ▪ A significant factor in our transports is transport of surgical babies that are within our tertiary area. These are not resourced from the case weight and transport of these babies has increased.

3.3.6 Mental Health Services

Annual Objectives		Approach	Milestones	Indicators / Targets
1. HE KOROWAI ORANGA				
1.1	**To: Promote a culturally responsive Mental Health Services**	▪ Maintain and build on the strength of Te Korowai Atawhai as the umbrella for bi-cultural development within the service by: ▪ Working in partnership with Iwi, whanau and tangata whaiora ▪ Ensuring appropriate resources for cultural assessment, specialist advice and teaching ▪ Ensure accurate data relating to service access ▪ All MH service staff to receive cultural training ▪ Ensuring core training for Pukenga Atawhai in Psychiatric Care and Cultural Development	▪ Ongoing	▪ Numbers of Pukenga Atawhai employed ▪ Numbers of Mental Health staff completed baseline Cultural Competency training ▪ Numbers of Pukenga Atawhai that have completed Psychiatric care training
1.2	**To: Improve ethnicity data collection throughout the hospital**	▪ Participate in draft ethnicity data collection policy consultation process ▪ Participate in ethnicity data collection baseline review	▪ July 2003	▪ Ethnicity data updated in each admission ▪ Review completed
2. MENTAL HEALTH BLUEPRINT				
2.1	**To: Increase MH service understanding of high use individuals with severe and persistent mental disorders**	▪ Participate in 'Knowing the People' project ▪ Develop project plan for 03-04 year, key actions: Access, co-ordination, health, social personal review, crisis, contact and evaluation ▪ Implement plan ▪ Implement planning cycle for next 12 month period	▪ July 2003 ▪ Completion June 2004 ▪ December 2003	▪ Positive consumer feedback ▪ Plan sign-off ▪ Milestones achieved ▪ Planning cycle in place

3. WORKFORCE				
3.1	**To:** **Achieve and maintain contracted establishment levels with appropriately qualified staff**	▪ Build existing relationships with Health Sector Unions to address significant issues affecting staff ▪ Develop an effective model of leadership and progression pathway for each occupational group ▪ Implement model ▪ Support Māori staff entry into the Psychiatric service ▪ Actively recruit to fill vacancies	▪ December 2003 ▪ June 2004 ▪ Ongoing ▪ June 04	▪ 6 weekly Senior Management/Union meetings ▪ Monthly Delegate/Senior management meetings ▪ Model signed off ▪ Implemented model ▪ 95% establishment in all staff groups <13% staff turnover in Nursing and Social work.
3.2	**To:** **Develop Nurse Practitioner role**	▪ Develop Scope of Nurse Practitioner in mental health	▪ April 04	▪ Nurse Practitioner definition fits with Scope of Practice Legislation and operational needs of DHB

OTHER PROJECTS		**INDICATORS/TARGETS**
1	Access Canterbury Projects - Shared Care - Discharge planning - GP Liaison	▪ Project plans are developed and implemented for these projects in line with the Principles of the Access Canterbury projects
2	Work with sector to establish GP Link Programme with WINZ	▪ Mental Health consumers and families increase their use of GP services
3	To achieve accreditation	▪ Put in place processes to achieve accreditation by September 04
4	Contribute to Memorandum of Understanding with South Island DHBs re regional provision of psychiatric services	▪ Consistency of Mental Health Services throughout South Island
5	Improve MHINC Compliance	▪ Information provided 100% accurate.

3.3.7 Princess Margaret Hospital

Annual Objectives		Approach	Milestones	Indicators / Targets
1. HE KOROWAI ORANGA				
1.1	**To: Progress the implementation of Ite Korowai Oranga and the Māori Health Action plan**	▪ Respond to the needs of Māori patients/ whanau through ensuring physical environment reflects bi-culturalism ▪ Reduce the barriers to Māori and whanau within the TPMH services ▪ Staff to attend cultural training	▪ Cultural corridor introduced Dec 2003 ▪ Weaving commissioned July 2003 ▪ Bi-cultural signage in place Oct 2003 ▪ Māori NASC demonstrating positive outcomes June 2004 ▪ Analysis of Māori Health worker position Dec 2003	▪ STR03 ▪ STR01
1.2	**To: Improve ethnicity data collection throughout the hospital**	▪ Participate in draft ethnicity data collection policy consultation process ▪ Participate in ethnicity data collection baseline review	▪ July 2003	▪ Ethnicity data updated in each admission ▪ Review completed
2. DISABILITY				
2.1	**To: Progress implementation of the New Zealand Disability Strategy**	▪ Involvement in LinkAGE project ▪ Monthly meeting with DSS/Planning and Funding until transition ▪ New Managers to attend DHB Management Training ▪ Elder friendly guidelines introduced ▪ Volunteers introduced	▪ Ongoing ▪ Transition occurs ▪ Ongoing ▪ December 2003 ▪ Audit of compliance June 2004 ▪ March 2004	▪ Number of meetings attended ▪ Number of managers attending training ▪ Number of training sessions attended ▪ Guidelines amended for environment ▪ Audit of Compliance with guidelines ▪ Number of volunteers

3. WORKFORCE				
3.1	**To: Ensure availability of an appropriately skilled workforce by promoting TPMH as a positive place to work**	▪ New graduate nursing programmes has 2 intakes	▪ June 2004	▪ Number of programmes
		▪ Support for Enrolled Nursing students	▪ June 2004	▪ Training occurred for precepting staff
		▪ Skill mix framework maintained and reviewed	▪ June 2004	▪ Completed review
		▪ Elder friendly guidelines implemented	▪ December 2003	▪ Audit of compliance June 2004
		▪ Staff Wellness day	▪ June 2004	▪ Wellness day held
		▪ Culture survey show improvements	▪ December 2003	▪ Improved result
		▪ Staff attendance at in-service training and conferences	▪ June 2004	▪ Number of hours training attended
4. MENTAL HEALTH BLUEPRINT				
4.1	**To: Monitor progress of the Mental Health Blueprint utilising the QHNZ Accreditation Standard**	▪ Action plan developed	▪ July 2003	▪ Completed action plan
		▪ Quality Health NZ survey	▪ May 2004	▪ Survey completed
		▪ Plan for promotion of healthy aging & discouraging ageism	▪ September 2003	▪ Completed plan
		▪ Increased consumer participation	▪ March 2004	▪ Number of hours consumer participation
		▪ Accreditation of TPMH PSE service	▪ June 2004	▪ Service accredited
5. INEQUALITIES				
5.1	**To: Reduce any barriers preventing any ethnic group accessing services**	▪ Barriers identified ▪ Plan to reduce barriers	▪ September 2003 ▪ February 2003	▪ Plan completed and implemented

OTHER PROJECTS		INDICATORS/TARGETS
1	Service Provision frameworks	▪ All clinical areas completed by December 2003
2	Restraint Minimisation project	▪ 90% of Restraint audit recommendations implemented ▪ Plan and timeframes in place to implement final 10% of recommendations
3	Volunteer introduction	▪ Volunteer Co-ordinator appointed and volunteer implementation plan developed.
4	Accreditation – Flight 2004	▪ Survey date planned for February 2004
5	ACC Workplace Safety Management compliance	▪ Action plan completed and recommended actions implemented by March 2004
6	Mental Health Strategy for Older People	▪ Strategy developed by June 04

3.3.8 Community and Public Health Services

Annual Objectives		Approach	Milestones	Indicators / Targets
1. HE KOROWAI ORANGA				
1.1	**To: Improve ethnicity data collection throughout the DHB**	▪ Participate in draft ethnicity data collection policy consultation process ▪ Participate in ethnicity data collection baseline review	▪ July 2003	▪ Review completed
2. PUBLIC HEALTH				
2.1	**To: Promote Public Health approaches within our District Health Boards and Providers**	▪ Assist CDHB to develop and implement Health Promoting Hospitals ▪ Deliver training programmes on inequalities ▪ Equity lens applied to CDHB plans ▪ Health promotion plans will reflect priority areas	▪ Support work to make all sites smokefree by December 04 ▪ June 2004 ▪ Ongoing ▪ Ongoing	▪ Training sessions scheduled ▪ Feedback provided
2.2	**Pilot comprehensive public health planning funding and delivery within a district health environment**	▪ Consult ▪ Sign-off by DHBNZ ▪ Pilot	▪ August 2003 ▪ May 2004 ▪ June 2004	▪ Pilot completed

2.3	**Deliver Public Health services reflecting an innovative and creative workforce**	▪ Develop and maintain current individual development plans for all staff ▪ Participate in regional and national workforce development forums	▪ 6 monthly for each staff member ▪ As required	▪ Number of staff with current performance plans
2.4	**Achieve measurable progress on public health outcomes**	▪ Ensure that all existing and new Health Promotion / Protection programmes are aligned with local and national health priorities ▪ All evaluation processes will include applicable equity measurement tools	▪ As required	▪ Referenced to strategic plan ▪ KPIs developed and reported on
2.5	**Programs detailed in the Community and Public Health service plan will be carried out**	▪ As detailed in the CPH service plan	▪ 6 monthly and annual reporting	▪ Key progress markers as detailed in the service plan

OTHER PROJECTS		**INDICATORS/TARGETS**
1	Rollout of National Immunisation and National Diabetes Registers	▪ Work with CDHB to identify requirements and contribute to these projects and lead as relevant .
2	Canterbury Local Mapping project	as above
3	Health Needs Assessment	as above
4	PHO promotion plans	as above

3.3.9 Brackenridge Estate Ltd

Annual Objectives		Approach	Milestones	Indicators / Targets
1. HE KOROWAI ORANGA				
1.1	**To: Increase staff cultural awareness**	▪ Support staff attendance at training ▪ Establish role for Kaumatua at Brackenridge	▪ June 04 ▪ Kaumatua appointed	▪ 50% of staff have attended cultural training ▪ Kaumatua available; assists with resident and staff issues
2. DISABILITY				
2.1	**To: Further develop provision of respite care for parents of children with intellectual disability who are medically fragile**	▪ Identify areas for provision ▪ Develop plan for this group ▪ Implement plan	▪ September 03 ▪ November 03 ▪ Completed June 04	▪ Increased number of respite days
2.2	**Review service provision for residents with challenging behaviour**	▪ Developed project plan ▪ Plan implemented/gap analysis ▪ Recommendations regarding service development ▪ Implementation of recommendations	▪ September 03 ▪ Completed December 03 ▪ February 04 ▪ June 04	▪ Project plan complete ▪ Gap analysis ▪ Service configuration recommendation ▪ Service structure in place
3. CERTIFICATION				
3.1	**To: Develop a project plan for achieving certification**	▪ Undertake needs analysis ▪ Plan developed and implemented ▪ Certification achieved	▪ August 03 ▪ June 04 ▪ October 04	▪ Compliance achieved

OTHER PROJECTS		INDICATORS/TARGETS
1	Forest area	▪ Developed plan for use ▪ Implementation underway by June 2004
2	Recreational activities/facility	▪ Conduct analysis of recreational requirements ▪ Develop and implement plan for provision

4.0 MANAGING FINANCIAL RESOURCES

4.1 Managing within budget

Canterbury DHB is budgeting a break-even position for 2003/04, which is consistent with the Minister of Health's expectation. This budget is prior to the impact arising from revaluation of land and building, as per Crown policy and is based on the critical assumption that any revaluation impact would be fully funded to address the increase in capital charge and depreciation expenditure.

The revaluation process for building and infrastructure plant is being finalised and preliminary valuation shows a write-up of an estimated $47M. The revaluation also resulted in a change in the economical life of some assets, which in turn has a significant impact on depreciation. The estimated net impact of the draft revaluation on operating result is $16.4M i.e. increased Capital Charge of $5.4M ($47M @ 11.5%) and increased depreciation of $11.0M.

We have shown in our forecast financial statements, the increase in capital charge and depreciation expense with corresponding increase in funding as off-sets. If the impact of the revaluation ($16.4M) is not fully funded by Ministry of Health /Treasury, Canterbury DHB's budgeted deficit would be $16.4M for 2003/04.

The following sets out the summary of our projections (**excluding** the impact of property revaluation, as this is assumed to be fully funded):

Overall, we estimated our increase in funding from Ministry of Health and other sources to be around $28.0M. Of the funding increase, $10.0M will go towards reducing the current deficit in 2002/03 to break-even in 2003/04, leaving a balance of $18.0M . The increase in costs in 2003/04 associated with the provision of similar level of services as 2002/03 is estimated at $27.5M, as follows:

	$M
Overall increase in external provider and in-house provider expenditure	18.7
Additional specific items	
Increased capital charge (for equity for Christchurch Women's Hospital relocation project only and excludes revaluation impact)	3.5
Increased depreciation (excludes revaluation impact)	1.3
Other specific e.g. interest on loans for Christchurch Women's relocation project, strategic health services investment, accreditation etc	4.0
	$27.5M

The estimated gap between funding increase and expenditure growth is $9.5M. This gap will require efficiencies and/or service reconfigurations (refer section 4.2 below) to be achieved. In addition, there may be costs associated with new technologies, abnormal increase demand and service specification changes that will impact the expenditure estimated above. These have not been factored into the forecast gap.

4.2 Efficiencies and Service Reconfigurations

In budgeting for the break-even position, Canterbury DHB had signalled the need to implement and achieve a number of efficiencies and/or service reconfigurations. Examples of the initiatives being considered include:

- Patient Flow project
- Managing acute medical and primary referred services growth by working collaboratively with primary care providers
- Non-clinical consumables and support services
- Reviewing the process by which new treatment regimes could be introduced
- Productivity and Best Practice initiatives

The initiatives will include input from clinicians, where appropriate, to ensure patient safety issues are considered. The ability to achieve efficiencies for contracting out support services is greatly reduced by the need to transfer existing staff on the same 'terms and conditions'.

In addition, Canterbury DHB will be undertaking service reconfigurations as outlined in Section 3.2.5.

The forecast financial performance is premised on achieving the efficiency initiatives and a number of the service reconfigurations.

4.3 Assumptions

With the introduction of population based funding, Canterbury DHB will receive a graduated lower funding increase from 2004/05 until its funding is at a level consistent with its population, relative to other DHBs. Underpinning the financial forecasts is the impact of population based funding and the efficiencies and/or service reconfigurations required to meet the net operating result of each year. The implications of these, and assuming no new major capital projects over the period, are set out as follows:

	2003/04 $M	2004/05 $M	2005/06 $M
Estimated Incremental Funding	28.0	19.4	12.9
Less: Net Deficit Reduction	(10.0)	-	-
Net Incremental Funding Available	18.0	19.4	12.9
Less: Estimated Incremental Expenditure	(27.5)	(25.2)	(24.6)
Annual Shortfall (Requiring 'Efficiencies' or Services Reconfiguration) - $M	**(9.5)**	**(5.8)**	**(11.7)**
Cumulative Shortfall (Requiring 'Efficiencies' or Services Reconfiguration) - $M	**(9.5)**	**(15.3)**	**(27.0)**

The above excludes grossed up Inter District Outflow revenue/expenditure of approx. $26.6M and projected increase in depreciation and capital charge of $16.4M arising from asset revaluation. Assumption is that the funding and expenditure for these items has a neutral impact, as follows.

Gross Inter-District Outflow and Depreciation and Capital Charge (revaluation) Funding	43.0	-	-
Less: Gross Inter-District Outflow and Depreciation and Capital Charge (revaluation) Expenditure	(43.0)	-	-

Other key assumptions for 2003/04 include:

- Ministry of Health revenue is per the Minister of Health's funding advice in December 2002 and February 2003 only as the final advice (expected in late June 2003) have not been received. Inter-DHB revenue, including gross inter-district outflow is being included as part of MOH revenue. The assumption is that net Inter-DHB revenue and expenditure will be neutral.
- Pharmac's 2003/04 budget increase is no greater than CPI
- The remaining Crown's equity injection for the new Christchurch Women's Hospital project of $30.65million will be received during the year (subject to timing of actual equity being received in 2002/03)
- Average increase for total expenditure will be within CPI other than specific items identified
- No significant growth in Acute medical volumes
- Increase in the price/volume mix of New Zealand Blood Services within CPI.
- New government/Ministry's policies and initiatives that have financial impact on Canterbury DHB will be fully offset by increased funding from Ministry.
- Additional expenditure for Primary Healthcare Organisations (PHOs), if any, will be fully offset by new primary care funding from the Ministry
- There will be no significant growth in the number of patients (in the South Island) requiring synthetic blood products
- Devolution of Disability Support Services (DSS) will have a neutral impact i.e. expenditure will be fully met by Ministry of Health's funding and/or risk pool.
- Additional loans of $7M will be raised at average interest rate of 6.5% to fund the Christchurch Women's Hospital relocation project.
- Additional capital charge and depreciation arising from asset revaluation will be fully funded by Ministry or Treasury (estimated at $16.4M). Cashflow relating to the increased depreciation ($11M) is to be re-paid to the Ministry of Health.
- Projected proceeds from sale of surplus assets are realised as planned and term loans are reduced accordingly

4.4 Asset Valuations

Currently, Canterbury DHB land is recorded at valuation as previously, Canterbury Health Limited (HHS) had a policy of recording land at valuation. In addition, property transferred from Healthlink South Limited (HHS) were recorded in Canterbury Health Limited at fair values, when the two organisations 'merged'.

Valuation process for building and infrastructure plant will be undertaken during 2002/03. Any change in accounting policy from historical cost to "historical cost adjusted for revaluations" will have a significant impact on Canterbury DHB operating results.

We expect that there will be a write-up in the carrying value of assets as Canterbury Health Limited assets had been written down in 1993 and 1996 as part of Ministry's balance sheet restructuring exercise. The write-up in carrying values will result in additional capital charge and depreciation expense.

We have shown in our forecast financial statements the increase in capital charge and depreciation expense which will flow on to the 'bottom line', increasing it to a deficit of $16.4M.

However, we have also assumed that this $16.4M will be fully funded by Ministry of Health and/or Treasury in 2003/04 and in future years, to ensure our financial performance meets the Minister's expectation.

4.5 Business Cases

The expected business cases requiring Minister's approval is for Primary Health Organisations (PHOs), and some service reconfigurations as outlined in 3.2.5.

4.6 Capital Expenditure

The estimated capital expenditure budget for 2003/04 is $63.65M. This consists of:

- $45.65M for the Christchurch Women Hospital relocation project which commenced in the previous year, and
- $18.0M for normal asset replacement and some priority new equipment

Details for the $18M will be established following an internal prioritisation process involving clinicians and management. This process is expected to be completed in late June 2003.

Funding for the capital expenditure will be:

- $30.65M of equity (balance of total equity approved by Minister),
- $7.0M from loans, and
- $26.0M from operating cashflow

We have also projected cash proceeds from asset disposal of $1.7M in 2003/04.

4.7 Debt and Equity

Estimated total debt will increase from $120M to $127M. With the BNZ term loan facility maturing in December 2003, the borrowing under this facility of approximately $45M will be refinanced with loans from the Crown Financing Agency (CFA).

In addition, the Westpac loans of $75M will mature in June 2004 and this will be refinanced with loans of from CFA except for working capital equivalent of 1/12th of provider arm funding (approximately $40M), which will be financed from either private loan or CFA.

Canterbury DHB is permitted to have private debt of up to one month of its cashflow funding or working capital. During the year, Canterbury DHB will evaluate the most cost effective option for this portion of its debt and will be discussing this with RHMU. Based on the definitions in the existing Westpac Banking loan document, which are slightly different from common definition, Canterbury DHB will be complying with the banking covenants required of its loans.

The forecast ratios for 2003/04 based on the forecast financial statements show:

- Interest cover ratio of 4.6
- Debt/Debt plus Equity ratio of 39%
- Net assets/Total Asset of 47%

4.8 Forecast Financial Statements for the Three Years Ending 30 June 2004, 2005 and 2006 (Indicative figures as at 13 June 2003)

4.8.1 Forecast Group Statement Of Financial Performance

	2002/03 Forecast $'000	2003/04 Forecast $'000	2004/05 Forecast $'000	2005/06 Forecast $'000
Operating Revenue				
MoH Revenue	670,705	741,162	760,048	772,271
Patient Related Revenue	22,294	22,715	23,169	23,633
Other Revenue	9,085	9,272	9,464	9,662
Total Operating Revenue	702,084	773,149	792,682	805,565
Operating Expenditure				
Employee Costs	316,290	326,656	338,699	344,897
Treatment Related Costs	85,693	89,113	90,895	92,419
External Providers & IDF	213,981	240,864	242,771	241,990
Non Treatment Related & Other Costs	52,233	50,536	51,037	51,478
Total Operating Expenditure	668,197	707,169	723,401	730,784
Result before Interest, Depn & Cap Charge	33,887	65,980	69,280	74,781
Interest, Depreciation & Capital Charge				
Interest Expense	(7,137)	(8,700)	(10,200)	(9,700)
Interest Received	355	355	355	355
Capital Charge Expenditure	(14,954)	(23,804)	(23,804)	(23,804)
Depreciation	(22,151)	(33,831)	(35,631)	(41,631)
Total Interest, Depreciation & Capital Charge	(43,887)	(65,980)	(69,280)	(74,780)
Net Operating Results	**(10,000)**	**(0)**	**0**	**0**

The net operating results are premised on the realisation of the efficiency targets and/or reconfigurations and the additional expenditure associated with the revaluation is fully funded.

4.8.2 Forecast Group Statement Of Financial Performance

	30/06/03 Forecast *$'000*	30/06/04 Forecast *$'000*	30/06/05 Forecast *$'000*	30/06/06 Forecast *$'000*
Public Equity				
Opening Equity	134,923	180,671	200,321	189,321
Equity Injection - Women Hosp & CC	9,350	30,650		
Depreciation funding on Revaluation		(11,000)	(11,000)	(11,000)
Revaluation of Land & Building	46,398			
Net Result for the period	(10,000)	(0)	0	1
Total Public Equity	**180,671**	**200,321**	**189,321**	**178,322**
Current Assets				
Cash & Bank (OD)	(3,041)	(2,859)	(278)	(4,046)
MoH Debtor	38,500	38,000	38,000	38,000
Other Debtors & Other Receivables	11,000	11,000	11,000	11,000
Prepayments	1,017	1,017	1,017	1,017
Stocks	7,400	7,400	7,400	7,400
Total Current Assets	54,876	54,558	57,139	53,371
Current Liabilities				
Creditors & Accruals	39,000	39,000	39,000	39,000
Capital charge payable	4,000	5,951	5,951	5,951
GST	4,069	4,069	4,069	4,069
Provision for Income Tax	17	17	17	17
Interest Accrual	312	312	312	312
Staff Entitlement	39,800	39,000	39,000	39,000
Short Term Borrowings	120,000	1,000		
Total Current Liabilities	207,198	89,349	88,349	88,349
Working Capital	(152,322)	(34,791)	(31,210)	(34,978)
Investments	466	466	466	466
Restricted Assets - Trust Fund	7,180	7,180	7,180	7,180
Fixed Assets	329,108	357,227	359,646	340,415
Term Staff Entitlement	(3,636)	(3,636)	(3,636)	(3,636)
Deferred Tax	(69)	(69)	(69)	(69)
Minority Interest	(56)	(56)	(56)	(56)
Term Loans		(126,000)	(143,000)	(131,000)
Net Assets	**180,671**	**200,321**	**189,321**	**178,322**

4.8.3 Forecast Group Statement Of Cashflow

	2002/03 Forecast $'000	2003/04 Forecast $'000	2004/05 Forecast $'000	2005/06 Forecast $'000
Cashflows from Operating Activities				
Cash provided from:				
MOH Receipts	668,956	741,662	760,048	772,271
Other Receipts	30,373	31,987	32,633	33,294
	699,329	773,649	792,682	805,565
Cash applied to:				
Employee Costs	316,283	327,456	338,699	344,897
Supplies & Expenses	352,050	380,513	384,703	385,887
Taxes Paid	(63)	-	-	-
	668,270	707,969	723,402	730,784
Net Cashflow from Operating Activities	**31,059**	**65,680**	**69,279**	**74,781**
Cashflows from Investing Activities				
Cash provided from:				
Sale of Assets	-	1,700	8,950	4,000
Interest Received	355	355	355	355
	355	2,055	9,305	4,355
Cash applied to:				
Advance to JV/Trust Investments	-	-	-	-
Purchase of Assets	27,796	63,650	47,000	26,400
	27,796	63,650	47,000	26,400
Net Cashflow from Investing Activities	**(27,441)**	**(61,595)**	**(37,695)**	**(22,045)**
Cashflows from Financing Activities				
Cash provide from:				
Equity Injection	9,350	30,650	-	-
Loans Raised	40,968	127,000	16,000	-
	50,318	157,650	16,000	-
Cash applied to:				
Loan Repayment	27,416	120,000		12,000
Equity re Depn on Revaluation		11,000	11,000	11,000
Capital Charge Payments	18,788	21,853	23,804	23,804
Finance Costs	7,137	8,700	10,200	9,700
	53,341	161,553	45,004	56,504
Net Cashflow from Financing Activities	**(3,023)**	**(3,903)**	**(29,004)**	**(56,504)**
Overall Increase/(Decrease) in Cash Held	594	182	2,580	(3,768)
Add Opening Cash Balance	(3,635)	(3,041)	(2,858)	(278)
Closing Cash Balance	(3,041)	(2,858)	(278)	(4,046)

5.0 MEASURING SUCCESS

5.1 Consolidated List of Indicators of DHB Performance (IDP)

The Ministry of Health has established a set of DHB Accountability Indicators to focus District Health Boards on priority health objectives identified in the NZ Health Strategy, monitor activity and compare District Health Board performance, and to hold District Health Boards accountable. CDHB is committed to performance improvement, both as a funder of services and as a provider of services. Progress toward achieving the Accountability Indicator targets will be reported as part of CDHB's quarterly performance reports.

Accountability Indicators
The accountability indicators reflect the accountability that CDHB has for securing improved health status for its population. As responsibility for funding some services is yet to be devolved to DHB's, there are indicators where the DHBs' ability to influence the outcome is not through direct funding but through influencing other funders.

Due to the evolving nature of DHB's and their responsibility for funding, the actions taken by the CDHB to influence the direction of performance in relation to specified targets is of as much importance as the match between actual performance and the indicator itself.

Qualitative Accountability Indicators
Performance against the qualitative indicators will be measured on the basis of reporting deliverables rather than numeric targets. Performance will be assessed not only on provision of reports that meet the stated content requirements but also compliance with the reporting timeframes.

Quantitative Accountability Indicators
The majority of the quantitative indicators are aimed at measuring DHB performance in addressing cardiovascular disease, diabetes, oral health and well child services - four priority areas within the New Zealand Health Strategy.
For each of the quantitative indicators set out in this plan targets have been set for the 2002/03 year. The setting of those targets has been based on:

Expectations expressed by the Ministry of Health
The latest national data
The latest CDHB specific data

It should be noted that for many indicators historical data is poor. Consequently there are some indicators for which a target is unable to be set at this stage. It is the intention of the CDHB to gather the required baseline data to allow for targets to be set for future plans.

It is noted that the Ministry will be using results outside 90% or 99% confidence intervals to trigger further analysis for a number of indicators.

Indicator results and targets have been stated for three population groupings, Māori, Pacific people and Other. The overall targets for the DHB reflect these ethnic specific results and the demographic characteristic of the Canterbury DHB.

The intent of this section is to recognise that Canterbury DHB understands the need to look at the health of the Canterbury DHB population although many factors effecting health care directly is outside its control.

The Canterbury District Health Board's accountability indicators are in addition to:

- Existing reporting requirements under service contracts.
- Information requirements contained in the Operational Policy Framework.
- The Balanced Scorecard for the Provider Arm.
- Monthly financial reporting to the Ministry's DHB Funding and Performance Directorate.

The Canterbury DHB will take part in an active review of DHB indicators of performance in 2003-04. As relevant indicators have been linked to key objectives in Section 3.1.1.

The DHB Accountability Indicators for 2003/04 are as follows:

IDP No.	Description	Target / Deliverable	Frequency
STR-01	Local Iwi / Maori engagement and participation in decision-making and the development of strategies and plans for Maori health gain.	Report giving sufficient detail and or evidence to determine the extent to which: The DHB meets with its Treaty Partner(s) on a regular basis in order to review and monitor planning and funding for Maori Health Gain. The DHB ensures that Iwi/Maori are engaged in Health Needs Assessment, Prioritisation, Planning, Service Delivery, Monitoring and Evaluation of Services including monitoring against He Korowai Oranga.	6 Monthly
STR-02	Progress in the development of Maori workforce and Maori providers.	*Part i) Annual* The following documents demonstrate planning to develop Maori workforce and the capacity of Maori providers ▪ Strategic Plan ▪ Annual Plan. *Part ii) Quarterly* Provide a report on: ▪ Number of DHB management and number of clinical positions held by Maori compared with the total number of management positions and total number of clinical positions ▪ Progress with plans to develop and promote the development of DHB and contracted providers' Maori workforce.	Annual / Quarterly
STR-04	Progress on DHBs conduct an ongoing cycle of reviews of pathways of care to ensure they improve access to effective services for Maori, improve outcomes, and reduce avoidable hospital admissions, mortality and morbidity.	The DHB provides the following: ▪ Progress report that DHB is conducting ongoing cycle of reviews of pathways of care that focus on ways of improving access to effective services for Maori. ▪ Report on an aspect of improved access to services for Maori.	6 Monthly
STR-05	Pacific people engagement and participation in decision-making and the development of strategies and plans for Pacific health gain.	Only nominated DHBs report: ▪ Report on progress made towards implementation of the priority areas identified in the Pacific Health & Disability Action Plan.	Annual
STR-06	Progress in the development of Pacific workforce and Pacific providers.	Report on progress made in the development of a Pacific workforce and the capacity of Pacific providers that takes account of the following documents: Mental health Workforce Development Plan; Pacific Mental Health Services and Workforce – Moving on the Blueprint (MHC); Pacific Health and Disability Action Plan.	Annual

QUA-01	Quality systems.	For Personal Health services the DHB reports to the Ministry of Health giving: 1. A summary of audit activity of the provider arm and contracted providers, by giving a list of all audited providers and the type of audit conducted (eg, routine, issues based), and the action(s) to be taken to ensure progress. 2. A high level summary (list) of key Quality Improvement Initiatives and results, focusing on those that are effective and/or ineffective.	6 Monthly
QUA-02	Mental health quality measures.	Report providing: 1. Summary of audit activity of the NGO sector, giving a list of all audited providers and the type of audit conducted (e.g., routine, issues based), any common issues identified, and the action(s) to be taken to ensure progress. 2. High-level summary (list) of key Quality Improvement Initiatives and Results for the provider arm, focusing on those that are effective and/or ineffective.	Quarterly
QUA-03	Nationally Consistent Clinical Assessment – Elective Services (each major surgical sub-specialty).	Provide a report updating progress for each of the four areas of focus for this measure. 1. Process quality audit. 2. Consistency of clinical decision-making. 3. DHB support for the ongoing improvement of nationally consistent referral and assessment guidelines. 4. Effectiveness of primary and secondary collaborative processes and structures.	6 Monthly
QUA-04	Responding to and resolving Service Coverage issues.	Report progress achieved during the quarter towards resolution of gaps in service coverage (not agreed as exemptions or exceptions through the DAP process) identified by the DHB or Ministry through: ▪ analysis of explanatory indicators ▪ media reporting ▪ risk reporting ▪ formal audit outcomes ▪ complaints mechanisms.	Quarterly
QUA-05	Identify funding priorities from prioritisation round.	Undertake a prioritisation round. Identify a list of funding options including planned sources of funding (which may include reprioritisation of current baseline expenditure) and provide the Ministry with a one page summary of the results by 31 May 2004.	Annual

QUA-06	Progress towards implementing the Reducing Inequalities in Health Intervention Framework.	A qualitative/quantitative report that demonstrates progress towards implementing the Reducing Inequalities Intervention framework and: (i) Demonstrates the nature of health inequalities in their district by: ▪ Health status ▪ Risk factors ▪ Access to services (ii) Describes current and new initiatives underway to address inequalities in health that span all levels of the Reducing Inequalities in Health Intervention Framework. (iii) Identify the levels in the Reducing Inequalities in Health Intervention Framework that the initiatives described in (ii) are taking place.	Quarterly
QUA-07	Progress towards WAVE implementation.	A qualitative report that demonstrates progress made: 1. Towards improving online access to clinical knowledge bases (such as Cochrane and Medline) and clinical guidelines or protocols. 2. Towards implementation of electronic referral letter and hospital discharge summary notification functionality between hospital and general practitioner.	6 Monthly
NUR-01	Nursing practice and development.	Provision of a report that in respect to the provider and funder arms of the DHB describe the following: How input is received from nurses into decision making. The lines of accountability for nurses in relation to the Director of Nursing and Director of Nursing to the Chief Executive Officer. Strategies in place to address retention and reducing turnover. Measures in place to support nurses in their first year of practice to ensure their development into more experienced and expert practitioners. How the development of the Nurse Practitioner role is being progressed within the DHB. Progress with the development of: (i) Coding mechanisms to capture nursing and Nurse Practitioner prescribing practices. (ii) Nurse identifiable numbers to use in patient records for evaluation and costing purposes. How are Maori nurses being supported in the development of either leadership or senior positions. What mechanisms are in place to ensure Maori nurses are supported both clinically and culturally in their practice. In relation to the development of primary health care nursing, each DHB is expected to demonstrate that:	Quarterly

		▪ A plan for the development of primary health care nursing has been established. ▪ The service delivery arm of the DHB (particularly with respect to community based nursing services) is engaging with providers who are moving towards a Primary Health Organisation environment. ▪ The Director of Nursing for each DHB is involved with the primary health care nursing aspects of Primary Health Organisation development in the DHBs.	
PRI-01	Level of progress towards implementing Primary Health Care Strategy.	A report is provided to MOH that identifies communities and provider groups in different localities who are interested in PHO formation (some of this may be by responding to requests, some by DHB initiated meetings). 1. Demonstrate that the DHB has had some discussions with prospective PHO providers. 2. Indicate a likely shape (or perhaps several scenarios) of future PHO arrangements throughout the DHB's District. 3. Identify any PHOs that have been approved by the end of the quarter with an indication of the enrolled population covered by each one, and where each one is in terms of governance, community participation, provider involvement, range of services, funding arrangements. 4. Demonstrate the ways in which the DHB has promoted enrolment in order to improve continuity of care for individuals and a population approach by organisations.	Quarterly
PRI-02	Progress in developing the capacity of primary care providers to impact on suicide prevention.	Report on promoting and encouraging the use of the specified guidelines by its contracted primary care providers. ▪ Guidelines for Primary Care Providers: Detection and Management of Young People at Risk of Suicide. ▪ Guidelines for the Treatment and Management of Depression by Primary Healthcare Professionals. ▪ Guidelines for Assessing and Treating Anxiety Disorders. ▪ Guidelines for Recognising, Assessing and Treating Alcohol and Cannabis Abuse in Primary Care.	Annual
PRI-04	Percentage of contracted providers of general practice services with an agreed Maori Health plan.	*Part A* DHBs to include in their reports to the Ministry on the establishment and development of PHOs in their regions a description of progress on how they are consolidating partnerships with Iwi and Maori communities to ensure that planning, funding and delivery of services improve Maori health and disability outcomes.	6 Monthly

		Part B The number of providers providing general practice services in the DHB area with a Maori Health plan that has been agreed with the funder (Excludes s88 and PHOs).	
MEN-01	Progress towards improving Maori mental health.	Provide a narrative report which gives sufficient detail and or evidence to determine the extent to which: ▪ A process is in place to ensure Iwi/Maori are engaged planning, design and purchasing of mental health services for Maori. ▪ A programme is in place to review service delivery for Maori by DHB and community providers.	Annual
MEN-02	Comprehensive and timely data is provided to MHINC.	Report confirming that the provider arm of the DHB is providing timely and comprehensive information to MHINC.	Quarterly
MEN-03	Access to services: average percentage of people domiciled in region, seen each month for the 3 months being reported for the total population.	The average number of people domiciled in the DHB region, seen each month for the three months being reported (the period is lagged by 3 months) for: children aged 0-9 0.26% children aged 10-14 0.58% children aged 15-19 0.71% adults aged 20-64 1.00% adults aged 65+ 0.16% **Targets for 03/04:** 0-9 years 0.26% 10-14 years 0.60% 15-19 years 0.81% 20-64 years 1.00% 65 years + 0.16% **As per Ministry of Health expectations**	Quarterly
OLD-01	Discharge rates for ambulatory sensitive admissions for people aged 65 and under 75 years.	Part i) Where the DHB region and ethnic rate is significantly greater than the total NZ (all ethnicity) national rate (99% confidence interval) DHBs will be asked to report: Providing information on the current and planned initiatives likely to influence future outcomes specifically for the effected population group(s). Data to be generated centrally by the Ministry on a 6 monthly basis (based on previous 12 months data) 99 percent confidence intervals will be used as a trigger for further analysis and questioning of DHB performance. It is proposed that in general the triggers are generic ie based on the confidence interval around the national average. DHBs can make a case for DHB specific triggers to be used, this will be considered on a case-by-case basis with Ministry service teams involved in the discussions. *Part ii)* By June 2004 each DHB will have developed a plan to implement the integrated continuum of care set out in the Health of Older People Strategy.	6 Monthly

OLD-02	Development of a Ministry approved plan to implement the integrated continuum of care set out in the Health of Older People Strategy.	▪ By 31 December 2003 each DHB will have developed a draft plan to implement the integrated continuum of care set out in the Health of Older People Strategy. ▪ By June 2004 each DHB will have a Ministry approved plan to implement the integrated continuum of care set out in the Health of Older People Strategy.	6 Monthly
DIA-01	Diabetes case detection rate.	**Targets** Maori: 50% Pacific: 90% Other: 80% Total: 78%	Annual, by 31 March 04
DIA-02	Diabetes case management.	**Targets** Maori: 44% Pacific: 53% Other: 20% Total: 22%	Annual, by 31 March 04
DIA-04	Retinal screening of people with diabetes in the last two years.	**Targets** Maori: 40% Pacific: 40% Other: 50% Total: 49%	Annual, by 31 March 04
DIA-07	Implementation of the Diabetes Minimum Data set – Local Diabetes Team.	Primary care organisations and diabetes teams contracted by the District Health Board comply with the reporting requirements specified in their agreements in particular: 1. The primary care organisation(s) includes the full aggregated data specified in Appendix A to the Free GP Annual Review for People with Diabetes service in its annual report to the local diabetes team. 2. Local diabetes teams include the full aggregated data provided by the primary care organisation(s) in their annual report and a copy is sent to the DHB and the Ministry of Health by 1 February 2004.	Annual, by 1 February 04
ORA-01	Percentage of children caries free at age 5 years.	**Targets** Total: 53.6	Annual, by 31 March 04
ORA-04	Mean MF score at Form 2 (year 8).	**Targets** Total: 1.6	Annual, by 31 March 04
CAN-01	Waiting times for radiotherapy.	*Part i)* Monthly templates supplied on time and complete from each DHB. *Part ii)* Provide a report updating on progress towards ensuring all patients receive oncology megavoltage radiation treatment according to nationally agreed standards. This report is to be agreed with all the peripheral DHBs whose populations have used the service during the quarter.	Monthly / Quarterly

*In regards to the oral health targets (ORA series) it should be noted that there is fluoridation of public water supplies in Methven only – **population approximately 1200 people.** Any changes affected now or in the near future will not show through in the MF rate of Form 2 children for another 7-12 years at the earliest. CDHB will endeavour to meet the target subject to the above constraint.

CAR-03	Number of people waiting with certainty who have been waiting for more than 6 months for coronary artery bypass graft.	**Target** Zero people waited more than 6 months for a coronary artery bypass graft, after being given certainty of treatment, during the reporting period.	6 Monthly
CAR-05	Number of people waiting with certainty who have been waiting for more than 6 months for angioplasty.	**Target** Zero people waited more than 6 months for a coronary angioplasty, after being given certainty of treatment, during the reporting period.	6 Monthly
CHIQ-02	Progress in implementing the Baby Friendly Hospital Initiative in maternity facilities.	Report: Describing what activities the DHB has undertaken to ensure that each maternity facility within the DHB's region is working towards implementing the Baby Friendly Hospital Initiative and has an agreed date for assessment by the NZ Breastfeeding Authority.	Annual
CHI-01	Children fully vaccinated by their 2nd birthday.	DHBs to provide two reports: 1. The total number and the percentage of children enrolled at birth on the NIR who received their 6-week vaccination on time (within 9 weeks). Only DHBs where NIR is operational to report – Reports to be based on the period of operation of the NIR in the DHB. **Target:** To improve on current performance. 2. A report outlining progress towards implementation of the National Immunisation Register.	Annual
CHI-06	Percentage of children passing school entry hearing test.	**Target:** To improve on current performance.	Annual
CHI-08	Repeat admissions for asthma in children under 5 years (rate per 100 discharges).	**Target:** To improve on current performance	6 Monthly
CHI-09	Repeat admissions for asthma in children 5 – 14 years (rate per 100 discharges).	**Target:** To improve on current performance.	6 Monthly
CHI-13	Percentage of babies born in public hospital with low birth weight.	**Target** Within National Confidence Levels	6 Monthly
CHI-17	Discharge rates for ambulatory sensitive admissions under 0 to 4 years.	**Target** Within National Confidence Levels	6 Monthly
CHI-18	Discharge rates for ambulatory sensitive admissions 5 to 14 years.	**Target** Within National Confidence Levels	6 Monthly
CHI-19	Standardised discharge rates for ambulatory sensitive admissions under 15 to 24 years.	**Target** Within National Confidence Levels	6 Monthly

FIN-01	Actual financial performance compared to the approved Annual Plan of the Funder, Provider and Governance functions of the DHB.		Monthly
FIN-02	Percentage of DHB's total expenditure on services provided by Maori providers compared to the percentage of the DHB's total expenditure on services provided by Maori providers.		Quarterly

6.0 REFERENCES

The Canterbury DHB has developed key documents which have been referenced throughout this District Annual Plan. These documents can be accessed via the Canterbury DHB website www.cdhb.govt.nz or by contacting Denise Denley on (03) 364 4160 or email denise.denley@cdhb.govt.nz.

- Statement of Intent (SOI) 2002-2005
- Crown Funding Agreement (CFA)
- District Strategic Plan Towards a Healthier Canterbury: Directions 2006 Summary and Full Documents
- Health Needs Assessment for Canterbury October 2001
- Health Needs Assessment for Older People February 2003
- South Island Regional Mental Health Plan February 2002 Parts A and B
- Information Systems Strategic Plan (in draft)
- Māori Health Plan – Whakamahere Hauora Māori Ki Waitaha 2002-2006
- Pacific Health Action Plan – March 2002
- Prioritisation Policy
- Consultation Policy
- Summary Annual Report 2001-02
- Rural Health in Canterbury DHB: An Action Plan May 2002
- Interim Diabetes Plan October 2002
- Child Health Report March 2002
- Disability Strategy Action Plan 2002-2006

7.0 ATTACHMENTS

A. Service Level Agreement (Volume Schedule)
B. Consolidated List of Service Coverage Exceptions
C. Revenue Reconciliation
D. South Island Mental Health Work Plan 2003-04
E. The CDHB In-house Health and Disability Services
F. Terms of Reference – Quality and Patient Safety Council
G. Disability Support Services Capability Criteria for Devolution of Older Persons Health monies
H. Establishment plan for DSS devolution
I. Glossary of Terms
J. CDHB Expenditure on Māori Health
K. Disability Strategy Action Plan
L. Key CDHB Population Statistics
M. Integrated Continuum of Care for Older peoples Health Services; Discussion Document March 2003
N. CDHB Workforce Details
O. Community and Public Health Business Plan 2003/04 (Draft)
P. Home Support Services Key Recommendations
Q. Mental Health Needs Assessment Service Coordination
R. Alcohol and Other Drug Services Key Recommendations
S. Mental Health Residential Accommodation Respite Care Services key recommendations
T. Diabetic Retinal Screening Provision Key Recommendations
U. Bone Health Services
V. Rural Health
W. Orthopaedic Service
X. Facilities Review

8.0 NOTES

8.1 Specific DAP Approvals

Details on approvals needed for Provider Selection, Private Involvement and Cooperative Agreements/Arrangements are provided under separate cover.

8.2 Update of Schedule E of Crown Funding Agreement

These will be provided under separate cover.

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

DISTRICT ANNUAL PLAN

2004 - 2005

June 2004

DISTRICT ANNUAL PLAN
1 July 2004 – 30 June 2005

Produced by
Canterbury District Health Board
PO Box 1600
Christchurch

Date

Telephone (03) 364 4160

www.cdhb.govt.nz

ISSN: 1176 3124

Table of Contents

1.0 EXECUTIVE SUMMARY

Statement from DHB Chair and CEO

This year's Annual Plan for the Canterbury District Health Board (CDHB) sets out the priorities and the plans that are proposed for the coming financial year. The Plan also identifies the challenges that the CDHB will face, particularly with the introduction of Population Based Funding (PBF) which will move the CDHB onto an equitable path of funding. The actions the CDHB will have to take to realign services to match this funding are outlined and involve community and staff engagement.

The Canterbury CDHB had made significant improvement to its financial performance and was on track to break even in 2003/04 and out years. However, the devolution of Disability Support Services contracts has added a significant challenge to the Canterbury DHB, as this has resulted in Canterbury DHB being further over funded by another $29M on top of the original $13M overfunding, ie a total of $42M over-funded, under the population-based funding formula.

This means that, while the CDHB will continue to receive an annual increase in its funding from the Government, the level of funding increase will be significantly less than previous years. The reason that CDHB is receiving a lower funding increase is that, currently it is considered an over-funded board (by about $42M) under the population-based funding formula. This has significant funding implications for the DHB as every year the same services will cost more to deliver than the funding increase.

For Canterbury, this means that in order to continue to meet our core directions and to encourage new initiatives in how we fund public health for the people of our region, we will need to make some tough decisions. We will need to inform our community and engage them on the need for change across a number of services.

We will need to reconfigure services to match funding under the PBF formula where the CDHB is considered to be over target, for example, in the area of aged care.

We will need to realign clinical service delivery models. Our hospitals must live within their budgets while at the same time increasing their productivity. Initiatives to introduce greater levels of efficiency within the hospitals while maintaining quality of service delivery will be a major challenge for us. The CDHB has 14 hospital sites in Canterbury with substantial infrastructure which will need to be reviewed in order to become more efficient.

We will work with Primary Health Organisations (PHOs) to deliver the CDHB's key health strategies. The emergence of four PHOs, which by 1 July will cover 90% of the CDHB population, also provides opportunities to better manage acute demand and referred services.

While we continue to pursue further efficiencies in the way we manage our resources, we must also better prioritise the services we fund and provide if we are to maintain existing services. Staff have high expectations of ongoing improvements in their terms

and conditions. Our ability to deliver within our funding path will be an ongoing challenge particularly in light of the increasing number of national employment agreements.

In addition the new Holidays Act had significant financial implications for Canterbury DHB and the DHB will not be able to achieve its breakeven target, if this is not fully funded.

The continual process of introducing new technology to our organisation and exploring better ways of communicating with our contracted providers through the medium of the internet and other forms of technology is another major challenge for the CDHB. Enabling our health workforce to gain a greater knowledge and insight into different practice methods via technology is also vital. We want to implement better information technology systems and look to achieve this in collaboration with other DHBs as well as with other health providers in our region. This will enable us to respond to the rapid growth in new diagnostic techniques, screening services, robotics and remote diagnostic educational systems. A key initial step will be putting in place the IT architecture to support these developments.

The CDHB recognises the Treaty of Waitangi as the founding document of New Zealand and acknowledges our obligations as defined in the New Zealand Public Health & Disability Act. This commitment is reflected in the projects and plans that are outlined in this Annual Plan for Māori health, primary care, Pacific peoples and those with specific needs. Our stated intention is to continue to reduce disparities and improve health outcomes for Māori.

The CDHB has introduced several new initiatives in the area of health promotion over the last 12 months and we plan to continue these projects and programmes over the next 2-3 years. Of importance is the introduction of smoke-free hospitals and other DHB facilities and the implementation of the Smokefree Environments Act 1990 which will have the effect of reducing smoking in public places. We intend promoting greater public awareness of important health issues like diabetes and respiratory and cardiac illnesses. Canterbury will also begin a new promotion focused on dental care for teenagers in the region.

In March 2005 the new Christchurch Women's Hospital will be completed and provide more appropriate facilities for staff, patients and their families. It is with significant pride to say that this project will be completed under budget.

We are proud of the progress the CDHB has made. This is due to the experience, quality and professionalism of staff within our hospitals and the community. Whilst there are many future challenges, we are confident we will be able to make the transition to support an equitable and sustainable funding path for all New Zealanders.

Syd Bradley
Chairman

Jean O'Callaghan
Chief Executive

1.2 Signatories – Minister/Chair/CEO

Signatories

AGREEMENT DATED THIS 30th day of June 2004

(Made under Section 39 (1) of the New Zealand Public Health and Disability Act 2000)

BETWEEN

Honourable Annette King
Minister of Health

Chairman of the
Canterbury District Health Board

Chief Executive Officer
Canterbury District Health Board

Note:

This District Annual Plan 2004-2005 was signed off by the Minister of Health, based on comments in the letter attached, pages 3(a), (b) and (c).

Minister of Health
Minister for Food Safety
MP for Rongotai (incl Chatham Islands)

- 2 JUL 2004

Mr Syd Bradley
Chair
Canterbury District Health Board
PO Box 1600
CHRISTCHURCH

Dear Mr Bradley

CANTERBURY DISTRICT HEALTH BOARD: 2004/05 DISTRICT ANNUAL PLAN

I have signed and approved Canterbury District Health Board's (CDHB) District Annual Plan (DAP) for 2004/05, with the exception of your proposals for service reconfiguration. I request that you provide me with more detail on the service reconfigurations that you are proposing before consulting with the public. Before implementing any service reconfigurations, I expect CDHB to seek the advice of the Ministry of Health and then obtain my agreement. I understand that it is not CDHB's intention to reduce services available to your population as a result of these reviews.

I wish to express my appreciation to the Board, management and staff for all the effort that has gone into producing the plan and the efforts made to manage your services within the funding available. I expect CDHB to continue to manage its financial risks and live within its allocated funding, particularly where these relate to Multiple Employer Collective Agreements. Where your DHB identifies severe risks of any type I expect you to notify the Ministry of them along with your strategies for mitigating them

I am pleased to advise you that in 2004/05 CDHB will continue to receive the benefit of early payment arrangements that you benefited from in 2003/04, based on the criteria agreed.

I have noted the service coverage exemptions you are seeking. I expect you to have resolved these service coverage gaps by the end of the 2004/05 financial year. In particular, I expect CDHB to make every effort to resolve the issues noted regarding elective services. Your exemption to the requirement to comply with new Ministry of Health guidelines is subject to your seeking the written agreement of the responsible DDG within the Ministry, and will apply to 2004/05 only.

3 (a)

Parliament Buildings, Wellington, New Zealand. Telephone: (04) 470 6554, Facsimile: (04) 495 8445

Work with West Coast

I have previously discussed with the Chairs of Canterbury and West Coast the need to work together on service and other functions, for example, "back office" and other administrative work.

Some service elements at West Coast DHB are becoming more and more difficult to deliver and need to be assisted in some areas by the Canterbury DHB. I would appreciate it if you could include a KPI in your Statement of Intent that reflects the need to establish a formal agreement on these matters and submit it to me by 30 September 2004. This initial agreement is likely to be just a process towards an agreement, but by the end of the financial year a draft agreement that is quite specific on service issues and administrative cost savings to the West Coast is sought. The Chairs and I can then meet to finally resolve any concerns or issues prior to 30 June 2005.

Mental Health

I note the improved understanding of the requirements of the Mental Health Ringfence and reiterate the importance of adhering to these requirements.

The Holidays Act (2003)

I am aware that concern has been expressed throughout the public health sector regarding the cost of implementing the Holidays Act 2003. I understand that the Ministry of Health has had discussions with DHBs, and that a number of community health providers have been in touch with the Ministry regarding the impact. The Ministry is working with The Treasury to assess the impact of the Holidays Act and prepare advice for Cabinet.

At the same time, you may be aware that the Minister of Labour has asked his officials to review some elements of the Act that are causing concern. Because this official process will take some time to work through, I am not able to provide a timeframe for decision-making about the shape or extent of any possible compensation for DHBs or other providers in this area. As soon as we have a timeframe I will ensure the Ministry conveys it to you.

Health Service Outputs

I am concerned that as technology and procedures change we are finding it difficult to assess how Government's significant additional investments in health have affected health services. During 2004/05 officials will be working with the sector to assess the value gained for New Zealanders from investments in health. I look forward to your co-operation with this work.

Please note that sign off on the 2004/05 DAP does not mean approval for any projects requiring equity or new lending. Approval for equity or new lending is managed via the annual capital allocation round. Such approval is dependent on

both completion of a sound business case and evidence of good asset management and health service planning by your DHB.

This letter should be attached to the copy of the signed plan held by the Board and a facsimile of the letter should be attached to all copies of the Plan made available to the public or any other third party.

Would you now please forward a copy of your final Statement of Intent 2004/05 to the Ministry within two weeks (10 working days) of receiving this letter.

Yours sincerely

Hon Annette King
MINISTER OF HEALTH

3 (c)

2.0 INTRODUCTION

2.1 Vision Statement and Values

2.1.1 Vision and Values

Our Vision – Ta Matou Matakite

To promote, enhance and facilitate the health and well-being of the people of the Canterbury District

Our Values

Care and respect for others	Manaaki me te kotua i etahi
Integrity in all we do	Hapai i a matou mahi katoa i ruka i te pono
Responsibility for outcomes	Kaiwhakarite I ka hua

2.1.2 Who are we

We are the health organisation responsible for funding most health services in Canterbury. We are funded by Government, but it is up to us to work together with Canterbury people, to decide what health services we need and how to best use our limited funding, noting Government policies. We:

- Fund most disability (for older people), mental health, Māori health and personal and family health services in Canterbury.
- Run Canterbury's 14 public hospitals and provide mental health, disability support, alcohol and drug and community health services within the provider arm.
- Promote community health and well-being through population health programmes such as health promotion and protection.

- Encourage all health and disability support providers in Canterbury to work together to streamline health care and make care more efficient and effective.

Our Ways of Working

Be people and community focused	Arotahi atu ki ka takata me ka iwi whanui
Demonstrate Innovation	Wakaba whakaaro hihiko
Engage with our stakeholders (those individuals and groups with an interest in our work)	Tuu atu ki ka uru (ratou ka takata me ka roopu e parekareka ana mai ki a tatou mahi)

Our Strategic Directions and Top Priorities

The Canterbury DHB completed a strategic planning process in 2002/03 "Toward a Healthier Canterbury: Directions 2006" which involved community consultation. The agreed strategic directions are:

Direction 1:	Improving the Health Status of our Community
Direction 2:	Finding better Ways of Working
Direction 3:	Working Together: Innovative Models of Service Integration
Direction 4:	Developing Canterbury's Health Care Workforce
Direction 5:	Being a Leader in Hospital and Health Care Services

In the Strategic Plan health areas were chosen for special attention based on a health needs assessment for Canterbury, consideration of key Government health strategies such as the New Zealand Health Strategy, New Zealand Primary Health Care Strategy, the Māori Health Strategy and the New Zealand Disability Strategy and feedback received in the formal consultation on the strategic plan.

Details of the health needs assessment and the summary of submissions can be found on our website: www.cdhb.govt.nz.

The priorities are:

- Child and Youth Health
- Primary Health
- Māori Health
- Mental Health
- Disease Prevention and Management
- Cardiovascular (Heart) Disease
- Diabetes
- Cancer

The Canterbury DHB Strategic Plan will be formally reviewed and publicly consulted on in 2005/2006.

The District Annual Plan 2004-2005

This Plan's objectives are aligned with Government objectives for District Health Boards as set out in the New Zealand Health Strategy and the New Zealand Disability Strategy, Māori and other Health Strategies as well as directions in the current Canterbury DHB Strategic Plan.

The Annual Plan outlines the planned performance, funding arrangements and services provided of the Canterbury DHB for the period 1 July 2004 – 30 June 2005 noting the Ministers 'Start Here' list and emphasis on:

- He Korowai Oranga
- New Zealand Disability Strategy
- Elective Services and Radiotherapy Waiting Times
- Diabetes Incidence and Impact
- Inequalities
- Primary Care
- Mental Health Blueprint
- Keeping Infrastructure Costs as low as possible
- Industrial Relations Strategies
- Innovative approaches to enable managing within budget

2.2 Treaty of Waitangi

The Canterbury DHB recognises and respects the principles of the Treaty of Waitangi partnership, participation and protection. We also acknowledge the expectations of the New Zealand Public Health and Disability Act 2000 and the Crown Funding Agreement. We are committed to reducing disparities and improving health outcomes for Māori and to ensuring Māori involvement in planning for these.

The Canterbury DHB has agreed a regular meeting schedule with Kai Tahu as manawhenua of the district, through the Manawhenua Health Group ki Waitaha, which comprises the seven Kai Tahu runaka supported by the Ngai Tahu Development Corporation. We also meet quarterly with Te Runanga o Nga Maata Waka representatives and the Māori community and engage in numerous other formal and informal interactions with Māori providers, services and community organisations. The outcomes of these meetings feed directly into Canterbury DHB planning processes.

The Canterbury DHB has established Te Kahui Taumata, which includes the Kaumatua and Taua and senior Māori staff who provide Māori specific advice and direction to the Chief Executive. A Director of Māori Health is due to be appointed and will join Te Kahui Taumata and be part of the Executive Management Team. This group will ensure that the Canterbury DHB recognises and respects the principles of the Treaty of Waitangi and actively works to improve the health of Māori.

2.3 Population Profile

Key Details

The Canterbury DHB catchment area covers rural communities from Kekerengu in the North, Rangitata in the South and Arthur's Pass in the West. 16% of the population live in rural towns (eg Kaikoura), rural centres (eg Rakaia) and wider areas (eg Malvern). The Canterbury DHB is the second largest DHB by population, the largest in geographical area and has the ninth largest Māori population. The total Canterbury population is 427,086 with 6.9% identifying as Māori (2001 Census). Canterbury DHB population statistics are attached in Appendix 1**.**

2.3.1 Overview of the Canterbury Population

An initial Needs Assessment Project was completed in October 2001 and more recently a Needs Assessment for Older People 2003. These assess the health status of the Canterbury population as they relate to the health objectives within the New Zealand Health and Disability Strategies. The Needs Assessment also covered issues raised in community consultation and linked the health needs of the Canterbury community with Government health strategies and others such as the Positive Ageing Strategy.

The Health Needs Assessment for Canterbury (October 2001) showed that the Canterbury population is similar to the NZ population as a whole in overall morbidity and mortality rates. The leading causes of death of people in Canterbury are cardiovascular disease and cancer. As yet, we do not have data which show that particular groups of people are at higher risk of dying from particular disorders. Greater emphasis on accurate collection of ethnicity data, and analysis of hospital discharges linked with NZDep2001 coding will help provide this information in coming years.

People in Canterbury have the highest life expectancy at birth (77.7 years) of all DHBs. Nationally, Māori life expectancy is lower than that of other ethnic groups. In Canterbury, Māori and Pacific communities are at higher risk of diabetes and associated complications. It is hoped that Canterbury DHB's plans to address diabetes, cardiovascular disease, and cancer will improve Māori and Pacific health status, and reduce inequalities in life expectancy. In addition, Canterbury DHB's Whakamahere Hauora Māori ki Waitaha (Māori Health) Plan is designed to address high health risk areas for Māori, including smoking, obesity and alcohol consumption, by working with Māori communities on public and personal health initiatives. Canterbury DHB's Pacific Health Action Plan is likewise aimed at reducing inequalities, and improving health outcomes for Pacific people.

Poorer health status is linked with high degrees of deprivation, and Canterbury DHB has about 80,000 people living NZ Dep deciles 8-9-10. Canterbury DHB health priority action plans recognise the need to provide services for hard-to-reach people who may not access primary and secondary health services. Our developing Primary Health Organisations will be working with high-need populations to try to reduce health inequalities associated with socio-economic status, in line with the DHB's health gain priority areas.

While the health status of rural Cantabrians is good, some rural areas of Canterbury do not have adequate access to primary or community-provided health services. Canterbury DHB's Rural Health Plan lists actions to improve rural access issues.

A fuller Needs Assessment for the Canterbury DHB population will be available August 2004. The CDHB has also commenced initial work on looking at health outcomes for the population. It will build on the DHB information using data from other government departments and Territorial Local Authorities (TLAs). Current documentation is available on the Canterbury DHB website (www.cdhb.govt.nz).

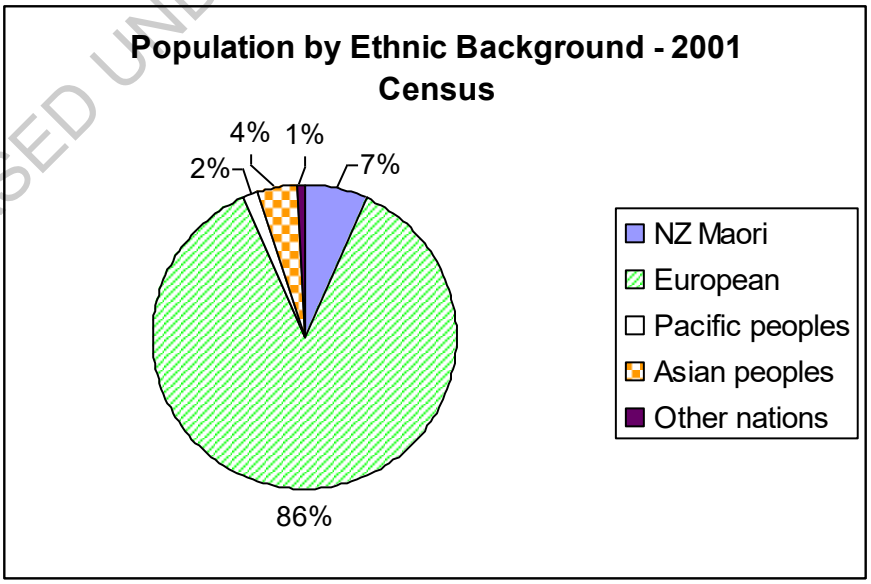
Key population trends for Canterbury include:

Ageing Population
Canterbury's population is ageing quickly compared to other parts of the country. The percentage of the population who are 65 or older will increase from 12% in 2001 to 20% in 2021. Both Māori and Pacific people aged 65 and over are projected to increase each of their share of the DHB's population from 3% to 7% by 2021. This has implications not only for the relative size of the population of working age to support the older people, but also for health as older people, particularly those over 75 years, consume a significant amount of health resources.

Decreasing Child Population
The population aged 0-14 will decrease to 15% of the Canterbury DHB population by 2021 compared to 18% in 2001.

Relatively Large Youth/Young People Population
Currently around 21% of New Zealand's population is in the age group 10-24 years. This is relatively large compared to the size of the rest of the population. The Canterbury figure is similar, at 20%.

Changing Ethnicity of the Canterbury DHB Population
An increasing number of the Canterbury DHB child and young people population are non-European, principally Māori, Pacific and Asian.



Māori
Most are under 30 years of age. Kai Tahu are manawhenua and make up about 25% of Māori in the Canterbury DHB region. Seven Kai Tahu runaka are in the Canterbury DHB area. Other Māori in Canterbury come from tribal regions throughout New Zealand.

The available health statistics indicate that Māori in Canterbury have a similar health profile to national statistics. Nationally Māori are high users of secondary services and under utilise primary services. This cannot be confirmed from local ethnicity data because it is incomplete although emerging information indicates that Māori in Canterbury use primary services at about the same rate as non-Māori. 'Māori' for Māori providers provide a range of public, primary and community health services, and some bicultural services are provided by mainstream providers.

Pacific Peoples
There are more than 7,254 Pacific people in Christchurch, based on Statistics NZ 2001 figures, most of them are under 25 years. They make up 1.7% of the Canterbury population and are comprised of a mixture of Island born and New Zealand born people. The Canterbury DHB currently has three Pacific providers and limited Pacific service within mainstream providers. An initial needs assessment has indicated Pacific peoples are difficult to reach due to communication and cultural difficulties and over utilise secondary services rather than primary and community services. Changing demographics and a youthful population will mean different methods will be needed to reach these groups.

Migrant and Refugee Communities
Christchurch has been a resettlement point for refugees during the past 10 years. Exact figures are not available but it is likely this population exceeds 4,000. Screening programmes for refugees and migrants have been established, however, migrant and refugee populations have particular needs in the areas of child health, mental health, primary health care and aged care.

Asian Population
The Asian population in Canterbury DHB is 4.2%. This population is steadily growing although at a slower rate than the Māori and Pacific peoples' populations. Many Asian-born individuals living in New Zealand are now ageing and the numbers of New Zealand born Asian children and youth are increasing. There has been a growth in information about the health needs of the Asian population in recent years and this will be covered in the next Canterbury DHB Health Needs Assessment.

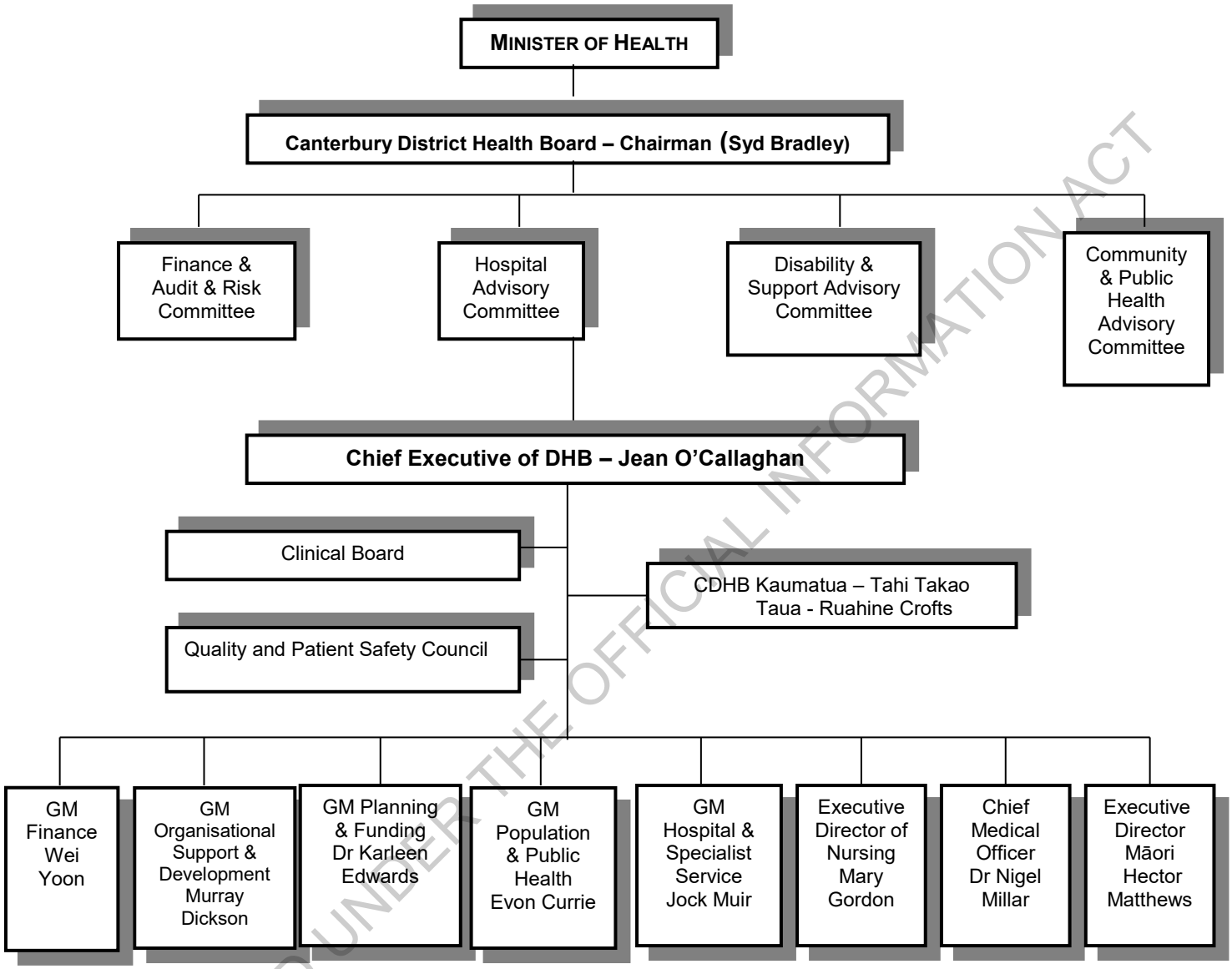
People with Disabilities
Using information from the New Zealand Disability Survey it is estimated there are about 160,000 people with disabilities in Canterbury DHB, of which about 58,000 have a disability requiring assistance. Māori are 1.35 times as likely to suffer from a disability not requiring assistance and 1.65 times as likely to have a disability requiring assistance, as non Māori. Appendix 2 gives the detail.

2.4 Key Issues

- Realigning services to match funding under the Population Based Funding formula where the CDHB is considered to be over-target especially in the area of aged care
- Informing and engaging with our community, staff and other stakeholders on the need for changes across a number of services
- Moving to equity in line with the funding path while still providing the required volume and range of services
- Reduce the gap between current funding for older persons services and future funding path and targets.
- Realigning clinical service delivery models in line with future funding path
- Hospital Services living within their allocated resources while increasing productivity
- Responding to the national industrial environment and being able to afford salary increases
- Optimising investment by ensuring the CDHB gets the revenue for the services it provides
- Working with other South Island DHBs and other DHBs on areas that benefit patient care
- Maintaining the morale and cooperation of staff in context of reduced funding
- Being able to sustain the same range of services in smaller parts of our district from a clinical viability and workforce perspectives
- Continuing to find efficiencies within the organisation in clinical and non clinical services.
- Complying with new legislation guidelines and requirements that set standards for services and health professional activity
- Ability to implement new technologies
- The need to address the organisations information systems architecture to enable it to implement better information systems that ensure providers can more effectively communicate and monitor patient care and provide better information for planning and funding purposes
- Addressing the increasing burden of chronic diseases, such as respiratory and cardiac illnesses, and diabetes, modern epidemics of the western world. Chronic disease reduce the quality of life for sufferers, and are expensive to treat over their life time. They are a major issue in New Zealand and in the Canterbury DHB, yet

there are opportunities for early prevention and disease management strategies. Increased demand will be a challenge to meet within our funding path.

2.5 Organisation Structure (As at June 2004)



3.0 ENSURING SERVICES FOR THE DHB'S POPULATION

3.1 Canterbury DHB Organisation Performance

3.1.1 Canterbury DHB Core Directions

The Canterbury DHB Board and senior management have collectively determined key strategies, actions to achieve outcomes in line with each of its five Core Directions.

For each strategy, key stakeholders have been identified including the community, staff, other government agencies, providers of health services and the Ministry of Health

DIRECTION 1: IMPROVING THE HEALTH STATUS OF OUR COMMUNITY				
Goals	Strategies	Actions	Timelines & Board Input	Outcomes/Measures of achievement
1.1 Reduce health inequalities	1.1.1 Target actions and resources to relevant populations particularly Māori, Pacific populations and other areas identified by the Health Needs Assessment	Support the development of a population health approach in primary care which will enable services to be targeted.	June 05 *Update on progress for information*	Improved access to primary care for target groups
	1.1.2 Support the ongoing development and enhancement of PHOs	Actively work with existing and prospective PHOs in the development and enhancement of PHO services Continually review government funding framework and make adjustments to fit local needs and target CDHB objectives Through PHO's support initiatives that reduce barriers for Māori, Pacific People and other disadvantaged groups Improve access to retinal screening to enable early identification and intervention for diabetic retinopathy	Ongoing *Update to CPHAC* June 05 *Update on progress for information* Nov 04 *CPHAC Information*	Barriers to access reduced. Measure on enrolled population baseline Services are viable and sustainable CDHB lives within budget for these services 90% of Canterbury's population will be covered by PHOs by July 2005 CDHB meets MoH targets
	1.1.3 Develop a vision for the future role of PHOs	Complete the community and primary health framework	December 04 *Approval*	Framework consulted on and utilised for planning
1.2 Better understanding of Health Needs of Community	1.2.1 Improve data collection in relation to our community	Continue to implement a project to collect accurate ethnicity data collection both within CDHB delivered services and those of funded external providers Establish and implement a framework for analysis and reporting on Māori and Pacific utilisation of health services	December 04 *Update on progress* December 04 *Approval*	CDHB has ethnicity data that is accurate and reliable CDHB has better information on which to base decisions

DIRECTION 1: IMPROVING THE HEALTH STATUS OF OUR COMMUNITY				
Goals	Strategies	Actions	Timelines & Board input	Outcomes/Measures of achievement
1.2 Better understanding of Health Needs of Community *(Cont…)*	1.2.2 Monitor the utilisation and impact of health services	Recognise the needs of Māori, Pacific, rural and high deprivation communities in needs assessment, planning and prioritisation processes Ensure programme planning and delivery is based upon best possible evidence and appropriate valuation	Ongoing Ongoing	Decision making on prioritisation is based on best possible information
1.3 Integrated health planning in Canterbury	1.3.1 Improve the early identification and coordinated treatment of people with chronic disease especially cardiovascular disease, diabetes and cancer	Develop and implement evidenced based delivery of service and guidelines for cancer and cardiovascular disease which promotes a continuum of care: - Project team established - Review of National Guidelines - Identification of local issues - Development of local guidelines - Information sharing and training - Evaluate process	March 05 *Noting* July 04 July 04 August 04 Nov 04 *Update on progress* February 05 June 05	Services are provided effectively and efficiently Improved outcomes for people presenting with cancer and cardiovascular disease Services are connected and service delivery and information sharing is linked between services
	1.3.2 Work with other agencies to develop approaches to preventing illness and maintaining health lifestyles	Complete development of a nutrition and physical exercise strategy that focuses on risk factors for heart disease, diabetes and cancer	October 04 *Approval*	Plan developed and implemented

DIRECTION 1: IMPROVING THE HEALTH STATUS OF OUR COMMUNITY				
Goals	Strategies	Actions	Timelines & Board input	Outcomes/Measures of achievement
1.3 Integrated health planning in Canterbury (Cont…)	1.3.2 Work with other agencies to develop coordinated approaches to preventing illness and maintaining health lifestyles (Cont…)	Implement the Heart Manual across service areas	July 04 *Information*	Better information on needs of/outcomes for patients
		Adopt a smokefree strategy for Canterbury	October 04 *Approval*	Plans developed and implemented
		Work with communities to build a better understanding of the value of community development approaches	June 05	Community informed
1.4 Strategic Review of Progress	1.4.1 Review Strategic Plan	Undertake review	July 04 *Noting*	Directions/priorities reviewed
	1.4.2 Rewrite Strategic Plan	Rewrite and consultation plan	October 05 *Approval*	Requirement of MoH to update
	1.4.3 EMT monitor Core Directions workplan	Review progress quarterly	*Regular Updates* October January April July	Progress on actions monitored

DIRECTION 2: FINDING BETTER WAYS OF WORKING				
Goals	Strategies	Actions	Timelines & Board input	Outcomes/Measures of achievement
2.1 To better inform the community over the changes to Canterbury' s health funding	2.1.1 Develop a communications plan for community and key stakeholders	Coordinated communication plan to be developed giving the overall context, issues and process CDHB will take to achieve the transition to PBFF as well as individual communications around for each strategy as they develop. Identify and implement specific strategies and key messages to increase the understanding of: - The public - Local politicians - Community leaders - Health related stakeholders - Staff - Include MoH Strategies in - - DAP/SOI - Presentation developed for general use that gives consistent messages	July 04 then ongoing *Plan to Board for noting*	Community and key stakeholders informed of the issues in an open and transparent manner. Well informed public and stakeholders Well informed staff and contracted providers
2.2. Project Management Workplan: Make it happen	2.2.1 Develop and implement consistent processes for all strategies and major projects	Create a core team to develop a standardised review and coordination process. Team to action: - Consistent set of principles for all projects under this alignment to PBFF - Ensuring people and resources are available to resource the projects - Standard review processes and templates - Standard reporting format and processes to keep Board informed - Standard Change Management procedures/templates - Standard financial analysis processes	October 04 *Information updates* October 04	Templates in place and used Project timelines met Projects are linked and coordinated Efficient use of resources across projects Regular reporting to the board on progress Project budgets observed Communications Plans for all reviews Implementation of approved projects

DIRECTION 2: FINDING BETTER WAYS OF WORKING				
Goals	Strategies	Actions	Timelines & Board input	Outcomes/Measures of achievement
2.2. Project Management Workplan: Make it happen (Cont….)	2.2.1 Develop and implement consistent processes for all strategies and major projects (Cont….)	Develop Public and Staff communications strategy for: - For each Strategy - For each Review	July 04 *Information*	
2.3 Realign Aged Care Services to match funding under the Population Based Funding formula recognising CDHB is over national averages by $29M	2.3.1 Develop a Strategy: - to align residential care to community needs (benchmarked to support Ageing in Place) - to review AT & R model of delivery to consider a move to some Community based rehabilitation - to ensure most effective use of limited Community Support Services resource using prioritisation criteria	Complete a public briefing paper on issues facing CDHB under the PBFF scenario for aged care. Communications strategy developed - Establish a cross agency group to develop a strategy to respond to the issues outlined, develop an options paper for Board sign off - Identify Stakeholders - Establish a small group (up to 6 people) - Agree TOR / Processes for working - Identify priority issues, gaps, duplications etc - Identify models of service delivery - Identify appropriate target for service delivery - Identify capital requirements - Recommendations to Board on service configurations Management of Change process implemented.	July 04 *Noting* July 04 *Noting and key messages for Board* April 05 *Approval* From June 05 *Board updated on progress*	Consultation completed Community is informed of issues Plans for alternative models of care developed Move to equity commenced Adoption of Ageing in Place as a CDHB Strategy Service delivery reflects evidenced based practice

DIRECTION 2: FINDING BETTER WAYS OF WORKING				
Goals	Strategies	Actions	Timelines & Board input	Outcomes/Measures of achievement
2.4 Develop a plan to reconfigure services for efficiency and effectiveness	2.4.1 Prepare specific plan for Ashburton for clinical and financial sustainability of health services in consultation with staff, unions and community	Review population health and service needs	July 04	Appropriate level of service delivery to rural population
		Identify options and models for future service delivery	October 04	Facilities and services are clinically and financially viable
		Identify role of technology to improve service effectiveness eg. Telemedicine.	October 04	Services in appropriate clinical and financial parameters
		Identify any capital requirements		
		Recommendations to Board	January 05 *Approval*	
		Undertake community consultation and involvement of key stakeholders including adjacent DHBs	January 05	
		Business Case to MoH	March 05	
		Develop Management of Change proposal where change required	April 05 *Noting*	
		Develop process plan for change implementation	May 05 Information	
		Implement change process	From June 05 *Progress updates*	
	2.4.2 Review the number of physical sites in the CDHB against service need for both clinical and non clinical areas	Stocktake existing sites including leased properties	August 04 *Information*	Optimal use of leased facilities and sites
		Prepare business case for transfer of Corporate staff from CLH to appropriate facilities	August 04 *Information*	Efficient use of facilities and capital equipment
		Target leased properties for exit as a priority to reduce expenditure where owned sites or alternatives are available	December 04 *Information*	Surplus sites identified and leased sites exited

DIRECTION 2: FINDING BETTER WAYS OF WORKING				
Goals	Strategies	Actions	Timelines & Board input	Outcomes/Measures of achievement
2.4 Develop a plan to reconfigure services for efficiency and effectiveness (Cont….)	2.4.2 Review the number of physical sites in the CDHB against service need for both clinical and non clinical areas (Cont….)	Identify requirements for community based services and models of service delivery (linked to strategies below)	April 05 *Information*	Develop service delivery models for specific communities
		Identify options for joint ventures and /or use of private facilities where appropriate	April 05 *Noting*	Key stakeholder involvement
		Identify opportunities for collaboration with PHOs, TLAs and communities of interest to achieve the optimal use of facilities and capital investments	April 05 *Nothing*	
		Identify duplication and/or surplus sites.	May 05	
		Recommend to Board options for service delivery models and how best to configure infrastructure	June 05 *Approval*	
		Consult with stakeholders and implement any management of change.	September 05	
		Board reviews consultation and considers any final recommendations resulting from consultation	November 05 *Approval*	
		Identify opportunities for investment in enabling new service delivery models		
		Implement any changes	Ongoing *Progress updates*	

DIRECTION 2: FINDING BETTER WAYS OF WORKING				
Goals	Strategies	Actions	Timelines & Board input	Outcomes/Measures of achievement
2.4 Develop a plan to reconfigure services for efficiency and effectiveness (Cont….)	2.4.3 Review range and mix of services to be delivered in rural areas	Develop a plan outlining an appropriate model for rural services by: Updating the previous work on rural services including the: - Stocktake of existing services (funded and non funded by CDHB) - Identification of gaps, issues and duplications - Link into information on health needs assessment of the CDHB rural population - Consultation with TLAs, communities on issues - Identify options and models of services delivery - Optimise links between PHOs and rural hospitals - Prepare an options paper for the Board - Recommendations to Board - Approval from Ministry of Health as required - Implementation of Management of Change processes	 July 04 September 04 October 04 *Information* January 04 *Noting* March 05 April 05 June 05 June 05	Rural communities have appropriate access to health services
	2.4.4 Re-design Clinical Services within the CDHB where beneficial for patient needs.	Establish steering groups of clinicians and management to oversee a review of clinical service delivery projects to include: - Identify overlaps, gaps and potential improvements.	July 2004 *Information* October 04	Optimal use of expenditure in clinical services Services are accessible to patients within the resources available

DIRECTION 2: FINDING BETTER WAYS OF WORKING				
Goals	Strategies	Actions	Timelines & Board input	Outcomes/Measures of achievement
2.4 Develop a plan to reconfigure services for efficiency and effectiveness (Cont….)	2.4.4 Re-design Clinical Services within the CDHB where beneficial for patient needs (Cont.…)	Identify opportunities for regional collaboration in relation to clinical services across DHBs.	December 04 *Information*	Identified improvements are implemented
	2.4.5 Re-design Clinical Services within the CDHB where beneficial for patient needs.	Develop an options plan which identifies key duplications and service configuration issues to meet clinical needs Recommendations on options and resources required presented to the Board Implement approved changes with robust business cases and consultation processes Identify and develop a plan to address clinical over-servicing	March 05 April 05 *Approval* June 05 and ongoing December 04	Achieve a patient focus in service delivery Cost effective service
2.5 HSS live within allocated resources	2.5.1 Control and manage employee costs	Ensure workforce management and reporting system (WMRS) (use of tools) fully operational across all cost centres Action plan developed by each Operational GM to address issues from post implementation audit on WMRS Rewrite of the WMRS is completed Budgets phased 2/52 and accurately reflect divisional efficiency plans Variances are managed and remedial action taken immediately	July 2004 Updates for noting July 04 *Information*	Individual action plans are implemented and improved results demonstrated in future audits Phasing accuracy is improved Expenditure is within budget parameters Cost centre managers able to demonstrate understanding of use of system Report to statutory committees

DIRECTION 2: FINDING BETTER WAYS OF WORKING				
Goals	Strategies	Actions	Timelines & Board input	Outcomes/Measures of achievement
2.5 HSS live within allocated resources (Cont….)	2.5.1 Control and manage employee costs (Cont….)	Identify competency and training needs of service managers in using WMRS and other management tools		Report to statutory committees
		Follow up audit(s)		
	2.5.2 Operating Expenditure and costs managed within budgets	Complete Work Plan that identifies HSS contribution to funding adjustments	July 2004	Achievement of all milestones within timeframe
		Plans are developed for each strategy identifying milestones and time frames	*FARC noting*	Operating Expenditure is controlled within budget
		Pilot a Budget Holding Department at Christchurch Hospital - Agree protocols and implementation - Fund department	September 04 *HAC Committee*	
		Continue to Identify and implement extra efficiency projects	June 05	
		Standardised control mechanisms and product list in place on ordering and authorising expenditure		
		Align performance objectives to performance based remuneration packages		
		Identify and develop a plan to address clinical service provision where above accepted benchmark criteria, eg, national intervention rates	December 04 *HAC*	
2.6 Enhancing hospital productivity	2.6.1 Maximise use of resources to maximise productivity	Establish Resource Unit to get: - Consistent costing and cost benefit analysis across HSS - Identification of areas where management of change processes needs to be activated.		Reliable and timely information

DIRECTION 2: FINDING BETTER WAYS OF WORKING				
Goals	Strategies	Actions	Timelines & Board input	Outcomes/Measures of achievement
2.6 Enhancing hospital productivity (Cont….)	2.6.1 Maximise use of resources to maximise productivity (Cont….)	Maximise Day of Surgery Admission (DOSA) rates and Day Surgery rates - Analysis by service and benchmarking - Change management to target areas	December 04 Briefing HAC Committee	Rates of DOSA and Day Surgery increase from baseline
		Day Surgery fully functioning and operating to full capacity - Increase Day Surgery proportion - Theatre Usage optimised	March 05 *Briefing HAC Committee*	Day Surgery proportion increases to national standard
		Continue reduction in average length of stay (ALOS) Role out Acute Management Projects at Christchurch and other hospitals	December 04 *Briefing HAC Committee*	Average length of stay comparable to Health Round Table levels
		Introduce Model for medical production planning initially at Christchurch Hospital	July 04 *HAC Committee*	Reliable prediction of resource requirements
		Develop, validate and introduce model for surgery production planning at Christchurch Hospital - Replicate medical model work and finalise theatre scheduling project	December 04 *HAC Committee*	
		Role out medical and surgical production planning models at Womens, Burwood and Ashburton Hospitals - Replicate production planning model post research	March 05 *HAC Committee*	
		Validate and achieve efficiencies planned in Womens Hospital transfer to Christchurch Hospital site - Review Business Case and transitional planning - Validate assumptions and work	March 04 – 05 *HAC Committee*	As per Business Plan

DIRECTION 2: FINDING BETTER WAYS OF WORKING				
Goals	Strategies	Actions	Timelines & Board input	Outcomes/Measures of achievement
2.6 Enhancing hospital productivity (Cont….)	2.6.1 Maximise use of resources to maximise productivity (Cont….)	Implement Christchurch Hospital Theatre Utilisation Review methodology to Burwood and Ashburton	December 04 *HAC Committee*	Efficient use (Health Round Table) levels Reduce trauma wait time Pilot commenced
	2.6.2 Maximise external revenue Overseas residents IDFs ACC Other	Develop consistent and clear administrative processes for increasing revenue capture in IDFs, Overseas residents and ACC. (eg. Coding requirements / invoicing etc) Identify and develop a plan to address clinical over-servicing	July 04 *HAC/FARC Update Board* December 04 *HAC*	Maximal collection of revenue due to CDH
2.7 Optimise future investment	2.7.1 Reconfigure Non-Clinical Services - where this results in more efficient services across the CDHB	Prepare Brief on principles, objectives and outcomes sought under management direction Stocktake current non-clinical services and identify duplications, overlaps, gaps and potential improvements. Eg, Maintenance, HR, Medical Records Ensure link with Clinical Services Reviews where appropriate Update to Board on potential changes Prioritise resources to projects where the most gain is identified in short/medium term Implement any changes with robust business cases, consultation and management of change processes	August 04 October 04 Ongoing December 04 *Information* December 04 *Update Board* January 05 and ongoing *Update Board for noting*	Reduced expenditure in non-clinical services Efficient consistent and standard non-clinical services and processes Identified improvements are implemented Clinical care not compromised

DIRECTION 2: FINDING BETTER WAYS OF WORKING				
Goals	Strategies	Actions	Timelines & Board input	Outcomes/Measures of achievement
2.7 Optimise future investment (Cont….)	2.7.1 Reconfigure Non-Clinical Services - where this results in more efficient services across the CDHB (Cont….)	Implement CDHB wide systems where beneficial, eg Procurement System with tighter controls using E-Commerce functionality	As agreed	
	2.7.2 Invest in technology (including IT infrastructure to improve service effectiveness	Identify information technology opportunities - Prepare Business Cases for IT Infrastructure - Gain approvals - Implement IT Infrastructure - Investigate emergent clinical technologies for potential CDHB investment Implement Clinical Framework Portal	*October 04 Update* December 04 March 05 June 05 Ongoing June 05	Improved information for decision making Platform for improved systems and point of care patient service.
2.8 Fund services that focus on outcomes	2.8.1 Pilot feasibility of outcome-based funding approach in one mental health and one personal health service.	Identify pilot services Work with providers and where appropriate MoH on framework (build on existing national projects) Develop Service Specifications and agree reporting requirements Implement the process and evaluate effectiveness	Contracts in place by 1 January 05 *Update to Board for information* Initial evaluation (6 months progress) by 31 May 05)	Pilot outcome model that could be extended to other services Measure health outcome for target group in relation to pilot Pilot is evaluated against agreed criteria

DIRECTION 2: FINDING BETTER WAYS OF WORKING				
Goals	Strategies	Actions	Timelines & Board input	Outcomes/Measures of achievement
2.9 Transparent planning in funding processes	2.9.1 Put in place a sustainable 3 year funding path	Enhance existing transparent budgeting process Communicate to Stakeholders 3 year funding and budget scenarios, including service implications, if any, under PBFF	July 04 *FARC & Board approval*	Reporting and monitoring which is timely, accurate and budget variances are appropriately identified and addressed Stakeholders informed of 3 year financial
2.10 Developing and strengthening intersectoral relationships	2.10.1 Develop Health and Wellness Plan.	Develop strategy through project basis under umbrella of Healthy Chch	June 05 *Board Approval*	Project scoped (March 04). Plan prepared Long Term Council Community Plan (LTCCP) reflects this
	2.10.2 Develop closer relationship with TLAs	Develop Memorandum of Co-operation with TLAs	October 04 *Approval*	Memorandum of Co-operation agreed by all parties. LTCCP reflects health issues.
	2.10.3 Develop closer working relationships with key agencies	Identify common concern area and develop joint approach for pursuing; Target ACC and Police in 04/05	June 05 *Approval*	Common areas identified (June 04) Strategy Developments (Oct 04) Action underway (March 05)
2.11 Eliminate waste or duplication from our services	2.11.1 Manage Primary Referred Services Expenditure Growth	Develop mechanisms to control growth in pharmaceutical expenditure growth through innovative funding models Develop a strategy for optimising the effectiveness of the CDHB's community laboratory funding	31 Dec 04 *Update progress to FARC* 31 Dec 04 *Approval*	More efficient use of primary referred expenditure Limit growth in primary referred expenditure
2.12 Optimising the use of information technology to support health care delivery	2.12.1 Attain MoH Sign-off CDHB Information Systems Strategic Plan (ISSP)	Complete aspects of plan to complement current Clinical Systems Strategic Plan	July 04	Completed CDHB ISSP

DIRECTION 3: WORKING TOGETHER: INNOVATIVE MODELS OF SERVICE INTEGRATION				
Goals	Strategies	Actions	Timelines & Board input	Outcomes/Measures of achievement
3.1 Integrate services for: Older Persons Child Health Mental Health	3.1.1 Work with wider sector to implement continuum of care as described in - Linkage report: - Child Health Strategy Action Plan - Implement PHO Guidelines - Mental Health Strategy	As outlined in Linkage Report Child Health Action plan implemented As per Mental Health Strategy	Ongoing July 04 *Board approval and ongoing* Ongoing *Update on progress for information*	Recommendations of report implemented Recommendations of report implemented Recommendations of report implemented
3.2 Contain (medical and acute) demand growth	3.2.1 Manage medical/acute demand	Continue development of clinical pathways in respiratory and cardiology Support CHC Hospital work with Community providers, such as: - DVT Ultrasound Pilot - Liaison Nurses in GP Medical Assessment Teams - Facilitated Early Discharge - Eldernet Rest Home Database Reduce acute demand from rest homes Cross sectoral Working Party continues.	Ongoing *Update HAC*	Acute medical growth is contained in line with Health Round Table benchmark
3.3 Encourage innovation	3.3.1 Develop a culture of innovation.	Encourage sharing of benefits from innovative services Target existing research investments to researching innovation opportunities	June 05 Update *Board on progress for information*	Implement innovative services

DIRECTION 3: WORKING TOGETHER: INNOVATIVE MODELS OF SERVICE INTEGRATION				
Goals	Strategies	Actions	Timelines & Board input	Outcomes/Measures of achievement
3.4 Continually improve quality and patient safety	3.4.1 Promote a systems approach to enhance patient safety	Improve reporting on: - Quality KPIs - Incident Management Processes Identify key indicators for service and patient quality Implement Work Plan from Quality & Patient Safety Council which includes establishing quarterly reporting on quality & risk management activities to the Board and organising the CDHB Quality & Innovation Awards Programme	March 2005 *HAC reporting on progress* May 2005 *Regular reports to Board*	KPI report plan prepared Template prepared Work Plan in preparation

DIRECTION 4: **DEVELOPING CANTERBURY'S HEALTH CARE WORKFORCE**				
Goals	Strategies	Actions	Timelines & Board input	Outcomes/Measures of achievement
4.1 Achieve a workforce which provides right skills at the right place and time for best delivery and outcomes	4.1.1 Build Strategic Workforce capability	Establish an Organisational Development Framework for the CDHB:		
		Establish necessary behaviours to underpin framework projects	December 04	A set of key behaviours developed as reference point for future projects
		Prioritise projects for implementation under the endorsed OD framework including actions to address: - The co-ordination of workforce development - Leadership development - IR capability	December 04 *Update board on progress for information*	Approved list of priority work areas established and underway
		Undertake projects as per endorsed Organisational Development Framework during 2004/05	December 04 – June 05	Delivery of priority projects within timeframe
		Credentialling Frameworks developed for key workforce groups for Hospital & Specialist Service	Completed by August 04 *Noting paper for Board and HAC*	Workforce maintains skills/competencies for the appropriate scopes of practice Clinical Board signed of on frameworks Implementation plans in place for registered health professionals frameworks
		Work with external contract providers to assist with ensuring compliance with Health Practitioners Competency Assurance (HPCA)		Contracted providers meeting legislative requirements Mental Health Scopes of Practice in place
		Continue with development of advanced nursing practice roles.	Ongoing	
		Mental Health – implement the outcome of the development of the Mental Health's Scope of Practice	Ongoing *Update progress to Board for information*	

DIRECTION 4: DEVELOPING CANTERBURY'S HEALTH CARE WORKFORCE				
Goals	Strategies	Actions	Timelines & Board input	Outcomes/Measures of achievement
4.1 Achieve a workforce which provides right skills at the right place and time for best delivery and outcomes *(Cont….)*	4.1.1 Build Strategic Workforce Capability *(Cont…..)*	Continue Primary Care Nursing Pilot	Primary Care -3 year pilot for completion June 06 *Noting paper*	*Primary Care* –continue with implementation. Year 2 evaluation report. *Priority areas* – Develop new scope for implementation in 05/06 year
		Development of scope of practice and models in rural nursing and acute nursing care	Commence July 04	Scope of practice developed for two priority nursing areas
		Continue development of Māori Workforce	March 05 R*egular updates on progress for information*	Implementation Tikaka Hauroa (Māori Mental Health) Development Programme. Identify strategies to encourage young Māori to enter the Health Workforce of Canterbury
		Regular forums with unions are held to address key issues	Ongoing	Stable and positive relationships with staff and unions maintained
		Continuing development of Pacific Peoples Workforce	May 05 *Regular update to Board on progress*	Identify strategies to encourage young Pacific people to enter the Health Workforce of Canterbury
	4.1.2 Improve workforce information	Build on the information and improve workforce currently collected	Commence July 04 and ongoing *Update HAC & Board*	CDHB workforce profile is produced and broadened to cover information on workforce that CDHB funded via contracted providers, NGOs etc
		Input into DHBNZ national data set/systems HWIS and MHWIS Identify data sets and sources required to monitor undergraduate workforce trends		Report on key workforce groups eg nursing, Māori and Pacific
		Collect Māori and Pacific workforce information accurately		

DIRECTION 4: DEVELOPING CANTERBURY'S HEALTH CARE WORKFORCE				
Goals	Strategies	Actions	Timelines & Board input	Outcomes/Measures of achievement
4.2 Strengthen Partnerships with Education Providers	4.2.1 To be in a position to formally influence education providers' planning	Strengthen formal relationships between education providers and programme advisory/board of studies for key workforce groups	Ongoing	Increased influence on course/programme and curriculum design and outcomes
		Identify the likely impacts on the health workforce of the future and identify opportunities to development new models	Commence July 04 and ongoing	Identify new models and implement pilots for evaluation
		Develop Strategic Plan for Postgraduate Education for Nursing	April 05 *Approval*	Align and target CTA funding, nursing professional development funds, Nursing Trust monies to priority areas
		CTA funds are accessed and fully utilised. Where possible additional funds are gained		CTA funds are fully utilised. Training programmes match workforce needs
		Create forums for continued debate and discussion on education and health policy and interaction	June 05	Forums held and outcomes distributed to key stakeholders
		Work with education providers to influence programme design and outcomes.	Ongoing	Targeted providers relationship developed
4.3 Canterbury is seen as the preferred district for health workers in New Zealand	4.3.1 CDHB develop practices to have CDHB seen as a preferred employer for health workers in New Zealand	Healthy Work Environment Practices are encouraged	Commence July 04	Enhances clinical governance. Reinforces retention of workforce. Role Models CDHB's commitment to healthy lifestyles
		Internally develop workplan to implement and enhance the principles of Healthy Work Environment (DHBNZ)	*Regular update to HAC & Board for information*	Areas for improvement highlighted by culture survey are addressed
		Monitor workforce issues in community services and work with providers		Cross functional staff team advises CEO & HR on any issues addressed internally

DIRECTION 5: BEING A LEADER IN HOSPITAL AND HEALTH CARE SERVICES				
Goal	Strategies	Actions	Timeframe & Board input	Outcomes/Measures of achievement
5.1 Services are responsive to user needs	5.1.1 Develop a Facilities Plan that reflects user needs (Link 2.3)	Incorporate high level facilities requirements into Asset Management Plan	July 04 *FARC report for noting*	
		Following high level assumptions utilise key health plans and stakeholders input into planning	December 04	Prioritised and efficient use of capital
		Integrate into revisions of Asset Management Plan	Ongoing in 04/05	Facilities reflect community and service needs
	5.1.2 Monitor and assess outpatient intervention rates, patient flows and explore options for improved access to diagnostic services (Link to 2.4 and 2.5)	Ensure appropriateness of outpatient attendance through: - Integrated Patient Flow Project, focussing on improving patient flow in Ophthalmology	Ongoing Ophthalmology completed by August 04 *Information report to HAC*	A series of reviews will be carried out on outpatient waiting room times with the objective of improving patient flows, reducing wait times and increasing satisfaction with the service. The reviews will involve appropriate patient representation such as Elder Care Canterbury.
		- Elective Services Steering Group to maintain high level oversight of electives	Ongoing *Information updates to HAC*	Early identification of problem s in electives and action taken.
		- Improving communication through use of GP Liaison positions		Improve management and access to elective services
		Facilitate appropriate GP access to diagnostics implementation of relevant clinical guidelines	October 04 *Information updates to HAC*	First Specialist Assessment (FSA) wait list is decreased through easier access to diagnostics
		Support trials of innovative new approach, eg Direct Access to Breast Screening currently underway		
		Review and develop a Clinical Services Plan for ambulatory and outpatient services	June 05 *Approval*	Stocktake and review of existing services Explore models of service delivery Develop Clinical Plan

DIRECTION 5: BEING A LEADER IN HOSPITAL AND HEALTH CARE SERVICES				
Goal	Strategies	Actions	Timeframe & Board input	Outcomes/Measures of achievement
5.1 Services are responsive to user needs (Cont….)	5.1.3 All provider arm divisions of the DHB will incorporate the Elder Friendly Guidelines into their daily functioning	Each division will develop an implementation plan by March 05 For GMs to update progress on quarterly basis	TPMH CPH CWH Ashburton & Rural hospitals by June 05	Elder Friendly Guidelines will be implemented by the provider arm within 12 months and will be audited, as part of the Disability Strategy Action Plan annually
	5.1.4 Clinical Governance	Coordinated incident reporting management system with good information Open disclosure - develop policy - implement policy	August 04 September 04 December 04	Reliable incident management on audit Open disclosure evident on audit
5.2 Optimise management of elective services	5.2.1 Implement national policy on electives and have clear mechanisms for managing elective services	Review hospital processes to ensure maximum productivity Retain data on un-met needs to utilise in needs assessment data report Look at emerging trends re electives and acute surgery Agree GP referral criteria Audit implementation of national waitlist policy Optimise day surgery and Day of Surgery Admission (DOSA) rates	July 04 Ongoing September 04 *Update to HAC & Board* October 04 June 05 *Report to HAC/Board for information* February 05 (See PBFF Core Direction 2)	National policy implemented Information provided for decision making and health needs assessment Patients have certainty about their access to elective surgery

DIRECTION 5: BEING A LEADER IN HOSPITAL AND HEALTH CARE SERVICES				
Goal	Strategies	Actions	Timeframe & Board input	Outcomes/Measures of achievement
5.3 Optimise delivery of services across the regions	5.3.1 Collaborate with other DHBs to improve access to clinical services regionally	Reach agreement on the provision of specialty services in the South Island /agree process for determining national services Agree arrangements for IDFs already agreed with other DHBs, and monitor progress against	By July 04	Efficient provision of services regionally DHBs agree on joint initiatives IDF funding and service delivery processes are clear

3.1.2 **Minister of Health's Objectives 2004**-05

Mandatory Strategic Objective 1: He Korowai Oranga

The Canterbury DHB adopted a Māori Health Action Plan in July 2002. The key focus of this has been implementing He Korowai Oranga. Key strategies for action on Māori health are included in the Canterbury DHB Core Directions.

Annual Objective(s)	▪ To continue to implement the Canterbury DHB Māori Health Plan
Approach Increase relative **investment in Māori** Health	▪ Implement Māori Indicators & Expenditure Targets project
Monitoring of progress to meet He Korowai Oranga and CDHB **Māori Health Plan**	▪ Review Māori Health Plan August 2004 ▪ MOU with Manawhenua ki Waitaha contains monitoring provision ▪ Implement Māori Indicators Project
Fostering Māori community development	▪ Implement CDHB Māori model of service delivery ▪ Undertake Quality improvement reviews of Māori providers ▪ Continue Māori Community Consultation Hui ▪ Undertake intersectoral Māori Hui for which funding received, during 2004 ▪ Continue support for collaboration and co-location of providers in appropriate Māori settings
Encouraging initiatives with other sectors that positively affect Whanau Ora	▪ Implement Memorandum of Agreement with Department of Child Youth and Family Service ▪ Continue CDHB involvement in Christchurch Social Policy Integration Network and activities e.g. Youth Plan; Strengthening Families; and foster relationships with Te Puni Kokiri, Ministry of Education, Ministry of Social Development
To remove barriers to **Māori with disabilities** and their whanau from fully participating in New Zealand society	▪ Continue NASC position for Older Māori and increase to 1.5FTE in 2004 ▪ Seek funding from MOH to continue Māori Disability Service Development Coordinator project (< & > 65 years) for 2 more years
Partnerships with **Māori**	▪ Finalise Memorandum of Understanding with manawhenua ki Waitaha (March 2004), and forward to Cabinet ▪ Publish and implement Tikanga Policy & Research & Māori Guidelines agreed with Manawhenua ki Waitaha
Training and networking for DHB Board members	▪ Māori Board members attend national networking and training meetings ▪ CDHB Board members offered MOH and DHB Māori Health training

Increa**sing Māori** provider capacity and capability	▪ Implement Māori Indicators and Expenditure Targets Project ▪ Evaluate impact of Māori Provider Development Scheme in Canterbury, and negotiate action for 2004-05
Developing the **Māori health and** disability workforce	▪ Implement South Island Māori Provider Hui 2004 in conjunction with Te Herenga Haoura o te Waka o Aoraki ▪ Develop and Implement Māori Workforce Development Stocktake, and Capacity and Capability Plan, funded by MPDS, in 2004 ▪ Ensure Māori input to CDHB Workforce Development projects ▪ Ensure Māori input into CDHB Primary and Community Health Strategy, ▪ PHO process and other integration initiatives e.g. Child Health, Diabetes, CVD, Cancer, and focus on reviews of pathways of care that will lead to better outcomes for Māori ▪ Reinforce key messages to Māori Providers: Quality, Sustainability, Collaboration, Cooperation
Addressing health inequalities for **Māori**	▪ Ensure Māori input and application of Equity Lens to all CDHB Planning and Funding activities
Improving mainstream effectiveness	▪ Ensure PHOs include effective Māori participation in all PHO activities ▪ Continue to agree and monitor Māori Health Plans with primary and community providers
Providing quality services	▪ CDHB Model of Māori Service Delivery ▪ CDHB Cultural Assessment model ▪ Tikanga Policy and Research and Māori document ▪ Māori input into all CDHB policy development processes ▪ Māori Health Plans agreed with primary and community providers ▪ LinkAGE Continuum of Care model ▪ Christchurch Hospital Māori Service Development project
Improving Māori health information	▪ Continue to implement Ethnicity Data Collection Policy (June 2003) and Action Plan (August to December 2003) , and undertake staff training and provide Ethnicity data information to staff, patients and community
Milestones/Actions	▪ As above
Risks and Mitigation Strategies	▪ Risks, particularly around resourcing, human and financial ▪ Risk are mitigated through consultative engagement, inclusion in budgeting processes
Indicators and Targets	▪ Data is captured in performance indicators in Section 5.

Mandatory Strategic Objective 2: New Zealand Disability Strategy

Canterbury District Health Board developed a Disability Strategy Action Plan which is monitored regularly every 6 months and a progress report of the Plan is given to the Disability Support Advisory Committee, also 6 monthly. This Plan is currently being revised. The new plan will be presented to the Board mid 2004.

Disability Support Advisory Committee Work Plan is attached as Appendix 5.

Annual Objective(s)	▪ Continue to promote and provide a non-disabling culture within the Canterbury District Health Board ▪ Continue to implement the Canterbury District Health Board's Disability Strategy Action Plan within our own services and with other providers ▪ Continue to work towards better coordinated services for people with disabilities
Approach	▪ Canterbury District Health Board will continue to work with the Disability Support Advisory Committee. This Committee's 2004 Work Plan will be informed by the Disability Strategy Action Plan ▪ Canterbury District Health Board will continue to ensure all site redevelopment conforms to current standards of accessibility through adherence to its Accessibility Plan ▪ Continue to provide interpreter services, including those for Deaf people, in all major hospitals 24 hours per day, 7 days per week ▪ Canterbury District Health Board will continue to work with other agencies such as Christchurch City Council, Healthy Christchurch on health and disability issues
Milestones/Actions	▪ The Disability Action Plan is reviewed and revised by April 2004 and will be consulted on with a wide variety of agencies, consumers and providers, including mental health ▪ The Disability Action Plan will include policies on collecting information on people with disabilities ▪ Initiatives to reduce service inequalities of service access and provision for Māori with disabilities will be developed
Risks and Mitigation Strategies	▪ Ongoing communication with disability community regarding activity within the Canterbury District Health Board with opportunities for feedback, discussion of issues and identification of potential problems
Indicators and Targets	▪ Initiatives for Māori with disabilities are developed ▪ Disability Strategy Action Plan reviewed and implementation continues

Mandatory Strategic Objective 3: Elective Services and Radiotherapy Waiting Times

Meeting Demand for elective services is of concern to the CDHB. The CDHB Elective Services Steering Committee continues to monitor compliance against Elective Services Performance Indicators. The key focus is provision of services within contracted volumes, communication of likelihood of service to patients and General Practitioners, developing new strategies for delivery of services in a cost-effective manner and the collection of information to demonstrate demand.

Annual Objective(s)	▪ To ensure ongoing processes of maintenance and monitoring are in place in compliance with MOH Policy and to respond to changes in policy with robust information and timely recommendations.
Approach	The plan for elective services will focus upon two streams of activity: ▪ Management of the referral interface and a focus upon patients remaining in the community / primary care until the optimal time for referral or treatment is reached (given limited hospital resources). ▪ Monitoring of key performance indicators within the hospital system to ensure the most effective and efficient use of elective services resources and funding. The objective of these streams of activity is to: ▪ Provide timely transfer of responsibility / duty of care for patients unlikely to be treated to the primary care provider and provide GPs with transparency around “rarely seen / treated” categories or conditions. ▪ Continue with provision of Active Review processes across all services for patients, without certainty of treatment within 6 months but who are likely to deteriorate or are just below the funding threshold. ▪ Proactive encouragement of communication between primary and secondary care – care plans for patients on elective waiting lists; referral guidelines; reassessment processes; GP Liaison; outpatient nurses with a special interest; integration forums (such as Elder Care Canterbury, Integration Design Group and the Elective Services Steering Group) ▪ Focus of hospital resources on what can be done efficiently – multi-disciplinary approach across services, cluster model, clinical governance, key performance indicators and advice and guidance to primary care. ▪ The maintenance and monitoring systems will be established in accordance with the Ministry of Health Continuous Quality Improvement (CQI) program for elective services. This strategy also complies with the CDHB program for moving towards Quality Health NZ accreditation.

Milestones/Actions	**September 2004** – Revised / updated guidelines for GPs distributed and website updated. Focus on threshold management for access to surgery (with aim to increase level of certainty in some services, dependent on 04/05 contract volumes). Formalise Active Review processes and education of staff, patients and GPs on processes (in accordance with report recommendations of Summer Studentships, February 04). **December 2004** To focus developmental work on quality and customer service particularly around improving correspondence and information to patients and GPs (in accordance with report recommendations of Summer Studentships, February 04). To support initiatives for improved community access to diagnostic services. **March 2005** Review financially sustainable thresholds and make recommendations to Annual Plan and budget process to address gaps in elective service delivery. To incorporate NZHIS datasheet of key performance indicators into regular performance monitoring processes (such as consistency of prioritisation). **June 2005** Confirm strategy for ongoing management of elective services within funding constraints (including review of provider arm capacity and capacity of primary care to manage the patients in the interim).
Risks and Mitigation Strategies	▪ Unmet promises – number of patients for whom certainty of treatment within 6 months was promised but who are now overdue for their surgery ▪ Provider capacity – ability of hospital provider arms to deliver funded volumes given constraints on site, staffing (anaesthetic, nursing, SMO, RMO) and level of community supports equipped to manage patients in the interim ▪ Level of need of patients – where patients not being offered assessment or surgery may fall into a state of unreasonable distress, ill health or incapacity with no ability by the provider arm to increase capacity to deliver a service once the patient has deteriorated. ▪ Reliability of assessment / CPAC tools – where the methods used to determine national access levels to assessment or surgery are unreliable, are applied inconsistently or change, causing risk or anomaly in the financially sustainable thresholds for whether a patient can access publicly funded services or not. ▪ Ad hoc responses to pressure or lobby groups – where one-off increases in services are introduced without reference to an overall plan for delivery of elective services, but are introduced to satisfy public or political pressure groups, hence creating disincentives for managing a robust rationing system.
Indicators and Targets	▪ Elective Services Performance Indicators (monthly) ▪ Internal audit reports (monthly and annually) ▪ Crown Funding Agreement reporting (quarterly) ▪ District Annual Plan reporting (quarterly)

Mandatory Strategic Objective 4: Diabetes Incidence And Impact

The Canterbury District Health Board has been implementing the recommendations of the Interim Diabetes Plan which was signed off in 2002. A further Diabetes Strategy is being developed which builds on the Interim Plan and the Local Diabetes Team Annual Report 2003.

Annual Objective(s)	▪ Combined action on diabetes and cardiovascular disease and cancer in conjunction with NZGG Guidelines ▪ Increase understanding of diabetes and self management for Māori and Pacific peoples ▪ Enhanced services for children and youth with diabetes
Approach	▪ Work with GPs to identify Type 2 diabetes earlier to ensure early treatment ▪ Work with PHOs to provide health promotion in physical activity and nutrition ▪ Work with Māori and Pacific providers and communities to support prevention, early intervention and ongoing uptake of services ▪ Work with Diabetes Youth to clarify needs ▪ Work to ensure all annual review data is collected for regional/national database
Milestones/Actions	▪ Increase the numbers of people with diabetes getting annual checks, particularly Māori and Pacific peoples ▪ Increase the number of patients with adequate glycaemic control, particularly Māori and Pacific peoples ▪ Increase access to community podiatry ▪ Improve self management of diabetes through enhanced provision of education and support to patients, families/whanau and caregivers ▪ Enhance access to retinal screening ▪ Develop a strategy to manage demand for publicly funding insulin pumps as current funding is insufficient
Risks and Mitigation Strategies	▪ Insufficient resources
Indicators and Targets	▪ As per the targets set out in the Diabetes Strategy

Mandatory Strategic Objective 5: Inequalities

The Canterbury District Health Board is aware of the inter-relationships that exist between socio-economic status, education, employment, housing and health. It will incorporate the equity lens in its service development planning and funding and work intersectorally through groups like Strengthening Families, Healthy Christchurch and Primary Health Organisations to reduce inequalities.

Community and Public Health have completed a plan on Infectious Diseases and issues for Canterbury. As these conditions are more prevalent in groups that face health inequalities, this piece of work is being used to plan services.

Annual Objective(s)	▪ To reduce inequalities
Approach	▪ Target resources to identified relevant populations ▪ Use equity lens in planning ▪ Support initiatives which develop community capital; building on the community's proposals to effect change
Milestones/Actions	▪ All health gain and clinical service plans include health promotion ▪ Continue to support Healthy Christchurch initiative
Risks and Mitigation Strategies	▪ Resources (staff and funding) not supporting this approach ▪ Mitigated by training and reorientating service plans to ensure inequalities a priority area
Indicators and Targets	▪ All plans have clearly identified intervention goals and monitoring against target: - Clear direction for each planning area - Links with Public Health funding decisions locally and regionally

Mandatory Strategic Objective 6: Primary Care

Canterbury DHB will implement the Primary Health Care Strategy 2001 by establishing Primary Health Organisations, and implementing a Community and Primary Health Care Plan in Canterbury. The aim is to improve population health by improving access to primary care and public health programmes designed to suit local needs.

Annual Objective(s)	▪ Complete the CDHB Community and Primary Health Care Plan ▪ Support and monitor the service delivery of Canterbury DHB's four Primary Health Organisations
Approach	▪ Develop integration initiatives and coordinate care across service areas ▪ Develop primary care workforce in particular opportunities for primary care nursing ▪ Develop information and quality improvement systems ▪ Work with the four CDHB Primary Health Organisations to demonstrate health gain in enrolled populations
Milestones/Actions	**Community and Primary Health Care Plan** ▪ Strategy presented to Board September 2004 ▪ Project plan for primary care developed by November 2004 and approved by Board ▪ Work begun on implementing the project plan **Primary Health Organisations** ▪ Work with MoH, DHBNZ, and PHOs to support sector action in the future development of Primary Health Organisations ▪ Work with provider arm of CDHB to encourage integrated service delivery in PHOs ▪ Work with PHOs to develop Care Plus plans ▪ Work with PHOs to maximise the positive effects of Health Promotion and Services to Improve Access plans ▪ Work with PHOs to promote enrolment of populations ▪ Work with PHOs to maximise involvement of Māori providers and iwi in PHOs ▪ Work with PHOs to develop participation by Pacific providers ▪ Work with PHOs to plan primary health nursing roles in the PHO ▪ Work with PHOs to develop roles of pharmacists in PHOs ▪ Work with PHOs to identify and support initiatives in workforce recruitment and retention in PHOs ▪ Quarterly review of progress of four PHOs ▪ Inclusion of PHOs in scoping work in future of rural hospitals and health centres **Acute Demand Projects** The DHB is working in partnership with Pegasus Health to reduce the ED attendances and acute admissions to Christchurch Hospital. Projects under way and scheduled to progress through the 04 / 05 financial year include : ▪ Step-up Step-down ▪ Admission alternatives / substitution ▪ Shard options for acute care ▪ Avoided hospital presentations

	Work driven from the projects scheduled to progress through the 04 / 05 financial year include : ▪ Admission alternatives for cellulitis followed by other diagnoses ▪ Mobile Assessment and Treatment Service targeting reduction in admissions from rest homes ▪ Active Care for frequent attendance / admission / long stay patients ▪ Acute Chest X-ray
Risks and Mitigation Strategies	**Community and Primary Health Care Plan** ▪ Plan is not agreed on by stakeholders ▪ Mitigation - Close consultation with stakeholders and adequate information provided ▪ Capital is not available to invest in actions intended for delivery in the first three years ▪ Mitigation – Advise financial planners very early. Look for the least capital-intensive solutions to the plan's proposals. Make the most use of assets and skills already in place in the primary and community health sector. ▪ Other public sectors unable to contribute to joint actions with the health sector. ▪ Mitigation – Include other sectors early as stakeholders. Contribute to their initiatives too. Keep high level contacts with other sector organisations open. **Primary Health Organisations** ▪ Risk - Some CDHB Primary Health Organisations fail, due to patients using non-PHO health services, high management costs ▪ Mitigation - Support PHOs, encourage cooperation, support DHB-wide initiatives ▪ Risk – PHOs experience technical problems associated with IT systems, which disrupts quarterly payments and reporting. ▪ Mitigation - Work closely with MoH and PHO to ensure IT systems are adequate and there are experts on hand to help as problems arise ▪ Risk - Population health gains not demonstrated, hospital admission rates not reduced ▪ Mitigation – long term monitoring required to demonstrate health gain. Robust KPI collection and service reporting and monitoring in place.
Indicators and Targets	▪ PRI-01 - Level of progress towards implementing Primary Health Care Strategy, including development and progress of PHOs. ▪ PRI-02 - Progress in developing the capacity of primary care providers to impact on suicide prevention. ▪ PRI-04 **-** Percentage of contracted providers of general practice services with an agreed Māori Health plan. See section 5 for details on reporting requirements.

Mandatory Strategic Objective 7: Mental Health Blueprint

Completion of the CDHB Strategic Plan for Mental Health in the 2004 year has provided a framework for managing access to and delivery of a System of Care. Two directions have been established, these are:

Direction One:
Improving access for people experiencing mental illness and alcohol and other drug problems.

Direction Two:
An improved 'System of Care' that is integrated, responsive and available in the consumer's chosen community.

The Strategic Plan is consistent with and compliments existing work at a national and regional level and is based that all service reconfiguration must occur within resources. The South Island Regional Mental Health Plan is attached as Attachment 7D. This includes the Regional Workforce Plan. This addresses in part the needs of the Child and Adolescent Workforce.

Annual Objective(s)	▪ Begin implementation of the action points from the CDHB Mental Health Strategic Plan ▪ Ensure that developments are consistent with the direction of Regional Mental Health Plan Attachment 7D and National Mental health planning ▪ Work with the South Island MH Network on regional initiatives as indicated in the South Island Regional Mental Health Plan ▪ Improve targeting of resources to those in need ▪ Improve the quality of information available to support clinical and service decision making; in particular resolve issues around MHINC Compliance ▪ Undertake Workforce Development work to develop the Mental Health Workforce, in particular in Child and Youth Services ▪ Complete Responsiveness to Pacific Peoples Project in Hospital and Specialist Mental Health Services
Approach	▪ Maintain consultation and communication pathways ▪ Ensure opportunities for inclusion of Older Persons and Alcohol and Other Drug services in all forums/planning ▪ Participate in relevant projects arising from implementation of Regional Plans eg: - Forensic - SI Alcohol & Other drug review - Kaupapa Māori Services ▪ Commence implementation of relevant aspects of the CDHB Mental ▪ Health Strategic plan especially: - Establishing a robust process to review service provision requirements for the System of Care - Develop Case Management Systems - Participate in the MH-SMART initiative - Continue work on improving the quality of information submitted to MHINC

	- Improve access for those with enduring mental illness (based on the Knowing the People methodology) - Working with providers to identify areas for funding adjustment and redistribution ▪ Establish a relationship with Werry Centre regarding Child and Youth training availability in the South Island.
Milestones/Actions	▪ Representation from Older Persons Mental Health consumers/family and providers on all mental health forums/group (MHDAG, MH Forum, LOAD) ▪ Business Plan and Training program for MH-SMART established as per project timelines ▪ South Island Alcohol & Other Drug recommendations actioned ▪ Completed review of Provider Arm Intellectual Disability Services
Risks and Mitigation Strategies	▪ Sector resistance to change will be addressed by regular communication regarding potential issues along with opportunities to discuss concerns ▪ Regional and Inter-sectorial projects fall behind schedule – close monitoring of progress, agreed escalation process and clear roles and responsibilities ▪ Provider response to threat of funding redistribution – similar to first point, regular communication and involvement in development of rationale for change
Indicators and Targets	▪ Achievement of milestones as indicated above ▪ Achievement of milestone and objectives as listed in Regional Plans ▪ See Section 5

Mandatory Strategic Objective 8: Keeping infrastructure costs as low as possible

Canterbury DHB has an ongoing process and objective to review its infrastructure costs and where appropriate, initiatives are implemented to manage and/or reduce these costs. Efficiency Initiatives over past years resulted in CDHB having a low administration component relative to the size of the organisation. Recent initiatives include the significant reduction in interest and maintenance costs.

Annual Objective(s)	▪ The areas being considered include: ▪ Further centralisation of some support services ▪ Utilising the cook-chill technology for Food Services ▪ Alignment of hospital sites to service needs ▪ Review administration functions
Approach	▪ The process will include identification of initiatives, assessment of risks and benefits and impact on service and patient care. This will include Clinicians input, where appropriate. Draft proposals will be prioritised for EMT review and/or sign-off, which will then be followed by a consultation process with the appropriate parties. Briefing to board and statutory committees together with Board approval (if required) will be an integral part of the process. Implementation process follows. ▪ A number of consultation processes are already underway and these include the Cook-Chill technology for Food Services and centralisation of telephone services.
Milestones/Actions	▪ Process is ongoing. Some specific milestones for the year will include implementation of reconfiguration of cardio-respiratory services, food services and consolidation of some support services e.g. telephonist.
Risks and Mitigation Strategies	▪ Each proposal or initiative will require a business case, which includes risk assessment. The review and sign-off process (EMT, statutory committees and Board, where appropriate) provides different levels of checks and risk mitigation. Proposals with significant capital expenditure, service and/or staff implications will follow appropriate briefing and sign off process, including o Ministry/Minister. ▪ Collaborative approach with other DHBs, where project commonality exists, will be part of the process.
Indicators and Targets	▪ Included in the Core Directions Section 3.1.1 and financial targets.

Mandatory Strategic Objective 9: Industrial Relations Strategies

The Canterbury DHB has in place an Industrial Relations Strategy that provides direction in terms of bargaining for its collective agreements. It is also actively seeking to work constructively with Unions to address local, regional and national workforce needs.

Annual Objective(s)	▪ Maintain a stable IR climate at the CDHB ▪ Implement the 2003/2004 IR (bargaining) Strategy ▪ Support Regional and National IR activity
Approach	▪ Continue open communications with Union representatives and staff ▪ Promote and participate in union relationships ▪ Proactively manage employee grievances with a constructive approach to resolution ▪ Bargain in good faith using best endeavours to deliver fair collective agreement settlements ▪ Apply vigorous costing methods to enable certainty of funds delivered in settlements and impact on totals funds available ▪ Develop individual bargaining strategies for collective agreements including appropriate internal and external benchmarking ▪ Participate in Regional and National negotiation to deliver the best outcome for the Canterbury staff and patients.
Milestones/Actions	▪ Ongoing scheduled Combined Health Union consultation meetings ▪ Collective Agreement settlements in accordance with IR (Bargaining) Strategy ▪ Regional collaboration ▪ National support
Risks and Mitigation Strategies	▪ National negotiations expectations of Unions may exceed CDHB ability to pay ▪ Expectations for Unions Influence on DHB activity can not be fulfilled ▪ Expectations for improvement in salaries and conditions can not be fulfilled ▪ Industrial action results as a reaction to unfulfilled expectations ▪ Unions do not participate in a constructive manner despite promotion of this by the CDHB ▪ Being aware of how negotiations influence settlements in the wider CDHB Health and Disability sector ▪ Mitigate these risks by open communication of financial and operating constraints with unions and staff
Indicators and Targets	▪ Industrial Harmony ▪ Milestones as set out above

Mandatory Strategic Objective 10: Innovative Approaches to Enable Managing within Budget

The move to population based funding (PBF) resulted in CDHB currently being $42M over-funded relative to other DHBs. Indicative funding shows that a gap of between $8M to $10M per annum exist between incremental revenue and incremental cost. Refer also to Section 4.0

Annual Objective(s)	▪ The financial imperatives will necessitate CDHB to reconfigure its services and/or realign its facilities to the appropriate service levels. These key requirements will form the basis of the annual objective over the next few years in order to meet the 'break-even' financial performance expectation as set out by the Minister of Health.
Approach	▪ Briefing to the Board, committees and staff on PBF are in progress. Also CDHB continues to liaise with the Ministry of the impact and implications of the PBF. ▪ The strategies and objectives to address the impact of PBF will be included in CDHB's Core Directions, which will encompass efficiencies, revenue enhancement and service/facilities reconfiguration. Some of the initiatives are set out in the Core directions and Section 4 of the plan.
Milestones/Actions	▪ Process is ongoing re: implementation of Core Directions initiatives. Due process and consultation will be undertaken, where required.
Risks and Mitigation Strategies	▪ Where service reconfiguration and facilities realignment is likely to have associated staffing, political and/or media risks, mitigation strategies will be effected and these will include ensuring due process and appropriate consultations are undertaken. Also early signal and/or advice to the Minister/ Ministry will be undertaken, where appropriate. ▪ Each proposal or initiative will require a business case, which includes risk assessment. The review and sign-off process (EMT, statutory committees and Board, where appropriate) provides different levels of checks and risk mitigation. Proposals with significant capital expenditure, service and/or staff implications will follow appropriate briefing and sign off process, including o Ministry/Minister. ▪ Collaborative approach with other DHBs, where project commonality exists, will be part of the process. ▪ There are also risks associated with planning assumptions not holding true e.g. national wage settlements higher than planned. These risks will be identified and provided to the Board to assist their decision-making process. Additional efficiency initiatives and service realignment may be required to mitigate this.
Indicators and Targets	▪ Part of the Core Directions Section 3.1.1 and efficiency target to achieve break-even result.

Mandatory Strategic Objective 11: Workforce Development

The Canterbury DHB has incorporated into its Core Directions (section 3.1.1)) process those key Workforce Development Areas identified in the Workforce Action Plan. These areas include the Building of strategic workforce capability, enhancing the standard of workforce information and improved relationships with those external stakeholders affecting workforce.

Annual Objective(s)	▪ Implement Core Directions activities associated with workforce development
Approach	▪ Develop an Organisation Development framework that addresses workforce capability ▪ Establish behaviour standards as reference point for the projects associated with the framework ▪ Prioritise projects for implementation under the endorsed OD framework including actions to address: ▪ The co-ordination of workforce development ▪ Leadership development ▪ IR capability ▪ Undertake projects as per endorsed Organisational Development Framework during 2004/05 ▪ Credentialling Frameworks developed for key workforce groups for Hospital & Specialist Service ▪ Work with external contract providers to assist with ensuring compliance with HPCA ▪ Continue with development of advanced nursing practice roles ▪ Work to implement Primary Care Strategy ▪ Identify priority areas for development of possible scopes and models such as rural nursing and acute care ▪ Implementation Tikaka Hauroa (Māori Mental Health) Development Programme ▪ Identify strategies to encourage young Māori to enter the health Workforce of Canterbury ▪ Identify strategies to encourage young Pacific Islanders to enter the Health Workforce of Canterbury ▪ Build on the current level of workforce information and improve standard of information currently collected ▪ Strengthen formal relationships between education providers and programme advisory/board of studies for key workforce groups ▪ Identify the likely impacts on the health workforce of the future and identify opportunities to develop new models ▪ Create forums for continued debate and discussion on education and health policy and interaction ▪ Internally develop workplan to implement and enhance the principles of Health Work Environment (DHBNZ) ▪ Regular forums with unions are held to address key issues

Milestones/Actions	▪ Components of framework agreed by Executive Management Team ▪ Behavioural exercise completed ▪ Priority projects established ▪ Framework projects underway ▪ Workforce maintains skills/competencies for the appropriate ▪ scopes of practice ▪ Contracted providers meeting legislative requirements ▪ Ensure that Māori and Pacific workforce information is collected completely and accurately ▪ Projects are established to encourage representation of Māori and Pacific ▪ CDHB workforce profile is produced and broadened to cover information on workforce that CDHB funded via contracted providers, NGOs etc ▪ Increased influence on course/programme and curriculum design and outcomes ▪ CTA funds are accessed and fully utilised. Where possible additional funds are gained ▪ Healthy workplace initiatives: - Enhances clinical governance - Reinforces retention of workforce - Role Models CHDB's commitment to healthy lifestyles Stable and positive relationships with staff unions maintained
Risks and Mitigation Strategies	▪ Resources (staff and funding) not supporting this approach ▪ Mitigate by careful prioritisation and signoff of key projects, and clear internal communication of expected delivery
Indicators and Targets	▪ See Milestones Core Directions section 3.1.1

3.1.3 Additional CDHB Objectives for 2004-05

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CDHB Strategic Objective 1: Pacific Peoples

The Canterbury DHB adopted Pacific Peoples Health Action Plan in May 2002. Its focus is:

a) Support Pacific People as health providers, including increasing the number of Pacific people in the health workforce
b) Involve Pacific Peoples in health service development
c) Accurately collect ethnicity data
d) Establish a Pacific People's primary health service
e) Help to increase collaboration between Pacific providers

Annual Objective(s)	▪ Incorporate Pacific focus in all CDHB planning and inter-sectoral activities ▪ Pacific Provider Development Fund fully expended according to agreed Plan ▪ Pacific Workforce Development ▪ Pacific participation – ensuring regular and robust involvement of Pacific communities and providers ▪ Ethnicity Data Collection [as with Māori] ▪ Complete Health Needs Assessment for Pacific with MoH Public Health Directorate ▪ LinkAGE project incorporates focus on Pacific elderly ▪ Pacific Primary Clinic continues to operate ▪ Complete Responsiveness Project in Hospital and Specialist Mental Health Services
Approach	▪ Canterbury DHB's approach is an inclusive, consultative one, that involves Pacific communities community providers, service workers in the development, implementation and monitoring of progress
Milestones/Actions	▪ Continue to use PPDF to support agreed development plans for 3 Pacific providers, to ensure sustainable, quality development, according to plan agreed with providers and MOH ▪ Monitored Pacific Primary Clinic ▪ Focused Pacific milestones are included in all CDHB plans to improve Pacific Health outcomes, including resourcing and targets ▪ A Pacific focus is included in intersectoral development activities e.g. CYFS, Ministry of Education, Ministry of Health [Public Health & Disability] ▪ LinkAGE project activities improve service access for Pacific elderly ▪ Workforce development – Provider arm staff meetings continue; Canterbury is seen as a positive environment for recruitment and retention of Pacific staff; Pacific career development pathways and mentoring of Pacific staff occurs [clinical, management, cultural]; CDHB actively participates in MOH Pacific Branch Workforce Development project
Risks and Mitigation Strategies	▪ Risks particularly around human and financial resources ▪ Mitigation of above through consultative engagement and inclusion in budgeting processes
Indicators and Targets	▪ Achievement of and progress on above milestones/actions ▪ As covered in Section 5

CDHB Strategic Objective 2: Health of Older People

Canterbury is a Lead DHB in relation to older people's health services. The LinkAGE Project is working towards implementation of the Action Plan approved by the Board in August 2003. Preparation of an Aged Care Strategy to realign older persons services in light of PPF will be mindful of LinkAGE work.

Annual Objective(s)	▪ To continue to implement the LinkAGE Strategic Direction and Action Plan, working closely with the Elder Care Canterbury Project. ▪ Commence work on Aged Care Strategy looking where CDHB is over target by $29 million
Approach	▪ Pilot the InterRAI comprehensive geriatric assessment tool in primary care and the AT & R unit, in conjunction with evaluation by the Christchurch School of Medicine. ▪ Continue to implement the recommendations of the District Nursing and Home Support Services Review, including contracting the new Central Co-ordinating Centre, managed by the Nurse Maude Association. ▪ Support the COSE model roll out to the community and continue to be part of the evaluation by the ASPIRE project team. ▪ Carer workforce issues are starting to be addressed locally, while working in with national project. ▪ Improve access to information by consumers and service providers. ▪ Enhance information sharing across the sectors. ▪ Enhance disability support services for Māori and Pacific People ▪ Undertake health promotion and maintenance for older people through a variety of programmes. ▪ Continue to support the Elder Care Canterbury Project through resourcing the project manager and administrator. ▪ Exploring nursing innovations. ▪ Establish links between the LinkAGE work and PHOs to ensure primary care services are enhanced for older people. ▪ Participate in consultation on Specialist Health Services for Older People
Milestones/Actions	▪ InterRAI pilot has commenced and evaluation process in place. ▪ COSE model continues to be well established in the community and the recruitment phase of the ASPIRE trial has been completed by November 04. ▪ Strategies are starting to be implemented using agreed philosophy for carer workforce. ▪ Project to enhance nutrition promotion for older people is in place. ▪ Stay on Your Feet project continues to be supported through contribution to co-ordinator's salary. ▪ Group to establish nursing innovations has been established and has developed project/s to progress this area. ▪ Oral Health Review recommendations have been implemented. ▪ Support Oral Health initiatives relating to oral health care for those in residential care. ▪ 65 and over postcards have been distributed with regard to flu vaccinations, staying warm to stay well and medication. ▪ The HIAP initiatives to improve sharing of information between services are progressing, including investigating sharing clinical results with general practitioners.

	▪ Mental Health Strategy for Older People has been developed as part of overall Mental Health Strategy. Advisory group relating to older people's mental health has been established and is meeting regularly and advising wider group. ▪ Intermediate care philosophy and guiding principles are being used by funders to assess new initiatives for service provision. ▪ Māori NASC worker's role is continuing to be developed and a Pacific NASC worker role is being developed. ▪ An acute stroke service has been implemented and work is being done on the community stroke service. ▪ Continue to be part of the Christchurch City Council's External Reference Group. ▪ "Working Together" regular column in "In Touch" and "Health Line" to encourage integration and collaboration. ▪ LinkAGE newsletter distributed quarterly. ▪ Reports to Elder Care Canterbury Project Forum bi-monthly meetings ▪ Reports to monthly Community Stakeholder Group meetings ▪ Outpatient clinics are as "elder friendly" as possible. ▪ The Elder Friendly guidelines are an integrated part of service provision across the sector and being audited as part of Disability Support Action Plan. ▪ Pacific People have access to a centre which meets their needs through collaboration with other sectors. ▪ Māori hui and Pacific fono are held every six months.
Risks and Mitigation Strategies	▪ Ongoing risks relating to inadequate funding for disability support services, particularly under the Population Based Funding Formula.
Indicators and Targets	▪ LinkAGE action plan met.

Canterbury District Health Board Strategic Objective 3: Child Health

The Child Health Project is based on the CDHB Child Health and Disability Action Plan (2003-06). The overall goal is to improve the health and disability status of Canterbury children, including tamariki, Pacific children and Asian children.

Annual Objective(s)	▪ Implement the CDHB Child Health and Disability Action Plan (2003-2006)
Approach	▪ Greater focus on health promotion, prevention and early intervention ▪ Better co-ordination and collaboration across child health and disability stakeholders ▪ Enhance child health information systems ▪ Child health workforce development ▪ Improve child health research and evaluation ▪ Leadership in child health
Milestones/Actions	▪ Launch a Quality Health Mark Pilot Project, focusing on improving the health and wellbeing of children within Early Childhood Centres, in collaboration with key stakeholders ▪ Support the implementation of the Review recommendations to improve the Assessment and Referral process for children with special needs in Canterbury ▪ Promote awareness and support to 'Repeal Section 59' of the Crimes Act 1961 ▪ Support and monitor the implementation of the Ministry of Health's Family Violence Guidelines on child and partner abuse ▪ Support establishment of local level child information systems that comply with national systems, e.g., National Immunisation Register (implementation expected end 2005).
Risks and Mitigation Strategies	**Risks** ▪ Resource limitations ▪ Failure by children and/or caregivers to adopt health promoting behavioural practices due to a variety of reasons, e.g., peer and media pressures ▪ Unplanned emergent child health issues ▪ Incompatibility of information technology systems and time and costs to upgrade child information technology systems **Mitigation Strategy** ▪ Identify actions, in collaboration with key stakeholders, that can be taken within existing resources ▪ Reprioritise resources to support actions ▪ Reduce inequalities
Indicators and Targets	▪ Improved health outcomes for participating children in the Pilot Quality Health Mark Pilot Project, in Early Childhood Centres ▪ Improved assessment and referral processes for children with special needs in Canterbury ▪ Increased awareness and support to 'Repeal Section 59' of the Crimes Act 1961 ▪ Improved child health information systems for Canterbury ▪ See Section 5

CDHB Strategic Objective 4: Cardiovascular Disease

A plan for minimising the effects of cardiovascular disease on Canterbury's population was developed in during 2003 and 2004. *The Canterbury Heart Health Strategy* was approved by the CDHB 'Cardiovascular Steering Group' , representing providers and users, who acted as advisors for the plan.

The Canterbury Heart Health Strategy includes:
- Public health issues in Cardiovascular disease
- Evaluation of a 24 hour angioplasty proposal
- Review of Literature
- National work

The plan will be consistent with other CDHB plans and contracts, with links in particular to Māori, Pacific and diabetes actions plans. The plan should build on Canterbury primary providers' and public health plans.

Annual Objective(s)	▪ Implement the actions associated with the Cardiovascular Action Plan for Canterbury, *The Canterbury Heart Health Strategy* (due March 2004), covering the continuum from health promotion, disease prevention, treatment, rehabilitation and palliative care
Approach	▪ Work with key stakeholders ▪ Coordinate actions with national guidelines on management of cardiovascular risk, stroke, and diabetes
Milestones/Actions	▪ Write Implementation Plan for The Canterbury Heart Health Strategy Actions to include: - A comprehensive approach across CDHB to reduce incidence and impact of CVD - Strategies to address heart health in Māori and Pacific peoples - Continuing review of current interventions being used for CVD in CDHB - Specific interventions to meet indicator targets
Risks and Mitigation Strategies	**Risk** ▪ Increasing incidence of cardiovascular disease due to ageing population and lifestyle choices ▪ Resource limitations – all actions must be achieved within a cost neutral environment ▪ Cooperation and coordination between community, primary, secondary, and tertiary providers of health services **Mitigation** ▪ Work closely with other sectors to encourage Canterbury people of all ages to adopt 'healthy lifestyle' ▪ Work with Primary Health Organisations to focus health promotion activities on identifying risks to reduce incidence of cardiovascular and related diseases ▪ Development of disinvestment strategy so that resources can be transferred from "non priority" areas to priority areas

Indicators and Targets	▪ % of people with known risk factors for cardiovascular disease (through primary care data) ▪ Proportion of Māori, Pacific and low decile patients receiving services ▪ % of people who wait no more than 6 months for Coronary Artery Bi-pass Graph (CABG) ▪ Delivery of target levels of cardiac surgery ▪ % of people who wait for no more than 6 months for an angioplasty ▪ Repeat admissions for acute rheumatic fever in people under 30 years of age ▪ Post acute mortality ▪ Cardiac rehabilitation attendance

CDHB Strategic Objective 5: Cancer/Palliative Care

The CDHB Cancer Strategy will build on national policies as well as noting issues raised in its Palliative Care Strategy presented to the Canterbury DHB Board May 2003 and review of Oncology Services (November 2002).
Key policy documents are:

- Cancer Control Strategy for New Zealand
- NZ Health Strategy
- Canterbury DHB Strategic Plan 2002-06
- The NZ Palliative Care Strategy
- Healthy Eating: Health Action (February 2003)

Annual Objective(s)	▪ Maintain current levels of public education regarding healthy lifestyle and its contribution to cancer prevention. ▪ Participate in implementation planning for the NZ Cancer Control Strategy ▪ Work with other South Island DHBs to establish processes to address common issues ▪ Continue to work for resolution of issues relating to funding for Cancer Drugs ▪ Achieve Radiation therapy waiting times ▪ Continue work towards improving access to and flow through palliative care services
Approach	▪ Continue to support programmes focusing on improving nutrition, smoke free lifestyles, limiting alcohol intake, increasing exercise and sun protection campaigns. ▪ SI CEOs to discuss acceptable process for discussion on common service provision issues ▪ Purchase (Linear Accelerators 1 x 04/05, 1 x 05/05) as approved by the CDHB ▪ Ensure relevant staff participate in national implementation working groups ▪ Develop and implement Radiation Therapist recruitment and Retention Strategy ▪ Complete service provision framework with 2 Palliative Care providers
Milestones/Actions	▪ Current level of health education maintained. ▪ Ongoing membership of relevant working groups ▪ SI CEO agreement of process for addressing common issues ▪ Radiation Therapist Strategy completed by 31 July 04 ▪ Radiation Therapist Strategy implemented and staffing establishment > 80% by September 04. ▪ Palliative care access criteria defined and utilised. ▪ Review national screening contracts annually to ensure the region's population is accessing all screening services
Risks and Mitigation Strategies	▪ Delays in development of plan for Cancer Control Strategy due to other priorities – mitigate by monitoring current work.
Indicators and Targets	▪ Section 5.

CDHB Strategic Objective 6: Oral Health

Within the Canterbury region 20% of Oral Health Care is publicly funded.

Annual Objective(s)	▪ Incorporate Oral Health focus in provision of existing health promotion work ▪ Communicate a position on water fluoridation ▪ Ensure service delivery structures are providing best access to services within the available funding ▪ Develop robust information regarding Oral Health status ▪ Maintain appropriate workforce
Approach	▪ To use relevant CDHB Action plans and contracts to ensure that Oral Health education is incorporated and promoted along with other 'healthy lifestyle' messages. ▪ Use a non-confrontational approach to educate regarding water fluoridation ▪ Use the Dental Clinic review to examine wider service delivery issues ▪ Work to ensure good data collection to help develop an accurate assessment of oral health status and service delivery performance.
Milestones/Actions	▪ Participation by representatives of Oral Health teams in relevant service reviews and Community and Public Health Program planning ▪ Take opportunities as they present to discuss benefits of water fluoridation ▪ Actively participate in the National review of School Dental Clinic facilities ▪ Implementation of Information system replacement and upgrade for Provider arm services by June 2005 ▪ Working relationship with the University to support recruitment to training ▪ Ongoing monitoring and internal reporting against actions identified in the Oral Health Strategy (Part B)
Risks and Mitigation Strategies	▪ Fluoridation: a recent decision to cease fluoridation of Ashburton's water supply indicated poor support for fluoridation. Ongoing communication of the CDHB position statement on this subject is required ▪ Raised awareness of oral health may increase demand for services increasing the waiting list for CDHB who is the key provider for people on low income. This requires monitoring.
Indicators and Targets	▪ Section 5 (ORA-04 and ORA-01) ▪ As per Oral Health Strategy

CDHB Strategic Objective 7: Information Management

The Canterbury District Health Board's Information and Communications Technology department is referred to internally as HIAP. HIAP is an acronym for Health Information and Processes, which reflects our role within the CDHB.

HIAP has invested considerable effort in 2003/04 in developing a strategic Information Services Strategic Plan (ISSP) to guide the CDHB through the five-year period to 2008.

The three major strands of the ISSP are as follows: -

- Clinical Systems Strategy
- Business Systems Strategy
- Technical Infrastructure Strategy

This Plan will be submitted 17 May 2004 as per the Guidelines/Framework April 2003.

Where possible, in developing strategy, we have tried to align specific aspects not only with the recommendations of the WAVE report but with as broad a range of inputs as possible including: -

Key drivers from the national Health Strategy
Health trends, both local and global
The Draft Strategic Plan for CDHB "Towards a Healthier Canterbury Directions 2006"
CDHB Core Directions
The CDHB Information Services Strategic Framework 2002
Other national programmes eg. National Immunisation Register, Diabetes, etc

The ISSP focuses on managing and analysing information and processes in order to facilitate the provision of health services. The emphasis is on providing clinical support and business solutions using stable, cost-effective, industry-standard platforms.

HIAP is committed to working closely with CDHB stakeholders to implement solutions that satisfy their clinical and business requirements.

Key priorities for the HIAP for 2004/05 include the following: -

Annual Objective(s)	▪ Implement a clinical portal to give an aggregated view of clinical information ▪ Continue the rollout of the Electronic Discharge Summaries via the portal ▪ Deliver a robust infrastructure framework ▪ Commence the implementation of the Business Systems Strategy ▪ Migrate key payroll and rostering software to supported platform ▪ Continue the development of key workforce management reporting systems ▪ Implement an outpatient booking system for Oral Health ▪ Implement a Patient Master Index to mitigate risks and issues arising out of three Patient Administration Systems ▪ Complete upgrade CWH patient management system ▪ Integration into the business of HIAP's Service Provision Strategy ▪ Assist Community & Public Health with national Immunisation register rollout ▪ Implement ePi Windose Pharmacy system

Approach	▪ Use organisationally driven project prioritisation framework to ensure that HIAP is responding to overall CDHB needs ▪ All major IS projects to be signed off by the HIAP Advisory Committee ▪ Use CDHB project methodology to ensure ongoing management and governance of projects ▪ Project governance groups to contain representatives from project stakeholders ▪ Projects impacting primary sector will involve a full consultation with interested primary sector parties. ▪ Leverage off established sector technologies and applications where possible ▪ Continue to use CDHB Core Directions, Wave and other key inputs to drive and prioritise projects ▪ Continue to build collaborative relationships with other DHBs
Milestones/actions	▪ Three service areas using electronic discharge summaries and accessing laboratory results via the clinical portal (Q4/04) ▪ Drive selected projects from the infrastructure project schedule (Q4/04) ▪ Deliver network (eg. VLAN) and mobility (eg. Wireless) enhancements (Q3/04) ▪ Implement a robust enterprise backup solution (Q4/04) ▪ Drive projects arising out of clinical and business project schedule to deliver to the goals of the Clinical and Business Systems strategy as per plan (Q3/04) ▪ Payroll and rostering migrated to supported platform (Q2/05) ▪ Molaris school dental system implemented (Q3/04) ▪ CWH patient management system upgraded (Q3/04)
Risks and Mitigation Strategies	▪ Significant funding is required to stabilise and consolidate infrastructure, which is aging, volatile and overly complex (partly as a result of the combination of two HHSs). This can be mitigated by the early involvement of senior management in the need for change ▪ Availability of funding mitigated by early involvement of DHB financial managers and Board to agree funds for the projects ▪ Human resources availability from both primary and secondary sectors/mitigated by setting a realistic implementation plan
Indicators and Targets	▪ Completed CDHB ISSP consolidating clinical, business and infrastructure strands ▪ As per project plans flowing from the above projects ▪ Compliance with national MIS requirements.

3.1.4 Other Population Health Activity

The Ministry of Health Public Health Directorate retains funding for Population and Public Health. The Canterbury DHB Community and Public Health Division is the major provider of services to the Canterbury community. Over the last year they have been working hard to align their activities with those of other public health providers and with initiatives within the Hospital and Specialist Service of the DHB. The Canterbury DHB plans to make all its hospital sites smokefree in 2004/05. Due to constrained resources, the DHB will have difficulty further implementing Family Violence Guidelines.

Work has already begun with PHOs on aligning their health promotion and service to improve access funds to areas of DHB health gain priorities. This will continue to be a significant piece of work in the 2004/05 year. In addition, the Canterbury DHB needs to work with PHOs to comply with the National Cervical Screening and Breast Screen Aotearoa programmes.

At the same time the DHB is working with Local Territorial Authorities (LTAs) on health outcomes associated with the creation of their Long Term Council Community Plans (LTCCP).

The Community Nutrition Programme is an example of a population approach to food and exercise for Māori/Pacific Peoples' families in Canterbury. Work is to commence on a nutrition and physical activity programme for older persons. Fundamental to all this work is linking initiatives that concentrate on reducing obesity, improving nutrition, increasing exercise and reducing smoking in targeted groups.

Initiatives to reduce suicide will be incorporated in to the Canterbury DHB Youth Health Strategy and Mental Health Strategy. The Canterbury Social Policy Inter-Agency Network (CSPIN) Collaborative Plan for Youth is currently being implemented and covers alcohol and drug and primary health care issues for youth. Work in 2004/05 will concentrate on defining outcome measurements and putting in place systems to measure these.

The Canterbury DHB and the Ministry of Health have begun identifying areas for potential work in the future, particularly in the areas of Māori Health, Primary Health Care Organisations, Nutrition and Physical Activity. A Nutrition and Physical Activity Plan will be completed by end of 2004 which will link with the Draft Canterbury DHB Cardiovascular Disease Strategic Plan: Healthy Heart Strategy 2004. This plan recommends the adoption of the National Heart Foundation Heart Manual Process in primary care.

The work of the Local Diabetes Team in the area of health promotion needs to be aligned with the above work.

Community and Public Health continue to take a lead nationally in strategies for development of the Public Health Workforce.

3.1.5 Consultation/Community Participation

The New Zealand Public Health and Disability Act 2000, specifies consultation in relation to the following matters:

- The District Strategic Plan
- Changes to the Annual Plan
- The disposal of land.

A number of the initiatives may warrant formal consultation such as reconfiguration of services. The Canterbury DHB will identify consultation needs in each instance and met its obligations in this regard.

One of our key objectives is to continue facilitating increased community participation in the assessment, planning and funding of health and disability services in Canterbury. Our Community Engagement and Consultation Policy and Procedure was updated in 2003 to ensure our policies and practices are up to date and supportive of this objective. Our Policy and Procedure is consistent with the Ministry of Health's consultation guidelines for DHBs.

3.1.6 Quality and Safety

The Canterbury DHB has established a Quality and Patient Safety Council. The purpose of the Canterbury DHB Quality Council is to provide advice to the Chief Executive on quality matters and a forum for the wider DHB (community providers and operating division) to discuss quality issues. It will facilitate ongoing improvement of the quality of health delivered to the population served by the Canterbury and progress development of a strategic quality plan.

The Canterbury DHB established a Credentials Board in July 2003 to put in place a Canterbury DHB policy and system on credentialling that both meets the needs of the organisation and health professional regulation bodies. Together with the newly established Clinical Board this will also provide a forum to clarify the implications of the Health Professionals Competency Assurance Act.

The Canterbury DHB has a responsibility to ensure that the health and disability services it funds (both internal and external) are of a high quality and also focuses on:

a) clinical governance structures with a focus on quality services and health outcomes
b) improving the type, mix and manner in which services are funded meet the health and disability needs of the district
c) providing responsive and culturally appropriate services to consumers
d) the coordination of service delivery
e) collaborative funding arrangements
f) pre agreement audits for new services
g) clear service specifications of services to be delivered
h) development, implementation and monitoring adherence to standards and clinical audit

i) achievement of Quality Health New Zealand Accreditation for the DHB in-house provider and adherence to the Health and Disability Sector Standards (including the National Mental Health Standards) for contracted providers

Key actions in 2003/04 are covered in Direction 3 Working Together and Direction 4 Workforce (Section 3.1.1)

3.1.7 Research and Teaching

A key development has been the establishment of a Centre for Evidence Based Medicine between the Christchurch School of Medicine and the Canterbury DHB and the CDHB Innovation Awards. Both have looked at practical ways of solving common problems and evaluating innovations for the Canterbury DHB health sector.

Canterbury DHB continues to have a close and positive professional relationship with Otago University's Christchurch School of Medicine and Health Sciences. Christchurch Hospital is one of the leading teaching hospitals in the country. Many Canterbury DHB staff in other hospitals in Christchurch also have a teaching or research role at the Christchurch School of Medicine.

The Canterbury DHB continues to foster a positive relationship with a range of other trainees of the medical workforce including the Christchurch Polytechnic Institute of Technology, University of Canterbury and others. The training of nurses, allied health professionals and scientists by these institutions is vital in ensuring a well trained workforce and the Canterbury DHB is working with them to align training with needs.

3.1.8 National and Regional Services

The Canterbury DHB works with the other five South Island DHBs on joint issues through a shared services agency, 'SISSAL' (South Island Support Services Agency Limited). It provides some of health planning and contract management functions required by DHBs. This agency also assists to facilitate matters that have regional and/or national implications, such as projects for the South Island Mental Health Network.

The Canterbury DHB sees it has a clear role to be a lead DHB in regional and national development, such as assisting the West Coast District Health Board with paediatric and general medicine services. The Canterbury DHB will continue to provide administrative support and clinical expertise to other DHBs. Future provision will need to resolve inter district flows (IDFs). The issues here are complex.

As the major centre in the South Island the Canterbury DHB provides secondary and tertiary services to other DHBs often via a number of historical arrangements. Canterbury DHB sends some patients out of the South Island for specialist treatment eg, paediatric heart surgery.

In 2004/05 the financial risk to DHBs of inter district flows will be limited to personal health case weighted discharges (ie acute and elective inpatient services). All DHBs will continue to provide full acute coverage for each others' residents, assessment,

treatment and rehabilitation services and Psychogeriatric inpatient services, and elective service coverage in line with historical practices.

Canterbury DHB holds a number of regional and national service contracts but the numbers are reducing as other DHBs take their part of these contracts to manage themselves.

The Canterbury DHB also has a role to work nationally and will contribute to the DHBNZ joint work plan in areas such as negotiating a contract with the New Zealand Blood Service and on a number of national employment agreements.

The Canterbury DHB supports DHB collaborative initiatives via DHBNZ including:

1. Smokefree DHB Workplaces and Sites
2. Quality Use of Medicines in Hospitals
3. Workforce Action Plan(WAP)
4. Inter-sectoral activity
5. Ministry – CEO Forum
6. Information Technology
7. Senior Medical Officer (SMO) Employment Relations
8. DHB Policies

3.1.9 Prioritisation Framework

The Canterbury DHB has agreed in 2002 a set of principles (Effectiveness, Cost, Equity, Māori Health, and Acceptability) to assist choices about the future funding of health services within the wider context of set Government health and disability policy and health gain areas (see CDHB website for details). Work has commenced on identifying how actions of the Canterbury DHB impact on health and disability outcomes for individuals as well a prioritisation process to assist decision making especially in light of the need to realign services as a result of Population based funding. This will include the following decision-making principles.

3.1.10 **Relationship with Māori**

The Canterbury DHB's response to the Treaty of Waitangi will be critical to the success of its activities in relation to Māori. In addition, using a Treaty of Waitangi Framework will ensure that Canterbury DHB activities have a sound basis from which to develop.

The Canterbury DHB has agreed to engage in an effective manner with Kai Tahu as manawhenua of Waitaha/Canterbury, as well as with Māori of other affiliations living in Canterbury. Monthly meetings are held with the Manawhenua Health Group ki Waitaha which comprises the seven Canterbury runaka and Ngai Tahu Development Corporation. A Memorandum of Understanding at governance level is under discussion, as are the operational relationships that will ensue.

Quarterly hui are held with Te Runanga o Nga Maata Waka, and valuable information and feedback is conveyed and gained from the quarterly Māori community consultation hui. the meetings are widely advertised within the Māori community, and meeting notes are freely distributed.

The Canterbury DHB continues to enact, in consultation with Māori, appropriate processes to engage with the Māori community and Māori providers. This assists the gathering of information regarding Māori needs, as well as the development of actions and measures that improve Canterbury DHB's responsiveness to Māori health needs. In addition, strong relationships exist between and with Māori staff working in the Canterbury DHB services, and with Māori community providers.

Canterbury DHB has a Māori Health Plan (Whakamahere Hauora Māori ki Waitaha) which recognises the Canterbury DHB's Treaty obligations to Māori within the framework of the NZ Public Health and Disability Act 2000, and is consistent with the national directions outlined in He Korowai Oranga and Whakatataka. Our Māori Health Plan is currently in its implementation phase.

3.1.11 Workforce Development

Core Direction 4: Developing Canterbury's Health Care Workforce outlines actions to complete the Workforce Action Plan (WAP) as per the guidelines from DHBNZ.

The Canterbury DHB has endorsed the Workforce Action Plan and its workforce development plan is to be consistent with the WAP and focus on workforce development needs at a local level.

In developing its workforce development plan, the Canterbury DHB has taken account of the Health Workforce Advisory Committee's report *The New Zealand Workforce Future Directions – Recommendations to the Minister of Health 2003 (Health Workforce Advisory Committee 2003).* Future Directions identifies the following seven priority areas for workforce development:

- addressing the workforce implications of the Primary Health Care Strategy
- promoting a healthy workplace environment
- educating a responsive health workforce
- building Māori health workforce capacity
- building Pacific health workforce capacity
- developing the health and disability support workforce capacity for people who experience disability
- research and evaluation.

Canterbury DHB has approved a proposal to set up an Occupational Health Service. The role of the service will be to monitor staff health in relation to their exposure to identified hazards. A top priority will be vaccinations and immunity against infectious diseases with the service then developing into other important areas of health monitoring and well being. The intention is to build on the excellent work that is already being carried out and develop a coherent DHB-wide occupational health programme. The DHB is able to fund this initiative through the reductions it will get on ACC levies as a result.

The CDHB is working to improve the capacity and capability of the child and youth mental health workforce locally. The provider arm service is focusing on the introduction of a system of care which the staff are becoming more actively involved in organising.

This is in part an interagency initiative. This organisational development and strengths based training will be the focus of inservice sessions as well as clinical skill development. NGO providers for child and youth mental health services are invited to some of this in service training.

The CDHB is working on delivering Child and Youth Mental Health Services through a number of strategies involving Succession Planning, working with other District Health Boards (in particular the West Coast) and seeking to promote appropriate staff to more senior positions while actively recruiting new/junior staff into the Child and Youth Mental Health Services.

Succession planning means working with educational institutions to support new recruits to Child and Youth Mental Health Services and to retain them, seeking to find within the wider Mental Health Workforce people who would like to work in this area and also carrying out such approaches in the West Coast and also South Canterbury. The CDHB Mental Health Services see the retention and development of the Child and Youth Mental Health Workforce as a priority.

3.2 Funding Health Services

3.2.1 Service Coverage

Within available resources, the Canterbury DHB will:

- Undertake service development to ensure that the health service outcomes, as outlined in the New Zealand Health Strategy and Disability Strategy, are taken into consideration.

- Fund in 2004/05 a range of services similar to those funded in 2003/04, including the services for Older People devolved in October 2003.being mindful of the development of an Aged Care Strategy (as in Section 3.1.1)

- Ensure, where appropriate, that the Nationwide Service Framework is applied when entering into service agreements. This includes utilising the nationally consistent service specifications and/or prices.

- Facilitate timely and equitable access to appropriate health services, in accordance with Crown Funding Agreement requirements.

- Ensure that the service coverage requirements of the Operational Performance Framework and Service Coverage Schedule requirement are met (see Attachment 7B for Service Coverage Exceptions).

- Ensure that ring-fenced mental health funding is spent funding mental health services.

The move to population based funding and adjustments to our funding path mean we have to work to manage within our share of public health funding. The CDHB has identified strategies (such as those listed in 3.1.1) to bring the DHB to funding equity under population based funding. These strategies will identify service coverage issues (including service gaps and over provision of services), and will facilitate a resolution of these issues.

The Canterbury DHB is working to foster the development of Māori capacity for meeting the health needs of Māori. As with other DHBs, Māori health and disability services are provided via a mixture of explicit Māori health funding and funding allocated to mainstream services. A process is underway under the oversight of Te Kahui Taumata (a group comprising the CEO and senior managers of CDHB) on Māori indicators of performance as part of this work.

The CDHB (comprising managers from Planning & Funding and Community & Public Health divisions) and MoH Public Health Directorate continue to use a shared decision model set up to undertake collaborative Public (Population) Health service planning. CDHB and MoH use the Public Health Services Handbook as a base for this work, noting the responsibility of the DHB on statutory issues.

Canterbury DHB will maintain existing mental health funding for mental health services, although some service reconfigurations are planned as a result of the South Island Alcohol and Other Drug Review, and the Canterbury DHB Mental Health and Addiction Strategy 2004.

As part of the Mental Health Strategy the Provider Arm CDHB Mental Health Services are concentrating on focussing on specialist and regional services. This requires some capacity building within the NGO and Primary Care Sector, in particular putting in place different ways of case management. Service reconfigurations will result from this and together with the outcome of the ID/Mental Health Review the Division will work to redress its current deficit position.

Other service reconfigurations are signalled in the Mental Health provider section (3.3) of this DAP, as the Division works to improve its efficiency.

The CDHB acknowledges there have been problems with the retention and recruitment of the Child and Youth Workforce in particular, which has impacted on delivery of contracted volumes. The Canterbury DHB is working to correct this and will continue their efforts in the 2004-2005 year. The CDHB will report to the MOH on FTE levels and service coverage after the first 6 month of 2004-05 (due 20.1.05)

3.2.2 Service Delivery

Volume Schedules for services to be provided in 2004/05 are in Attachment 7A.

3.2.3 Service Monitoring and Evaluation

Financial management of the DHB is organised into three sections:

- Overall DHB financial management, including its subsidiaries funding, and
- In-house provider

The purpose of the above separation is to provide transparency between the financial performance of the two key functions of the DHB (
the funding and the in-house provider) while keeping an overall view of the whole organisation and related subsidiaries.

Separate financial and activity reports are prepared for each of the above three sections monthly, to facilitate monitoring at both the management level as well as to the Finance Audit and Risk Committee.

A comprehensive Risk Register has been developed to identify the financial and non-financial risks for both the DHB in-house provider and externally funded providers. The Canterbury DHB continues to enhance systems to manage both financial and non-financial service risks.

Canterbury DHB will actively monitor and assess the quality of services provided by both the DHB in-house provider and the externally funded providers via service agreements. Monitoring includes appropriate procedures for reporting adverse incidents as well as routine reporting against standards (such as Health and Disability Safety Standards 2001) and processes. The introduction of certification is also being monitored. In addition, the DHB monitors provider service quality through a programme of routine quality audits, service evaluations and issues-based audits.

It is acknowledged that Canterbury DHB's ethnicity data collection methods require attention; hence the policy and implementation work noted earlier in this and earlier District Annual Plans.

The development of Primary Health Organisations (PHOs) will assist in the collection and reporting of patient NHI numbers, through patient register "cleansing" and NHI updates.

Collaboration with the South Island Shared Services Agency Limited (SISSAL), and Health Payments Agreements and Compliance (HealthPAC) in collecting, summarising and analysis of contract information is vital to the ongoing success of the DHB in providing relevant information for ongoing decision making.

Service monitoring is in line with individual contractual arrangements, and new requirements contained in the Crown Funding Agreement, Service Coverage Document and Operational Policy Framework, will be worked into new service agreements over time.

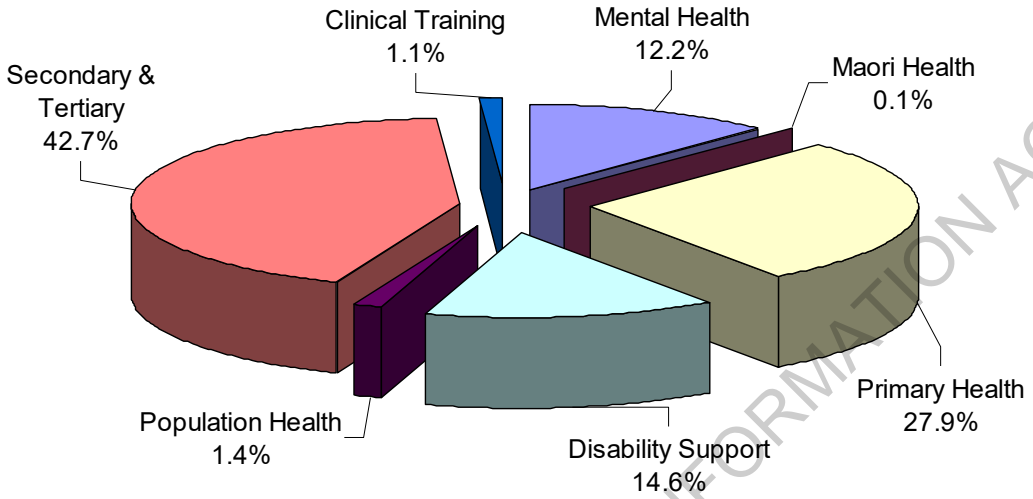
The Canterbury DHB is working within national and regional (South Island) arrangements relating to the funding impact of Inter-District Flows (IDFs).

3.2.4 Additional Funding Responsibilities

The major funding changes expected in 2004/05 will be:

- The management of additional funding related to PHOs, in light of the almost 100% coverage of the Canterbury population by four PHOs; and
- Annualisation of the funding for age-related disability services devolved to DHBs on 1 October 2003.
- The following diagram indicates how current funding is allocated in the Canterbury DHB.

Canterbury DHB Funding



Note 1: Includes Brackenridge Estate
Note 2: Excludes funding spent by mainstream on Māori Health Services
Note 3: Excludes revenue recovered from other parties by provider arm, capability funding.

The Canterbury DHB will continue the process to review existing Māori health services currently being funded in Canterbury and to identify gaps and/or duplication. The focus continues to be on consolidation and development.

Māori Health service development co-ordinators are working in the Christchurch Hospital, Mental Health, and Disability areas, to support Māori service development and sectoral collaboration. The Disability co-ordinator will also focus on developing a robust information set about Māori with disabilities in Canterbury.

The Māori health expenditure stocktake and review that Canterbury DHB undertook during 2003/04 identified expenditure of $7.2 million per annum through a combination of Māori community providers, mainstream community providers and the Canterbury DHB provider arm. This equated to an average expenditure on Māori health services of $228 per Māori capita, which compared favourably with the national average of $200 per Māori capita.

The Māori health expenditure target for the 2004/05 financial year is set at $7.6 million (an increase of 6%). This equates to an average expenditure on Māori health services of $242 per Māori capita, and details of this target, including forecast targets for the 2005/06 and 2006/07 years are provided in the schedule in Appendix 6.

The Canterbury DHB will continue to liaise with the Ministry of Health and DHBNZ work groups to review the service specifications for these services to help ensure they align with improving health status for population groups who face inequalities.

Canterbury DHB is part of the South Island Mental Health Network. The South Island Regional Mental Health Strategic Plan was adopted by South Island DHBs and Ministry of Health in 2002. The draft plan for 2004/2005 is yet to be signed off by the South Island CEOs and is attached as Appendix 7D.

The Canterbury DHB is not funded to Blueprint levels.

The South Island is generally considered 'overtarget' by PBFF standards and well funded against Blueprint targets compared to the North Island regions. Although three South Island DHBs received additional mental health "Blueprint" funding for service growth, the focus for all South Island DHBs in the 2004/05 Regional Mental Health Strategic Plan is on improving collaboration, service consolidation and service quality, while optimising service configuration within the available resources.

Key areas in the Regional Mental Health Strategic Plan are:

- The South Island Alcohol and Other Drug Review;
- Forensic governance;
- Regional access to services;
- Māori mental health; and
- Workforce development.

Canterbury DHB does not receive any additional mental health funding in 2004/05.

The Canterbury DHB has taken the lead role in the establishment of a South Island Youth Alcohol and Other Drug (Residential and Day Programme) Service and South Island Kaupapa Māori Adult Alcohol and Other Drug Service. The funding for these sit outside Blueprint targets and PBFF at this time.

3.2.5 Future Funding Pressures

The factors driving funding pressures faced by CDHB are similar to those faced by other DHBs, namely reflecting the pressure to increase both volumes and prices paid to providers. However with CDHB's current funding being estimated at $42m ($38m GST excl.) above its "equitable" funding share, CDHB will receive lower than average DHB sector funding increase from which these pressures must be managed. With lower than average funding increases CDHB will face significantly greater funding pressures than those experienced by other DHBs.

With population based funding we use benchmark pricing in the funding of providers. The CDHB current over-target funding is considered to be primarily reflective of higher volume delivery rather than over pricing.

During the transition to PBFF equity the DHB as a funder of health services will need to continue to:

- Constrain growth in prices to less than the levels indicated by the Ministry of Health (MOH) CPI adjustments.
- Re-allocate volumes between discretionary and non-discretionary services to meet demand driven growth, while providing incentives to providers to minimise and manage growth in demand.

As a provider of health services the DHB will need to continue to:

- Constrain the growth in the cost of service delivery to enable the provider to deliver the desired mix of services within the available funding.
- Manage growth in demand for acute hospital services via the ongoing development of the interfaces with primary care and other providers. This will include the ongoing management of the introduction of new treatment regimes and technologies.

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In addressing these pressures, a delicate balance must be achieved between funding levels and demand and cost management to ensure these pressures are appropriately balanced between the funder and provider. Planning and Funding is working to develop a more detailed view of future funding pressures to provide a basis for managing these funding risks particularly during the period of transition to PBFF equity.

Summary of Hospital and Specialist Service Issues

The Hospital and Specialist Service also has a number of funding and pricing issues which are summarised with the current action for each:

- Blood products price increase – DHBNZ is negotiating on behalf of the CDHB.
- Spinal rehabilitation pricing – the issue has been escalated to the CEO of Accident Compensation Corporation.
- Brain Injury Rehabilitation Pricing – concerns raised with MOH and preparing to escalate.
- Air retrieval costs – reimbursement of staff costs being pursued from neighbouring DHBs
- Intellectual disability services – additional revenue sought from MOH: awaiting outcome of review.
- Tertiary adjustor – the CEO has raised the issue with the Deputy Director General (DDG) of MOH.
- Overseas revenue/bad debts – the CEO will raise this issue with the MOH.
- Rituximab – the Planning and Funding Division are negotiating formal agreements with DHBs.

3.2.6 Service Reconfigurations 2004-05

As part of the Core Directions work noted in section 3.1.1, the CDHB plans to consider significant service reconfigurations to help it live within its funding under Population-Based Funding. Under the MoH's latest calculations Canterbury DHB is considered to be "over-target" by $38M ($42M GST inclusive), and the Government will move the CDHB to equity over future years.

This means that Canterbury DHB will receive relatively less funding in future years, through the loss of funding changes for increases in population (the DHB's demographic adjustor).

This is a matter not well understood by the community and Health and Disability providers in Canterbury, so service reconfigurations will be achieved by consulting and working with clinicians in the primary, community and secondary areas. It will involve consultation with hospital and community based service providers, to determine appropriate solutions that best meet the needs of CDHB's community. These solutions will then be actioned to meet the DHB's adjusted funding levels.

Some service reviews have been undertaken in 2003/04, to be implemented in 2004/05, while some reviews will be in preparation for service change in the 2005/2006 year. In all cases processes keeping stakeholders informed have been undertaken or are planned.

In addition to the areas identified in the Core Directions, Section 3.1.1, (2.4) and smaller service reconfigurations identified in Section 3.3 under each of the Hospital and Specialist Service areas, the following reviews are planned to be implemented in 2004/05:

Referred Radiology, Laboratory (referred services management)
Health Needs Assessment Service Coordination
Alcohol and Other Drug Services
Older Persons Health as per the LinkAGE document
Intellectual Disability Services (including Psychiatric Services for Adults with an Intellectual Disability)

The CDHB will take part in the national and regional review of School Dental Clinics. The outcome of this planning is expected in October 2004.

The Canterbury DHB is aware of implications of the Ministry of Health letter of expectation regarding contracting out of services, and will deal with these as appropriate.

3.2.7 Efficiency Gains and Service Technology Change

Canterbury DHB continues to look at efficiency gains, technology changes and service reconfiguration as part of its ongoing process to enhance patient care and to achieve its financial targets. These include local initiatives as well as working collaboratively with other DHBs and health providers. The targeted savings are an integral part of the budget to achieve a break-even financial performance for the year.

3.3 Providing Health and Disability Services

3.3.1 Introduction

The Canterbury DHB has three fully owned subsidiaries, Canterbury Laundry Services Limited, Burwood Rehabilitation Limited and Brackenridge Estate Limited which it intends to keep operating in the medium term.

The Canterbury DHB provides services mainly to the people of the north and mid Canterbury districts. A range of secondary and tertiary services are provided to people living throughout the South Island and in some cases to some people who live throughout New Zealand. Population/public health services in Canterbury, South Canterbury and West Coast include health protection, health promotion, Māori health promotion and the Medical Officer of Health. Laboratory Services support is provided to five other DHBs in North and South Islands.

Inpatient and outpatient services are provided from a number of facilities and sites and by teams working in the community. The major hospitals include Christchurch, Burwood, Christchurch Womens, Ashburton, Hillmorton and The Princess Margaret as well as a number of hospitals in rural areas.

An organisation chart of the in-house provider and details of services provided by the Canterbury DHB are found in Appendix 3.

ASHBURTON AND COMMUNITY HEALTH SERVICES

	Annual Objectives	**Approach**	Milestones	Indicators / Targets
1. HE KOROWAI ORANGA				
1.1	▪ Education provided to all staff on Māori cultural issues.	▪ Session by Māori Health Advisor at staff annual training days. "Talking Together".	▪ Staff participation.	▪ 90% of staff attendance at sessions.
2. NEW ZEALAND DISABILITY STRATEGY				
2.1	▪ Ensure compliance with standards of QHNZ to meet both personal and physical access to services.	▪	▪ Successful Accreditation and certification audit.	▪ Hospital Certification and Accreditation maintained - June 05
2.2	▪ Provide incentives and ability for people to maintain mobility and independence.	▪ Stay on Your Feet programme supported. ▪ Establishment of ACC Fall Prevention Programme.	▪ Training of volunteer community support persons. ▪ Programme in place for >80 years old, Dec 04	▪ Training completed. ▪ Dec 04 ▪ Participation by 70 people aged 80 and over - June 05
3. ELECTIVE SERVICES AND RADIOTHERAPY WAITING TIMES				
3.1	▪ Maintain waiting lists for General Surgery at guideline levels.	▪ Continue with assessment and prioritisation processes.	▪ Booked patients have procedure within 6 months.	▪ 100% of booked patients have procedure within 6 months.
4. DIABETES INCIDENCE AND IMPACT				
4.1	▪ Continue diabetes nutrition service throughout rural Canterbury.	▪ Two education sessions delivered to targeted population in rural Canterbury communities.	▪ Sessions provided positive feedback.	▪ 2 sessions delivered by June 05

5. INEQUALITIES				
5.1	▪ Access to services to rural population.	▪ Identify barriers to accessing hospital and specialist services.	▪ Comprehensive data available on barriers.	▪ Report completed Sept 04
6. PRIMARY CARE				
6.1	▪ Engage with Primary Health Organisations (PHO).	▪ Establish formal linkages with rural PHO's.	▪ Dialogue on rural health issues and strategies.	▪ Linkages established between CDHB / ACHS Division and PHO's.
	▪	▪	▪	▪
WORKFORCE				
7.1	▪ Review options for medical staffing at Ashburton. (refer 3 under Service Reconfigurations)	▪ Options for immediate and longer term medical staff configuration developed.	▪ Strategy for next 5 – 10 years developed	▪ Acceptance by CDHB and Ashburton Community on defined future direction June 05
7.2	▪ Develop leadership skills.	▪ Include in ACHS education and training programme leadership training for current and potential leaders.	▪ Programme developed Implementation. Oct 04	▪ Attendance / participation levels.

	OTHER PROJECTS	INDICATORS/TARGETS
1	Develop options for services and facilities at Kaikoura.	Plan for services and facilities in place and adopted by CDHB.
2	Assess facilities for Ashburton Campus services.	Review of service facility needs completed.
3.	Develop strategies to reduce unnecessary admissions from rest homes and long term care hospitals.	Programme developed whereby hospital team assesses need for acute hospital admission in conjunction with rest home / hospital and GP.
4	Review nursing medication administration systems.	Comprehensive review completed and revised policies in place.

SERVICE RECONFIGURATIONS		BRIEF COMMENTARY
1	Cease providing dental services at Ashburton Hospital.	Limited extraction service has been available. Staff no longer available to provide. Patients can access Christchurch services
2	Cease maternity labour and delivery services at Kaikoura.	Lead Maternity Carers no longer prepared to provide service in Kaikoura. Could be reintroduced if new LMC's in district.
3	Review clinical services at Ashburton	Difficulties in recruitment of Senior medical staff (Internal Medicine and Anaesthetists) and junior medical staff (House Surgeons) continues. Review needs and options for staffing arrangements to maintain a comprehensive range of services in the Ashburton District - June 05
4	Review services provided at rural hospitals (Akaroa, Darfield, Ellesmere, Kaikoura, Oxford and Waikari)	Utilisation of these hospitals for a variety of admissions / conditions. A number of admissions are people resident in other areas eg. Christchurch for convalescence / rehabilitation care. Appropriateness of use and possibility of other service development eg. increased range of community services to be considered - June 05

BURWOOD HOSPITAL

Annual Objectives	Approach	Milestones	Indicators / Targets
1. HE KOROWAI ORANGA			
1.1 ▪ **Increase staff cultural awareness**	▪ Staff core competency days have a Māori cultural component	▪ Programmed into day	▪ 50% of staff attendance December 2004
1.2 ▪ **Increase Māori signage**	▪ Review signage according to Māori policy	▪ Plan developed April 2004	▪ Completed October 2004
1.3 ▪ **Increase staff skills in Te Reo, Kawa and Tikanga**	▪ Komiti Kaiwhakahaere to have a working knowledge of Te Reo & Tikanga	▪ Komiti to attend relevant education sessions. Te Reo &Tikanga to be practised at meetings and relevant events.	▪ Burwood Hospital staff demonstrate cultural appropriateness
1.4 ▪ **Cultural Assessment**	▪ Develop an assessment tool and implementation	▪ Tool developed Cultural assessments completed	▪ July 2004 ▪ December 2004
2. NEW ZEALAND DISABILITY STRATEGY			
2.1 ▪ **To improve waiting times for Brain Injury Rehabilitation Service patients**	▪ Work with DSS ▪ Analyse current costs and activity	▪ Business case completed by July 2004. Negotiations with DSS	▪ Increased funding for 04/05 ▪ To provide appropriate clinical service.
3. ELECTIVE SERVICES AND RADIOTHERAPY WAITING TIMES			
3.1 ▪ **To reduce orthopaedic elective waiting times for FSA and elective surgery**	▪ Increase volume 04/05	▪ Increased FSA and increased elective surgery to meet contracted volume.	▪ Waiting times meet MOH standard. December 2004 ▪ Increased surgical volume to meet contracted volume.
4. WORKFORCE			
4.1 ▪ **Reduce staff injuries at work**	▪ Complete rollout of safe handling project to all units/services	▪ Education completed	▪ December 2004. Reduction in work place injuries

4.2	▪ **Cost Centre Manager Development Programme**	▪ 2 x workshops annually to address identified needs	▪ Workshops commenced by July 2004	▪ Workshops completed by December 2004
4.3	▪ **Smokefree Environment**	▪ To work with CDHB staff to implement a smokefree environment at Burwood Hospital	▪ Establish an implementation plan for Burwood Hospital	▪ December 2004 plan in place
4.4	▪ **To improve staff satisfaction**	▪ Use the results of the staff culture survey to develop an action plan	▪ Feedback culture survey results to staff. ▪ Work with staff to develop an action plan	▪ Feb 2005. ▪ Improved staff satisfaction.

OTHER PROJECTS		INDICATORS/TARGETS
1	Strategic Planning	▪ Complete Burwood Hospital Strategic Plan by July 2004
2	Consumer Participation	▪ Establish Burwood Consumer Advisory Group by July 2004
3.	ACC Outstanding invoices	▪ Clear invoice backlog from 2000 ▪ Complete implementation of new systems for invoicing to ensure all paid within 60 days. December 2004

SERVICE RECONFIGURATIONS		BRIEF COMMENTARY
1	Orthopaedic Surgery	▪ Business Case exploring collaborative partnership to address facilities and service delivery issues.
2	Cardio Respiratory Rehabilitation Unit	▪ Service review completed. Recommendations being developed, possibility of Burwood beds being reabsorbed into Christchurch Hospital.

CHRISTCHURCH HOSPITAL DIVISION

Annual Objectives		Approach	Milestones	Indicators / Targets
1. HE KOROWAI ORANGA				
1.1	**Improve ethnicity data collection throughout the hospital**	▪ Pilot staff training modules for data collection with Emergency Department staff ▪ Extend staff training to two other departments	▪ July 2004 ▪ June 2005	▪ Ethnicity data updated at each admission. ▪ Number of departments provided with training
1.2	**Ensure CDHB is recognised as a leader in Māori health worker development**	▪ Implement Māori Service development plan ▪ Māori Staff to attend Te Ao Marama and Te Komiti Whakarite ▪ Staff to attend cultural training	▪ Ongoing ▪ Ongoing ▪ Ongoing	▪ Appoint four further Māori project workers (six Māori project workers in total) ▪ Number of meetings held and number of attendees ▪ Three training sessions completed.
1.3	**Reduce health inequalities**	• Support reduction in inequality through service development in priority areas by: • Staff participation in service and clinical planning activities to reduce inequalities • Support Cardio-Respiratory outreach proposal • Support research on Māori health outcomes	▪ Ongoing ▪ Ongoing ▪ Ongoing	• Meeting minutes • Meeting minutes • Research proposals supported
2. ELECTIVE SERVICES AND RADIOTHERAPY WAITING TIMES				
2.1	**Ensure that patients referred for a First Specialist Assessment s are seen within six months**	▪ Management of the referral process to ensure that referral from primary/community care occurs at the optimal time for treatment or referral.	▪ June 2005	▪ Minimum of 97% of patients seen within six months
2.2	**Ensure patients given certainty of surgery receive surgery within six months**	▪ Monitoring of key performance indicators within the hospital to ensure the most effective use of elective services resources.	▪ June 2005	▪ Minimum of 97% of patients receive surgery within six months

2.3	**Ensure that contracted volumes of elective services are delivered.**	▪ Monitor and manage production, and take prompt action to rectify any under-delivery	▪ June 2005	▪ All volumes delivered.
2.4	**Achieve Radiation Therapy Waiting Times**	Recruit and retain sufficient Radiation Therapists to deliver contracted volumes ▪ Develop Radiation Therapist Recruitment and Retention Strategy ▪ Implement Radiation Therapist Recruitment and Retention Strategy	▪ 31 July 2004 ▪ Ongoing from 30 September 2004	▪ Strategy complete ▪ Improve staffing to above 90% of establishment
3. DIABETES INCIDENCE AND IMPACT				
3.1	**Deliver the Primary Health Care Strategy**	Working collaboratively with the Primary Care Sector to: ▪ Undertake health promotion activities ▪ Review the podiatry service ensure most effective use of expertise and resources ▪ Continue to support the Pacific peoples and Māori leadership programme	▪ Ongoing from July 2004 as per Diabetes Strategy ▪ 31 December 2004 ▪ Ongoing	▪ Admission rates for patients with diabetic ketoacidosis ▪ Presentation rates to ED with hypoglycaemia ▪ Number of programmes supported
3.2	**Continue to develop the Diabetes Service to meet the objectives of the Diabetes Strategy**	▪ Participate in the Local Diabetes Team and Diabetes Sector meetings.	▪ Monthly from July 2004	▪ Number of meetings attended
3.3	**Supply data on Diabetes checks undertaken by the Diabetes Service to the "Get Checked" database**	▪ Develop system to collect data ▪ Implement data collection	▪ 31 December 2004 ▪ 30 June 2005	▪ Systems in place ▪ Data supplied to "Get Checked"

3.4	**Improve glycaemic control in Type 1 patients**	▪ Develop an Advanced Management Course ▪ Provide Advanced Management Courses	▪ 31 December 2004 ▪ 30 June 2005	▪ Course developed ▪ Run 3 Courses
4. INEQUALITIES				
4.1	**Contribute to the reduction of health inequalities**	▪ Clinical plans to include a health promotion component, where appropriate	▪ December 2004	▪ Number and percentage of clinical plans with health promotion component.
5. PRIMARY CARE				
5.1	**Maintain and strengthen links with primary care providers**	▪ Work with primary care providers to minimise inappropriate utilisation of hospital acute services ▪ Work with primary care providers to improve elective services referral practices. ▪ Work with primary care providers to ensure health services are delivered in the most appropriate setting	▪ As per Terms of Reference and project plans ▪ As per Terms of Reference and project plans	▪ Number of meetings ▪ Completed projects ▪ Number of meetings ▪ Completed projects ▪ Undertake two projects to change service delivery setting.
6. WORKFORCE				
6.1	▪ **Improve staff retention in key areas**	▪ Improve staff retention in: - Allied Health (OT, PT, Social Work) - Anaesthetic Technicians - Nursing	▪ 31 December 2004 - Identify reasons for turnover - Review recruitment and selection practices in these areas - Review performance management practices in these areas - Review formal and informal recognition practices in these areas	▪ Turnover reduced significantly and preferably below 15%

6.2	▪ **Provide appropriate training opportunities to support CDHB strategy implementation**	▪ Harassment training provided to Christchurch Hospital staff	▪ 30 June 2004 ▪ 31 December 2004	▪ 70% completed ▪ 90% completed
6.3	▪ **Review skill and resource mix after hours that best suits patient needs**	▪ Develop and implement night audit to ascertain an appropriate mix of staff	▪ 30 June 2004 ▪ 31 December 2004	▪ Audit completed, recommendations made ▪ Strategy implemented
6.4	▪ **Improve HR information that is available to Clinical Leaders, Line and Senior Divisional Managers**	▪ Liaise with HIAP to develop remuneration and turnover databases	▪ 31 March 2004 ▪ 31 December 2004	▪ Project objectives developed ▪ New databases operational (depends on available IS support)
6.5	▪ **Ensure compliance with CDHB policies and strategies**	▪ Review compliance of: - Recruitment and selection policies - Performance review practices ▪ Project undertaken to resolve issues	▪ 30 June 2004. ▪ 31 December 2004	▪ HR Audit completed and Analysis of audit completed ▪ Recommendations made to CHMG and Divisional GM
6.6	▪ **Ensure policies and procedures align to CDHB strategies and comply with legal requirements**	▪ HR manual for Christchurch Hospital developed	▪ 30 June 2004 ▪ 30 June 2005	▪ 90% completed ▪ Completed

	OTHER PROJECTS	INDICATORS/TARGETS
1.	New premises planning for Diabetes service	▪ Complete needs identification ▪ Complete planning December 2004
2.	Attain accreditation	▪ First survey due by September 2004
3.	Continue implementation of Patient Flow project	▪ Focus on efficient use of resources ▪ Optimal average length of stay
4.	Other potential projects ▪ Plan for day surgery theatres ▪ Audit admissions/admission and develop admission policy ▪ Electronic prescribing pilot	▪ Maximise efficiency of Day Surgery ▪ Admission criteria developed and implemented ▪ Pilot in at least one specialty by 31 December 2004
5.	Review of Emergency Department	▪ Consult with stakeholders ▪ Complete external Review ▪ Fund any reconfiguration within resources

WOMEN'S HEALTH DIVISION

Annual Objectives		Approach	Milestones	Indicators / Targets
1. HE KOROWAI ORANGA				
1.1	▪ **Continue to promote the integration and deployment of Cultural policies.**	▪ Appoint 1.0 FTE Māori Health Worker. ▪ Publicise availability of WHD Māori Health Worker to staff , patients and community. ▪ Support staff to attend cultural awareness sessions.	▪ Inclusion of Māori Health Worker in Multidisciplinary team. ▪ Staff interest in attending Cultural Awareness sessions and support for Cultural Policies.	▪ Women are aware of WHD Māori Health Worker prior to admission to a WHD facility. ▪ Staff awareness of culture and ability to demonstrate same in an appropriate manner.
1.2	▪ **Further improve ethnicity data collection throughout the Division.**	▪ Provide information to women/patients and staff as to why collection of ethnicity data is relevant. ▪ Ensure forms seeking ethnicity data assist the process.	▪ Staff awareness for importance of data collection is high and information given by staff to patients and family is relevant and supportive of the objective.	▪ Women feel able to answer the admission questions including identification of ethnicity and the relevance of doing so. ▪ Staff approach to ethnicity data collection is comfortable and informed.
2. NEW ZEALAND DISABILITY STRATEGY				
2.1	▪ **To continue to promote a non disabling culture within WHD as per the CDHB Disability Strategy Action Plan.**	▪ Utilise the Disability and Support Advisory Committee as an advisory group to assist WHD to ensure new facilities, workforce training and employment practices promote a non disability environment within WHD.	▪ As HR policies are updated they reflect EEO principles. ▪ Staff are encouraged and supported to attend relevant training opportunities.	▪ Staff attendance at training in disability issues occurs. ▪ Feedback from patients, families and staff positive re WHD efforts to promote a non disabling culture within WHD.

3. ELECTIVE SERVICES AND RADIOTHERAPY WAITING TIMES				
3.1	▪ **To continue to maintain and monitor Ministry of Health Policy in relation to Elective Services (and Radiotherapy) Waiting Times.**	▪ Manage the referral interface with a focus on patients remaining with their primary care provider and only accessing secondary or tertiary services at the optimal time for referral and treatment. ▪ Monitor key performance indicators within WHD to ensure the most effective and efficient use of elective services resources and funding is occurring.	▪ Patient status i.e. Certainty , Active Review or GP care has been identified and the patient and their GP is aware./ ▪ Processes are implemented to support WHD's attendance to CDHB and MOH policy in relation to Elective Services (and Radiotherapy) Waiting Times.	▪ Elective Services Performance Indicators (monthly). ▪ Internal Audit Reports (Monthly and Annually). ▪ Crown Funding Agreement reporting (quarterly). ▪ District Annual Plan reporting (quarterly).
4. INEQUALITIES				
4.1	▪ **Reduce Health Inequalities.**	▪ Identify relevant populations and target resources accordingly.	▪ Service and clinical plans within WHD reflect an awareness of and support for strategies which take into account the need to reduce health inequalities.	▪ Links to CDHB focus as a whole on reducing inequalities and relevant intersectoral groups can be seen in WHD Planning.
5. WORKFORCE				
5.1	▪ **To achieve a workforce which provides the right skills at the right place and time for best delivery and outcomes, within WHD.**	▪ Identify multidisciplinary workforce required to deliver healthcare as per WHD services, taking into account new and emerging approaches and treatments.	▪ Service plans reflect multidisciplinary approach to healthcare and need to achieve an appropriate workforce to support efficient, effective healthcare delivery.	▪ Medical, Midwifery, Nursing and Allied Health Staff are engaged in healthcare activities which support best delivery and outcomes for patients needing the services offered by WHD.

OTHER PROJECTS		INDICATORS/TARGETS
1	New Christchurch Women's and Day Surgery Hospital.	Project meets construction and financial milestones. Project completed March 2005.
2	Information system upgrade.	Upgrade complete on time and on budget. Staff trained and utilising the system.

SPECIALIST MENTAL HEALTH SERVICE

Annual Objectives		Approach	Milestones	Indicators / Targets
1. HE KOROWAI ORANGA				
1.1	**Promote a culturally responsive Mental Health Service**	Maintain and build on the strength of Te Korowai Atawhai as the umbrella for bi-cultural development within the service by: • Working in partner-ship with Iwi, whanau and tangata whaiora • Ensuring appropriate resources for cultural assessment, specialist advice and teaching • Ensure accurate data relating to service access • All MHS staff to receive cultural training • Ensuring core training for Pukenga Atawhai in Psychiatric Care and Cultural Development	• Ongoing	• Numbers of Pukenga Atawhai employed • Numbers of MH staff completed baseline Cultural Competency training • Numbers of Pukenga Atawhai who have completed training in core competencies in MH
1.2	**Improve ethnicity data collection throughout the hospital**	• Participate in ethnicity data collection policy consultation process • Participate in ethnicity data collection		• Ethnicity data updated in each admission
2. MENTAL HEALTH BLUEPRINT				
2.1	**To assist the MHS to move towards its vision as a specialist MHS by developing Clinical Pathways with NGOs and Primary which ensure right skills, right place, right time**	• Review pilot of 'Clinical Management' with Pathways Trust and 40 clients in Residential Rehab Service	• July 2004	
		• Identify other 'Clinical Management' opportunities which are supplied by outcomes of pilot	• July 2004	Other appropriate client gaps identified and model implemented in their care
		• Negotiate and develop key Case Management relationships with NGOs and Primary Care	• July 2005	Case Management criterias agreed with Planning & Funding and NGO, Primary Care Sector. Understood by all staff in SMHS.
		• Implement outcomes /directions of Canterbury MH system plan as it relates to the Specialist MHS	• Ongoing	Agreed actions implemented as per project plans
		• Implement relevant recommendations of the SI Regional Mental Health and Alcohol and Drug plans	• Ongoing	Agreed actions implemented as per project plans

Annual Objectives		Approach	Milestones	Indicators / Targets
2.2	**To understand the needs of those individuals who have enduring mental illness**	• Identify people in Specialist Mental Health Service (SMHS) with enduring mental illness (using the KPP framework) • Identify services funded to meet the needs of individuals with enduring mental illness • Develop a model for support/management of these people that includes: - Improving access to appropriate services - Addressing interfaces between DHB funded and services available from other providers.	• Dec 2004	
2.3	**To improve co-ordination of information collection systems**	• Ensure accurate, timely information is being recorded into Mental Health National Info Collection (MHNIC)	• Ongoing	• MHNIC data 100% accurate • Specialist Mental Health Service has developed systems for outcome data collection
3. WORKFORCE				
3.1	**To ensure that staff have identified learning needs met to assist the Service's movement to a Specialist MHS**	• Model of needs identification established and implemented	Ongoing	• All Clinical staff receive annual Performance Appraisal June 2005 • Core skills modules developed and delivered to 20% required workforce
3.2	**Implement staff recognition activities**	• Formal recognition of service 25 yrs + • Develop and pilot annual process for staff/team awards	Dec 2004 Sept 2004	• Improved staff morale

Annual Objectives		Approach	Milestones	Indicators / Targets
3.3	**Focus on staff Health & Safety**	• Review practices surrounding management of violence & aggression in workplace • Implement recommendations of review	August 2004 March 2005	

OTHER PROJECTS		INDICATORS/TARGETS
1.	Access Canterbury Projects - Shared Care - Discharge planning - GP liaison	• Project plans have been implemented for these projects in line with the Principles of the Access Canterbury projects • Outcomes meet expectations of project plans
2.	Develop GP Link Programme with WINZ	• Mental Health consumers and families increase their use of GP services
3.	To achieve accreditation	• Put in place processes to achieve accreditation by Sept 04
4.	Contribute to Memorandum of Under-standing with South Island DHBs re regional provision of Specialist Mental Health	• Consistency of Mental Health Services throughout South Island
5.	Participate in Mental Health - Standard Measures of Assessment & Recovery (MH-SMART) project	• Participation in the MH-SMART establishment group
6.	Complete Project on improving responsiveness of mental health services to Pacific Peoples	• Project complete and recommendations implemented

SERVICE RECONFIGURATIONS		BRIEF COMMENTARY
1.	Implement agreed outcomes of Intellectual disability service review	• Project plans are established for agreed outcomes of review and progress made towards implementation

THE PRINCESS MARGARET HOSPITAL

Annual Objectives		Approach	Milestones	Indicators / Targets
1. HE KOROWAI ORANGA				
1.1	▪ To progress the Implementation of Te Korowai Oranga and the Māori Health action plan	▪ Respond to the needs of Māori patients/whanau through ensuring that the environment reflects bi-culturalism	▪ Continue to role the cultural corridor concept out through the Division	
		▪ Reduce the barriers to Māori and whanau within the TPMH services	▪ Continue to roll out cultural corridor concept throughout the Division	
			▪ Develop links for the Psychiatric Services for the Elderly with Te Korowai Atawhai	▪ Clinical corridors reflect cultural themes
			▪ Include the Māori Health Worker overview in the orientation program	▪ September 2004
			▪ Increasing Māori NASC dedicated staff by 0.5 FTE	▪ Appointed by June 2004
			▪ Review the implementation of the Māori Health Worker role	▪ May 2005
		▪ Staff to attend cultural training	▪ Minimum of 50 staff attend further cultural training	▪ June 2005
			▪ All new staff receive an overview of Māori initiatives on site at orientation	▪ November 2004

Annual Objectives		Approach	Milestones	Indicators / Targets
1.2	▪ To continue to improve ethnicity data collection throughout the division	▪ To continue to participate in ethnicity data collection and to ensure data collection accuracy meets identified targets	▪ Audits of ethnicity data	▪ Targets established ▪ Minimum of quarterly audits occur ▪ Ethnicity data collection updated at each admission
			▪ Establish a data base of cultural groups utilising the services to assist with service planning	▪ Have this in place by March 2005
2. NEW ZEALAND DISABILITY STRATEGY				
2.1	▪ To continue to progress the implementation of the NZ Disability Strategy	▪ The Division continues their involvement in the Linkage Steering group and resulting projects	▪ As per Linkage Action Plan	▪ As per Linkage action plan
		▪ Bi-monthly meetings with Planning and Funding	▪ Meetings occur and minutes of each meeting are kept	▪ Bi-monthly meetings attended
		▪ Continue to integrate the Elder Friendly Guidelines throughout the Division	▪ Elder Friendly Guidelines are included in the orientation process	▪ December 2004
		▪ Review the introduction of the volunteer program on site	▪ Formal review occurs ▪ Findings communicated	▪ March 2005
		▪ Improve the documentation of goal setting within the division	▪ Service Provision Framework audits include goal setting review ▪ Action plans developed where audit results fall below identified target	▪ Minimum of six Service Provision Framework Audits
		▪ Continuation of staff participation in Elder Care Forums	▪ A minimum of two staff attend each Elder Care Canterbury forum	▪ Attendance at bi-monthly meetings
		▪ Consumer Participation continues to be a focus for the division	▪ A minimum of one focus group established in the period	▪ July 2005

Annual Objectives		Approach	Milestones	Indicators / Targets
			▪ The Consumer Participation Group continues to meet and minutes reflect that their skills are utilised by the service	▪ ongoing
			▪ Consumer representative attends Clinical Management Board meetings	▪ Attendance reflected in minutes
3. MENTAL HEALTH BLUEPRINT				
3.1	▪ To progress the Mental Health Blueprint utilising the Quality Health NZ accreditation Standard as a tool	▪ Following the Quality Health NZ accreditation survey in June 2004 an action plan is developed	▪ October 2004	▪ Plan developed
		▪ Review the blueprint funding project for the delivery of Psychiatric Services for the Elderly to the Kaikoura community	▪ Review completed ▪ Report to Planning and Funding	▪ July 2004 ▪ August 2004
		▪ Initial training of recovery model implemented within Psychiatric Services for the Elderly	▪ Initial training completed	▪ December 2004
		▪ Process for implementation of recovery model assessment tool (HOMAS) identified	▪ Implementation completed as per plan	▪ December 2004
4. WORKFORCE				
4.1	To ensure availability of an appropriately skilled workforce by promoting TPMH as a positive place to work	▪ Division identifies and continues to implement positive staffing initiatives	▪ New Graduate program has two intakes ▪ Staff Wellness day ▪ Staff attendance at inservice training and conferences ▪ Support for Enrolled Nursing students continues	▪ Number of programmes ▪ Wellness day held ▪ Number of hours training attended
4.2	To develop Senior Clinical Nursing positions within the Division	▪ Implement a minimum of one senior clinical nursing position	▪ Part time geriatric nurse specialist nurse position appointed	▪ October 2004

OTHER PROJECTS		INDICATORS/TARGETS
1	Continence Services	▪ Continence Service scoping completed. ▪ Staff requirement identified ▪ Potential streams for funding identified
2	Memory Assessment Service	▪ Number of patients utilising Memory Assessment Service captured Memory Service implementation reviewed ▪ Benefits of Memory Service to patients documented
3.	Community Stroke Service	▪ Potential for Community Stroke Service scoped and presented to Executive Management Team. ▪ Feasibility of implementing analysed
4	Alcohol and Drug Services for Older People	▪ Requirements for services scoped by June 2005 ▪ Potential pathways for funding identified
5	Quality Health NZ Action Plan	▪ Action plan following Quality Health NZ Survey developed ▪ Actions implemented as per action plan

SERVICE RECONFIGURATIONS		BRIEF COMMENTARY
1	Reconfigure service delivery in line with the national direction for School And Community Dental Services	▪ Project coordinator will need to be assigned. Funding for project to be ascertained. ▪ Review of clinic facilities completed. ▪ Stakeholder consultation completed and scoping of service reconfiguration options completed.

COMMUNITY AND PUBLIC HEALTH

Annual Objectives		Approach	Milestones	Indicators / Targets
1. HE KOROWAI ORANGA				
1.1	**To: Improve ethnicity data collection throughout the DHB**	▪ Participate in draft ethnicity data collection policy consultation process ▪ Participate in ethnicity data collection baseline review		▪ Review completed
2. PUBLIC HEALTH				
2.1	**To: Promote Public Health approaches within our District Health Boards and Providers**	▪ Assist CDHB to develop and implement Health Promoting Hospitals ▪ Deliver training programmes on inequalities ▪ Equity lens applied to CDHB plans ▪ Health promotion plans will reflect priority areas	▪ Support work to make all sites smokefree by December 04 ▪ Ongoing ▪ Ongoing	▪ Training sessions scheduled ▪ Feedback provided
2.2	**Pilot comprehensive public health planning funding and delivery within a district health environment**	▪ Consult ▪ Sign-off by DHBNZ ▪ Pilot		▪ Pilot completed
2.3	**Deliver Public Health services reflecting an innovative and creative workforce**	▪ Develop and maintain current individual development plans for all staff ▪ Participate in regional and national workforce development forums	▪ 6 monthly for each staff member ▪ As required	▪ Number of staff with current performance plans
2.4	**Achieve measurable progress on public health outcomes**	▪ Ensure that all existing and new Health Promotion / Protection programmes are aligned with local and national health priorities ▪ All evaluation processes will include applicable equity measurement tools	▪ As required	▪ Referenced to strategic plan ▪ KPIs developed and reported on

2.5	**Programs detailed in the Community and Public Health service plan will be carried out**	▪ As detailed in the CPH service plan	▪ 6 monthly and annual reporting	▪ Key progress markers as detailed in the service plan

OTHER PROJECTS		INDICATORS/TARGETS
1	Rollout of National Immunisation and National Diabetes Registers	▪ Work with CDHB to identify requirements and contribute to these projects and lead as relevant .
2	Canterbury Local Mapping project	▪ As above
3	Health Needs Assessment	▪ As above
4	PHO promotion plans	▪ As above

BRACKENRIDGE ESTATE

Annual Objectives		Approach	Milestones	Indicators / Targets
1. HE KOROWAI ORANGA				
1.1	**All Brackenridge staff have received appropriate cultural awareness training**	▪ Using variety of options as identified by our cultural advisors	▪ Evidence of new learning being used in workplace	▪ Audit of staff training profile by June 2005 to ensure training has occurred
1.2	**Establish and maintain appropriate levels of Māori staff**	▪ Consult with iwi as to how best to achieve this	▪ Set target and review quarterly	▪ Set targets achieved and reviewed at least quarterly
2. NEW ZEALAND DISABILITY STRATEGY				
2.1	**All Brackenridge residents given every opportunity to live an ordinary life**	▪ Review all residents plans put in place revised plans and supports aimed at achieving an "ordinary Life"	▪ Schedule 6 monthly reviews monitor objectives set in residents plans	▪ Residents will be living an ordinary life with the necessary levels of support
3. WORKFORCE				
3.1	▪ **Upskill team leader staff**	▪ Develop core set of competencies	▪ Successful completion of training targets	▪ Team Leaders group demonstrates increased skill levels
3.2	▪ **Further 10% increase in staff attendance at IDCT modules**	▪ Promote value of upskilling make it part of persons development plan	▪ Measure attendance on regular basis to see target is reached	▪ 10% increased target achieved

OTHER PROJECTS		INDICATORS/TARGETS
1.	Certification	▪ Achieved by October 2004
2.	Forest Park construction completed	▪ July 2004

4.0 MANAGING FINANCIAL RESOURCES

4.1 Managing Within Operating Budget

The overarching parameter impacting Canterbury DHB's financial planning is the level of baseline funding advised by the Minister and estimated revenue from other health and non- health sources. In addition there are key factors and/or constraints which need to be taken into account. These include the Mental Health ring-fence; level and type of services to be funded and provided (including Inter-District flow); Core Directions impact and the requirement to achieve a stable financial performance of a 'break-even' result.

Canterbury DHB is budgeting for a break-even position for 2004/05, an objective consistent with the Minister of Health's expectation of the DHB's financial performance. However, in arriving at the break-even budget, a number of key assumptions were made, in particular, that the financial impact of the new Holidays Act and the devolved DSS aged-related services will be fully funded. The budget is also dependent on the achievement of additional efficiencies and the need to undertake a number of operational and service reconfigurations to align services to the population-based funding (refer section 4.7 below).

The budget had taken into account the impact of the new Christchurch Women's Hospital and Day Surgery Unit being fully operational by March/April 2005 as well as the financial impact of working towards attaining accreditation.

The following sets out the summary budget estimations for 2004/05:

	$M (GST excl)
Overall net increase in funding & revenue (incl non Base funding)	19.6
Less:	
Net increase in expenditure for external and CDHB provided services	(25.4)
Incremental depreciation & interest – new CW Hosp & Day Surgery Unit	(2.0)
Other specific items e.g. accreditation	(0.5)
Estimated 2004/05 Operating Gap (before new Holidays Act impact)	**(8.3)**
Efficiencies/revenue enhancement required to break-even	8.3
Budgeted Net Result (before impact of new Holidays Act)	**Nil**
Add: New Holidays Act Impact – 2004/05 Impact	(6.5)
Estimated 2004/05 Operating Gap (if Holidays Act impact not fully funded)	**(6.5)**

Note: $25.8M revenue and expenditure relating to the annualisation impact for Disability Support Services (DSS) contracts devolved in Oct 2003 is neutral and hence excluded

Although the DHB will endeavour to generate efficiencies and other revenue to address its operating gap of $8.3M, it will not be able to sustain the additional costs associated with the new Holidays Act. If these additional costs were not appropriately funded, Canterbury DHB will be operating at a deficit of about $6.5M for 2004/05.

Outyears scenario

The introduction of population based funding has resulted in Canterbury DHB receiving a graduated lower funding increase from 2004/05 until its funding is at a level consistent with its population. Latest assessment indicates that Canterbury DHB is about $38M ($42M GST inclusive) over-funded, relative to other DHBs, under the population-based funding regime. Of the $42M over-funding, about $29M resulted directly from the DSS aged-related contracts that were devolved to the DHB in October 2003.

The move to funding equity between DHBs will see Canterbury DHB receiving a smaller funding increase over the next few years until its funding is in line with its share of the population based funding. This will mean Canterbury DHB is expected to receive a funding increase of approximately $19M to $21M per annum compared to previous years increase of about $28M per annum i.e. about a 1% or $7.5M per annum drop (also known as transitional funding reduction).

The projected financial scenario over the next three years under population based funding, is as follows:

Table 1

2003/04 $M		2004/05 $M	2005/06 $M	2006/07 $M
28.0	Estimated Increase in Annual Funding (incl non MOH funding)	19.6	21.5	17.0
(10.0)	Less: Deficit Reduction Required (assume breakeven in 2003/04)	Nil	Nil	Nil
18.0	Net Funds Available per annum	19.6	21.5	17.0
(27.5)	Less: Normal Annual Cost Increase (excluding new Holidays Act)	(27.9)	(29.5)	(28.5)
(9.5)	Annual Operating Shortfall (before new Holidays Act)	(8.3)	(8.0)	(11.5)
	Cumulative Operating Shortfall From 2004/05	(8.3)	(16.3)	(27.8)
9.5	Cumulative Efficiencies Required to Meet Shortfall	8.3	16.3	27.8
Breakeven	Budget Net Result After Efficiencies (before new Holidays Act)	Breakeven	Breakeven	Breakeven

Additional costs associated with abnormal increase in service demands and changes to service specification that impact on the DHB resources have not been factored into the forecast gap

The estimated operating gap between funding increase and expenditure growth over the next three years is between $8M to $10M per annum, excluding the financial cost of the new Holidays Act. Efficiencies and revenue enhancement initiatives will be required to meet this gap in order to breakeven.

If the cost of the Holidays Act is not funded by new funding from the government, then the financial results are as follows.

Table 2

2003/04 $M		2004/05 $M	2005/06 $M	2006/07 $M
Breakeven	Budget Net Result after Efficiencies (before new Holidays Act)	Breakeven	Breakeven	Breakeven
(1.5)	Less: Estimated Cost of new Holidays Act	(6.5)	(6.0)	(6.0)
(1.5)	Net Deficit Result If Cost of New Holidays Act Not Funded	(6.5)	(6.0)	(6.0)
	Cumulative Deficit Result If Cost of New Holidays Act Not Funded	(6.5)	(12.5)	(18.5)

4.2 Key Assumptions and Risks

In addition to the need for of efficiencies, revenue enhancement and/or service reconfigurations, other key assumptions to achieve the breakeven budget for 2004/05 include:

- Baseline funding is per Minister/Ministry of Health's funding advice
- Net Inter-DHB revenue and expenditure will be fully realised
- Financial impact of the new Holidays Act is fully funded by new funding from Ministry.
- Financial impact of the Board elections is fully funded by the Ministry.
- Collective agreements and employment conditions are settled within CPI. Additional costs to move to national rates per government directive, if any, will be fully funded.
- No significant change to previous year's service contract volumes

  (Note: New elective services funding, if any, and associated cost to delivery the services, have not been included)
- Net Pharmaceuticals including product mix increase is no greater than CPI
- Pharmac budget for community referred spending is as per agreed by DHBs and forecast savings on stats dispensing and other initiatives are achieved
- Interest rate increase is within forecast
- Average increase in expenditure, including employee costs is within overall CPI
- Growth in acute medical and acute mental health volumes within sector average
- Additional capital charge and depreciation arising from asset revaluation will continue to be fully funded by Ministry. Cashflow relating to increased depreciation is available for debt/equity repayment
- Increase in price/volume mix of NZ Blood Service (NZBS) products is within CPI and no significant growth in South Island patients requiring synthetic blood products

- New government/Ministry's policies and initiatives that have financial impact on Canterbury DHB will be fully offset by increased funding from Ministry
- Additional expenditure for Primary Healthcare Organisations (PHOs), if any, will be fully offset by new primary care funding from the Ministry
- Devolution of Disability Support Services (DSS) will have a neutral impact i.e. expenditure will be fully met by Ministry of Health's funding and/or risk pool
- Capital charge applied remains at 11%
- Projected proceeds from sale of surplus assets are realised as planned and term loans are reduced where appropriate.

The over-riding risk to achieving the financial performance relates to the key assumptions above not holding true, in particular the risks around funding to move to national pay rates, appropriate new funding for the new Holidays Act and DSS aged related services. Other risks include inability to implement identified service reconfiguration and/or facility realignment, according to planned timeframe and inability to achieve efficiencies and address cost over-runs internally.

4.3 Fixed Asset Valuations

In June 2003, Canterbury DHB assets were revalued as part of the FRS3 requirements. The revaluation resulted in a write-up of asset value of approximately $77M and this has been included in the 2003/04 opening financial position.

The forecast financial statements below include the increased capital charge ($8.5M) and depreciation expenses ($10.8M) resulting from the revaluation and the corresponding revenue from the Crown to off-set these expenses in each of the years. The continuing funding of this $19.3M in out-years is a critical assumption to achieve a break-even result.

4.4 Business Cases

The expected business cases requiring Minister's approval is for possibly another new Primary Health Organisation, redevelopment of Burwood hospital to meet additional elective Orthopaedic volumes, possible service reconfigurations and facilities realignment outlined in this plan.

Business cases, if any, relating to IT and other significant capital projects will include regional capital asset committee review.

4.5 Capital Expenditure

The estimated capital expenditure budget for 2004/05 is $62M and consists of:

- $31M for the Christchurch Women's Hospital and Day Surgery Unit project which commenced in 2002/03,
- $6M is for Diabetes/Dialysis Unit and other facilities projects

- $25M for normal asset replacement and priority new equipment, e.g. replacement linear accelerator.

Details for the $25M will be established following an internal prioritisation process involving clinicians and management. This process is expected to be completed in late June 2004. Some of the key items are outlined in the draft Asset Management Plan.

Funding for the capital expenditure will be:

- $10M loan approved by Minister for the CWH and Day Surgery Unit,
- $11M from term loans, and
- $31.4M from operating cashflow
- $9M from asset sale proceeds

Disposal of significant surplus assets over the next three years include Canterbury DHB owned sites at Hanmer Springs, Hillmorton and the existing Christchurch Women's Hospital. The timing will be subject to the consultation and other due processes required of the DHB, including Board and Minister's approval. Consultation process on two of the sites had started. The financial assumptions include the proceeds from asset sale/s expected in 2004/05.

Investment in new technology is likely to include the food services reconfiguration where 'cook-chill' technology is envisaged. Some new clinical technology may also be envisaged, eg, new diagnostic techniques, screening services, robotics and remote diagnostic educational systems within the capital expenditure funding. A replacement linear accelerator had been approved for 2004/05.

4.6 Debt and Equity

Estimated total debt will increase from $80M in 2003/04 to $100M in 2004/05. The increase is primarily to fund the Christchurch Women's Hospital and Day Surgery project. During 2003/04, Canterbury DHB accepted an offer from the Crown Financing Agency (CFA) to swap the remaining $30.65M approved equity relating to the Christchurch Women's Hospital and Day Surgery project for additional loan.

Taking this into account, total term loan and credit facilities available through the CFA are approximately $121M. These loan facilities are in place and had been approved by the CFA.

In addition working capital of approximately $45M (equivalent of $1/12^{th}$ of provider arm funding), will be financed from private finance institutions.

Canterbury DHB is complying with the banking covenants required of its loans. The key covenants together with forecast ratios for 2004/05 based on the forecast financial statements are:

	Required	**Forecast Ratio**
▪ Interest cover ratio:	>2.75 times	Approx 7 times
▪ Debt/Debt plus Equity ratio:	<50%	Approx 32%

4.7 Efficiencies and Service Reconfigurations

In budgeting for break-even results, Canterbury DHB will be planning to implement and achieve a number of efficiencies and/or service reconfigurations to meet the $8M to $10M operating gap (excluding Holidays Act impact). Examples of the initiatives to be undertaken include:

- Continue implementation of the Patient Flow project
- Consolidation of support services
- Increase day surgery activity on commissioning of new Day Surgery unit
- Managing acute medical and primary referred services growth
- Clinical and non-clinical consumables usage
- Review of processes by which new treatment regimes could be introduced
- Productivity and best practice initiatives
- Alignment of aged care services to its population based funding
- Optimising hospital facilities and sites
- Collaborative arrangement with external providers on elective services
- Enhancing other revenue streams

In addition, Canterbury DHB will be undertaking service reconfigurations as outlined earlier in this plan and in its Core Directions.

Some of the initiatives are longer term and are only expected to generate major savings in future years. Early planning is essential to ensure the implications of the reduction in transitional funding (1% or approximately $7.5M per annum) in out years are adequately addressed.

The initiatives will have input from clinicians, where appropriate, to ensure patient safety and related issues are adequately considered.

4.8 Forecast Financial Statements for the Years Ending 30 June 2005, 2006 and 2007 (Figures are indicative as at 26 May2004)

4.8.1 Forecast Group Statement Of Financial Performance

	2003/04 Forecast $'000	2004/05 Forecast $'000	2005/06 Forecast $'000	2006/07 Forecast $'000
Operating Revenue				
MoH Revenue	815,678	856,333	876,461	893,790
Patient Related Revenue	22,622	24,074	24,556	25,047
Other Revenue	11,466	13,255	13,900	12,339
Total Operating Revenue	849,766	893,662	914,917	931,176
Operating Expenditure				
Employee Costs	338,499	353,661	362,777	370,583
Treatment Related Costs	88,342	90,436	92,675	95,131
External Providers & IDF	313,815	334,898	340,804	346,870
Strategic Investment Fund	1,000	1,000	500	500
Non Treatment Related & Other Costs	49,722	50,612	50,706	51,338
Total Operating Expenditure	791,378	830,607	847,462	864,422
Result before Interest, Depn & Cap Charge	58,388	63,055	67,455	66,755
Interest, Depreciation & Capital Charge				
Interest Expense	(4,315)	(5,515)	(5,915)	(5,215)
Interest Received	135	279	279	279
Donation and Trust Funds	1,011	-	-	-
Capital Charge Expenditure	(23,400)	(23,400)	(23,400)	(23,400)
Depreciation	(33,319)	(34,419)	(38,419)	(38,419)
Total Interest, Depreciation & Capital Charge	(59,888)	(63,055)	(67,455)	(66,755)
Net Operating Results	**(1,500)**	**0**	**(0)**	**(0)**

Note: The Ministry of Health revenue figure is based on funding advice from the Ministry of Health as at February 2004 plus adjustment for regional/national contracts, which Canterbury DHB was the lead contractor, that have subsequently been transferred back to other DHBs. Where the amounts have been finalised between the DHBs concerned, the respective revenue and expenditure figures have been adjusted for in the above financial statement.

Note: The $1.5M deficit in 2003/04 is a direct result of the 'unfunded' financial impact of the new Holidays Act. For 2004/05 to 2006/07 the break-even results assumed that the cost of the new Holidays Act will be fully funded, otherwise the result will be approximately $6.5M deficit per annum – refer also Table 2 in Section 4.1.

4.8.2 Forecast Group Statement Of Financial Position As At 30 June 2005, 2006 and 2007

	30/06/03 *$'000*	30/06/04 Forecast *$'000*	30/06/05 Forecast *$'000*	30/06/06 Forecast *$'000*	30/06/07 Forecast *$'000*
Public Equity					
Opening Equity	133,868	211,585	210,085	210,085	210,085
Revaluation of Land & Building	77,717				
Net Result for the period	-	(1,500)	0	(0)	(0)
Total Public Equity	**211,585**	**210,085**	**210,085**	**210,085**	**210,085**
Current Assets					
Cash & Bank (OD)	(4,295)	(115)	154	638	117
MoH Debtor	41,854	5,688	5,688	5,688	5,688
Other Debtors & Other Receivables	15,000	14,750	14,500	14,225	14,000
Prepayments	295	300	300	300	300
Stocks	6,920	7,000	7,000	7,000	7,000
Total Current Assets	59,774	27,623	27,642	27,851	27,105
Current Liabilities					
Creditors & Accruals	70,032	67,000	66,500	66,000	65,000
Capital charge payable	3,677	5,700	5,700	5,700	5,700
GST	2,681	2,749	2,749	2,749	2,749
Provision for Income Tax	(10)		-	-	-
Interest Accrual	519	360	460	500	435
Staff Entitlement	41,496	42,000	42,500	43,000	43,500
Short Term Borrowings	99,380				
Total Current Liabilities	217,775	117,809	117,909	117,949	117,384
Working Capital	(158,001)	(90,186)	(90,267)	(90,098)	(90,279)
Investments	378	378	378	378	378
Restricted Assets - Trust Fund	7,394	7,394	7,394	7,394	7,394
Fixed Assets	366,163	376,770	396,851	389,682	370,863
Term Staff Entitlement	(4,271)	(4,271)	(4,271)	(4,271)	(4,271)
Deferred Tax	(78)				
Term Loans		(80,000)	(100,000)	(93,000)	(74,000)
Net Assets	**211,585**	**210,085**	**210,085**	**210,085**	**210,085**

4.8.3 Forecast Group Statement Of Cashflow For The Years Ending 30 June 2005, 2006 and 2007

	2003/04 Forecast *$'000*	2004/05 Forecast *$'000*	2005/06 Forecast *$'000*	2006/07 Forecast *$'000*
Cashflows from Operating Activities				
Cash provided from:				
MOH Receipts	851,844	856,333	876,461	893,790
Other Receipts	34,349	35,079	36,731	37,611
	886,193	891,412	913,192	931,401
Cash applied to:				
Employee Costs	337,995	353,161	362,277	370,083
Supplies & Expenses	455,996	477,446	485,185	494,839
Capital Charge Payments	21,377	23,400	23,400	23,400
Finance Costs	4,474	5,415	5,875	5,280
Taxes Paid	-	-	-	-
	819,842	859,422	876,737	893,602
Net Cashflow from Operating Activities	**66,351**	**31,990**	**36,455**	**37,800**
Cashflows from Investing Activities				
Cash provided from:				
Sale of Assets	2,000	9,000	7,750	2,400
Interest Received	135	279	279	279
	2,135	9,279	8,029	2,679
Cash applied to:				
Advance to JV/Trust Investments	-	-	-	-
Purchase of Assets	44,926	61,000	37,000	22,000
	44,926	61,000	37,000	22,000
Net Cashflow from Investing Activities	**(42,791)**	**(51,721)**	**(28,971)**	**(19,321)**
Cashflows from Financing Activities				
Cash provide from:				
Equity Injection	-	-	0	(0)
Loans Raised	-	20,000	-	-
	-	20,000	0	(0)
Cash applied to:				
Loan Repayment	19,380		7,000	19,000
	19,380	-	7,000	19,000
Net Cashflow from Financing Activities	**(19,380)**	**20,000**	**(7,000)**	**(19,000)**
Overall Increase/(Decrease) in Cash Held	4,180	269	484	(521)
Add Opening Cash Balance	(4,295)	(115)	154	639
Closing Cash Balance	**(115)**	**154**	**639**	**117**

5.0 Measuring Success

5.1 Consolidated List of Indicators of DHB Performance (IDP)

The Ministry of Health has established a set of DHB Accountability Indicators to focus District Health Boards on priority health objectives identified in the NZ Health Strategy, monitor activity and compare District Health Board performance, and to hold District Health Boards accountable. CDHB is committed to performance improvement, both as a funder of services and as a provider of services. Progress toward achieving the Accountability Indicator targets will be reported as part of Canterbury DHB's quarterly performance reports.

Accountability Indicators

The accountability indicators reflect the accountability that Canterbury DHB has for securing improved health status for its population. As responsibility for funding some services is yet to be devolved to DHBs, there are indicators where the DHB's ability to influence the outcome is not through direct funding but through influencing other funders.

Due to the evolving nature of DHBs and their responsibility for funding, the actions taken by the Canterbury DHB to influence the direction of performance in relation to specified targets is of as much importance as the match between actual performance and the indicator itself.

Qualitative Accountability Indicators

Performance against the qualitative indicators will be measured on the basis of reporting deliverables rather than numeric targets. Performance will be assessed not only on provision of reports that meet the stated content requirements but also compliance with the reporting timeframes.

Quantitative Accountability Indicators

The majority of the quantitative indicators are aimed at measuring DHB performance in addressing cardiovascular disease, diabetes, oral health and well child services – four priority areas within the New Zealand Health Strategy.

For each of the quantitative indicators set out in this plan targets have been set for the 2004/2005 year. The setting of those targets has been based on:

-Expectations expressed by the Ministry of Health
-The latest national data
-The latest Canterbury DHB specific data

It should be noted that for many indicators historical data is poor. Consequently there are some indicators for which a target is unable to be set at this stage. It is the intention of the Canterbury DHB to gather the required baseline data to allow for targets to be set for future plans.

It is noted that the Ministry will be using results outside 90% or 99% confidence intervals to trigger further analysis for a number of indicators.

Indicator results and targets have been stated for three population groupings, Māori, Pacific People and other. The overall targets for the DHB reflect these ethnic specific results and the demographic characteristic of the Canterbury DHB.

The intent of this section is to recognise that Canterbury DHB understands the need to look at the health of the Canterbury DHB population although many factors effecting health care directly is outside its control

The Canterbury DHB's accountability indicators are in addition to:

- Existing reporting requirement under service contracts
- Information requirements contained in the Operational Policy Framework
- The Balanced Scorecard for the Provider Arm
- Monthly financial reporting to the Ministry's DHB Funding and Performance Directorate.

The DHB Accountability Indicators for 2004/05 are as follows:

IDP No.	Description	Target / Deliverable	Frequency
HE KOROWAI ORANGA			
HKO-01 (Was STR-01)	Local Iwi / Māori engagement and participation in decision-making and the development of strategies and plans for Māori health gain.	Report giving sufficient detail and or evidence to determine the extent to which: ▪ The DHB meets with its Treaty Partner(s) on a regular basis in order to review and monitor planning and funding for Māori Health Gain. ▪ The DHB ensures that Iwi/Māori are engaged in Health Needs Assessment, Prioritisation, Planning, Service Delivery, Monitoring and Evaluation of Services including monitoring against He Korowai Oranga. ▪ The DHB is making progress in implementing the Māori Health Plan. ▪ The progress reports above have been endorsed by the local Treaty Partner(s).	Annual in the fourth quarter
HKO-02 (Was STR-02)	Progress in the development of Māori workforce and Māori providers.	A qualitative/quantitative report that provides the following information: 1) The DHB's progress, compared to the previous year, on increasing the capability and capacity of its Mäori health workforce at all levels of the organisation, including clinical, managerial, administrative and other. 2) A progress report detailing over last 12 months, the implementation of plans to promote the increase in capacity and capability of the Māori health workforce in the DHB's funded mainstream providers. 3) A progress report detailing over last 12 months, (i) the implementation of plans to develop the DHB's funded Mäori Health providers and (ii) a brief description of key outcomes achieved. 4) Report the number of (i) management FTEs, (ii) clinical FTEs, (iii) administrative FTEs and (iv) other FTEs held by Mäori out of the total numbers of (i) management, (ii) clinical FTEs in the DHB, (iii) administrative and (iv) other FTEs in the DHB.	Annual in the fourth quarter
HKO-03 (Was STR-04)	Progress on DHBs conduct an ongoing cycle of reviews of pathways of care to ensure they improve access to effective services for Māori, improve outcomes, and reduce avoidable hospital admissions, mortality and morbidity.	The DHB provides the following: ▪ Progress report that DHB is conducting ongoing cycle of reviews of pathways of care that focus on ways of improving access to effective services for Māori. ▪ Report on an example(s) of actions taken to address issues identified in the reviews	Annually in the fourth quarter

PACIFIC HEALTH AND DISABILITY ACTION PLAN			
PAC-01 (Was STR-05)	Progress towards implementation of priority areas identified in the Pacific Health & Disability Action Plan.	Only nominated DHBs report: ▪ Report on progress made towards implementation of the priority areas identified in the Pacific Health & Disability Action Plan.	6 Monthly in the second and fourth quarters
PAC-02 (New)	Engagement and participation of Pacific peoples in DHB decision-making and the development of strategies and plans which include goals for Pacific Health gain.	Report outlining the following: Description of how Pacific peoples are engaged and participate in DHB decision-making and the development of strategies and plans which include goals for Pacific Health gain. ▪This will demonstrate that Pacific peoples are engaged and participate in DHB decision-making on equity, accessibility and resource allocation at a governance and management level in the DHB organisation. ▪ It will also give the number, purpose and outcomes of any fono (community participation) that have been, or are planned to be, conducted during the reporting period.	6 Monthly in the second and fourth quarters
REDUCING INEQUALITIES IN HEALTH			
RIH-01 (Was QUA-06)	Progress towards implementing the Reducing Inequalities in Health Intervention Framework.	A qualitative/quantitative report that demonstrates progress towards implementing the Reducing Inequalities Intervention framework and: (i) Demonstrates the nature of health inequalities in their district by: ▪ Health status ▪ Risk factors ▪ Access to services (ii) Describes current and new initiatives underway to address inequalities in health that span all levels of the Reducing Inequalities in Health Intervention Framework. (iii) Identify the levels in the Reducing Inequalities in Health Intervention Framework that the initiatives described in (ii) are taking place.	Annually in the fourth quarter

POPULATION PRIORITIES			
POP-01 (new)	Cardiovascular Services 1) Primary prevention The proportion of men aged 45 and above and women aged 55 and above who have had their five year absolute CVD risk recorded in the last five years 2) Acute Coronary Syndromes Risk Adjusted 30 day mortality rate following acute myocardial infarction. Where the CDHB rate is outside the National 90% confidence interval a resolution plan will be supplied. 3) Stroke The presence of a geographically identified area for stroke patients Percentage of stroke patients admitted to a stroke unit/area identified for stroke patients	**Targets Yet to be confirmed** Māori: Pacific: Other: Total: **Targets** Māori: 1.0 Pacific: 1.0 Other: 1.0 Total: 1.0 **Target:** The DHB confirms the presence of a geographically identified area for stroke patients **Targets** Māori: Pacific: Other: Total: The CDHB does not currently have a geographically identified stroke area, and following this cannot set targets for admissions	Annually in the fourth quarter Primary prevention targets cannot be set because providers do not currently collect this data. For them to do so would require changes to contracts so for 2004/05 the CDHBs goal is to start primary care providers collecting this data.
POP-02 (Was DIA-01)	Diabetes case detection rate.	**Targets** Māori: 80% Pacific: 120% Other: 80% Total: 80%	Annual, by 31 March 04 Note: the Pacific peoples rate is 120% because the Canterbury Local Diabetes Team believes that the estimate for number of Pacific people with diabetes is too low
POP-03 (Was DIA-02)	Diabetes case management.	**Targets** Māori: 40% Pacific: 45% Other: 20% Total: 22%	Annual, by 31 March 04

POPULATION PRIORITIES			
POP-04 (Was DIA-04)	Retinal screening of people with diabetes in the last two years.	**Targets** Māori: 45% Pacific: 32% Other: 50% Total: 50%	Annual, by 31 March 04
POP-05 (Was ORA-01)	Oral health: percentage of children caries free at age 5 years	**Targets** Māori: 52% Pacific: 52% Other: 52% Total: 52%	Annual, by 31 March 04
POP-06 (Was ORA-02)	Oral health: mean DMFT score at year 8 (Form 2)	**Targets** Māori: 1.6 Pacific: 1.6 Other: 1.6 Total: 1.6 *In regards to the oral health targets it should be noted that there is fluoridation of public water supplies in Methven only – population approximately 1200 people. Any changes affected now or in the near future will not show through in the MF rate of Form 2 children for another 7-12 years at the earliest. CDHB will endeavour to meet the target subject to the above constraint. The CDHB agreed Position Statement on Fluoridation in 2003. This is available on the CDHB website.	Annual, by 31 March 04
POP-07 (New)	Reducing Violence	The DHB will report complete, comprehensive and timely information on the deliverable outlined in the Family Violence Programme .	6 Monthly in the second and fourth quarters
POP-08 (Was MEN-03)	Improving the health status of people with severe mental illness	Access to services: average number of people domiciled in the DHB region, seen each month for the three months being reported (the period is lagged by 3 months) for: - children and youth aged 0-19 years adults aged 20-64 years - for Māori, Other, and in total **Targets for 04/05:** 0-19 years 20-64 years 65 years + Māori: 0. 5% 1.31% .28% Other: 0.65% 1.0% .19% 1 month's access .65% 1.1% .19%	Quarterly
POP-09 (Was CHI-13)	Percentage of babies born in public hospital with low birth weight.	**Targets** Māori: 7.2% Pacific peoples: 4.9% Other: 6.1% Total: 6.2%	6 Monthly in second and fourth quarters

POPULATION PRIORITIES			
POP-10 (Was CHI-02)	Progress in implementing the Baby Friendly Hospital initiative in maternity services.	Report: Listing all maternity facilities in the DHB and the BFHI status of each facility. For those facilities not BFHI accredited a detailed timeline for progressing toward accreditation for each facility will be provided, and an agreed date for accreditation assessment by the NZ Breastfeeding Authority. In addition, a quantitative analysis, including the proportion, for each major ethnic group, of "hospital born" babies delivered in an accredited baby friendly hospital, will be included.	6 Monthly in second and fourth quarters
POP-11 (New)	Youth Health Part 1: Teen pregnancy The percentages of babies born live in a public hospital to mothers aged 13 to 17 inclusive Part 2: Teen Abortions: The percentage of abortions carried out on young women 13 to 17 inclusive	**Current rate: (2003)** Māori: 0.46% Pacific peoples: 0.03% Other: 1.38% Total: 1.87% **Current rate: (2003)** Māori 0.66% Pacific peoples: 0.16% Asian: 0.94% Other: 5.47% Total: 7.23%	6 Monthly in second and fourth quarters
POP-12 (Was CHI-01)	Progress towards implementation of the National Immunisation Register (NIR)	Report describing: 1) Implementation progress and time lines 2) Issues or risks, including staffing levels required 3) Budgets and risks	Quarterly
POP-13 (Was CHI-17, 18, 19, and OLD-01)	Ambulatory sensitive admissions. Children and Older People. Discharge rate per 1000 population	Targets Children <5 5-14 15-24 Māori: 63.0 14.0 12.0 Pacific peoples: 90.0 20.0 13.0 Asian: 76.0 17.0 12.0 Other: 76.0 17.0 12.0 Total: 76.0 17.0 12.0 Older People 65-74 years Māori: 90.0 Pacific peoples: 105.0 Asian: 55.0 Other 55.0 Total: 55.	6 Monthly, second and fourth quarters
POP-14 (New)	Residential Care/Home Care Relative expenditure on long-term community support compared to expenditure on residential care	Target Targets will be agreed within 3 months of the data becoming available (end 2004)	Quarterly

SERVICE PRIORITIES			
SER-01 (Was PRI-01)	Primary Health Care.	Report. Describing how the DHB is supporting its PHOs to develop a collaborative, multi-disciplinary approach and coordinating care between the PHOs and the following: -secondary care services -public health services -disability support services -mental health services -specific population groups (e.g. older people)	6 Monthly, second and fourth quarters
SER-02 (Was PRI-04)	Participation by Māori in decision making in Primary Health.	Report. 1) Progress on the establishment and development of PHOs and a description of progress on how partnerships with Iwi and Māori communities are being consolidated to ensure that planning, funding and delivery of services improve Māori health and disability outcomes. 2) The names of PHOs with Māori Health Plans that have been agreed to by the DHB or, for newly established PHOs, a report on progress in the development of MHPs.	6 Monthly, second and fourth quarters
SER-03 (New)	Continuous Quality Improvement- Elective Services.	Report detailing the DHB's continuous quality improvement work on equity of access to elective services, with particular emphasis on internal service improvements.	6 Monthly, second and fourth quarters
SER-04 (Was CAN-01)	Radiation oncology treatment waiting times.	Part 1 Monthly templates supplied on time and complete from each DHB (including provision of information by DHB of domicile and ethnicity). Part 2: A report updating on progress towards ensuring all patients receive oncology megavoltage radiation treatment according to nationally agreed standards. This report is to be agreed with all the peripheral DHBs whose populations have used the service during the quarter	Part 1 monthly Part 2 quarterly

QUALITY			
QUA-01	Quality systems.	Report providing the following information: 1) Confirmation that the quality requirements in new and renewed service agreements are consistent with the quality requirements in applicable national service frameworks. Provide a resolution plan for any exceptions. 2) Report confirming that appropriate procedures for managing and reporting adverse (sentinel and serious) incidents have been maintained and that all such events have been reported to the Ministry of Health. 3) The DHB funding arm demonstrates the capacity/resources to initiate issues based audits of both its provider arm and contracted providers as necessary, by reporting: A summary of audit activity of the provider arm and contracted providers, giving a list of all audited providers and the type of audit conducted (e.g., routine, issues based), and the action(s) to be taken to ensure progress for: *-Personal Health* *-Mental Health* 4) The DHB provider arm demonstrates an organisational wide commitment to quality improvement and effective clinical audit by reporting: A high level summary (list) of key quality improvement and Clinical audit initiatives and results, focusing on those that are effective and/or ineffective against the Goals in *Improving Quality (IQ): A Systems Approach for the New Zealand Health and Disability Sector for:* *-Personal Health* *-Mental Health* 5) DHBs to confirm that complete and timely information has been provided to: i) the following components of the balanced scorecard: Patient satisfaction Blood stream infections ii) the New Zealand Health Information Service for the Mental Health Information National Collection (MHINC).	Part 1: Annual in the fourth quarter Parts 2-5: Six monthly in the second and fourth quarters

INVESTING IN THE FUTURE			
INV-01 (Was QUA-07)	Information management initiatives/capabilities.	Report detailing progress towards: 1. Improving online access to clinical knowledge bases (such as Cochrane and Medline) and clinical guidelines or protocols such as clinical decision support systems for cardio-vascular, diabetes and referral guidelines 2. Towards implementation of electronic referral letter and hospital discharge summary notification functionality between hospital and General Practitioner 3. Towards increasing the number of General Practitioners using electronic pharmaceutical prescribing 4. Towards increasing the number of General Practitioners using electronic laboratory test ordering and receiving electronic laboratory results.	6 monthly, second and fourth quarters
INV-02 (Was NUR-01)	Nursing practice and development.	Report showing that the DHB provides adequate support for nursing practice and development. In respect to the provider and funder arms of the DHB will describe the following: 1) How the CEO involves the Director of Nursing (DON) in operational decision-making, including examples of current projects they are involved in. 2) Strategies in place to address retention and reducing turnover, including measures in place to support nurses in their first year of practice to ensure their development into more experienced and expert practitioners. 3) The plans in place to progress the Nurse Practitioner role, including the numbers of Nurse Practitioners expected for the 04/05 year. 4) Progress with the development of: -coding mechanisms to capture nursing and Nurse Practitioner prescribing practices -nurse identifiable numbers to use in patient records for evaluation and costing purposes. 5)How Māori nurses are being supported in the development of either leadership or senior positions. 6) The mechanisms in place to ensure Māori nurses are supported clinically and culturally in their practice. 7) In relation to the development of primary health care nursing, the DHB will demonstrate that a plan for the development of primary health care nursing has been established. 8) The DHB will demonstrate that the Director of Nursing is involved with the primary health care nursing aspects of Primary Health Organisation development in the DHB.	In full at the end of the first quarter, updated thereafter

KEY RISKS AND NEW INITIATIVES			
RIS-01 (Was QUA-04)	Responding to and resolving Service Coverage issues.	Report progress achieved during the quarter towards resolution of gaps in service coverage (not agreed as exemptions or exceptions through the DAP process) identified by the DHB or Ministry through: ▪ analysis of explanatory indicators ▪ media reporting ▪ risk reporting ▪ formal audit outcomes ▪ complaints mechanisms.	Quarterly
RIS-02 (Was FIN-02)	Targets to increase funding for Māori health and disability initiatives.	The DHB will report: - Actual expenditure on Māori Health Providers by GL code and by Purchase Unit - Actual expenditure for mainstream services components targeted to improving Māori health - Performance against the following targets See Appendix 6	Annually in the fourth quarter

6.0 REFERENCES

The Canterbury DHB has developed key documents which have been referenced throughout this District Annual Plan. These documents can be accessed via the Canterbury DHB website www.cdhb.govt.nz or by contacting Denise Denley on (03) 364 4159 or email denise.denley@cdhb.govt.nz.

- Statement of Intent (SOI) 2003-06
- Statement of Intent (SOI) 2004-07
- Crown Funding Agreement (CFA)
- District Strategic Plan Towards a Healthier Canterbury: Directions 2006 Summary and Full Documents
- Health Needs Assessment for Canterbury October 2001
- Health Needs Assessment for Older People February 2003
- South Island Regional Mental Health Plan February 2002 Parts A and B
- Information Systems Strategic Plan ISSP(in draft)
- Māori Health Plan – Whakamahere Hauora Māori Ki Waitaha 2002-06
- Pacific Health Action Plan – March 2002
- Prioritisation Policy
- Consultation Policy
- Summary Annual Report 2003-04
- Rural Health in Canterbury DHB: An Action Plan May 2002
- Interim Diabetes Plan October 2002
- Child Health Report March 2002
- Disability Strategy Action Plan 2004-07
- Mental Health and Addiction Strategy 2004
- LinkAGE Action Plan 2003

7.0 ATTACHMENTS

A. Service Level Agreement (Price/Volume Schedule)
B. Consolidated List of Service Coverage Exceptions
C. Revenue Reconciliation
D. South Island Regional Mental Health Plan
E Asset Management Plan (Available on request)
F Information Services Strategic Plan (Available on request)

Appendix 1: Key Population Statistics
Appendix 2: Disability Estimates
Appendix 3: Details on Structure and Services of Hospital and Specialist Service
Appendix 4: Glossary of Terms
Appendix 5: Disability Support Advisory Committee Work Plan
Appendix 6: Maori Health Expenditure

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

DISTRICT ANNUAL PLAN

2005 – 2006

July 2005

Our Vision – Ta Matou Matakite

To promote, enhance and facilitate the health and well-being of the people of the Canterbury District.

Ki te whakapakari, whakamaanawa me te whakahaere I te hauora M te orakapai o ka takata o te rohe o Waitaha

DISTRICT ANNUAL PLAN
1 July 2005 – 30 June 2006

Produced by
Canterbury District Health Board
PO Box 1600
Christchurch

July 2005

Telephone (03) 364 4160

www.cdhb.govt.nz

ISSN: 1176 3124

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1. EXECUTIVE SUMMARY

1.1 Statement from Canterbury DHB Chair and Chief Executive

This District Annual Plan completes the first cycle of the Canterbury DHB's five year Strategic Plan – *Towards a Healthier Canterbury: Directions 2006* - which was developed in consultation with the Canterbury community and health providers in 2001. The initiatives and projects that have been developed and gradually implemented over the last four years are the outcome of this first planning round. It is important to acknowledge that the real progress achieved over this time is due to the skills and expertise of the staff who are employed by the Canterbury District Health Board (DHB), and also the many health agencies who are funded by the Canterbury DHB in the community. This has also involved good governance and management of an organisation that has been seriously tested over the period since its establishment.

Notwithstanding the quality of work, nor the fact that we have successfully achieved a breakeven budget in the last financial year, after taking on a $21.5m deficit following the merger of the two Crown Health Enterprises, we are nevertheless faced with further challenges over the next few years as the impact of Population Based Funding and national equity is implemented. As the funder of public health services in Canterbury, the Canterbury DHB has a responsibility to ensure the best health outcomes for the people in our district. That means, that with our fair share of health funding, we must improve the health outcomes of the people in our district by looking at new, innovative and better ways of working.

This District Annual Plan provides a comprehensive overview of the projects, activities and associated milestones, budget components and monitoring that the Canterbury DHB intends to pursue in the financial year 2005/2006. It reaffirms our top priorities, the Minister of Health's priorities within the New Zealand Health Strategy, and our five Core Directions. It also gives emphasis to some key areas like encouraging people to take greater responsibility for their individual health through increased health promotion and education, the implementation of the Mental Health Blueprint, reducing inequalities and improving access to primary care. Within the Hospital & Specialist Service Division of the Canterbury DHB, there will be ongoing work to improve our operational performance in waiting times for elective services. The new project 'Improving the Patient Journey' and a number of other initiatives will put in place operational strategies and activities that will look at how services are best configured to serve the needs of the patient.

In determining the needs of its community, the Canterbury DHB will make use of the comprehensive Health Needs Assessment Document that was updated in September 2004 and which describes the population, demography and health status of the people of Canterbury and some projections into the short and medium term future.

Key issues for the Board this year will be our ability to move to equity in line with our fair share of funding while still providing the appropriate range and volume of services, which means we will need to continue to look for efficiencies in clinical and non-clinical areas. We will also continue to look at information technology as a major health tool to optimise patient care and to work with other DHBs in areas of mutual interest. Implementing the Older People's Strategy, the Mengingococcal B vaccination programme and the project 'Improving The Patient Journey' will be key issues this year as will the need to increase our promotion of healthy eating and active lifestyles. There will be expectations of flow-on effects from the national industrial environment that will need to be carefully managed and well understood and communicated to Canterbury's health workforce.

Finally, we must continue to plan for the future of health in Canterbury. While much of this work will be undertaken later in 2005 as public consultation begins for the new District Strategic Plan taking us through from 2006 to 2010, many of the initiatives that begin in this financial year will be implemented over the next 12-24 months. This level of continuity provides a solid background to maintaining and improving health outcomes for the people of our district.

Syd Bradley
Chairman

Jean O'Callaghan
Chief Executive

1.2 Signatories – Minister / Chair / Chief Executive

Signatories

AGREEMENT DATED THIS 11th day of July 2005

(Made under Section 39 (1) of the New Zealand Public Health and Disability Act 2000)

BETWEEN

Honourable Annette King
Minister of Health

Chairman of the
Canterbury District Health Board

Chief Executive
Canterbury District Health Board

Minister of Health
Minister for Food Safety
MP for Rongotai (incl Chatham Islands)

13 JUL 2005

Syd Bradley
Chair
Canterbury District Health Board
P O Box 1600
CHRISTCHURCH

Dear Mr Bradley

Canterbury District Health Board: 2005/06 District Annual Plan

This letter is to advise you that I have signed Canterbury District Health Board's (CDHB) District Annual Plan (DAP) for 2005/06 and the Board has my support for the implementation of this plan.

I wish to express my appreciation to the Board, management and staff for all the effort that has gone into producing the plan and the efforts made to manage your services within the funding available.

CDHB will break even across the current year as well as the outyears, the DAP meets my expectations for the DHB's planned financial performance.

It is my pleasure to advise you that because of your ongoing good performance, CDHB will continue to receive in 2005/06 the early payment arrangements that you benefited from in 2004/05.

I note the service reviews in 2005/06 that you are proposing as part of your DAP. I expect CDHB to seek the advice of the Ministry of Health (the Ministry) before any major service reconfigurations are carried out. I understand that it is not CDHB's intention to reduce services available to your population as a result of these reviews.

I note the risks and associated mitigation strategies you have identified. I expect CDHB to continue to manage its financial risks and live within its allocated funding. Where your DHB identifies severe risks of any type, I expect you to notify the Ministry of them along with your strategies for mitigating them.

Parliament Buildings, Wellington, New Zealand. Telephone: (04) 470 6554, Facsimile: (04) 495 8445

You will be aware that I want to see all DHBs make progress on the management and delivery of elective services in 2005/06. This is a priority for the Government. I note you have an approved recovery plan for Elective Services Patient Flow Indicators (ESPIs) that will assist you to be fully compliant with all of the ESPIs by 30 June 2006.

I realise that the implementation of the agreed ESPI recovery plans will require change in some practices and behaviours of clinical staff. The DHB will need to work with them closely to achieve this. I have asked the relevant staff within the Ministry of Health to work with you to achieve these goals.

I urge you to manage your acute demand so that elective volumes are not compromised, and to seek all opportunities to deliver additional elective procedures. During 2005/06, increased monitoring of volume and caseweight delivery will be undertaken using the data now available on the Hospital Surgical Activity website. I also ask you to consider your delivery of key elective procedures where they are below the national average, as measured by standardised intervention rates. For the 2006/07 financial year DAP, I will expect your elective service volumes to be included within the DAP deliverables.

I am pleased to note the efforts you outline in your plan on primary care and the management of chronic disease. As you know chronic disease management can be facilitated by the Primary Health Organisation environment. DHBs should now be embedding integrated approaches to chronic disease management, which take advantage of local delivery and the DHB model that spans older persons, primary, and hospital services.

I am pleased to see CDHB has made mental health a focus in its DAP in line with mental health being one of my priority areas for the 2005/06 year.

Your DAP notes the possibility of implementing aspects of the local Mental Health and Addiction Strategy during the year. I will expect that proposed service reconfigurations are discussed with the Ministry beforehand so that it can be ascertained whether my approval is required as described in the Operating Policy Framework.

Please note that sign off on the 2005/06 DAP does not mean approval for any capital projects requiring equity or new lending or self-funded projects that require the support of the National Capital Committee. Approval of such projects is dependent on both the 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 managed through the annual capital allocation round also.

This letter should be attached to the copy of the signed plan held by the Board and a facsimile of the letter should be attached to all copies of the Plan made available to the public or any other third party.

Would you now please forward a copy of your final Statement of Intent 2005/06 to the Ministry within two weeks (10 working days) of receiving this letter.

Yours sincerely

Hon Annette King
MINISTER OF HEALTH

2.0 INTRODUCTION

2.1 Vision Statement and Values

2.1.1 Vision and Values

Our Vision – Ta Matou Matakite

To promote, enhance and facilitate the health and well-being of the people of the Canterbury District

Our Values

Care and respect for others	Manaaki me te kotua i etahi
Integrity in all we do	Hapai i a matou mahi katoa i ruka i te pono
Responsibility for outcomes	Kaiwhakarite I ka hua

2.1.2 Who are we?

The Canterbury DHB is the health organisation responsible for funding most health services in Canterbury. Funded by Government, the Canterbury DHB works with the Canterbury community to decide what health services are needed and how to best use its limited funding, noting Government policies. The Canterbury DHB:

- Funds most disability (for older people), mental health, Māori health and personal and family health services in Canterbury.
- Runs Canterbury's 14 public hospitals which provide hospital and specialist mental health, disability support, alcohol and drug and community health services, through its provider arm (Hospital and Specialist Service).
- Promotes community health and well-being through population health programmes such as health promotion and protection.
- Encourages all health and disability support providers in Canterbury to work in collaboration to streamline health care, make care more efficient and effective and to work to address inequalities of access to health services.

Our Ways of Working

Be people and community focused	Arotahi atu ki ka takata me ka iwi whanui
Demonstrate Innovation	Wakaba whakaaro hihiko
Engage with our stakeholders (those individuals and groups with an interest in our work)	Tuu atu ki ka uru (ratou ka takata me ka roopu e parekareka ana mai ki a tatou mahi)

2.1.3 Our Strategic Directions and Health Gain Priorities

The Canterbury DHB completed a strategic planning process in 2002/03 –*Toward a Healthier Canterbury: Directions 2006*" which involved community consultation on its Strategic Plan. The agreed strategic objective, or ‗Core Directions' that came out of this process were:

Direction 1:	Improving the Health Status of our Community
Direction 2:	Finding Better Ways of Working
Direction 3:	Working Together: Innovative Models of Service Integration
Direction 4:	Developing Canterbury's Health Care Workforce
Direction 5:	Being a Leader in Hospital and Health Care Services

A number of areas were also chosen for special attention, based on the Health Needs Assessment for Canterbury, consideration of key Government health strategies such as the New Zealand Health Strategy, New Zealand Primary Health Care Strategy, Māori Health Strategy and the New Zealand Disability Strategy and on feedback received during this formal consultation on the Canterbury DHB's Strategic Plan.

The agreed health gain priorities were:

- Child and Youth Health
- Primary Health
- Māori Health
- Mental Health
- Disease Prevention and Management
  - Cardiovascular (Heart) Disease
  - Diabetes
  - Cancer.

Details of the Health Needs Assessment (updated in 2004) and the summary of submissions, received on the Strategic Plan, can be found on the Canterbury DHB website: www.cdhb.govt.nz.

In addition, since 2002, the Canterbury DHB has been progressively looking at other areas of work that have become priorities through needs assessment, changes in policy, environment or funding. These include:

- Pacific Peoples Health
- Oral Health
- Respiratory Illness
- Rural Health
- Alcohol & Other Drugs Treatment
- Elective Surgery
- Tobacco Control
- Infectious Diseases
- Demands on the Emergency Department.

A new District Strategic Plan for 2006/2010 is currently being written and will be published at the end of 2005. As a result of this process the new Canterbury DHB Board may update its goals, core directions and priority health gain areas.

Updates on progress on the Core Directions: goals, strategies and actions are regularly provided to the Canterbury DHB's Board.

2.1.4 The District Annual Plan 2005-2006

This Plan's objectives are aligned with Government objectives for DHBs as set out in the New Zealand Health Strategy, the New Zealand Disability Strategy, Māori and other health strategies as well as directions in the current Canterbury DHB Strategic Plan.

The District Annual Plan outlines the planned performance, funding arrangements and service provision of the Canterbury DHB for the period 1 July 2005 – 30 June 2006 noting the Minister of Health's Start Here' list with emphasis on the following Strategic Priorities:

- New Zealand Disability Strategy
- Reducing Inequalities
- He Korowai Oranga
- Health of Older People
- Improving Mental Health and the Mental Health Blueprint.

The Minister has also signalled the following Implementation Priorities for 2005/2006:

- Primary Care and the development of Primary Health Organisations
- Workforce Development
- Progressing the Meningococcal Vaccine Strategy
- Improving Elective Services and Orthopaedic Services
- Implementing the New Zealand Cancer Control Strategy
- Implementing Healthy Eating, Healthy Action
- Collaboration Across Agencies – to progress health programmes
- Keeping Infrastructure Costs as Low as Possible
- Industrial Relations Strategies (fostering workforce cooperation and affordable resolutions)
- Innovative approaches to Enable Managing Within Budget.

2.2 Treaty of Waitangi

The Canterbury DHB recognises and respects the principles of partnership, participation and protection embedded in the Treaty of Waitangi. We also acknowledge the expectations of the New Zealand Public Health and Disability Act 2000 and the Crown Funding Agreement. We are committed to reducing disparities and improving health outcomes for Māori and to ensuring Māori involvement in planning for these.

The Canterbury DHB has agreed a regular meeting schedule with Ngāi Tahu, as manawhenua of the district, through Manawhenua ki Waitaha; a representative group which comprises the seven Ngāi Tahu rūnanga. We also meet quarterly with Te Rūnanga o Ngā Maata Waka representatives and the Māori community and engage in numerous other formal and informal interactions with Māori providers, services and community organisations. The outcomes of these meetings feed directly into Canterbury DHB planning processes.

The Canterbury DHB has established Te Kahui Taumata, which includes the Kaumātua and Taua and senior Māori staff who provide Māori specific advice and direction to the Chief Executive. An Executive Director of Māori and Pacific Health has been appointed to the Executive Management Team and is part of Te Kahui Taumata. This group will ensure that the Canterbury DHB recognises and respects the principles of the Treaty of Waitangi and actively works to improve the health of Māori.

2.3 Population Profile

In September 2004 the Canterbury DHB completed a comprehensive Health Needs Assessment (HNA) which attempted to bring together information to describe the population and health status of the people of Canterbury. The changing demography of the population is described in some detail in the 2004 HNA and readers who would like more information than that which is provided in the following brief sections are directed there. The HNA can be found on the Canterbury DHB website www.cdhb.govt.nz under Publications in the Communications Section.

The Canterbury DHB catchment area covers rural communities from Kekerengu in the North, Rangitata in the South and Arthur's Pass in the West. 16% of the population live in rural towns (eg Kaikoura), rural centres (eg Rakaia) and wider areas (eg Malvern). The Canterbury DHB is the second largest DHB by population and the largest in geographical area and has the ninth largest Māori population. The total Canterbury population is 462,800 with 6.9% identifying as Māori (projected 2006 from the 2001 Census). The Canterbury DHB population projections are attached see Appendix 1.

2.3.1 Overview of the Canterbury Population

The Canterbury DHB's 2004 HNA showed the health of the Canterbury population is similar to the New Zealand (NZ) population as a whole in overall morbidity and mortality rates. The primary causes of death for people in Canterbury are diseases of the circulatory system and cancer. The 2002/2003 NZ Health Survey reveals that more than 90% of Canterbury people believe they have good health.

People in Canterbury have the highest life expectancy at birth (77.8 years) of all the DHBs. Nationally, Māori life expectancy is lower than that of other ethnic groups. In Canterbury, Māori and Pacific communities are at higher risk of diabetes and associated complications. The Canterbury DHB's plans addressing Diabetes, Cardiovascular Disease and Cancer, the Whakamahere Hauora Māori ki Waitaha (Māori Health) Plan and the Pacific Health Action Plan are expected to improve Māori and Pacific peoples' health status and to assist with reducing inequalities in life expectancy in Canterbury.

Poorer health status is linked with high degrees of deprivation, and the Canterbury DHB has about 80,000 people living in NZ Deprivation Deciles 8, 9 and 10. Canterbury's Primary Health Organisations are working with high-need populations to try to reduce health inequalities associated with socio-economic status; in line with the Canterbury DHB's health gain priority areas.

The Canterbury DHB is currently reviewing rural health services to determine how best to improve rural access issues.

2.3.2 Key Population Trends for Canterbury

Ageing Population
Canterbury's population is ageing quickly compared to other parts of the country. The percentage of the population aged 65 and over will increase from 12% in 2001 to 19% by 2021. The proportions of Māori and Pacific peoples aged 65 and over are projected to increase from 3% to 8% for Māori and to 6% for Pacific peoples by 2021. This has implications not only for the relative size of the working age population able to support older people but also for health. Older people, particularly those over 75 years, consume a significant amount of health resources.

Decreasing Child Population
The population aged 0-14 will decrease to 15% of the Canterbury DHB population by 2021 compared to 18% in 2001.

Relatively Large Youth/Younger Population
About 22% of Canterbury's population is aged between 15 and 24. This is similar to the national figure of 21%.

Changing Ethnicity of the Canterbury DHB Population
An increasing number of the Canterbury DHB's child, youth or younger population are non-European, principally Māori, Asian and Pacific. About one-third of the Māori and Pacific peoples populations are aged under 15, younger populations than the remainder of the Canterbury DHB population. Of the 13-19 year olds in Canterbury 11% are Asian.

Migrant and Refugee Communities
Christchurch has been a resettlement point for refugees during the past 10 years. Migrant and refugee populations have particular needs in the areas of child health, mental health, primary health care and aged care.

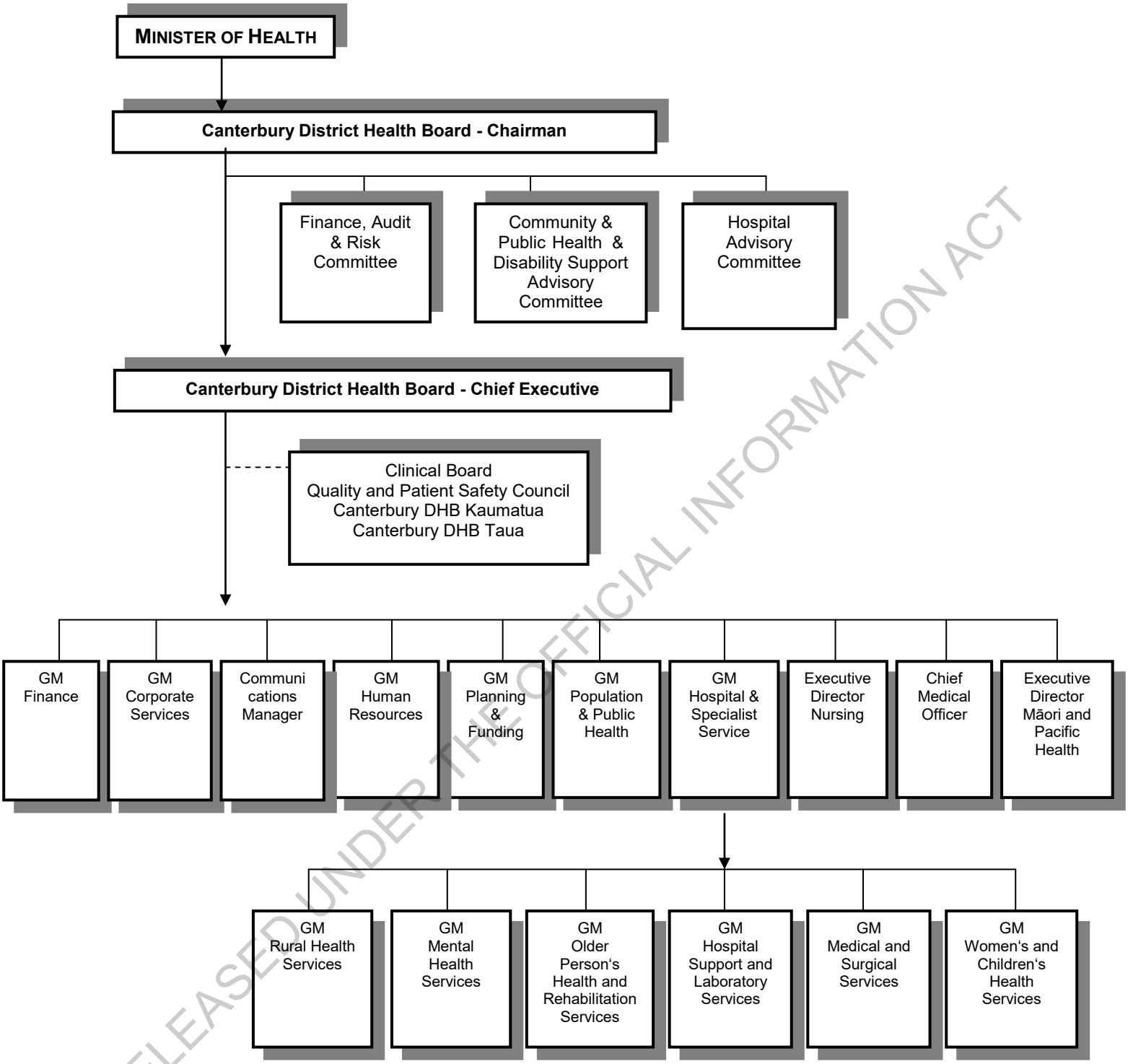
People with Disabilities
Using information from the New Zealand Disability Survey it is estimated there are about 160,000 people with disabilities within the Canterbury DHB's district, of which about 58,000 have a disability requiring assistance. Māori are 1.35 times as likely to suffer from a disability not requiring assistance and 1.65 times as likely to have a disability requiring assistance, as non Māori; see Appendix 2.

2.4 Key Issues

The Canterbury DHB is facing a number of key issues over the next year:

- Continuing to move to equity in line with Population Based Funding while at the same time providing the required volume and range of services.
- Maintaining positive relationships and morale in a constrained funding environment and managing the flow on effects from Industrial Agreements.
- Managing community expectations while undertaking a number of service reconfigurations.
- Hospital and Specialist Service increasing productivity while reducing expenditure and meeting their volume targets.
- Updating Information Technology infrastructure to improve patient care and deliver relevant information to the organisation.
- Implementing the Older People's Service Strategy key service changes.
- Implementing elective surgery programmes for orthopaedics and cataracts
- Implementing the 'Improve the Patient Journey' project; the goal of which is reducing unnecessary waits and delays within the patient continuum of care through innovation, reducing variation, focusing processes on patient orientated processes and collaboration.
- Responding to the impact of lifestyle diseases such as Diabetes
- Communicating with our community on service developments such as Primary Health Organisations.
- Working with other South Island DHBs on closer clinical and non-clinical collaboration.

2.5 Organisation Structure (as at June 2005)



3.0 ENSURING SERVICES FOR THE CDHB'S POPULATION

3.1 Canterbury DHB Organisational Performance

3.1.1 Canterbury DHB Core Directions

The Canterbury DHB Board and senior management have collectively determined key strategies, or actions, to achieve outcomes in line with each of the Canterbury DHB's five Core Directions.

- Direction 1: Improving the Health Status of our Community
- Direction 2: Finding Better Ways of Working
- Direction 3: Working Together: Innovative Models of Service Integration
- Direction 4: Developing Canterbury's Health Care Workforce
- Direction 5: Being a Leader in Hospital and Health Care Services

For each strategy, key stakeholders have been identified including the community, staff, other government agencies, providers of health services and the Ministry of Health (MoH).

Progress on the Core Directions and key Canterbury DHB Strategies are reported to the Board and appropriate Statutory Committees throughout the year.

DIRECTION 1: IMPROVING THE HEALTH STATUS OF OUR COMMUNITY				
Goals	**Strategies**	**Actions**	**Timeframe**	**Outcomes/Measures of achievement**
1.1 Reduce health inequalities	1.1.1 Target actions and resources to relevant populations particularly Māori, Pacific populations and other areas identified by the Health Needs Assessment	Prioritise actions in primary care that will enable services to be targeted to relevant populations.	Dec 05 *Update on progress for information*	Improved access to primary care for target groups
	1.1.2 Support the ongoing development and enhancement of PHOs	Actively work with existing and prospective PHOs in the development and enhancement of PHO services Implement PHO enhancements consistent with Government direction. Through PHO's support initiatives that reduce barriers for Māori, Pacific People and other disadvantaged groups Support initiatives that strengthen community governance Provide information to the community on PHO's in conjunctions with PHOs	Ongoing *Update to CPHAC* Ongoing *Update on progress for information*	Barriers to access reduced (measured on enrolled population baseline). CDHB lives within budget for these services 90% of Canterbury's population will be covered by PHOs by July 2005 Community Representation on PHO Boards Community awareness / knowledge on PHOs increases
	1.1.3 Develop a vision for the future role of primary and community services	Complete the community and primary health framework Work with PHOs on initiatives that support the implementation of a sector approach to primary and community health (eg: pharmacy medicine management)	June 06 Ongoing *Update on progress for information*	Framework consulted on and utilised for planning
1.2 Better understanding of Health Needs of Community	1.2.1 Improve data collection in relation to our community	Continue to implement a project to collect accurate ethnicity data collection both within CDHB delivered services and those of funded external providers Establish and implement a framework for analysis and reporting on Māori and Pacific utilisation of health services	Ongoing Feb 06 *Scope to Board*	CDHB has ethnicity data that is accurate and reliable CDHB has better information on which to base decisions

DIRECTION 1: IMPROVING THE HEALTH STATUS OF OUR COMMUNITY				
Goals	**Strategies**	**Actions**	**Timeframe**	**Outcomes/Measures of achievement**
	1.2.2 Monitor the utilisation and impact of health services	Recognise the needs of Māori, Pacific, rural and high deprivation communities in needs assessment, planning and prioritisation processes Ensure programme planning and delivery is based upon best possible evidence and appropriate evaluation	Ongoing Ongoing	Decision making on prioritisation is based on best possible information New health services or service reviews based on evidence, local health assessment and are patient population focused
1.3 **Integrated health planning in Canterbury**	1.3.1 Improve the early identification and coordinated treatment of people with chronic disease especially cardiovascular disease, diabetes and cancer	Develop and implement evidenced based delivery of service and guidelines for cancer which promotes a continuum of care: ▪ Project team established ▪ Review of National Guidelines ▪ Identification of local issues ▪ Development of local guidelines ▪ Information sharing and training ▪ Evaluate process Implement the Heart Manual across service areas	*Awaiting information and timelines from the MoH* Commence Feb 06	Services are provided effectively and efficiently Improved outcomes for people presenting with cancer and cardiovascular disease Services are connected and service delivery and information sharing is linked between services Better information on needs of/outcomes for patients
1.3 **Integrated health planning in Canterbury (Cont…)**	1.3.2 Work with other agencies to develop approaches to preventing illness and maintaining health lifestyles	Implement a nutrition and physical exercise strategy that focuses on risk factors for heart disease, diabetes and cancer Work with communities to build a better understanding of the value of community development approaches	Commence by July 05 June 06	Plan implemented Planning implementation requires the physical and social environments within the community Community informed Imported health intelligence for use in service development
1.4 **Strategic Review of Progress**	1.4.1 Review and rewrite Strategic Plan	Review and rewrite the District Strategic Plan Undertaken public consultation and consult with stakeholders, interest groups, Māori and Pacific communities etc Consider feedback and prepare final draft	July 05 *First draft to Board and MoH*	Requirement of MoH to update DSP following community communication
	1.4.2 EMT monitor Core Directions workplan	Review progress to Board and sub-Committees	Monthly and quarterly *Regular Updates*	Progress on actions monitored

DIRECTION 2: BETTER WAYS OF WORKING				
Goals	**Strategies**	**Actions**	**Timeframe**	**Outcomes/Measures of achievement**
2.1 **To better inform the community over the changes to Canterbury's health funding**	2.1.1 Implement a communications framework for community and key stakeholders	Coordinated communication plans to be developed giving the overall context, issues and process CDHB will take to achieve the transition to PBF as well as individual communications for strategies/events as they develop. Identify and implement specific strategies and key messages to increase the understanding of: ▪ The public ▪ Local politicians ▪ Community leaders ▪ Health related stakeholders ▪ Staff.	As required Ongoing	Community informed of the issues in an open and transparent manner.
2.2. **Optimise project management resources and processes**	2.2.1 Co-ordinate key projects and standardise templates and methodologies	Standard reporting format and processes to keep Board informed in place Develop and implement standard project templates Develop, agree and implement standard project methodologies Delivery regular reports and updates on all key CDHB operational projects	Dec 05 Ongoing	Projects are linked and coordinated Standard project templates in place Standard project methodologies in place Regular reporting on progress
2.3 **Realign Aged Care Services to match funding under the Population Based Funding formula recognising best practice and ageing in place initiatives**	2.3.1 Implement Older Peoples Service Strategy	Options Paper presented to Board Utilise sector expert group, community consultation and internal policy groups to develop an Older People's Health Services Strategy Final recommendations to Board on Service Configurations Management of Change process.	Sept 05 Ongoing *Updates to the Board* December 05 From Jan 06 *Board updated on progress*	Consultation completed Plans for alternative models of care developed Move to equity commenced Implementation of Ageing in Place as a CDHB Strategy Service delivery reflects evidenced based practice

DIRECTION 2: BETTER WAYS OF WORKING				
Goals	**Strategies**	**Actions**	**Timeframe**	**Outcomes/Measures of achievement**
2.4 Develop a plan to reconfigure services for efficiency and effectiveness	2.4.1 Complete and implement specific plan for Ashburton for clinical and financial sustainability of health services in consultation with staff, unions and community	Discussion document that: outlines key clinical and access issues impacting on Ashburton clinical services across the continuum of care (including primary interface), highlight likely population trends impacting on health services within the next 5 years, the likely technology and advances in health care delivery impacting on clinical services, possible service models of care for clinical services and the likely investments such options would require.	June 05	Appropriate level of service delivery to Mid Canterbury population
2.4 Develop a plan to reconfigure services for efficiency and effectiveness (contin..)	2.4.1 Complete and implement specific plan for Ashburton for clinical and financial sustainability of health services in consultation with staff, unions and community (contin..)	Undertake Consultation Process with internal and external stakeholders including staff representative organisations, and adjacent DHBs. Complete analysis of consultation process and develop business case/proposal for change for the most sustainable option Develop Implementation Plan Implementation	October 05 December 05 *Approval* December 05 Begin Feb 06	Community ownership of issues and solutions is evident Ashburton health and hospital services are clinically and financially viable and sustainable to meet the local population needs
	2.4.2 Continue to rationalise use of sites – leased and owned to target funds for services not facilities	Prepare business case for future location of corporate Target leased properties for exit as a priority to reduce expenditure where owned sites/ alternative are available Ensure costs minimised and revenues maximised from leasing arrangements	July 05 *Approval* Ongoing *Progress Updates for Information*	Net Present Value cost saving to CDHB Surplus sites exited Revenues and cost reimbursement from leases achieved
	2.4.3 Review range and mix of services to be delivered in rural areas	Present the rural services options paper outlining an appropriate model for rural services and provide recommendations to Board Approval from Ministry of Health as required Implementation of Management of Change processes	July 05 *Approval* Sept 05 Begin Dec 05 Complete June 06	Rural communities have appropriate access to health services

DIRECTION 2: BETTER WAYS OF WORKING				
Goals	**Strategies**	**Actions**	**Timeframe**	**Outcomes/Measures of achievement**
2.5 HSS live within allocated resources	2.5.1 Control and manage employee costs	Development of WMRS phase II is progressing	June 06	All employee costs are reported/ managed each pay period
		All employee costs paid via invoice reported each pay period to management	July 05	Variance reporting shows understanding of costs
		Electronic learning tool is implemented	August 05	
		Audits of variance reporting	July 05, Nov 05, Mar 06	FTEs within budget
		Audits of sick leave management	Aug 05, Feb 06, May 06	Sick leave rates below target
		Annual leave plans in place for all cost centres	June 06	Annual leave liability is reduced
	2.5.2 Operating Expenditure and costs managed within budgets	Maintain and enhance HSS Work Plan that identifies HSS contribution to funding adjustments identifying milestones and time frames	*Quarterly to Board* *Ongoing to HAC*	Achievement of timeframe milestones Operating Expenditure is within budget
		Improve financial controls ▪ Review and tighten delegations authorities ▪ Review and tighten purchasing practices ▪ Limit purchasing product catalogue items	 July 05 Sept 05 Sept 05	Achieve the savings identified in the HSS workplan to eliminate the HSS deficit
		Ongoing review of HSS non clinical and clinical support areas to reduce operating expenditure ▪ Maintenance services ▪ Administration/clerical services ▪ Centralise clinical records ▪ Review and streamline non acute patient transfers	 July 05 May 06 Feb 06	Standardised control mechanisms across the HSS HSS deficit is reduced/eliminated
		Pro-actively participate in ongoing external benchmarking work to identify future areas for cost reduction and savings	Ongoing from July 05	

DIRECTION 2: BETTER WAYS OF WORKING				
Goals	**Strategies**	**Actions**	**Timeframe**	**Outcomes/Measures of achievement**
2.6 Enhancing Hospital Productivity	2.6.1 Maximise use of resources to enhance capacity, maximise access to hospital services and remove key constraints within the patient process (~~-i~~mproving the patient journey")	Progress Governance and Leadership structures in place to oversee programme streams Programme goals, plans with milestones, targets in place Management of Change Consultation processes are undertaken when service changes require Business cases developed and approved for changes to service configurations Implementation of approved changes	June 05 July 05 Ongoing as required Ongoing as required As required	Improved clinical staff satisfaction Increased throughput of patients Enhance capacity Project and programme goals and targets achieved
	2.6.2 Undertake diagnostics as part of all programmes of the Improving the Patient Journey'	Undertake ED diagnostics of length of time patients remain in the dept Track patient flow from ED for related programmes Identify diagnostics for General Surgery programme and the next phase of the Operating Theatre programme work	July 05 July 05 onwards July 05	Key indicators identified for all programmes are in place
	2.6.3 Improving access to Emergency Care	Internal model of care developed and implemented Identify staff skill mix and numbers for model of care Review and develop appropriate inter-service models of care between ED and the following: - child health - orthopaedics - psych emergency Identify physical constraints within the dept that impede delivery Implement monitoring of key indicators	Sept 05 Sept 05 March 06 May 06 Dec 05 Dec 05 July 05	Key indicators identified for all programmes are in place

DIRECTION 2: BETTER WAYS OF WORKING				
Goals	**Strategies**	**Actions**	**Timeframe**	**Outcomes/Measures of achievement**
2.6 Enhancing Hospital Productivity (contin…)	2.6.4 To improve the capacity and productivity of Operating Theatre and elective procedures	Each speciality has established targets for day surgery and DOSA Monitoring of progress against targets commences Identify current day procedures that could be performed on an outpatient basis Identify current inpatient procedures that could be day procedures Review current theatre schedule against contract volumes and demand to identify potential capacity and enhanced elective productivity	July 05 July 05 Onwards Dec 05 Dec 05 June 06	Day Surgery and Day of Surgery Admission (DOSA) rates are increased for each speciality Targets identified in the Womens' Hospital Business Case are achieved Improved capacity demonstrated from theatre utilisation
	2.6.5 After Hours Models of Care	Implementation of the three key findings from the Night Audit Study: ▪ Development and implementation of 'Beep' policy ▪ Development and implementation of a 'Handover' model for clinical staff for the night shift ▪ Develop and implement a multi-disclipinary 'Night' team Undertake Audit Study into the Afternoon Shift	Ongoing Aug 05 Dec 05 June 06 June 06	Resources and skill mix aligned to patient activity
	2.6.6 To improve access to general surgery and improve acute patient flow	From the work completed from the Diagnostic Programme, identify key constraints Develop programme for next two years to improve the service flow Identify and develop plan for workforce for general surgical department Pilot project to improve acccess to lap cholecystectomy	July 05 Dec 05 Feb 05 July 05	Improved access to acute theatre Reduce readmissions for cholecycstisis Reduce elective waiting time for cholecystectomy

DIRECTION 2: BETTER WAYS OF WORKING				
Goals	**Strategies**	**Actions**	**Timeframe**	**Outcomes/Measures of achievement**
2.6 Enhancing Hospital Productivity (contin…)	2.6.7 To enhance hospital wide capacity through production analysis, planning, matching resource to patient flow and monitoring and adjusting resources to meet early changes to patient demand. Capacity Planning	Begin to implement CapPlan© Health web based capacity planning tools Redesign operational processes to incorporate patient flow info into annual, monthly, weekly, daily and hourly planning and management of the hospital Develop pilot tool for ‗real' time patient flow information to staff Convert forecast information into resource requirements ▪ Identify work drivers and appropriate standards ▪ Identify resources requirements Review roster patterns and/or shift structures for the divisions against patient flow information Develop business processes to match forecast activity with appropriate resources Develop operational process maps for resourcing budgeted beddays include Easter, winter and Christmas periods with ongoing refinement Culture change focused on using real time information to manage/allocate resources to meet patient demand	July 05 Commences July 05 July 05 Ongoing June 06 Feb 06 June 06 Commences July 05	Forecasts in place for all divisions Monitoring demonstrates that resources match patient activity in the Medical/Surgical Division Increased productivity
	2.6.8 To improve access of the radiology department	Identify key constraints of the patient flow within the department, within the referrer processes Develop operational management processes to improve patient flow activity within each area of the department Identify the workforce requirements to meet patient activity including FTE, skill mix and shift structures	June 06	Waiting times are managed within guidelines Improved patient throughput. Timely information is provided to clinical staff for use in managing the patient's care.

DIRECTION 2: BETTER WAYS OF WORKING				
Goals	**Strategies**	**Actions**	**Timeframe**	**Outcomes/Measures of achievement**
2.7 Optimise future investment	2.7.1 Reconfigure Non-Clinical Services - where this results in more efficient services across the CDHB	Ensure link with Clinical Services Reviews where appropriate Prioritise resources to projects where most gain is identified short/medium term Implement changes with robust business cases, consultation and management of change	Ongoing *Progress updates as identified*	Reduced expenditure in non-clinical services Efficient consistent and standard non-clinical services and processes Identified improvements are implemented Clinical care not compromised
	2.7.2 Invest in technology (including IT infrastructure) to improve service effectiveness	Implement Information Technology Infrastructure Stabilisation Implement Clinical Information System (Portal) Identify appropriate HR Payroll and Rostering System for the CDHB	(fit with Workplan) Ongoing *Progress Updates to FARC* RFP completed by Dec 05	Platform for improved systems and point of care patient service. Improved access to clinical information and timely use of information in provision of care and treatment Improved functionality to meet CDHB business, HR and rostering requirements Reduced risk of system failure due to aged legacy system
2.8 Fund services that focus on outcomes	2.8.1 Pilot feasibility of outcome-based funding approach in one mental health service and one personal health diabetes service.	Work with providers and where appropriate MoH on framework (build on existing national projects) Develop Service Specifications and agree reporting requirements Implement the process and evaluate effectiveness	Sept 05 Dec 05 June 06	Pilot outcome model that could be extended to other services Measure health outcome for target group in relation to pilot Pilot is evaluated against agreed criteria
2.9 Developing and strengthening intersectoral relationships	2.9.1 Develop Health and Wellness Plan.	Develop strategy through project basis under umbrella of Healthy Christchurch	Ongoing through 2005	Project scoped and Long Term Council Community Plans (LTCCP) reflect this
	2.9.2 Develop closer working relationships with key agencies	Identify common concern area and develop joint approach for pursuing goals	Ongoing	Common areas identified Strategy Developments Action underway
2.10 Eliminate waste or duplication from our services	2.10.1 Manage Primary Referred Services Expenditure Growth	Implement mechanisms to control pharmaceutical expenditure growth through innovative funding models Complete a strategy for optimising the effectiveness of the CDHB's community laboratory funding	Dec 05 Sept 05 *Present to Board*	More efficient use of primary referred expenditure Limit growth in primary referred expenditure

DIRECTION 3: WORKING TOGETHER - INNOVATIVE MODELS OF SERVICE INTEGRATION				
Goals	**Strategies**	**Actions**	**Timeframe**	**Outcomes/Measures of achievement**
3.1 Integrate services for: Older Persons Child Health Mental Health CVD / Diabetes	3.1.1 Work with wider sector to implement continuum of care as described in: ▪ Linkage Report ▪ Child Health Strategy Action Plan ▪ PHO Guidelines ▪ Mental Health and Addictions Strategy	Child Health Action plan implemented As per Mental Health and Addictions Strategy, Health Heart Strategy Strengthen service planning relationships with PHOs Participate in WINZ —PATHS" initiative	Ongoing Ongoing *Update on progress for information*	Recommendations of reports implemented Process in place to support people on sickness benefit with Mental Health issues
3.2 Contain (medical and acute) demand growth	3.2.1 Manage medical/acute demand	Progress current acute demand project into wider forum to incorporate PHO's as key partners in the management of demand. Identify workplan for the next 1-2 years focused on improving access of primary care and reducing the need for hospital level service provision Commence new initiative pilot of an 'Initial Assessment Team' (first response for ambulance calls for rest home/long stay residents) Maintain oversight of current initiatives: ▪ Liaison nurses in GP ▪ Medical Assessment team ▪ Facilitated Early Discharge ▪ Eldernet Rest Home Database Maintain links with the 'Improving the Patient Journey' work programme	July 05 November 05 June 06 Ongoing Ongoing	Acute demand growth is contained below national average rates Avoidable hospital admissions are reduced

DIRECTION 3: WORKING TOGETHER - INNOVATIVE MODELS OF SERVICE INTEGRATION				
Goals	**Strategies**	**Actions**	**Timeframe**	**Outcomes/Measures of achievement**
3.3 Encourage innovation and improve quality and patient safety	3.3.1 Promote a systems approach to enhance patient safety	Implement workplan to achieve the Quality and Patient Safety Council's Strategic Plan, including: ▪ Stocktake of quality processes and indicators utilised by contracted providers ▪ Development of Open Disclosure Policy Identify and implement a framework of clinical governance for the CDHB Identify preferred system for managing incidents	Ongoing Ongoing Ongoing	Work Plan implemented Cohesive quality and risk management structures across the CDHB Culture of patient safety in place Clinical governance framework in place and embedded in CDHB culture
	3.3.2 Develop a culture of innovation	Hold CDHB Quality & Innovation Awards annually and continue to review and develop Awards Joint research grants funded by CDHB are targeted towards service development that improves patient flow, enhances access or promotes alternative access to hospital services	Annually Ongoing	Quality and Innovation Awards produce range of projects to implement Pilots demonstrate key objective Percentage are self sustaining for ongoing implementation

DIRECTION 4: DEVELOPING CANTERBURY'S HEALTH CARE WORKFORCE				
Goal	**Strategies**	**Actions**	**Timeframe**	**Outcomes/Measures of achievement**
4.1 Achieve a workforce which provides right skills at the right place and time for best delivery and outcomes	4.1.1 Build Strategic Workforce capability	Integrate and apply key behaviours as established through Organisational Development (OD) Framework activity Continue OD Framework project activity: - Recruitment and Selection - Change Management - Remuneration - Learning and Development (Leadership and Management Development)	June 06	Actions as detailed in communication and integration plan in place Recruitment and selection systems and processes review undertaken and improvements recommended Develop guidelines/tools to support managers & staff in managing change Review policy direction IEA & Collectives Leadership programme review undertaken Alternative delivery considered/developed
		National Activity - Support National recruitment employer branding activity in conjunction with DHBNZ	Within Workforce Action Plan (WAP) Project Scope	As per WAP Project Scope
		Credentialling -Frameworks developed for key workforce groups for Hospital & Specialist Service	Completed by August 05 *Noting paper for Board and HAC*	Workforce maintains appropriately scoped skills/competencies Clinical Board oversees credentialling frameworks Nursing credientialling framework Professional Development and Recognition Programme (PDRP) implemented
		Nursing - Continue with development of advanced nursing practice roles.	Ongoing	Paper identifying area for advanced practice roles within the DHB
		Mental Health – implement the outcome of the development of the Mental Health's Scope of Practice	Ongoing *Updates on progress to Board*	
		Continuation of the three year Aranui Nursing Pilot for advanced nursing practice role within primary care.	Implement year 2 of the pilot 04/05; 05/06	Continue with implementation. Year 2 evaluation report.
		Review year 1 evaluation report and make changes as necessary	July 05	Any changes implemented.

DIRECTION 4: DEVELOPING CANTERBURY'S HEALTH CARE WORKFORCE				
Goal	**Strategies**	**Actions**	**Timeframe**	**Outcomes/Measures of achievement**
4.1 Achieve a workforce which provides right skills at the right place and time for best delivery and outcomes *(Cont….)*	4.1.1 Build Strategic Workforce Capability *(Cont….)*	*Maori* - Continue development of Māori Workforce	Commence July 05	Identify strategies to encourage young Māori to enter the Health Workforce
		Continue development of Māori workforce ie support Tikaka Hauora initiative	August 05 *Ongoing updates on progress*	Implementation Tikaka Hauroa (Māori Mental Health) Development Programme.
		Pacific - Continuing development of Pacific Peoples Workforce	May 06 *Regular updates*	Identify strategies to encourage young Pacific people into the Health Workforce
	4.1.2 Improve workforce information	Progress local Human Resources Information Systems (HRIS) activity	June 06	Enhancement of local HR monthly reporting activity
		Support WSG to identify future workforce planning requirements	June 06	Scoping processes in place and links to national future workforce activity highlighted
		National Activity - Input into DHBNZ national data set/systems HWIS and MHWIS	As per HWIP Work Plan	Support and resources as required of HWIS implementation - reports generated as required
		Support and participate in regional standardisation of HR policy/procedure in conjunction with DHBNZ	Within WAP Project Scope	Identify key local policy & procedures to share within the region
4.2 Strengthen Partnership with Education Providers	4.2.1 To be in a position to formally influence education providers' planning	Continue to influence local and regional tertiary providers in line with WSG determinations	Ongoing	Increased influence on course/programme and curriculum design and outcomes
		Identify the likely impacts on the health workforce of the future and opportunities to development new models	Ongoing	Identify new models and implement pilots for evaluation
		CTA funds are accessed and fully utilised. Where possible additional funds are gained	Ongoing	CTA funds are fully utilised. Training programmes match workforce needs
		Ongoing forums established for continued debate and discussion on education and health policy interaction	Ongoing	Forums held annually outcomes distributed to stakeholders Participate in combined Tertiary Provider Advisory Groups
		Continue to support and participate in local/regional development of Primary Health Sector relationships	Ongoing	Continued access to training & development opportunities for Primary Health staff available with progression of current initiatives

DIRECTION 4: DEVELOPING CANTERBURY'S HEALTH CARE WORKFORCE				
Goal	**Strategies**	**Actions**	**Timeframe**	**Outcomes/Measures of achievement**
4.3 Canterbury is seen as the preferred district for health workers in New Zealand	4.3.1 CDHB develop practices to have CDHB seen as a preferred employer for health workers in New Zealand	Strategies to improve healthy lifestyles and work environments are implemented in line with national directions including:		
		▪ Ongoing membership of the ACC Accredited Employers Partnership Programme	Sept 05 and Ongoing	Annual Audit completed
		▪ Progress Occupational Health Service	August 05	Service implemented and operating
		▪ Support national/regional/local union forum activity	Ongoing	Stable and positive relationship with staff and unions maintained
		▪ Develop Bipartite employer and Combined Trade Union (CTU) affiliated approach to working	Ongoing	
4.3 Canterbury is seen as the preferred district for health workers in New Zealand (contin..)	4.3.1 CDHB develop practices to have CDHB seen as a preferred employer for health workers in New Zealand (contin..)	Progress a local healthy workplace and employee wellbeing programme	June 06	Review of stocktake findings undertaken and recommendations developed to be incorporated in programme
		National Activity - Participate in stocktake of healthy workplace initiatives and detail as applicable remedial actions as necessary	Within WAP Project Scope	As per WAP Project Scope stocktake completed and reported to MoH
		Implement identified remedial action/s/new initiative/s	Jan-May 06	Remedial action/new initiatives/s implemented and reported to the Ministry of Health
		Monitor workforce issues in community services and work with providers	Ongoing	Service Development work considers workforce implications such as in Rural Services and Older People's Strategy work

DIRECTION 5: BEING A LEADER IN HOSPITAL AND HEALTH CARE SERVICES				
Goal	**Strategies**	**Actions**	**Timeframe**	**Outcomes/Measures of achievement**
5.1 Services are responsive to user needs	5.1.1 Develop a Facilities Plan that reflects user needs	Incorporate high level facilities requirements into Asset Management Plan Following high level assumptions utilise key health plans/stakeholders input into planning Integrate into revisions of Asset Management Plan	Ongoing in 04/05	Priorities and efficient use of capital Facilities reflect community and service needs
5.2 Optimise management of elective services	5.2.1 Maintain compliance on the management of elective services demonstrating clear mechanisms for managing electives and improving access.	Audit implementation of national waiting list policy and guidelines Monitor performance of national Elective Services Performance Indicators Develop and implement remedial action plans for services or specialities outside of indicator targets Identify strategies to improve access to FSAs Identify strategies for implementation to manage and control the number of ‗follow ups' Identify targets for each speciality FSAs vs followups Identify initiatives to improve primary care access to diagnostics to reduce demand for FSAs Link with the ‗Improving the patient Journey' project to improve access to electives	July 05 Ongoing June 06 Ongoing Ongoing June 06 Ongoing Ongoing	Ministry indicators for performance met and demonstrate achievement of all targets Reduced waiting time for First Specialist Assessments (FSAs) Improved compliance with national guidelines Patients given ‗certainty' are treated within 6 months.
5.3 Optimise delivery of services across the regions	5.3.1 Collaborate with other DHBs to improve access to clinical services regionally	Agree arrangements for Inter District Flows (IDFs) already agreed with other DHBs, and monitor progress against Implement MOU with West Coast DHB and over closer collaboration Support Sth Island clinical service projects in vascular surgery, cardiology and oncology - reach agreement on South Island provision	Ongoing Dec 05 July 05	DHBs agree on joint initiatives IDF funding and Service Response clear Closer collaboration in clinical and non-clinical areas Reach agreement on provision for South Island

3.1.2 Minister of Health's Priorities 2005 – 2006

Minister of Health's Strategic Priority 1: New Zealand Disability Strategy

In June 2004 the Canterbury DHB approved the updated Disability Strategy Action Plan 2004/2007. A monitoring report on progress against the Disability Action Plan goes to the Disability Support Advisory Committee (DSAC) every six months regarding the progress on implementing the Action Plan.

DSAC aims to ensure the kinds of disability support services provided or funded and the policies adopted promote the inclusion and participation in society, and maximise the independence of the people with disabilities within the Canterbury DHB's resident population. This Committee is now meeting with the Community and Public Health Advisory Committee (CPHAC) and they receive a combined monthly monitoring report. The workplan of DSAC focuses on oversight of the Older Persons Service Strategy, monitoring progress on actioning the Canterbury DHB Action Plan for Disability and providing advice on disability issues to the DHB; as they relate to other pieces of work such as strategy development and monitoring processes. The monitoring report, DSAC agenda, Disability Strategy Action Plan 2004/2007 and minutes are available on the Canterbury DHB website www.cdhb.govt.nz under the Public Meetings section.

Annual Objective(s)	The CDHB will: ▪ Continue to promote and provide a non-disabling culture ▪ Continue to implement the CDHB's Disability Strategy Action Plan for Disability 2004/2007 within our own services and with other providers ▪ Continue to work towards more coordinated services for people with disabilities.
Approach	▪ Continue to ensure all site redevelopment conforms to current standards of accessibility through adherence to its Accessibility Plan ▪ Continue to provide interpreter services, including those for Deaf people, in all major hospitals 24 hours per day, 7 days per week ▪ Continue to work with other agencies such as Christchurch City Council and Healthy Christchurch on health and disability issues ▪ Update the patient admission form to provide information on a patient's disability, which will include type of disability, severity, particular needs and any other information the patient deems relevant ▪ Continue to provide access to services for those with language barriers via the provision of interrupters ▪ Comply with the requirements of the NZ Speech language Bill when enacted into law.
Milestones/Actions	▪ Survey consumers and consult on survey results. The survey will be based on determining what consumers of health services want in order to improve their experience of these services ▪ The DSAC 2005 Work Plan will be informed by the Disability Strategy Action Plan and the results of the CDHB's NZ Disability Strategy Questionnaire ▪ Implement actions from the CDHB Māori Disability Strategy Development Project to help meet disability needs of Māori, as funding allows.
Risks and Mitigation Strategies	▪ Ongoing communication with disability community regarding activity within the CDHB with opportunities for feedback, discussion of issues and identification of potential problems ▪ The CDHB and Ministry of Health have had a number of discussions in relation to boundary issues. The proposed clarification by the Disability Directorate in relation to eligibility for DSS Services is a major risk to DHBs. Work will continue at a local district and national level to address this.
Indicators and Targets	▪ As per the Disability Strategy Action Plan 2004/2007 ▪ Refer to Section 5.1.

Minister of Health's Strategic Priority 2: Reducing Inequalities

The Canterbury DHB is aware of the inter-relationships that exist between socio-economic status, education, employment, housing and health. It incorporates the Equity Lens in its strategy and service development and planning and funding. As an example the Community and Public Health division of the Canterbury DHB has completed a plan on Infectious Diseases and issues for Canterbury. As these conditions are more prevalent in population groups that face health inequalities, this piece of work is being used to assist in planning services.

The Canterbury DHB works intersectorally through groups like Strengthening Families, Healthy Christchurch and Primary Health Organisations (to target and reduce inequalities).

Annual Objective(s)	The CDHB will work to reduce inequalities.
Approach	▪ Activities continue to be incorporated into day to day operations to ensure the focus on reducing inequalities is always to the fore ▪ Specific activities are underway to create a ~~-~~healthy health environment" approach (e.g. Smokefree CDHB policies) ▪ Emphasis on developing a sector/settings approach to service delivery to target specific populations continues ▪ Supporting PHOs to identify groups who face inequalities for whom resources should be targeted ▪ All strategy produced by the DHB is passed by a team with expertise in the equity lens and their recommendations considered as part of the strategy development.
Milestones/Actions	▪ All health gain and clinical service plans include health promotion ▪ Support for the Healthy Christchurch initiative continues.
Risks and Mitigation Strategies	▪ Resources (staff and funding) not supporting this approach ▪ Mitigated by training and reorientating service plans to ensure inequalities is a priority area.
Indicators and Targets	▪ All plans have clearly identified intervention goals ▪ All plans are monitored against targets ▪ Clear direction for each planning area ▪ Links with public health funding decisions locally and regionally ▪ Refer to Section 5.1.

Minister of Health's Strategic Priority 3: He Korowai Oranga

The Canterbury DHB adopted a Māori Health Plan in July 2002 which is currently being reviewed and revised and will be presented to the Board mid 2005. A Canterbury DHB Māori Workforce development plan is under development. The main aim is ~~-~~whânau ora" with the key focus being the implementation of He Korowai Oranga.

Annual Objective(s)	Continue to implement the CDHB Māori Health Plan.
Approach	**Foster Māori Community Development** ▪ Implement CDHB Māori model of service delivery ▪ Undertake quality improvement reviews of Māori providers ▪ Continue Regular Māori Community Consultation Hui ▪ Participate in intersectoral Māori networking forums ▪ Continue to support provider collaboration in appropriate Māori settings ▪ Contribute to support the development of Māori Health providers through use of MPDS, mental health funding and cooperation with the other South Island DHBs in Te Herenga Projects (lead by the NMDHB) ▪ Encourage inter-sector initiatives that positively affect Whanau Ora ▪ Continue CDHB involvement in the activities of groups such as: Christchurch Social Policy Integration Network, the Housing Network and Strengthening Families and foster relationships with Te Puni Kokiri, Ministry of Education and the Ministry of Social Development. **Partnerships with Māori** ▪ Finalise Memorandum of Understanding (MoU) Manawhenua ki Waitaha and forward to Cabinet. **Networking for DHB Board members** ▪ CDHB Board members offered MoH & DHB Māori Health training. **Develop the Māori Health and Disability Workforce** ▪ Ensure Māori input to CDHB workforce development projects ▪ Ensure Māori input into CDHB Primary and Community Health Strategy, PHO process and other integration initiatives e.g. Child Health, Diabetes, Cardiovascular Disease (CVD), Cancer, and focus on reviews of pathways of care that will lead to better outcomes for Māori ▪ Increase Māori provider capacity and capability and reinforce key messages: Quality, Sustainability, Collaboration, Cooperation ▪ Evaluate the impact of Māori Provider Development Scheme in Canterbury and the negotiation process to provide actions for 2005-06 ▪ Participate in Regional & National projects and networking forums ▪ Remove barriers to Māori with disabilities and their whanau from fully participating in New Zealand society ▪ Seek funding from MOH to continue Māori Disability Service Development Coordinator project (<&>65 years) for two more years ▪ Maintain relative investment in Māori Health ▪ Implement expenditure targets determined in the Māori Indicators & Expenditure Targets project.
Milestones/Actions	**Improving Mainstream Effectiveness** ▪ Work to ensure PHOs include effective Māori participation in all activities ▪ Encourage staff to actively participate in improving the ethnicity data collection process ▪ Continue to agree and monitor Māori Health Plans with primary and community providers. **Providing Quality Services:** ▪ Implement CDHB Model of Māori Service Delivery ▪ Implement CDHB Cultural Assessment Model ▪ Develop Cultural Safety Policy ▪ Lead some Regional projects focused on improvements in Māori health ▪ Implement Christchurch Hospital Māori Service Development Project.

	Improving Māori Health Information ▪ Continue to implement Ethnicity Data Collection Policy (June 2003), by focusing on the Ethnicity Data Collection Roll-out Program in Christchurch Hospital.
Risks and Mitigation Strategies	▪ Risks, particularly around resourcing, both human and financial ▪ Risk are mitigated through consultative engagement and inclusion in budgeting processes.
Indicators and Targets	▪ Monitor progress to meet He Korowai Oranga and CDHB Māori Health Plan targets ▪ MOU with Manawhenua ki Waitaha contains monitoring provision ▪ Implement Indicators identified in the Māori Indicators and Expenditure Targets Project ▪ Updated Māori Health Plan presented to the Board mid 2005 ▪ Refer to Section 5.1.

Minister of Health's Strategic Priority 4: Health of Older People

The Canterbury DHB is developing an Older People's Services Strategy to realign older persons services to address short and long term resource issues relating to the Population Based Funding Formula and devolution of age-related disability support services funding see Appendix 3 for the Project Plan. This integrated continuum of care work will continue and be linked to the resulting recommendations developed in the Older People's Services Strategy.

Annual Objective(s)	The CDHB will: ▪ Work to ensure older people's services are provided in an effective, integrated and efficient way within the resources available ▪ Complete the Older People's Services Strategy, including recommendations and an action plan, and start implementation of short-term recommendations ▪ Determine at least two specific older people's health performance measures consistent with the aims of the Strategy ▪ Continue to implement the LinkAGE Action Plan ▪ Work closely with Elder Care Canterbury ▪ Positively manage change in line with changes to Asset Testing.
Approach	▪ Utilise sector expert group, community consultation and internal policy group to develop Older People's Services Strategy ▪ Continue to pilot the International Resident Assessment Instrument (InterRAI) comprehensive geriatric assessment tool in conjunction with the Ministry's evaluation ▪ Continue to implement the recommendations of the District Nursing and Home Support Services Review. This will include developing packages of care and exploring different models of funding home based support services ▪ Continue to support the Co-ordinator of Services for the Elderly (COSE) model in the community and continue to be part of the evaluation by the ASPIRE project team ▪ Carer workforce issues continue to be a high priority – working with local providers taking note of National projects ▪ Improve access to information by consumers and service providers. ▪ Mental Health Strategy includes strategies for older people ▪ Continue to enhance disability support services for Māori and Pacific People ▪ Undertake health promotion and maintenance for older people through a variety of programmes, including "Stay on Your Feet' and the "Eat Well' nutrition promotion project ▪ Continue to support Elder Care Canterbury ▪ Continue to build positive provider relationships especially with PHOs ▪ Regular communication with the aged care residential sector ▪ Continue to implement the Residential Care Managed Bed Policy to ensure client choice and increase chances sector viability ▪ Conduct a regular aged residential care bed census to ascertain supply and demand of aged care facilities in all service types ▪ Residential care clients receive a level of care commensurate with need within resources available.
Milestones/Actions	▪ InterRAI pilot continues and is monitored effectively ▪ COSE model continues to be well established in the community and the ASPIRE research results are taken into account when considering rolling the model out to all GP practices ▪ Strategies to be implemented using agreed philosophy for carer workforce ▪ Project to enhance nutrition promotion for older people has been successfully implemented and funding secured for 2006/07 ▪ Oral Health Review recommendations have been implemented ▪ Support Oral Health initiatives relating to oral health care for those in residential care. Results of research by Oral Health team are reviewed and action taken where necessary and within funding constraints ▪ Review day care service provision to older Pacific People ▪ "65 or over" postcards have been distributed

	▪ Continue to develop the Information Services initiatives to improve sharing of information between services are progressing, including investigating sharing clinical results with general practitioners ▪ Mental Health Older People Advisory group continues to meet ▪ Intermediate care philosophy and guiding principles are being used by funders to assess new initiatives for service provision ▪ Māori Needs Assessment & Service Co-ordination (NASC) worker's role continues and a Pacific NASC worker role are being developed ▪ Work with the ChCh City Council re housing options for older people ▪ "Working Together" regular column in "In Touch" and "On Board" to encourage integration and collaboration ▪ Reports to Elder Care Canterbury and Community Stakeholder Group meetings.
Risks and Mitigation Strategies	▪ Ongoing risks relating to inadequate funding for disability support services, particularly under the Population Based Funding Formula.
Indicators and Targets	▪ Older People's Services Strategy developed and short-term recommendations are being implemented ▪ The rate of influenza vaccination for 65 year olds and health professionals has improved ▪ Refer to Section 5.1.

Minister's Strategic Priority 5: Improving Mental Health/ Mental Health Blueprint

Completion of the Canterbury DHB Mental Health and Addictions Strategy in May 2004 provided a framework for managing access to and delivery of a System of Care based on advancing recovery for service users. Two directions have been established and these are:

- Improving access for people experiencing mental illness and alcohol and other drug problems.
- An improved ‗System of Care' that is integrated, responsive and available in the consumer's chosen community.

The Canterbury DHB Mental Health and Addictions Strategy is consistent and complimentary to existing work at national and regional levels and is clear that service reconfiguration must occur within resources. Its vision is ‗Improving the health and well-being of people experiencing mental illness and alcohol and other drug problems'

The draft South Island Regional Mental Health Strategic Plan is attached as Attachment 7D. This Plan includes the Regional Workforce Plan that addresses, in part, the needs of the child and adolescent workforce. Another key document outlining work for Māori mental health is the SI Māori Mental Health Plan ‗Te Waipounamu Māori Mental Health Strategy.

The Strategy's vision is for Te Waipounamu Māori mental health workforce and services (kaupapa Māori mental health and dedicated Māori mental health) to grow in strength and numbers with the aim of providing a choice for tangata whaiora and their whanau. The action plan is outlined in the draft South Island Regional Mental Health Strategic Plan and includes capacity building with Māori Mental Health providers and workforce development. An additional 0.5 FTE has been recruited for this work.

Annual Objective(s)	The CDHB will ▪ Continue implementation of the action points from its Mental Health and Addictions Strategy and work to establish sector-wide mechanisms to review and implement an improved System of Care ▪ Work on incorporating the experiences of consumers / tangata whaiora and their families within the planning and delivery of services ▪ Work on improving the targeting of resources to those in greatest need ▪ Improve the quality of information available to support clinical and service decision making; in particular resolve issues around Mental Health National Information Collection (MHNIC) Compliance ▪ Undertake workforce development work to develop the Mental Health Workforce, in particular in Child and Youth Services ▪ Implement Responsiveness to Pacific Peoples Project in Hospital and Specialist Mental Health Services ▪ Progress the implementation of the South Island Māori Mental Health Strategy as it relates to Canterbury ▪ Undertake a number of projects with other SI DHBs in the areas of Māori Mental Health and locally. ▪ Improve access to Mental Health Services for Māori

Approach	Maintain and improve consultation and communication pathways Participate in relevant projects arising from implementation of Regional Plans and Regional Access including: Forensic, SI Alcohol & Other Drug Services Review and Kaupapa Māori Commence implementation of relevant aspects of the CDHB Mental Health and Addictions Strategy especially: Establishing a robust process to review service provision requirements for the System of Care Develop Case Management Systems Participate in the Mental Health Standard Measures of Assessment and Recovery (MH-SMART) initiative Continue work on improving the quality of information submitted to MHINC Ensure needs of older peoples with mental health issues are reflected in CDHB Older Peoples Health Strategy Continue to identify areas for the application of any underspend against Blueprint and any new Blueprint funding Establish a relationship with Werry Centre regarding Child and Youth training availability in the South Island. Trial outcome-based funding with one country based provider Increase number of providers who report to MHINC Continue to improve access for those with enduring mental illness (based on the Knowing the People (KPP) methodology) Continue to roll-out KPP with other integration initiatives such as the case management project
Milestones/Actions	▪ Implement updated mechanisms for advice to DHB from the mental health sector ▪ Business Plan and Training Program for MH-SMART established ▪ Action South Island Alcohol & Other Drug recommendations, especially development of workforce, increasing use of tele/video-conferencing. ▪ Complete South Island review of methadone services ▪ Support DSS review of Provider Arm Intellectual Disability Services and associated work ▪ Pursue Systems Based Training and National Resource Training for staff and sector ▪ Continue to support Māori Provider Development
Risks and Mitigation Strategies	▪ Sector resources insufficient to support implementation of services from any additional funding or underspend ▪ Sector resistance where service developments arising from service reviews increased blueprint funding or underspend require change to the status quo. To be addressed by regular communication with regarding potential issues along with opportunities to discuss concerns. ▪ Regional and Inter-sectorial projects fall behind schedule – close monitoring of progress, agreed process for remedy and clear roles and responsibilities
Indicators and Targets	▪ Implementation of MH-SMART as planned ▪ Achievement of milestones indicated above and in required plans ▪ Achievement of milestone and objectives in regional plans ▪ Refer to Section 5.1.

3.1.3 Minister of Health's (Implementation) Priorities 2005 – 2006

Minister of Health's Implementation Priority 6: Primary Care

The Canterbury DHB will support the ongoing implementation of the New Zealand Primary Health Care Strategy 2001 and will aim to improve population health by improving access to primary care and public health programmes designed to suit local needs. A review of Rural Services currently underway (Appendix 6) incorporates Primary Care issues in rural Canterbury.

Annual Objective(s)	The CDHB will support the implementation of the New Zealand Primary Health Care Strategy by : ▪ Completing the CDHB Community and Primary Health Care Strategy ▪ Supporting and monitoring the service delivery of PHOs in Canterbury ▪ Implementing and monitoring National and local primary health improvement programmes.
Approach	▪ Develop integration initiatives and coordinate care across service areas ▪ Support the development of the primary care workforce ▪ Develop information and quality improvement systems ▪ Support national health initiatives ▪ Work with Primary Health Organisations (PHOs) to demonstrate health gain in enrolled populations.
Milestones/Actions	**Community and Primary Health Care Plan** ▪ Consolidate sector feedback into a way forward ▪ Strategy presented to the Board by June 2006 ▪ Project plan for Community and Primary Care Strategy developed by December 2005 and approved by Board. **Primary Health Organisations** ▪ Work with MoH, DHBNZ, and PHOs to support sector action in the future development of PHOs and work with provider arm to encourage integrated service delivery. Work with PHOs to: ▪ Deliver Care Plus services focusing on patients with chronic diseases ▪ Build integration with HSS services so care can happen in a community setting ▪ Actively involve PHOs in finding solution to improving access to health care in rural communities ▪ Implement mental health demonstration programs ▪ Implement Key Performance Indicator (KPI) reporting ▪ Implement 18–24 year co-payments ▪ Maximise the positive effects of Health Promotion and Services to improve Access Plans ▪ Promote enrolment of populations ▪ Maximise involvement of Māori providers and iwi in PHOs ▪ Develop participation by Pacific providers ▪ Plan primary health nursing roles and develop roles of other health care providers in PHOs ▪ Identify and support initiatives in PHO workforce recruitment and retention ▪ Undertake a six monthly review of progress of the PHOs in Canterbury. Other Primary Care Projects ▪ Continue Acute Demand projects ▪ Implement Pharmacy Medicines Management ▪ Work with PHOs to establish a satisfactory approach to after hours services ▪ More effectively target home support services.

Risks and Mitigation Strategies	**Community and Primary Health Care Strategy** ▪ Risk – stakeholders do not agree on Strategy. Capital is not available to invest in actions intended for delivery in the first three years. Other public sectors unable to contribute to joint actions with the health sector. ▪ Mitigation – Close consultation with stakeholders and adequate information provided. Advise financial planners very early. Look for the least capital-intensive solutions to the plan's proposals. Make the most use of assets and skills already in place in the primary and community health sector. Include other sectors early as stakeholders. Contribute to their initiatives too. Keep high level contacts with other sector organisations open. **PHOs** ▪ Risk – Some CDHB PHOs fail, due to patients using non-PHO health services and high management costs. Population health gains not demonstrated and hospital admission rates not reduced. ▪ Mitigation – Support PHOs, encourage cooperation, support DHB-wide initiatives. Long term monitoring to demonstrate health gain. Robust KPI collection and service reporting and monitoring in place.
Indicators and Targets	▪ Increase participation by Māori and Pacific Peoples in decision making in Primary Health ▪ Reporting requirements met ▪ Refer to Section 5.1.

Minister of Health's Implementation Priority 7: Workforce Development

The Canterbury DHB has incorporated into its Core Directions key workforce development areas identified in the DHBNZ Workforce Action Plan. These areas include the building of strategic workforce capability, enhancing the standard of workforce information and improving relationships with external stakeholders.

Annual Objective(s)	Implement CDHB Core Direction activities associated with workforce development.
Approach	▪ Integrate and apply key behaviours as established through the Organisational Development Framework activity and continue project activity under priority segments: - Recruitment & Selection - Change Management - Remuneration - Learning & Development (Leadership & Management Development) ▪ Credentialling Frameworks developed for key workforce groups (HSS) ▪ Work with external contract providers to assist with HPCA compliance ▪ Continue with development of advanced nursing practice roles ▪ Identify priority areas for development of possible scopes and models such as rural nursing and acute care ▪ Continue development of Māori Workforce supporting Tikaka Hauora initiative ▪ Identify strategies to encourage and develop Pacific Workforce ▪ Progress local Human Resources Information Systems activity ▪ Support Workforce Steering Group (WSG) to identify future workforce planning requirements. ▪ Continue to influence local and regional tertiary providers in line with WSG determinations ▪ Build on the current level of workforce information and improve standard of information currently collected ▪ Ongoing forums established for continued debate and discussion on education and health policy interaction ▪ Continue to support and participate in local/regional development of Primary Health Sector relationships ▪ Continue to develop local health and wellbeing initiatives. ▪ Support national, regional, local union forum activity. **National Activity** ▪ Support National recruitment employer branding activity in conjunction with DHBNZ ▪ Provide input into DHBNZ National data set/systems HWIS and MHWIS ▪ Support and participate in regional standardisation of HR policy/procedure in conjunction with DHBNZ ▪ Participate in stocktake of healthy workplace initiatives and implement identified actions.
Milestones/Actions	(Details covered in Section 3.1, Core Directions 4) ▪ Review policy direction for IEA and Collectives ▪ Recruitment & selection systems and processes review undertaken ▪ Leadership programme review undertaken ▪ Develop guidelines/tools to support managers/staff in managing change ▪ Workforce maintains appropriate skills/competencies ▪ Contracted providers meeting legislative requirements ▪ Māori and Pacific workforce information is collected and accurate ▪ Projects established to encourage representation of Māori and Pacific including Tikaka Hauroa (Māori Mental Health) Development ▪ Scoping processes in place and links to national future workforce activity highlighted ▪ Clinical Training Agency (CTA) funds are accessed, fully utilised, possible additional funds gained

	▪ Participation in combined Tertiary Provider Advisory Groups ▪ Access to training and development opportunities for Primary Health staff available ▪ Progression of current initiatives ▪ Annual ACC Accredited Employers Partnership Programme Audit completed ▪ Occupational Health Service implemented and operating. **National Activity** ▪ Achievement of Workforce Action Plan Project Measures ▪ Support and resource as required Health Workforce Information System (HWIS) Implementation and reports generated as required for MoH ▪ Healthy Workplace stocktake completed and identified action/s implemented with reports generated as required for the MoH ▪ Healthy workplace initiatives enhance clinical governance, reinforces retention of workforce and role Models CHDB's commitment to healthy lifestyles.
Risks and Mitigation Strategies	▪ Resources (staff and funding) not supporting this approach ▪ Mitigate by careful prioritisation and signoff of key projects, and clear internal communication of expected delivery.
Indicators and Targets	▪ See Section 3.1.1, Core Direction 4 ▪ Refer to Section 5.1.

Minister of Health's Implementation Priority 8: Progress Meningococcal Vaccine Strategy and Achieve Improved Overall Immunisation Rates

A separate Project Implementation Plan (PIP) covering the detail of this initiative has been sent separately to the Ministry of Health.

Annual Objective(s)	The CDHB will: ▪ Implement a mass immunisation programme to control the current New Zealand epidemic of group B meningococcal. ▪ Record all immunisations given to children born after 21 November 2005 and children receiving the MeNZB™ immunisation, and retain this information throughout the life span of the individual.
Approach	▪ Through good organisation and communication with the CDHB community, provide and deliver immunisations to over 120,000 people under 20 years.
Milestones/Actions	▪ Installation of School Based Vaccination System on CDHB server. ▪ National Immunisation Register (NIR) Project Implementation Plan signed off by MoH ▪ Meningococcal B Vaccine (MVS) draft PIP completed and forwarded to MoH for sign-off ▪ Recruitment, training and education of vaccinators, Public Health Nurses, PHOs and providers and development of links with education providers and schools ▪ Raising awareness of storage requirements for vaccines ▪ Development and implementation of Māori and Pacific community awareness rising strategy and communication plan ▪ NIR Go Live for Pre-Entry of MVS Consent Forms ▪ MVS Go Live for School Based Campaign ▪ MVS Go Live for Primary Care Based Campaign ▪ NIR Go Live for Birth Cohort.
Risks and Mitigation Strategies	Risk - NIR Software delivery is delayed or there are implementation problems. Targeted immunisation rate not reached. Mitigation - Work to ensure vendor implementation support is available at crucial times. Ensure implementation plan is flexible enough to allow a variable software implementations schedule. Choose effective population awareness campaigns and appropriate immunisation outreach activities. Risk - Lack of suitable base for NIR staff and lack of suitable workforce/adequate number of Registered Nurses to provide vaccination in school, primary care and outreach settings. Mitigation - Inform early of workforce and workload issues.
Indicators and Targets	▪ Refer to Section 5.1.

Minister of Health's Implementation Priority 9A: Improving Elective Services

Meeting demand for elective services is of concern to the Canterbury DHB. Its Elective Services Steering Committee continues to monitor compliance against Elective Services Performance Indicators (ESPIs). The key objectives are to:

- Deliver services within contracted volumes and improve capacity within existing resources,
- Communicate to patients and referrers of the likelihood of service,
- Continue to develop strategies to deliver elective services within current resources and improve milestones,
- Continue to collect information to identify future demand/need.

The Canterbury DHB is committed to implementing the Government initiatives in Orthopaedic and cataract Surgery.

Annual Objective(s)	The CDHB will follow the key objectives above, it will also ensure compliance with MoH policy and respond to any changes in policy with robust information and timely recommendations.

Approach	Achievement of elective services objectives continues to be monitored through the MoH ESPIs. The CDHB has seen sustained improvement in the ESPIs over the past 12–18 months. The ongoing maintenance of these improvements will be achieved through:
	▪ Continued communication of referral guidelines and access thresholds for outpatient assessment to referring doctors with the objective of patients remaining in the community / primary care until the optimal time for referral or treatment is reached.
	▪ Monitoring of KPIs within the hospital system to ensure the most effective and efficient use of elective services resources and funding.
	▪ Continuation of active review processes across all services for patients, without certainty of treatment within six months but who are likely to deteriorate or are just below the funding threshold.
	▪ Production planning organised and streamlined.
	▪ Continued planning and development of new initiatives to enhance the interface between primary and secondary care through the Acute Demand Management Group and the Elective Services Working Group including:
	  ▪ ongoing support of the GP Liaison team
	  ▪ further development of nurse-led initiatives
	  ▪ implementation of the GP access to diagnostics project
	  ▪ development of the Shared Options for Acute Care Strategies
	  ▪ further development and implementation of GP follow up.
	
	An Action Plan for ESPI improvement has been developed which incorporates the requirements of the orthopaedic initiative and is modelled upon the CQI strategy. The CDHB will have this Plan agreed with the Ministry of Health by 30 June 2005 and will achieve compliance with all ESPIs by 30 June 2006. Specific objectives to achieve Continuous Quality Improvement are available through the Improving the Patient Journey Programme of work. Achievement of the CQI strategies will be evident in the delivery of the ESPI action plan targets.
	
	Specific objectives of the ESPI action plan are:
	▪ Establish targets for compliance to ESPIs one to eight
	▪ Link ESPI compliance objectives with those of the Orthopaedic Initiative Recovery Plan
	▪ Specify timeframes and deliverable's for implementation of the actions required for compliance
	▪ Specify internal audit mechanisms to ensure ongoing maintenance of ESPI compliance.
	
	Key features of the Action Plan include:
	Outpatient Services

	Vascular ▪ Integration of services with Nurse Maude Association Wound Care Clinic. Medical ▪ Implementation of GP Care criteria for patients unlikely to be seen in six months. Urology ▪ Development of strategy for continence management in the community and catheter care. All Other Services ▪ Improve access to Community Referred Radiology and implementation of GP Care policy as well as introduction of pilot for GP follow up for Oncology Services. **Inpatient Services** Cardiology & Cardiothoracic Surgery ▪ Improved collaboration regarding duty of care for waiting list patients and delivery of contracted volumes. Ophthalmology & ENT ▪ Revised certainty threshold moving closer to ATT. Gynaecology ▪ Implementation of GP Care policy and continued access to GP clinics for Mirena. General Surgery & Vascular ▪ Increased cholecystectomy and thyroid surgery and improved access to theatres subject to funding. ▪ Development of plan for GP MOSS position as part of Elective Services Innovation Fund. Plastic Surgery ▪ Implementation of GP Care policy for patients awaiting breast reduction. Urology ▪ Implementation of GP Care policy. All Services ▪ Monthly monitoring of throughput processes including score profiles for incoming referrals and treatment thresholds using KPIs. ▪ Additional education and training to all staff regarding active review processes. ▪ Increased accuracy of expected dates of discharge and expected length of stay for elective patients. ▪ Ongoing implementation of improving the patient journey strategy for elective throughput including theatre access and forecasting demand. ▪ Implementation of revised DOSA/Day Stay procedures including outpatient consenting and screening process and use of pending admissions process for monitoring and forecasting. ▪ Development of project to undertake GP preadmission process in some services. **Improving Elective Services** ▪ Prioritisation compliance will be monitored through monthly score profile analysis of waiting and treated patients. ▪ Consultation with targeted surgeons will be undertaken by the Clinical Director in conjunction with the Chief Medical Advisor. ▪ Participation on the Ministry of Health consortium to review CPAC will inform the process of achieving consistency of application of the score tools. ▪ Where available all surgeons will use national score tools correctly mapped for ESPI reporting. ▪ Unscored patients will not be accepted onto the waiting list. ▪ Patients with a score below the threshold for Active Review will be returned to GP Care immediately; those in Active Review, remaining stable for up to 3 reviews, will then be returned to GP Care.

Milestones/Actions	**September 2005** - GP Access To Diagnostics project implemented and evaluated (Phase I). Shared Options for Acute Care Strategy implemented and evaluated (Phase I). Participate in MOH Innovation Working Group and Elective Services Forums to ensure CDHB strategies are aligned to MoH future direction. Day of Surgery Admission revised processes implemented and evaluated. **December 2005** – Development of nurse-led initiatives and strategy for GP follow up. Continue to monitor the Day of Surgery Admission rates and Day Surgery rates to maximise effective and efficient use of the new theatres in the Christchurch Women's Hospital and Day Surgery Unit. **March 2006** - Review financially sustainable thresholds and make recommendations to Annual Plan and budget process to address gaps in elective service delivery. Implement nurse-led initiatives and GP follow up strategies. **June 2006** - Evaluation of nurse-led initiatives, GP follow up strategies and access to diagnostic projects. **Improving Elective Services** ▪ There are no plans to reduce elective surgery. ▪ The 05/06 contractual volumes remain the same as 04/05 with some increase. With the opening of the new Christchurch Women's Hospital and Day Surgery Unit there is extra theatre capacity. ▪ Theatre productivity will be monitored monthly to maximise the utilisation of the theatres. ▪ The pre-admission, consenting and day of surgery processes have been established to increase the efficiency at Christchurch Hospital.
Risks and Mitigation Strategies	▪ Unmet promises – number of patients for whom certainty of treatment within six months was promised but who are now overdue for their surgery. ▪ Provider capacity – ability of hospital provider arms to deliver funded volumes given constraints on site, staffing (anaesthetic, nursing, SMO, RMO) and level of community supports equipped to manage patients in the interim. ▪ Level of need of patients – where patients not being offered assessment or surgery may fall into a state of unreasonable distress, ill health or incapacity with no ability by the provider arm to increase capacity to deliver a service once the patient has deteriorated. ▪ Reliability of assessment / Clinical Prioritisation Assessment Criteria (CPAC) tools – where the methods used to determine national access levels to assessment or surgery are unreliable, are applied inconsistently or change, causing risk or anomaly in the financially sustainable thresholds for whether a patient can access publicly funded services or not. ▪ Ad hoc responses to pressure or lobby groups – where one-off increases in services are introduced without reference to an overall plan for delivery of elective services, but are introduced to satisfy public or political pressure groups, hence creating disincentives for managing a robust rationing system.
Indicators and Targets	▪ Elective Services Performance Indicators (monthly) ▪ Internal audit reports (monthly and annually) ▪ Crown Funding Agreement reporting (quarterly) ▪ District Annual Plan reporting (quarterly) ▪ Refer to Section 5.1.

Minister of Health's Implementation Priority 9B: Improving Orthopaedic Services

The Canterbury DHB is committed to the principles and objectives of the Orthopaedic Initiative and a Steering Group has been convened to oversee the successful implementation of this project

Annual Objective(s)	A dedicated Project Facilitator has been appointed for the Orthopaedic Initiative with the following responsibilities: ▪ Facilitate and monitor the delivery of elective orthopaedic volumes to meet annual contracts ▪ Develop a plan to achieve the agreed ESPIs for the Orthopaedic Service ▪ Facilitate the implementation of the Continued Quality Improvement (CQI) component of the initiative by way of a productivity and efficiency plan ▪ Ensure links to the Burwood Redevelopment are maintained and developed to meet the future needs of the service.
Approach	Project Deliverables There are five key performance components: ▪ Deliver on existing contract volumes in addition to the Orthopaedic Initiative volumes ▪ ESPIs ▪ CQI Productivity and Efficiency Plan ▪ Build sustainable public sector capacity & capability ▪ Support nursing scholarships. The approach is as follows: ▪ Deliver major joint replacement volumes for both base contract and key marker cases ▪ Meet the Governments expectations of Orthopaedic Service providers, as measured by the ESPIs ▪ All patients with a level of need which can be met within the resources available are provided with surgery within six months of assessment ▪ Patients have equity of access to services ▪ Maximum waiting time of six months for First Specialist Assessment ▪ Identify initiatives where productivity and efficiency gains can be made by streamlining patient flow ▪ Process mapping ▪ Develop and Implement KPIs ▪ Validate the Pre Admission Process, Admitting Process and Discharge Planning Processes ▪ Optimise outpatient capacity and capability ▪ Build sustainable public sector capacity and capability ▪ Nursing scholarships available to support the above initiatives with appropriate training. An ESPI Recovery Plan for Orthopaedics has been agreed with the Ministry Orthopaedic Initiative Team (27/04/05). Compliance will be achieved in all ESPIs by 30 June 2006. This will be achieved in conjunction with improved Primary Care interfaces due to the appointment of a GP Liaison specifically for the Orthopaedic Service. A focus will be to ensure adequate and appropriate referral information is received from GPs. Discussion will also take place with Primary Care to introduce primary care resources into the Orthopaedic outpatient arena, with an initial focus on pre admission. Improving Orthopaedic Services - the focus for 2005/06 will be three-fold: ▪ Meeting and maintaining ESPI compliance ▪ Ensure equitable selection of patients to be given certainty ▪ Ensure promises made match capacity available. These will be achieved by: ▪ Delivering the ESPI Recovery Plan as agreed and involving Primary care in improving the gateway management

	▪ Providing surgeons with ongoing information showing scoring patterns and links between priority and treatment ▪ Ensuring surgeons select cases from reports specifically designed to assist them match promises with their capacity to treat.
Milestones/Actions	**July 05** ▪ KPIs Developed and Implemented ▪ Pre Admission Process validated and streamlined ▪ Admitting Process validated and streamlined ▪ Redevelopment for increased public sector elective orthopaedic capacity planning finalised. **December 2005** ▪ Complete validation of Discharge Planning Process with community involvement ▪ Improve utilisation of outpatient capacity and capability. **June 2006** ▪ Finalise workforce planning to ensure capability matches new capacity. **Improving Orthopaedic Services:** The Orthopaedic Initiative provides for P&E processes that have already commenced within the CDHB Orthopaedic service and will continue throughout 2005/06. This includes: ▪ active theatre productivity planning to maximise theatre utilisation ▪ a complete review of the Elective Orthopaedic Patient Journey ▪ process mapping being completed and the results informing the diagnostic stage of the pathway review ▪ a review of the Pre Admission and Discharge Planning process (this has commenced and will be completed by 31 December 05). All of the above are necessary to inform the appropriate model of care to flow into the new facility, to be commissioned in December 2007. Orthopaedic Initiative volumes have been agreed with the Ministry of Health as 800 cases in 2005/06. Capacity is available to deliver these.
Risks and Mitigation Strategies	▪ Unmet promises – number of patients for whom certainty of treatment within six months was promised but who are now overdue for their surgery. ▪ Provider capacity – ability of hospital provider arms to deliver funded volumes given constraints on site, staffing (anaesthetic, nursing, SMO, RMO) and level of community supports equipped to manage patients in the interim. ▪ Level of need of patients – where patients not being offered assessment or surgery may fall into a state of unreasonable distress, ill health or incapacity with no ability by the provider arm to increase capacity to deliver a service once the patient has deteriorated. ▪ Reliability of assessment / CPAC tools – where the methods used to determine national access levels to assessment or surgery are unreliable, are applied inconsistently or change, causing risk or anomaly in the financially sustainable thresholds for whether a patient can access publicly funded services or not.
Indicators and Targets	▪ Elective Services Performance Indicators (monthly) ▪ District Annual Plan (IDF) reporting (quarterly) ▪ Refer to Section 5.1.

Minister of Health's Implementation Priority 10: NZ Cancer Control Strategy

The Canterbury DHB Cancer Strategy will build on national policies as well as noting issues raised in its Palliative Care Strategy (presented to the Canterbury DHB Board May 2003) and its review of Oncology Services (November 2002). Other key policy documents are:

- The NZ Cancer Control Strategy 2003
- NZ Cancer Control Strategy Action Plan 2005-2010 (March 2005)
- NZ Health Strategy 2000
- CDHB Strategic Plan 2002-2006
- The NZ Palliative Care Strategy 2001
- Healthy Eating:Healthy Action 2003
- CDHB Healthy Eating Active Living Strategy April 2005.

Annual Objective(s)	The CDHB will: ▪ Use the NZ Cancer Control Strategy Action Plan 2005-2010 to guide the planning, development, and delivery of existing and new cancer control activities and services. A focus for 0506 will be on Goal 1 (Reduce the incidence of cancer through primary prevention) and Goal 4 (Improve the quality of life for those with cancer, their family and whanau through support, rehabilitation and palliative care) ▪ Work with other South Island DHBs, through the Oncology Clinical Forum Project, to identify options for improved collaboration in delivering cancer treatment services across the South Island. ▪ Continue to work for resolution of issues relating to funding for cancer drugs ▪ Achieve radiation therapy waiting times ▪ In 05/06 towards improving access to and flow through palliative care services with the introduction of "SupportCare" and implement nutrition and physical activity actions from the CDHB Healthy Eating Active Living Strategy.
Approach	▪ Align the CDHB Cancer Control services and actions with the Cancer Control Strategy Action Plan 2005-2010 ▪ Continue to support programmes focusing on improving nutrition, smoke free lifestyles, limiting alcohol intake, increasing exercise and sun protection campaigns ▪ South Island Chief Executives (CEOs) to discuss acceptable process for discussion on common service provision issues ▪ Prepare business case to purchase equipment ▪ Staff participate in national implementation working groups ▪ Complete service provision framework with two palliative care providers.
Milestones/Actions	▪ Current level of health education maintained ▪ Ongoing membership of relevant working groups ▪ South Island CEO agreement of process for addressing common issues, and service delivery relationships ▪ Palliative care access criteria defined and utilised ▪ Review national screening contracts annually to ensure the region's population is accessing all screening services.
Risks and Mitigation Strategies	▪ Delays in development of plan for CDHB Cancer Control Strategy due to competing priorities – mitigate by monitoring current work.
Indicators and Targets	▪ Refer to Section 5.1.

'SupportCare' is a new initiative brought about by the redevelopment of existing Palliative Care and Chronic Medical Illness systems, processes and funding. The term 'SupportCare' reflects the desire of Canterbury DHB to provide services that support people with severe chronic medical illness and those in the end-of-life phase. In order to qualify for SupportCare, patients need to meet specific criteria. The type and level of services patients receive is determined through an assessment process.

SupportCare funding provides for either:-
Residential care in a community residential care facility (ie rest Home or Private Hospital); OR
'Packages of Care' services provided in the patient's home environment.

Each patient is assigned a care coordinator who is responsible for coordinating services available to patients who qualify for SupportCare.

The concept of SupportCare enables transparent, flexible and equitable service provision to people, centralises the funding process, eliminates the historical funding wait lists, and will enable monitoring of spend. This in turn gives patients, their families/whanau and health professionals certainty and flexibility in terms of service provision, and ensures patient need is met in the best possible way.

Minister of Health's Implementation Priority 11: Healthy Eating, Healthy Living

The Healthy Eating, Active Living (HEAL) Action Plan is in development and will be presented to the Board in early 2005 – the draft is attached as Appendix 9.

Annual Objective(s)	The CDHB will implement the Healthy Eating, Health Living Action Plan.
Approach	▪ An Implementation Plan for the HEAL Action Plan is under developed ▪ The HEAL Action Plan has three focus areas: - Working with other sectors and communities; and - Working with individuals, families and whanau; and - Building foundations ▪ The Equity Lens has used in the development of the HEAL Action Plan.
Milestones/Actions	▪ The HEAL Action Plan will be implemented in collaboration with Māori and Pacific Peoples communities and providers and with PHOs ▪ Agree the Terms of Reference of a Steering group which will cover the interagency nutrition and physical; activity group.
Risks and Mitigation Strategies	▪ Health promotion activities for HEAL are funded by the MoH hence the CDHB will need to work collaboratively with other sectors such as SPARK to implement the Action Plan.
Indicators and Targets	▪ As per the HEAL Action Plan (April 2005).

Minister of Health's Implementation Priority 12: Collaboration Across Agencies

The Canterbury DHB works actively with a range of funders (such as Housing, MSD, and TLAs) of public health and social development to achieve gains in public health.

A Business Plan (2005) has been developed for Community and Public Health (CPH). This Plan recognises the need to make the most of new opportunities to improve the health of our community. The three key changes are the establishment of a Strategic Management Group, a Public Health Intelligence Team and the strengthening of a settings based approach. The increased focus on settings recognises that public health achievements in the future will be less about CPH delivering discreet projects to groups and more about facilitating sustainable changes to the social and physical environments that our communities live in.

Annual Objective(s)	The CDHB will: ▪ Integrate services for Older People's Health, Child Health, Mental Health, Cardiovascular Disease (CVD) and Diabetes ▪ Contain (medical and acute) demand growth ▪ Encourage Innovation ▪ Continuously improve quality and safety.
Approach	▪ Work with the wider sector to implement the continuum of care as described in the LinkAGE Report, Child Health Strategy Action Plan, PHO Guidelines and Mental Health and Addictions Strategy ▪ Manage medical/acute demand ▪ Develop a culture of innovation ▪ Promote a systems approach to enhance patient safety.
Milestones/Actions	▪ Strengthen service planning relationship with PHOs, TLAs, MPIA, TPIs, CYF, Police and MSD via CSPIN and interagency nutrition forum as an example ▪ Child Health Action Plan implemented ▪ Participate in Work and Income New Zealand (WINZ) PATHS' initiative ▪ Support Christchurch Hospital's work with community providers ▪ Encourage sharing of benefits from innovative services ▪ Target existing research investments to researching innovation opportunities ▪ Improve reporting on Quality KPIs, Incident Management Processes and identify key indicators for service and patient quality ▪ Begin implementing the work plan from the Quality and Patient Safety Council's Strategic Plan including: quarterly reporting on quality and risk management to the Board and organising the CDHB Quality and Innovation Awards Programme.
Risks and Mitigation Strategies	▪ Difficulties in bringing groups on board and agreeing priorities mitigated by regular communication and agreeing early on joint priorities for work.
Indicators and Targets	▪ Recommendations of reports implemented ▪ Process in place to support people on sickness benefit with mental health issues ▪ Acute medical growth is contained in line with Health Round Table Benchmarks ▪ Quality and Innovation Awards produce a range of projects to implement ▪ Improved understanding of CDHB-wide innovative initiatives

Minister of Health's Implementation Priority 13: Keeping infrastructure costs as low as possible

The Cantebrury DHB has an ongoing process and objective to review its infrastructure costs and, where appropriate, initiatives are implemented to manage and/or reduce these costs. Efficiency initiatives over past years have resulted in the Canterbury DHB having a low administration component relative to the size of the organisation and assisting with improving productivity.

Annual Objective(s)	The areas being considered by the CDHB include: ▪ Further centralisation of some support services ▪ Alignment of hospital sites to service needs ▪ Review of business support functions.
Approach	▪ The process will include identification of initiatives, assessment of risks, benefits and impact on services and patient care - including clinicians input, where appropriate. Draft proposals will be prioritised for Executive Management Team review and/or sign-off, which will then be followed by a consultation process with the appropriate parties ▪ Briefings to the Board and Statutory Committees together with Board approval (if required) will be an integral part of the process. Implementation processes will then follow ▪ A number of consultation processes are already underway including the centralisation of maintenance support services.
Milestones/Actions	▪ The process is ongoing. Some specific milestones for the year include the implementation of centralised telephonist and medical records ▪ Other milestones expected include the implementation of the new Oracle financial system that will provide additional functionalities to facilitate changes to improve requisition and/or purchasing processes.
Risks and Mitigation Strategies	▪ Each proposal or initiative will require a business case, including a risk assessment. The review and sign-off process provides different levels of checks and risk mitigation. Proposals with significant capital expenditure, service and/or staff implications will follow appropriate briefing, consultation and sign off processes, including the MoH/Minister of Health, where applicable ▪ Collaborative approaches with other DHBs, where project commonality exists, will be part of the process. An example of this is the Oracle Financial System, which involves Waikato, Bay of Plenty and Canterbury DHBs.
Indicators and Targets	▪ Refer to Section 3.1.1, Core Direction 2.

Minister of Health's Implementation Priority 14: Industrial Relations Strategies

The Canterbury DHB has an Employment Relations (ER) position that provides our direction in relation to the bargaining of collective agreements. We also work constructively with Unions to address local, regional and national workforce requirements.

Annual Objective(s)	Our aim is to: ▪ Maintain a stable ER climate at the CDHB ▪ Ensure the 2005/2006 ER Collective Agreement Bargaining Strategy represents the CDHB complex environment ▪ Support regional and national IR activity.
Approach	▪ Continue open communications with Union representatives and staff ▪ Promote and participate in union relationships ▪ Proactively manage employee grievances with a constructive approach to resolution ▪ Bargain in good faith using best endeavours to deliver fair collective agreement settlements ▪ Apply vigorous costing methods to enable certainty of funds delivered in settlements and impact on totals funds available ▪ Develop individual bargaining strategies for collective agreements including appropriate internal and external benchmarking ▪ Participate in regional and national negotiation to deliver the best outcome for the Canterbury staff and patients. ▪ Ensure Regional IR Specialist is supported in their endeavours. ▪ Commitment to 'Bipartite' process.
Milestones/Actions	▪ Ongoing scheduled Combined Health Union consultation meetings ▪ Collective Agreement settlements in accordance with Bargaining Strategy Scope.
Risks and Mitigation Strategies	▪ Expectations of Unions may exceed CDHB's ability to pay ▪ Industrial action results as a reaction to unfulfilled expectations ▪ Unions do not participate in a constructive manner, despite promotion of this by the CDHB ▪ Being aware of how negotiations and settlements influence providers in the wider CDHB Health and Disability sector ▪ Participation in National/Regional MECA's may lead to CDHB being under pressure to settle beyond its ability to pay. ▪ Mitigate these risks by open communication of financial and operating constraints with Unions, staff and providers.
Indicators and Targets	▪ Industrial Harmony ▪ Milestones as set out above ▪ Refer to Section 3.1.1, Core Direction 4.

Minister of Health's Implementation Priority 15: Innovative Approaches to Enable Managing within Budget

Population Based Funding (PBF) continues to have significant financial impact for the Canterbury DHB. As an over-funded DHB, the Canterbury DHB's funding will be subject to a reduction in transitional funding until its funding is in line with its population share. A gap of between $8M to $10M per annum exists between incremental revenue and the incremental cost of maintaining existing services which is envisaged for 2005/2006.

Annual Objective(s)	The financial imperatives will necessitate CDHB to reconfigure its services and/or realign its resources and facilities to the appropriate service levels. These key requirements will form the basis of the annual objective over the next few years in order to meet the 'break-even' financial performance expectation of the Minister of Health.
Approach	▪ Briefings to the Board, Committees, staff and the Canterbury community on the impact of PBF will be ongoing. ▪ The strategies and objectives to address the financial gap will be an integral part of CDHB's Core Directions. The strategies will encompass efficiencies, revenue enhancement and service/facilities reconfiguration.
Milestones/Actions	▪ The implementation of Core Directions actions is ongoing. Due process and consultation will be undertaken, where required.
Risks and Mitigation Strategies	▪ Where service reconfiguration and facilities realignment is likely to have associated staffing, community, political and/or media risks, mitigation strategies will be applied. These will include ensuring due process and appropriate consultations and communication are undertaken. Also early signals and/or advice to the MoH/Minister where appropriate. ▪ Each proposal or initiative will require a business case, including risk assessment. The review and sign-off process (EMT, Committees and Board, where appropriate) provides different levels of checks and risk mitigation. Proposals with significant capital expenditure, service and/or staff implications will follow appropriate briefing and sign off process, including the Ministry/Minister of Health. ▪ Collaborative approaches with other DHBs, where project commonality exists, will be part of the process. ▪ There are also risks associated with planning assumptions not holding true and these will be identified and provided to the Board to assist their decision-making process. Additional efficiency initiatives and service realignment may be required to mitigate these risks.
Indicators and Targets	▪ Refer to Section 3.1.1 Core Direction 2 and efficiency targets to achieve break-even result.

3.1.4 Additional Canterbury DHB Objectives for 2005 – 2006

Canterbury DHB Strategic Objective 1: Pacific Peoples

The Canterbury DHB adopted the Pacific Health Action Plan in May 2002. Its focus is on:

- Supporting Pacific People as health providers, increasing numbers in the health workforce
- Involving Pacific Peoples in health service development
- Accurately collect ethnicity data
- Establishing a Pacific People's primary health service
- Helping to increase collaboration between Pacific providers.

Annual Objective(s)	The CDHB will: ▪ Incorporate a Pacific focus in CDHB planning and inter-sectoral activities ▪ Expend Pacific Provider Development Funds (PPDF) according to agreed Plan ▪ Work on Pacific workforce development and ensuring regular and robust involvement of Pacific communities and providers ▪ Improve Ethnicity Data Collection (as with Māori) ▪ Implement Pacific Peoples Responsiveness Project in Hospital and Specialist Mental Health Services.
Approach	▪ CDHB's approach is an inclusive, consultative one, that involves Pacific communities, community providers and service workers in the development, implementation and monitoring of progress ▪ Use details from the Pacific People Health Needs Assessment 2004 to target service development especially in primary care.
Milestones/Actions	▪ Continue to use PPDF to support agreed development plans for three Pacific providers, to ensure sustainable, quality development, according to plan agreed with providers and MOH ▪ Focused Pacific milestones are included in all CDHB and PHO plans to improve Pacific Health outcomes, including resourcing and targets ▪ A Pacific focus is included in intersectoral development activities e.g. CYFS, Ministry of Education, MoH (Public Health & Disability) ▪ LinkAGE project activities improve service access for Pacific elderly ▪ CDHB actively participates in MOH Pacific Branch Workforce Project ▪ Participate in national DHB Pacific managers' meetings ▪ Continue to develop CDHB's Pacific Workforce Plan and review the CDHB Pacific Health Action Plan ▪ Support Pacific providers participation in regional initiatives ▪ Meet regularly with the Ministry of Pacific Island Affairs (MPIA).
Risks and Mitigation Strategies	▪ Risks particularly around human and financial resources mitigated through consultative engagement and inclusion in budgeting processes.
Indicators and Targets	▪ Achievement of and progress on the above milestones and actions ▪ See Section 5.1.

Canterbury DHB Strategic Objective 2: Child Health/Youth Health

The Child Health Project is based on the Canterbury DHB Child Health and Disability Action Plan Mahere o te Hauora Tamariki me te Hauātanga (2004/2007). The overall goal is to improve the health and disability status of Canterbury children, including tamariki, Pacific children and Asian children. The MoH's Child Health Strategy Principles guide this objective. A Canterbury DHB Youth Health Plan will be complete in 2005.

Annual Objective(s)	The CDHB will implement its Child Health and Disability Action Plan Mahere o te Hauora Tamariki me te Hauātanga (2004/2007)
Approach	▪ Work to reduce child and youth inequalities in health ▪ Provide access to services in an equitable and timely manner ▪ Improve child health information systems by making them clinically useful, appropriate, up-to date and available ▪ Work with providers to coordinate health promotion, prevention and early intervention, especially hearing screening and immunisation ▪ Increase awareness of injury prevention ▪ Improve oral health ▪ Promote healthy nutrition and physical activity, support effective parenting programmes and support smoke-free environments ▪ Work to improve child and youth mental health services.
Milestones/Actions	▪ Improve waiting times for children requiring assessment and elective surgery ▪ Early Childhood Centre Pilot Project commenced focusing on improving the health and wellbeing of children ▪ Continue to develop a child and youth mortality review group ▪ Work on the Healthy Families Project ▪ Upgrade Dental Service clinical information systems ▪ Support the implementation of the MoH's Family Violence Guidelines on child and partner abuse.
Risks and Mitigation Strategies	**Risks** ▪ Resource limitations ▪ Poor uptake of children and/or caregivers to adopt health promoting behavioural practices. **Mitigation Strategies** ▪ Identify actions, in collaboration with key stakeholders, that can be taken within existing resources ▪ Reprioritise resources to support actions ▪ Communicate with providers and stakeholders.
Indicators and Targets	▪ As per targets set out in the Child Health and Disability Action Plan (2004/2007) ▪ Refer to Section 5.1.

Canterbury DHB Strategic Objective 3: Cardiovascular Disease

A plan for minimising the effects of cardiovascular disease on Canterbury's population was approved by the Canterbury DHB Board in 2004. *The Canterbury Heart Health Strategy* was developed in consultation with Canterbury DHB's Cardiovascular Steering Group', representing providers and users and includes:

- a profile of Cardiovascular Disease (CVD) in Canterbury
- an overview of inequalities in treatment of CVD in Canterbury
- an overview of the disease control continuum
- population based strategies for reducing and preventing CVD
- ways to reduce the impact of CVD
- links between diabetes and CVD
- the importance of improving rehabilitation and community treatment after acute heart events
- recommended actions to improve heart health in Canterbury.

Annual Objective(s)	Implement the actions associated with the Cardiovascular Action Plan for Canterbury, *The Canterbury Heart Health Strategy* (November 2004), covering the continuum from health promotion, disease prevention, treatment, rehabilitation and palliative care.
Approach	▪ Work with key stakeholders and link with other key strategies ▪ Work with health promotion providers to promote messages related to physical activity, healthy eating, weight reduction, smoking cessation ▪ Work to ensure services are culturally appropriate ▪ Work with Māori and Pacific communities to support prevention, early detection, and service uptake. ▪ Continue to work with primary care and hospital services to ensure and integrated approach to patient care. ▪ Coordinate actions with national guidelines on management of cardiovascular risk, stroke, and diabetes.
Milestones/Actions	Implementation Plan for the *Canterbury Heart Health Strategy* to include: ▪ A comprehensive approach to reduce incidence and impact of CVD including Healthy Eating, Active Living (HEAL) ▪ Strategies to address heart health in Māori and Pacific peoples especially in primary care ▪ Continuing review of current interventions being used for CVD in CDHB and specific interventions to meet indicator targets for cardiac surgery and angioplasty.
Risks and Mitigation Strategies	**Risk** ▪ Increasing incidence of CVD due to ageing population/lifestyle choices ▪ Resource limitations – all actions must be achieved within a cost neutral environment ▪ Cooperation and coordination between community, primary, secondary, and tertiary providers of health services. **Mitigation** ▪ Work closely with other sectors to encourage Canterbury people of all ages to adopt 'healthy lifestyles' ▪ Work with PHOs to focus health promotion activities on identifying risks to reduce incidence of cardiovascular and related diseases ▪ Development of disinvestment strategy so that resources can be transferred from —on priority" areas to priority areas.

Indicators and Targets	To confirm but may cover: ▪ Percentage of people with known risk factors for CVD (through primary care data) ▪ Proportion of Māori, Pacific and low decile patients receiving hospital services ▪ Percentage of people who wait no more than six months for Coronary Artery Bypass Graft (CABG) ▪ Delivery of target levels of cardiac surgery ▪ Percentage of people who wait for no more than six months for an angioplasty ▪ Repeat admissions for acute rheumatic fever in people under 30 years of age ▪ Post acute mortality ▪ Cardiac rehabilitation attendance.

Canterbury DHB Strategic Objective 4: Oral Health

Within the Canterbury region 20% of Oral Health Care is publicly funded.

Annual Objective(s)	The CDHB will: ▪ Incorporate an Oral Health focus in health promotion work ▪ Continue to communicate its position on water fluoridation ▪ Review service delivery structures to improve best access to services within the available funding ▪ Develop robust information regarding Oral Health status and link with Child Health information project work ▪ Maintain appropriate workforce ▪ Improve the inequalities and poor oral health status of Māori and Pacific children.
Approach	▪ To use relevant CDHB Action Plans and contracts to ensure that Oral Health education is incorporated and promoted along with other ‗healthy lifestyle' messages. ▪ Use a non-confrontational approach to education regarding water fluoridation ▪ Use the Dental Clinic review to examine wider service delivery issues ▪ Work to ensure good data collection to help develop an accurate assessment of oral health status and service delivery performance.
Milestones/Actions	▪ Participation by representatives of Oral Health involved in relevant service reviews and Community and Public Health Program planning such as HEAL ▪ Take opportunities as they present to discuss benefits of water fluoridation ▪ Actively participate in outcomes of the the National Review of School Dental Clinic Facilities ▪ Working relationship with external education providers support recruitment to training ▪ Ongoing monitoring of actions identified in the CDHB's Oral Health Strategy (Part B) including review of services.
Risks and Mitigation Strategies	▪ Decisions to cease fluoridation of water supplies indicated poor support for fluoridation. Ongoing communication of the CDHB position statement on this subject is required ▪ Raised awareness of oral health may increase demand for services increasing the waiting list for CDHB who is the key provider for people on low income. This requires monitoring.
Indicators and Targets	▪ As per the CDHB's Oral Health Strategy. ▪ Refer to Section 5.1.

Canterbury DHB Strategic Objective 5: Diabetes Incidence And Impact

The Canterbury DHB continues to implement the recommendations of the 2002 Diabetes Interim Plan through the actions, timeframes and outcomes described in *Disease Prevention and Management: CDHB Diabetes Actions 2004/05*. These will be reviewed again in 2005 once the Local Diabetes Team 2004 Annual Report is complete.

Improving access to retinal screening in the community is part of the objectives of the review of Ophthalmology Services (Appendix 7). This review will be completed by July 2005.

Annual Objective(s)	The CDHB will: ▪ Combine action on diabetes and cardiovascular disease and cancer in conjunction with the New Zealand Guidelines Group (NZGG) ▪ Work to increase understanding of diabetes and self management for Māori and Pacific peoples ▪ Work to enhanced services for children and youth with diabetes.
Approach	▪ Continue to work with all diabetes providers to ensure a sustainable coordinated approach. ▪ Work towards the development of a comprehensive chronic disease management strategy for diabetes, cardiovascular disease and cancer. ▪ Continue to work with primary care teams to identify people with Type 2 Diabetes earlier to ensure early treatment ▪ Continue to work with PHOs to provide health promotion in physical activity and healthy eating ▪ Continue to work with Māori and Pacific providers and communities to support prevention, early intervention and ongoing uptake of services ▪ Work with Diabetes Youth to clarify needs ▪ Work with community podiatry services to provide access for those with uncomplicated high risk feet ▪ Work to ensure all annual review data is collected for regional/national databases.
Milestones/Actions	▪ Increase the numbers of people with diabetes getting annual checks, particularly Māori and Pacific peoples ▪ Increase the number of patients with adequate glycaemic control, particularly Māori and Pacific peoples ▪ Increase access to community podiatry ▪ Improve self management of diabetes through enhanced provision of education and support to patients, families/whanau and caregivers ▪ Enhance access to retinal screening.
Risks and Mitigation Strategies	▪ Insufficient resources.
Indicators and Targets	▪ As per targets set out in the CDHB Diabetes Interim Plan ▪ Refer to Section 5.1.

Canterbury DHB Strategic Objective 6: Information Management

2005/2006 is a year of significant activity and investment for Information Services in the Canterbury DHB. In addition to the implementation of a Clinical Portal (delivering to our Clinical Systems Strategy), significant changes are being made to Information Services infrastructure. The most significant infrastructural change being the rollout of a common desktop environment.

These activities, and the others identified in the annual objectives below, build on the considerable investigation and analysis work from 2004/2005 and are consistent with the three major strands of Information Services activity identified in that period, namely: the Clinical Systems Strategy, Business Systems Strategy and the Technical Infrastructure Strategy.

The Information Services Strategic Plan (ISSP) Attachment 7E re-enforces the objectives outlined here and is also consistent with, and aligned to, organisational and National strategies where appropriate. Information Services is committed to working closely with Canterbury DHB stakeholders to implement solutions that satisfy their clinical and business requirements.

Annual Objective(s)	The CDHB will: ▪ Implement a clinical portal to give an aggregated view of clinical information including - Implementation of a Patient Master Index - Continue to rollout Electronic Discharge Summaries ▪ Deliver a robust infrastructure framework including - Design and delivery of a common desktop environment for all users - Implementation of a common email environment - Consolidation and simplification of our file and print environment - Implementation of a single identity management system - Process improvements to ensure ongoing ease of maintenance - Analysis of our information and storage requirements - Implementation of enterprise systems management capability ▪ Complete the signoff of the Business Systems Strategy and begin implementation of key components of that strategy - HR / Payroll / Rostering - Complete project planning and begin implementation of selected solution - Support the Multi DHB Oracle Financials initiative ▪ Implement an Oral Health Clinical System incorporating outpatient bookings ▪ Implement National Immunisation Register and School Based Vaccination System as per national recommendations ▪ Support the implementation of MH-SMART ▪ Formulate a strategy to move to a single Patient Administration System. ▪ Actively participate in Health Information Service New Zealand (HIS-NZ), the development of standards defined in HIS-NZ projects.
Approach	▪ Use organisationally driven project prioritisation framework to ensure that Information Services are responding to overall CDHB needs ▪ Use CDHB project methodology to ensure ongoing management and governance of projects ▪ Project governance groups to contain representatives from project stakeholders ▪ Projects impacting primary sector will involve consultation with interested primary sector parties. ▪ Leverage off established sector technologies and applications where possible ▪ Continue to use CDHB Core Directions, HIS-NZ and other key inputs to drive and prioritise projects ▪ Continue to build collaborative relationships with other DHBs.
Milestones/actions	▪ Implementation of electronic discharge summaries and accessing laboratory results via the clinical portal (12/05) throughout Christchurch Hospital ▪ Design and begin implementation of new desktop environment (12/05) ▪ Complete signoff of Business Systems Strategy (03/06) ▪ Oral Health implemented (12/05) ▪ NIR (30/06/06) / SBVS – (09/05)

	▪ Successful data extracts for MH-Smart (06/06) ▪ Forms developed – May/July 05 ▪ Data extract development – (06/06) ▪ Project all complete – (06/06) ▪ Strategy approved for Single Patient Admin System – (06/06) ▪ Active participation in at least three National Action Zones.
Risks and Mitigation Strategies	▪ Lack of management of corporate Information Technology assets mitigated by asset management process review and infrastructure stabilisation projects. ▪ Untimely approval from the MoH for key projects mitigated by early involvement. ▪ Availability of funding mitigated by early involvement of DHB financial managers and Board to agree funds for the projects ▪ Human resources availability from both primary and secondary sectors/ mitigated by setting a realistic implementation plan.
Indicators and Targets	▪ Update CDHB Information Services Strategic Plan consolidating clinical, business and infrastructure strands ▪ As per project plans flowing from the above projects ▪ Compliance with national programs with Information Technology requirements ▪ Refer to Section 5.1.

3.1.5 Other Population Health Activity

The MoH's Public Health Directorate retains funding for Public Health. The Canterbury DHB's Community and Public Health Division is the major provider of services to the Canterbury community. The Canterbury DHB works actively with a range of funders (such as Housing, MSD, MPIA and TLAs) of public health and social development to achieve gains in public health.

Community and Public Health Division continues to take a lead nationally in strategies for development of the Public Health Workforce. Over the last year the service has been working hard to align their activities with those of other public health providers and with initiatives within the Hospital and Specialist Services of the Canterbury DHB. All Canterbury DHB hospital sites went smokefree in 2004/2005. This integration focus has lead to the creation of a Public Health Intelligence Team to start to integrate public health service developments into PHOs and other settings such as schools.

The Canterbury DHB is committed to ongoing participation in the collaborative mechanisms that have developed in the Southern Region (South Island) since 2001. These mechanisms operate at the following four levels:

1. **Relationships between the MoH/DHB as planners and funders:**
   - The Canterbury DHB continues to participate in the Regional Public Health Steering Group, which is the regional funding forum set up to share decision making for public health planning and funding.
   - The Canterbury DHB participates in any equivalent national forums facilitated by DHBNZ
   - The Canterbury DHB will liaise with an assigned Public Health Operations Team member on day-to-day district public health matters including consultation on annual PHO health promotion programmes.

2. **Wider sector involvement in public health planning:**
   - The Canterbury DHB participates in wider sector consultation on public health issues to better inform decision making.

3. **Specific joint projects and information sharing:**
   - The Canterbury DHB participates in joint venture projects developed under the auspices of the Steering Group.
   - The Canterbury DHB participates in the development of Long Term Council Community Plans through a working relationship with its Local Authorities. This work will be reflected in the District Strategic Plan 2006/2010, which is currently under development.

4. **Reorienting provider service plans and specifications:**
   - The Canterbury DHB works with the South Island-based Public Health Operations Team and other South Island DHBs to, where appropriate, progressively amend provider service plans and specifications to reflect a more collaborative way of working. This includes re-orientating regional public health provider plans to respond to Canterbury DHB priorities and public health objectives as set out in the Ministry of Health's –Achieving Health for All People".

The Canterbury DHB is in the process of establishing the National Immunisation Register and beginning to plan the roll out of the Meningococcal B Vaccine. These will be key activities on the 2005/2006 year.

Canterbury has a large and growing older peoples population and work continues to increase the coverage of the Stay on Your Feet, Working Together for Winter and Health Elderly Nutrition programmes. These plans involve working with other agencies including the TLAs, Greypower and Ministry of Housing. We are working with these groups on Tobacco Control also. Up and coming Canterbury DHB Strategic Plans on Respiratory Health, Cancer and Youth Health will incorporate health promotion and community development initiatives.

The Canterbury DHB has been working closely with the Ministry of Social Development and the establishment of Hornby Heartland, the service which will provide a venue for health promotion initiatives in that part of the city, as well as working with the Alcohol Liquor Advisory Council (ALAC) on supporting their initiative to limit the harm caused by addictive behaviours.

Work has already begun with PHOs on aligning their health promotion and services with the areas of Canterbury DHB health gain priorities of smokefree, nutrition and physical activity. This will continue to be a significant piece of work in the 2005/2006 year. In addition, the Canterbury DHB is aware of the KPIs for PHOs to comply with the National Cervical Screening and Breast Screen Aotearoa programmes.

A limited amount of work is under way on implementing the Family Violence Guidelines. The Canterbury DHB has noted its position regarding resources for this work in the Service Coverage Attachment 7B. Results of a recent national audit of DHB's performance on the guidelines are being considered, particularly in the areas where the Canterbury DHB has limited resources. The audits support of the excellent coverage in Child services is encouraging.

Section 3.1.3 provides an overview of Canterbury DHB population health activity against the Minister of Health's ~~–~~Start Here" list and Canterbury DHB priorities.

3.1.6 Consultation/Community Participation

The New Zealand Public Health and Disability Act 2000 (NZPHDA 2000), specifies consultation in relation to the following matters:

- The District Strategic Plan; and
- Changes to the Annual Plan; and
- The disposal of land.

A number of initiatives may also warrant formal consultation, such as reconfiguration of services. The Canterbury DHB will identify consultation needs in each instance and meet its obligations in this regard.

The Canterbury DHB works closely with Māori and Pacific communities, meets regularly with Manawhenua ki Whaitaha and pacific community groups and holds regular consultation hui to ensure input into the development of strategies and initiatives to improve health care access and delivery. The recent and current reviews and development of the Māori Health Plan, Primary and Community Health Plan and Pacific Health Action Plan has involved consultation with these communities which has fed into the development of this District Annual Plan. In addition the Canterbury DHB works closely with the ACC on areas such as the development of the Orthopaedics Initiative and the development of an Occupational Health Service and the feedback from this work also feeds into the District Annual Plan.

One of the Canterbury DHB's key objectives is to continue facilitating increased community participation in the assessment, planning and funding of health and disability services in Canterbury. The Canterbury DHB Community Engagement and Consultation Policy was updated in 2003 and again in 2005 to ensure policies and practices continue to be up to date and supportive of this objective. The Policy is consistent with the Ministry of Health's *Consultation Guidelines for District Health Boards*.

3.1.7 Quality and Safety

The Canterbury DHB established a Quality and Patient Safety Council in October 2002 as an advisory board to the Chief Executive on quality and safety matters. The Council includes representatives from general practice, community providers, hospital staff and consumer representation and it is supported by the Canterbury DHB Corporate Quality and Risk Team. A primary goal is for the Council to act as a forum that will show leadership in improving quality and patient safety in the health services covered by the Canterbury DHB.

The Council has developed a Strategic Quality Plan to assist in further development of a health care system which is focused on consumer needs, and strives for continuous improvement in all aspects. The Plan was developed within the context of the MoH document *Improving Quality (IQ): A Systems Approach for the NZ Health & Disability Sector*. It builds on the areas of quality and the five core directions outlined in the Canterbury DHB's Strategic Plan.

The Canterbury DHB Quality Plan has ten initiatives grouped into five goal areas - community participation/community involvement, initiating organisational change and development, clinical risk management, instituting mechanisms for effective reporting and accountability and knowledge management for clinical services and quality.

The Canterbury DHB has established a Clinical Board, in late 2003, the primary function of which is to lead and develop clinical governance within the Canterbury DHB. It includes representation and participation from public health and primary care. The first year has been completed and following the lead of the Patient Safety Council the Clinical Board will initiate development of a Clinical Governance System for the Canterbury DHB in 2005.

Key areas of work in 2005/2006 are covered in Section 3.1.1, Core Direction 3 and 4.

3.1.8 Research and Teaching

Two key developments over the past year have been the establishment of the Laurel Whitford Memorial Trust Education Centre and continued growth of the Canterbury DHB Innovation Awards. Both have looked at practical ways of solving common problems and evaluating innovations for the Canterbury DHB health sector. A number of these have featured in the National Health Quality Awards.

The Canterbury DHB continues to have a close and positive professional relationship with Otago University's Christchurch School of Medicine and Health Sciences. Christchurch Hospital is one of the leading teaching hospitals in the country. Many Canterbury DHB staff in other hospitals in Christchurch also have a teaching or research role at the Christchurch School of Medicine and Health Sciences.

The Canterbury DHB continues to foster a positive relationship with a range of other trainees of the medical workforce including the Christchurch Polytechnic Institute of Technology, University of Canterbury and others. The training of nurses, allied health professionals and scientists by these institutions is vital in ensuring a well-trained workforce and the Canterbury DHB is working with them to align training with future needs.

3.1.9 National and Regional Services

The Canterbury DHB works with the other five South Island DHBs on joint issues through a shared services agency the South Island Support Services Agency Limited (SISSAL). SISSAL provides some of the health planning and contract management functions required of DHBs. This agency also assists to facilitate matters that have regional and/or national implications, such as projects for the South Island Mental Health Network.

The Canterbury DHB sees it has a clear role to be a lead DHB in regional and national development, such as assisting the West Coast DHB with its service development. The Canterbury DHB will continue to provide administrative support and clinical expertise to other DHBs. Future provision will need to resolve Inter District Flows (IDFs). The issues here are complex.

As the major centre in the South Island the Canterbury DHB provides secondary and tertiary services to other DHBs and this is now reflected in arrangements for IDFs in funding. However the Canterbury DHB sends some patients out of the South Island for specialist treatment eg, paediatric heart surgery.

In 2005/2006 the financial risk to DHBs from IDFs will be limited to personal health case weighted discharges (ie acute and elective inpatient services). All DHBs will continue to provide full acute coverage for each others' residents, assessment, treatment and rehabilitation services and psychogeriatric inpatient services, and elective service coverage in line with historical practices.

The Canterbury DHB holds a number of regional and national service contracts but the numbers are small, as other DHBs take their part of these contracts to manage themselves.

The Canterbury DHB also has a role to work nationally and will contribute to the DHBNZ joint work plan in areas such as negotiating a contract with the New Zealand Blood Service and on a number of national employment agreements.

3.1.10 Prioritisation Framework

The Canterbury DHB agreed in 2002 to a set of principles (Effectiveness, Cost, Equity, Māori Health, and Acceptability) to assist choices about the future funding of health services within the wider context of set Government health and disability policy and health gain areas. Work has commenced on identifying how actions of the Canterbury DHB impact on health and disability outcomes for individuals as well as a prioritisation process to assist decision making especially in light of the need to realign services as a result of Popular Based Funding.

3.1.11 Relationship with Māori

The Canterbury DHB's response to the Treaty of Waitangi will be critical to the success of its activities in relation to Māori. In addition, using a Treaty of Waitangi Framework will ensure that Canterbury DHB activities have a sound basis from which to develop.

The Canterbury DHB has agreed to engage in an effective manner with Ngāi Tahu as manawhenua of Waitaha/Canterbury, as well as with Māori of other iwi affiliations living in Canterbury. Regular meetings are held with the Manawhenua ki Waitaha, a representative group which comprises the seven Canterbury rūnanga. A MoU at governance level is under discussion, as are the operational relationships that will ensue.

Regular hui are held with Te Rūnanga o Ngā Maata Waka, and valuable information and feedback is conveyed and gained from quarterly Māori community consultation hui. The meetings are widely advertised within the Māori community, and meeting notes are freely distributed.

The Canterbury DHB continues to enact, in consultation with Māori, appropriate processes to engage with the Māori community and Māori providers. This assists the gathering of information regarding Māori needs, as well as the development of actions and measures that improve Canterbury DHB's responsiveness to Māori health needs. In addition, strong relationships exist between and with Māori staff working in the Canterbury DHB services, and with Māori community providers.

The Canterbury DHB is currently updating its Māori Health Plan (Whakamahere Hauora Māori ki Waitaha). It recognises the Canterbury DHB's Treaty obligations to Māori within the framework of the NZPHDA 2000, and is consistent with the national directions outlined in He Korowai Oranga and Whakatataka.

3.1.12 Workforce Development

Core Direction 4 *Developing Canterbury's Health Care Workforce* outlines actions to complete the Workforce Action Plan (WAP) as per the guidelines from DHBNZ. The Canterbury DHB has endorsed the WAP and its own workforce development plan will be consistent with the WAP and focus on workforce development needs at a local level.

In developing its own workforce development plan, the Canterbury DHB has taken account of the Health Workforce Advisory Committee's report *The New Zealand Workforce Future Directions – Recommendations to the Minister of Health 2003* which identifies the following seven priority areas for workforce development:

- Addressing the workforce implications of the Primary Health Care Strategy
- Promoting a healthy workplace environment
- Educating a responsive health workforce
- Building Māori health workforce capacity
- Building Pacific health workforce capacity
- Developing the health and disability support workforce capacity for people who experience disability
- Research and evaluation.

The Canterbury DHB has approved a proposal to set up an Occupational Health Service. The role of the service is to monitor staff health in relation to their exposure to identified hazards.

A top priority is vaccinations and immunity against infectious diseases with the service also developing into other important areas of health monitoring and well being. The intention is to build on the excellent work that is already being carried out and develop a coherent Canterbury DHB-wide occupational health programme. The Canterbury DHB is able to fund this initiative through the reductions it will get on ACC levies as a result.

3.2 Funding Health Services

3.2.1 Service Coverage

Within available resources, the Canterbury DHB will:

- Facilitate timely and equitable access to appropriate health services, in accordance with Crown Funding Agreement requirements
- Undertake service development to ensure that the health service outcomes, as outlined in the New Zealand Health Strategy and Disability Strategy, are taken into consideration
- Fund in 2005/2006 a range of services similar to those funded in 2004/2005.
- Ensure, where appropriate, that the Nationwide Service Framework is applied when entering into service agreements, including utilising nationally consistent service specifications and/or prices.
- Ensure that the service coverage requirements of the Operational Performance Framework and Service Coverage Schedule requirement are met (see Attachment 7B for Service Coverage Exceptions).
- Ensure that ring-fenced mental health funding is spent funding mental health services.

The move to PBF and adjustments to the Canterbury DHB's funding path mean will have to work to manage within our share of public health funding. The Canterbury DHB has identified strategies to bring the DHB into funding equity under PBF. These strategies will identify service coverage issues (including both service gaps and over provision of services).

The Canterbury DHB is working to foster the development of Māori capacity for meeting the health needs of Māori. As with other DHBs, Māori health and disability services are provided via a mixture of explicit Māori health funding and funding allocated to mainstream services. A process is underway to revise indicators of performance as part of the revision of the Canterbury DHB Māori Health Plan.

Service reconfigurations as a result of the South Island Alcohol and Other Drug Review are substantially complete and the focus is now on qualitative service development.

The Canterbury DHB Mental Health and Addiction Strategy 2004 supports the provider arm provision of Canterbury DHB Mental Health Services, focussing on specialist and regional services. This development requires capacity building within the NGOs and the primary care sectors, in particular putting in place different ways of case management. Funding of PHOs to work in primary service and other service reconfigurations as are signalled in the Mental Health Division Section (3.3) of this document.

The Canterbury DHB is working within national and regional arrangements relating to the funding impact of IDFs.

3.2.2 Service Delivery

Volume Schedules for services to be provided in 2005/2006 are detailed in Attachment 7A.

Māori Health

The Canterbury DHB will continue reviewing existing Māori health service delivery currently being funded in Canterbury and to identify gaps and/or duplication. The focus continues to be on consolidation and development. Māori Health service development co-ordinators are now working in the Christchurch Hospital.

The Māori health expenditure stocktake and review that the Canterbury DHB undertook during 2004/2005 identified expenditure of $7.9m per annum through a combination of Māori community

providers, mainstream community providers and the Canterbury DHB's provider arm. This equated to an average expenditure on Māori health services of $252 per Māori capita, which compared favourably with the previous national average of $200 per Māori capita.

The Māori health expenditure target for the 2005/2006 financial year is set at $8.1 million (an increase of 3%). This equates to an average expenditure on Māori health services of $280 per Māori capita (based on the Canterbury DHB's 2004 Health Needs Assessment population figures). Forecast target for 2006/2007 is $8.4 million (see Appendix 8).

Five South Island Māori health regional projects are to be undertaken over 2005/2006 through the Ministry of Health's Māori Provider Development Scheme these include:

(1) Te Waipounamu Review of Mäori Health Provider Development 2000 – 2004: A review of the contributions from the Mäori Provider Development Scheme

(2) Te Waipounamu Mäori health provider profiles and workforce information

(3) Feasibility for the development of Te Waipounamu Mäori health provider website

(4) Te Waipounamu Mäori health training and education opportunities resource

(5) Te Waipounamu Hui Whakapiripiri Ratonga 2005

A Regional coordinator has been appointed to oversee the progress of the above regional projects as well as being responsible for the implementation of the South Island Māori health workforce plan and the Te Waipounamu Māori mental strategy developed by Te Roopu Awhiowhio.

Mental health
The Canterbury DHB continues to fund services on the basis of the nationwide service framework for adult, child and youth, Kaupapa Māori and pacific mental health and alcohol and other drug services, Blueprint targets, local and regional needs and national policy directions.

Blueprint Funding

The Canterbury DHB is funded below Blueprint levels, and therefore will receive an additional $2.81m in 2005/2006. The Canterbury DHB will target its additional Blueprint Mental Health Funding in 2005/2006 to the following areas:

Service Area	**Projected Developments** Project work, including sector consultation, will help finalise the specifics of the developments proposed below.	**Projected Funding**
Māori Mental Health	Identify and fund new clinical and non-clinical FTEs for Māori youth mental health.	$250,000
Pacific Child & Youth Mental Health	Identify and fund new clinical and non-clinical FTEs for Pacific youth mental health.	$280,000
Alcohol & Other Drug	Identify new service developments and fund. Ensure consistency with South Island regional AOD plan.	$200,000
Respite Care Services (Māori & General)	Review planned and crisis respite services and identify new service developments to enhance respite system.	$470,000
Specialised Community Support Work (CSW)	Identify new CSW FTEs with specialised functions and run processes to fund.	$300,000
Long-term Residential Services	Identify new services for people who require a longer-term approach to mental health support services in a residential context.	$450,000
Psychogeriatric Services	Identify and fund new services for Older People with mental illness.	$300,000

Parental Mental Health	Fund new services to address the needs of parents with mental illness.	$250,000
CDHB Primary Mental Health Strategy – Linkage Services	Fund services that encourage synergies between the NGO and specialist mental health services for the 3% of the population with the most severe and disabling mental illness and mental health developments in primary care/PHOs.	$150,000
Dual Sensory Disability and Mental Illness	Identify and fund support services for people with dual sensory disabilities and mental illness.	$160,000
Total		$2,810,000

There is considerable project work to identify the exact nature of how the funding will be allocated in each area. A work plan for each area's development has been drawn up which will further identify the FTEs/beds or programmes for each area. The providers of these new services will be a mix of DHB, PHO and NGO service providers.

Planning and Funding develops an annual audit plan that covers non-DHB providers, as part of the Contract Monitoring process.

Regional Mental Health Network

At a regional level, the South Island is generally considered well funded against Blueprint targets compared to the North Island regions. The focus for all South Island DHBs in the 2005/2006 Regional Mental Health Strategic Plan is on improving collaboration, service consolidation and service quality, while optimising service configuration within the available resources.

Key areas in the draft Regional Mental Health Strategic Plan are:
- Regional access to services including a review of South Island Methadone Services
- Implementing the South Island Māori Mental Health Plan
- Workforce development
- Implementation of the recommendations of the South Island Alcohol and Other Drug Review.

The Canterbury DHB has taken the lead role in the establishment of a South Island Youth Alcohol and Other Drug (Residential and Day Programme) Service and South Island Kaupapa Māori Adult Alcohol and Other Drug Service. The funding for these sit outside both the Blueprint targets and the PBF Formula at this time

There are ongoing challenges in recruiting staff to improve access. As part of the agreements between Planning and Funding and specialist mental health services and to comply with the rules of Blueprint funding support has been provided around an active recruiting plan. There has been significant progress in the area of Child and Youth Recruitment where the teams substantially meet their FTE levels. This service is also working locally and across the South Island with other DHB services and NGO providers to facilitate workforce development. The South Island Regional Workforce Coordinator is working to assist this process.

In 2004 Te Roopu Awhiowhio carried out a review of Kaupapa Māori mental health services which led to the development of the Te Waipounamu Māori Mental Health Strategy.

The strategies vision is for Te Waipounamu Māori mental health workforce and services (Kaupapa Māori mental health and dedicated Māori mental health) to grow in strength and numbers with the aim of providing a choice for tangata whaiora and their whanau.

Implementation of the strategy is the focus of regional work over the next three years and is the primary vehicle for implementing Te Puawaitanga - the Māori Mental Health National Strategic Framework' at a regional and district level. The DHB continues to support Te Korowai Hinengaro o Waitaha (TKHOW) as a mechanism to grow capacity and capability within Māori Mental Health providers including the DHB service.

3.2.3 Service Monitoring and Evaluation

Financial management of the Canterbury DHB is organised into three sections:

- Overall Canterbury DHB financial management (including subsidiaries)
- Funding
- In-house provider.

The purpose of the above separation is to provide transparency between the financial performance of the two key functions of the Canterbury DHB (the funding and the in-house provider) while keeping an overall view of the whole organisation and related subsidiaries.

Separate financial and activity reports are prepared for each of the above three sections monthly, to facilitate monitoring at management level as well as to the Board's Finance Audit and Risk Committee.

A comprehensive Risk Register has been developed to identify the financial and non-financial risks for both the Canterbury DHB in-house provider and externally funded providers. The Canterbury DHB continues to enhance systems to manage both financial and non-financial service risks.

The Canterbury DHB will actively monitor and assess the quality of services provided by both the Canterbury DHB in-house provider and the externally funded providers; via service agreements. Monitoring includes appropriate procedures for reporting adverse incidents as well as routine reporting against standards (such as Health and Disability Safety Standards 2001) and processes. The introduction of certification is also being monitored. In addition, the Canterbury DHB monitors provider service quality through a programme of routine quality audits, service evaluations and issues-based audits.

Activity in Hospital and Specialist Services Mental Health Division for the 2004/05 year has focused on preparation for MoH Certification audit and specific follow-up work related to service improvement. The programme of work for 2005/06 will have a particular focus on the quality of service delivery including specific interventions for service users e.g. regular review of treatment and support processes, including risk management plans, individual crisis plans for long term patients, relapse prevention plans and consumer outcomes.

The Canterbury DHB's ethnicity data collection methods are the subject of work particularly at Christchurch Hospital and with PHOs, and relates to the policy and implementation work noted earlier in this and previous District Annual Plans.

Collaboration with SISSAL, and Health Payments Agreements and Compliance (HealthPAC) in collecting, summarising and analysing contract information is vital to the ongoing success of the Canterbury DHB in providing relevant information for decision making.

Service monitoring is in line with individual contractual arrangements, and new requirements contained in the Crown Funding Agreement, Service Coverage Document and Operational Policy Framework, will be worked into new service agreements over time.

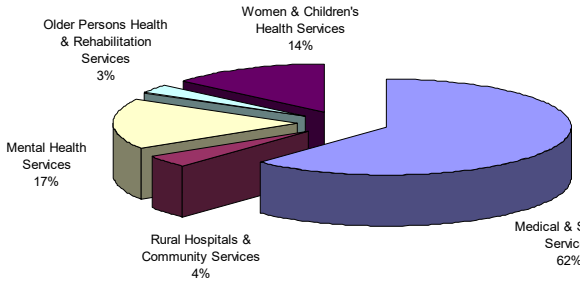
As in 2004/05 a Service Level agreement will be put in place between Planning and Funding and the HSS service to monitor internal performance of DHB funded service agreements. The performance of the HSS is the subject of a monthly report by Planning and Funding to the Hospital Advisory Committee (HAC).

3.2.4 Funding Allocations

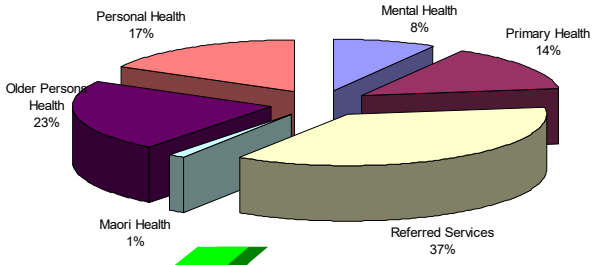
The Canterbury DHB has agreed and circulated a funding strategy to providers. Together with contracting processes including the use of Request for Proposal processes the Canterbury DHB works hard to treat provider arm and NGO providers equitably.

The following diagram indicates how current funding is allocated in the Canterbury DHB:

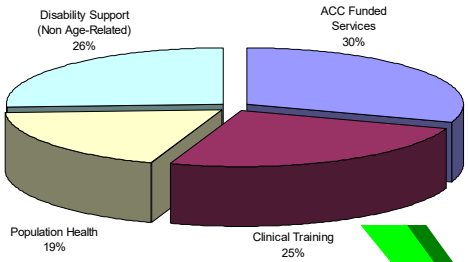
Hospital & Specialist Services



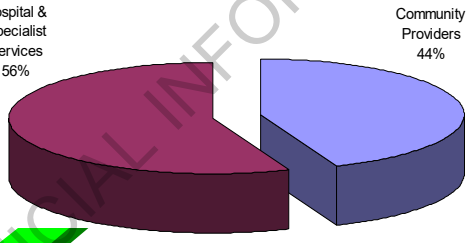
Community Providers



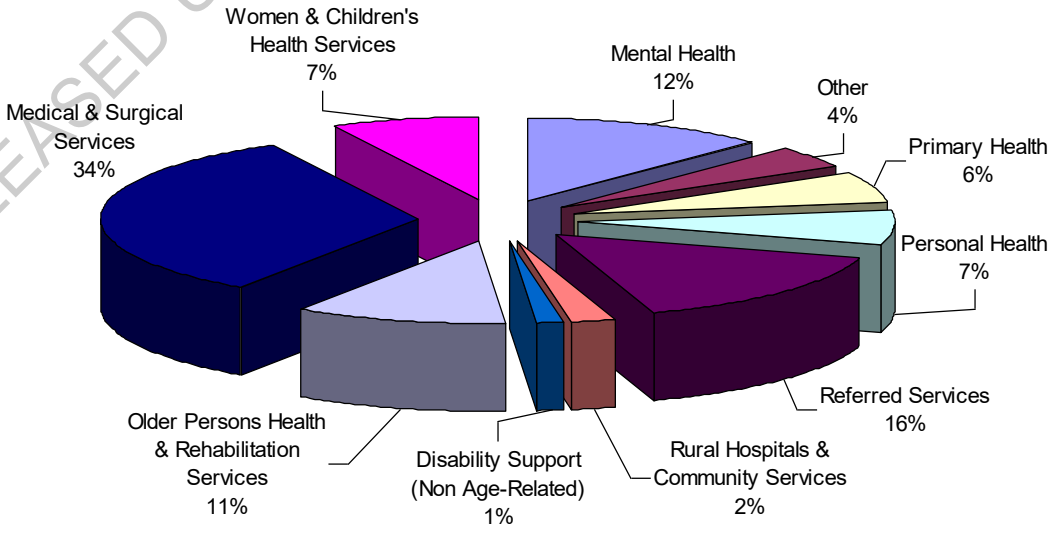
Funding from External Sources



Funding Arm



All Sources



3.2.5 Additional Funding Responsibilities

The major funding changes expected in 2005/2006 will be:

- An additional $2.81m new Blueprint funding for Mental Health Services
- Additional 3% funding for Aged Care Services
- Additional funding of $0.4m for Assisted Reproductive Technology service (second cycle fertility services
- Additional funding (yet to be quantified) to compensate the Canterbury DHB for the increased cost of Older Persons Health Services as a result of the changes to the Income and Asset Testing rules relating to Aged Residential Care
- National Transport and Accommodation Policy funding transfers to the DHBs from January 2006, and equates to additional funding responsibility of $0.8m in the 2005/2006 year for the Canterbury DHB.

3.2.6 Future Funding Pressures

The factors driving funding pressures faced by the Canterbury DHB are similar to those faced by other DHBs, namely reflecting the pressure to increase both volumes and prices paid to providers. However with the Canterbury DHB's current funding being estimated at above its ~~-~~equitable" funding share, the Canterbury DHB will receive a lower than average DHB sector funding increase from which these pressures must be managed. With lower than average funding increases the Canterbury DHB will face significantly greater funding pressures than those experienced by other DHBs.

With PBF, benchmark pricing is used in the funding of providers. The Canterbury DHB's current over-target funding is considered to be primarily reflective of higher volume delivery rather than over pricing.

During the transition to PBF equity the Canterbury DHB as a funder of health services will need to continue to:

- Constrain growth in prices to less than the levels indicated by the MOH Consumer Price Index (CPI) adjustments.
- Re-allocate volumes between discretionary and non-discretionary services to meet demand driven growth, while providing incentives to providers to minimise and manage growth in demand.

As a provider of health services the Canterbury DHB will need to continue to:

- Constrain the growth in the cost of service delivery to enable the provider to deliver the desired mix of services within the available funding.
- Manage growth in demand for acute hospital services via the ongoing development of the interfaces with primary care and other providers. This will include the ongoing management of the introduction of new treatment regimes and technologies.

In addressing these pressures, a delicate balance must be achieved between funding levels and demand and cost management to ensure these pressures are appropriately balanced between the funder and provider. The Canterbury DHB's Planning and Funding Division is working to develop a more detailed view of future funding pressures to provide a basis for managing these funding risks particularly during the period of transition to PBF formula equity.

The DHB works as part of national forums such as the national pricing programme and on the aged residential care agreement to find better ways of dealing with funding issues.

The accounting policies adopted are consistent with those in the prior year. A full statement of accounting policies is contained in the 2005-06 Statement of Intent.

Summary of Hospital and Specialist Service Issues

The Hospital and Specialist Service also has a number of funding and pricing issues:

- *Blood products price increase.*
- *CTA Pricing.*
- *Brain Injury Rehabilitation Pricing – the DHB's concerns have been raised with the MoH and we are currently preparing to escalate the matter. This largely relates to patients under 65 years of age and therefore is an issue for the HSS and the MoH.*
- *Air Retrieval Costs – reimbursement of staff costs being pursued from neighbouring DHBs. A process is now in place between all DHBs for invoicing staff costs for retrievals and transfers of other DHB residents.*
- *Tertiary adjustor – the CEO has raised the issue with the Deputy Director General of Health at the MoH. Tertiary adjustors are being reviewed as part of a joint Ministry of Health, DHB and Treasury National Benchmarking Program. This will be reflected in the adjuster for 2006/2007.*
- *Overseas revenue/bad debts – the CEO will raise this issue with the MoH. The Ministry of Health has made some adjustment within the funding formula to ensure DHBs are not disadvantaged.*
- *Rituximab – The 2005/2006 IDF prices for cancer services have been adjusted to reflect the cost of the basket of drugs. This includes further adjustments for the extended use of retuximab. The Planning and Funding Division are negotiating formal agreements with other DHBs.*

3.2.7 Service Reconfigurations 2005-2006

The Canterbury DHB plans to consider significant service reconfigurations to help it live within its funding under PBF. As noted earlier, under the MoH's latest calculations the Canterbury DHB is considered to be ~~-~~over-target" and will be moved to equity over future years.

This means that the Canterbury DHB will receive less funding (relative to other DHBs) in future years, through the loss of funding changes for increases in population (the DHB's demographic adjustor).

This is a matter not well understood by the community or by health and disability providers in Canterbury, so service reconfigurations will be achieved by consulting and working with clinicians in the primary, community and secondary areas. It will involve consultation with hospital and community based service providers, to determine appropriate solutions that best meet the needs of the Canterbury DHB's community. These solutions will then be actioned to meet the Canterbury DHB's adjusted funding levels. Where service reconfigurations are in the area of Mental Health the ringfence requiremnents will be maintained.

Reconfiguration processes will comply with Section 5 of the Operational Policy Framework. Any detailed planning completed around mental health service reconfiguration will include input from key stakeholders including the Ministry of Health and Mental Health Commission prior to seeking Ministerial approval as appropriate.

Some service reviews have been undertaken in 2004/2005, to be implemented in 2005/2006, while some reviews will be in preparation for service change in the 2005/2006 year.

As identified throughout this document, particularly in Section 3.1.1 and in Section 3.3.1, the following reviews are planned or will be underway in 2005/2006:

- Ashburton Clinical Services Review
- Rural Health Services Review – Access to Services for Rural Communities
- Review of Tuarangi Home (Ashburton)
- Older Peoples Services (Strategy) Review
- Intellectual Disability Services (including Psychiatric Services for Adults with an Intellectual Disability) Review
- Mental Health Services (Access and Responsiveness) Review
- Mental Health Services (High and Complex Needs) Review
- Ongoing HSS Non-clinical Support Services Reviews and Consolidations
- Implementation of ‗Improving the Patient Journey' and ‗Patient Flow' Projects
- Improving access to and delivery of Elective Services
- Hospital and Community Laboratory Services Review

- Review and Alignment of Hospital Sites to Service Needs
- Integration of Womens' and Childrens' Services Review
- Clinical and Non-clinical Consumables Usage Review
- Ophthalmology Review
- Oral Health and School Dental Clinic Review
- Staff Structural Review (Brackenridge Estate Limited)
- Review of processes by which new treatment regimes could be introduced
- Collaborative arrangement with external providers on elective services
- Review and streamline non acute patient transfers
- Review role and functioning of Community Therapy Services

3.2.8 Efficiency Gains and Service Technology Change

The Canterbury DHB continues to look at efficiency gains, technology changes and service reconfiguration as part of its ongoing process to enhance patient care and to achieve its financial targets. These include local initiatives as well as working collaboratively with other DHBs and health providers. The targeted savings are an integral part of the budget to achieve a break-even financial performance for the year.

3.3 Providing Health and Disability Services

3.3.1 Introduction

The Canterbury DHB has two fully owned subsidiaries, Canterbury Laundry Services Limited and Brackenridge Estate Limited which it intends to keep operating in the medium term.

The Canterbury DHB provides services mainly to the people of the north and mid Canterbury regions. A range of secondary and tertiary services are provided to people living throughout the South Island and in some cases to some people who live throughout New Zealand. Population/public health services in Canterbury, South Canterbury and the West Coast include health protection, health promotion, Māori health promotion and the services of the Medical Officer of Health. The Canterbury DHB's Laboratory Services provides support to a number of other DHBs in both the North and South Islands.

Inpatient and outpatient services are provided from a number of facilities and sites and by teams working in the community. The major hospitals include Christchurch, Burwood, Christchurch Womens, Ashburton, Hillmorton and The Princess Margaret as well as a number of smaller hospitals in rural areas.

The Canterbury DHB's HSS is facing some major challenges over the coming years including significant budget deficits, moving to PBF and the relocation of the Christchurch Women's Hospital. The Canterbury DHB has reviewed the allocation and management of financial resources within its HSS and is implementing changes to its management structure that will enable it to appropriately and effectively support its clinical teams to the best effect and to provide its patients with enhanced service delivery going forward.

Previously the HSS had several separate (primarily site based) operating units: Ashburton and Rural Health Services, Mental Health Services, Christchurch Women's Hospital, The Princess Margaret Hospital, Burwood Hospital, Christchurch Hospital, and the Canterbury Health Laboratories.

The new structure sees the creation of a number of new divisions structured along clinical lines, with a move towards a service focus rather than a site-based model. The Canterbury DHB believes these divisions will position its HSS to meet the coming challenges, whilst continuing to strengthen the relationships between the clinicians and management, and provide a more logical and therefore improved patient journey.

The service focused divisions are: Rural Health Division and Mental Health Division (both unchanged), Women's and Children's Health Division (incorporating the former Christchurch Hospital based Children's Services), Older Person's Health and Rehabilitation Division (combining of The Princess

Margaret Hospital and Burwood Hospital services), Medical and Surgical Division (incorporating general and specialist medicine, acute care and elective surgical services) and a Hospital Support and Laboratories Division (incorporating Laboratory and facilities management of the Christchurch Hospital site).

An organisational chart of the in-house provider and details of services provided by the Canterbury DHB is provided (Appendix 4).

The Canterbury DHB's HSS has established a Strategic Workplan for 2005 that outlines its focus and priority projects. Regular reports are provided to the Board's Hospital Advisory Committee on progress on the various projects within the Workplan. These are incorporated in Section 3.1.1, of the Canterbury DHB's Core Directions:

HSS Strategy	**Initiative/Project**
Improving Financial Rigour	Financial Controls - Review Delegated Authorities - Review Purchasing Practices Performance Monitoring KPIs - WMRS installed - WMRS upgrade V3 - KPIs installed Clinical Budget Holding External Revenue Review
Changing Clinical and Patient Processes	Improving the Patient Journey - Improving Access to Emergency Care - Maximise DOSA and Day Surgery - Improving Access to Acute General Surgical Care - After Hours Models of Care - Outpatient Services Review Capacity Planning Clinical Focus Groups
Review of Clinical Services	Ashburton Clinical Services Review Rural Access to Specialist Services Accreditation and Certification Non Acute Patient Transfers Christchurch Hospital Radiology Review Christchurch Hospital Blood Use Review West Coast Support Services
Infrastructure Improvement	Christchurch Womens' Implementation Burwood Stage 2 Development Clinical Portal and Electronic Record Riverside Space Review
Realign Services to Match Funding Under PBFF	Communication Strategy Benchmarking
Other	ACC Partnership Programme IV Pump Consumables ACC Spinal Adjustment Backdated Tertiary Adjuster

3.3.2 Regional National Health Emergency Planning

In the past year the Canterbury DHB has successfully taken part in a number of regional and national emergency exercises, including those with CEO and Senior Management participation. This year the Canterbury DHB is placing particular emphasis on the involvement and preparation of community health providers with a number of PHOs and community health providers being involved in an exercise planned for September.

The Canterbury DHB has been part of the establishment and ongoing review of the South Island Regional Health Emergency Plan in conjunction with the Ministry of Health, St John Ambulance and the other South Island DHBs. This Plan covers a multi-DHB response to any emergency.

The Canterbury DHB has, on the basis of the earlier influenza plan and adding the experience derived from operation Virex and the SARS operations, developed a draft format for dealing with emergency disease situations. This format is being further developed in the light of the Ministry of Health's Communicable Disease Plan and will encompass public health response, primary care preparations, hospital services readiness and regional cooperation.

The Canterbury DHB has also developed its own major incident and emergency plans identifying how essential health services will continue to be delivered in the event of a national health-related emergency. These plans will be updated on an ongoing basis with the 2005/2006 Emergency Readiness Plan currently awaiting approval from the Executive Management Team.

The Canterbury DHB maintains 'code white' status with Avian Flu (in particular) being monitored and preparations are underway for winter snow.

ASHBURTON AND RURAL HEALTH SERVICES

Annual Objectives		Approach	Milestones	Indicators / Targets
1. HE KOROWAI ORANGA				
1.1	Support provided to all staff on Māori cultural issues and service delivery	Create and foster closer linkages between Māori advisory service and clinical staff Develop booklet to assist staff in dealing with issues	Clinical staff involvement and interaction with Māori Health Plan Booklet developed	Clinical interaction with Māori Health Adviser Launch of booklet by December 05
2. NEW ZEALAND DISABILITY STRATEGY				
2.1	Ensure compliance with standards of QHNZ to meet both personal and physical access to services		Accreditation and certification progress site visit by surveyors / auditors	Acceptable progress to meeting last survey / audit recommendations August 05
2.2	Provide incentives and ability for people to maintain mobility and independence	Stay on Your Feet programme supported	Training of volunteer community support persons in conjunction with Presbyterian Support Service	Training ongoing throughout 05/06 year
3. ELECTIVE SERVICES AND RADIOTHERAPY WAITING TIMES				
3.1	Maintain waiting lists for General Surgery at guideline levels	Continue with assessment and prioritisation processes	Booked patients have procedure within 6 months	100% of booked patients have procedure scheduled within 6 mths
4. DIABETES INCIDENCE AND IMPACT				
4.1	Continue diabetes nutrition service throughout rural Canterbury	Two education sessions delivered to targeted population in rural Canterbury communities	Sessions provided positive feedback	2 sessions delivered by June 06
5. INEQUALITIES				
5.1	Access to services by rural population	Review services provided and access to specialist services by rural people	Comprehensive data available on services provided locally, gaps and areas for improvement	Report completed by July 05
6. PRIMARY CARE				
6.1	Engage with PHOs Support primary care providers	Linkages with rural PHO's maintained Work with GP's / PHO's on support for after-hours services	Dialogue on rural health issues and strategies After hours services maintained in rural areas	Regular dialogue between Rural Health Services and PHO's Work on consensus on roles of primary / rural hospital services
7. WORKFORCE				
7.1	Prepare clinical development and recruitment plan for clinical services at Ashburton	Options for clinical staff configuration developed	Finalisation of Ashburton Clinical Services Review Strategy for next 5 – 10 years developed	Long term strategy in place with targets and milestones June 05 Implementation 05/06 ongoing

OTHER PROJECTS		INDICATORS/TARGETS
1	Develop options for services and facilities at Kaikoura	Plan for services and facilities in place and adopted by CDHB following completion of Rural Health Services Review
2	Assess facilities for Ashburton Campus services	Review of service facility needs developed following completion of Ashburton Clinical Services Review
3	Develop strategies to reduce acute admissions from primary providers	Plans developed whereby hospital team assesses need for acute hospital admission in conjunction with rest home / hospital or GP for key group of referrals

SERVICE RECONFIGURATIONS		BRIEF COMMENTARY
1	Implementation of agreed option from the Ashburton Clinical Services Review	Review concluded in early 2005 will provide direction for services at Ashburton. Plan for implementation of agreed option will be in place by June 05 for action throughout 05/06 year
2	Review access to services provided for rural people (Akaroa, Darfield, Ellesmere, Kaikoura, Oxford and Waikari)	CDHB Rural Health Services Review will look at all services being provided in rural Canterbury and develop options and priorities for ongoing development and/or charges
3	Identify options for service development and management of Tuarangi Home	Review and identify the longer-term needs of the residents and client groups of Tuarangi Home.

BURWOOD REHABILITATION SERVICES

Annual Objectives		Approach	Milestones	Indicators / Targets
1. HE KOROWAI ORANGA				
1.1	Maintain and further improve staff cultural awareness	Increase staff knowledge and skills in Te Reo and Tikanga by offering a 10 Hour Te Reo Training Course on site	Course is held on site at Burwood Hospital	10% of staff have undertaken the Te Reo Training course by March 2006
1.2	Appropriate Māori signage for redevelopment	Dedicated committee to develop the new signage	Committee meets regularly	Signs ready for redevelopment opening
1.3	Develop Cultural Assessment Tool	Pilot assessment tool and implement into clinical documentation	Assessment tool implemented into clinical documentation	December 2005
2. NEW ZEALAND DISABILITY STRATEGY				
2.1	To improve waiting times for Brain Injury Rehabilitation Service patients	To present business case to CDHB. The business case is to address appropriate resourcing for waiting list and service growth issues	Business Case is approved with appropriate resources to meet objective	Waiting Times are reduced
3. ELECTIVE SERVICES AND RADIOTHERAPY WAITING TIMES				
3.1	To facilitate Orthopaedic initiative volumes	Utilise all available mechanisms to increase 05/06 volumes to targets	Plans established as to resourcing and monitoring aides to assist in MoH Initiative contract being achieved	Increased surgical volume to meet Orthopaedic initiative volume for 2005/06
4. WORKFORCE				
4.1	Reduce staff injuries at work	Continue safe handling project within services	Review program by December 2005	Further reduction in work place injuries by June 2006
4.2	Smokefree Environment	To implement Phase 2 of the Smokefree Evironment at Burwood Hospital	Implementation plan for Burwood Hospital established	October 2005 plan in place
4.3	To improve staff satisfaction	Use the results of the staff culture survey to develop an action plan	Feedback culture survey results to staff. Develop an action plan to resolve any issues that arise out of survey	Plan developed by October 2005. Improved staff satisfaction.
4.4	Compliance with HPCA expectations	Process for credentialling all clinical staff in place	Ongoing	Current job descriptions for all staff Credentialling of all applicants for positions All have current Annual Practising Certificate

OTHER PROJECTS		INDICATORS/TARGETS
1	Burwood Redevelopment	Plan for and accommodate development once MoH approval given
2	Strategic Planning	Response to CDHB Master Planning Exercise Response to CDHB Core Directions Review
3	Spinal Benchmarking	Working partnership developed with ACC and Counties Manakau Continuing participation and membership of Health Round Table spinal benchmarking project

MEDICAL SURGICAL DIVISION, CHRISTCHURCH HOSPITAL

Annual Objectives		Approach	Milestones	Indicators / Targets
1. HE KOROWAI ORANGA				
1.1	Improve ethnicity data collection throughout the hospital	Extend staff training to two further departments	June 2006	Ethnicity data updated at each admission Number of departments provided with training
1.2	Ensure CDHB is recognised as a leader in Māori health worker development	Implement Māori Service development plan Māori Staff to attend Te Ao Marama and Te Komiti Whakarite Staff to attend cultural training	Ongoing Ongoing Ongoing	Māori Health Service established & staffed to approved level Appointment of Kaiako Tikanga Māori (Tutor) 05 Number of meetings held and number of attendees
1.3	Reduce health inequalities	Support reduction in inequality through service development in priority areas by: Staff participatein service and clinical planning activities to reduce inequalities Support Cardio-Respiratory outreach proposal Support research on Māori health outcomes	 Ongoing Ongoing Ongoing	 Meeting minutes Weekly meetings with Māori Health services Research proposals supported
2. ELECTIVE SERVICES AND RADIOTHERAPY WAITING TIMES				
2.1	Ensure that patients referred for a First Specialist Assessment s are seen within six months	Management of the referral process to ensure that both internal and external referrals occurs at the optimal time for treatment or referral	June 2006	Minimum of 97% of patients seen within six months
2.2	Ensure patients given certainty of surgery receive surgery within six months	Monitoring of Elective Services Performance Indicators to ensure the most effective use of elective services resources	June 2006	Minimum of 97% of patients receive surgery within six months
2.3	Ensure that contracted volumes of elective services are delivered	Monitor and manage production, and take prompt action to rectify any under-delivery	June 2006	All volumes delivered
2.4	Achieve Radiation Therapy Waiting Times	Monitor and manage production, take prompt action to ensure waiting time targets achieved	June 2006	98% of patients commence radiation treatment within specified waiting times

3. DIABETES INCIDENCE AND IMPACT				
3.1	Deliver the Primary Health Care Strategy and Action Plan and Diabetes Action 04/05	Working collaboratively with the Primary Care Sector to: ▪ Increase the uptake to Annual Reviews ▪ Support health promotion activities	Ongoing	Admission rates for patients with diabetic ketoacidosis Annual Reviews increasing 10%
3.2	Continue to develop the Diabetes Service to meet the objectives of the Diabetes Strategy	Participate in the Local Diabetes Team and Diabetes Sector meetings.	Monthly from July 2005	Number of meetings attended
3.3	Supply data on Diabetes checks by the Diabetes Service to the —Get Checked" database	Develop system to collect data Implement data collection	31 December 2005 30 June 2006	Systems in place Data supplied to —Get Checked"
3.4	Improve glycaemic control in Type1 Diabetes	Introduce newly developed module into routine courses	1 July 2005	Number of courses delivered
3.5	Confirm Group courses are current, relevant, make best use of available resources	Review existing course material and make adjustments as necessary	December 2005	Courses are found to be interesting and enjoyable
3.6	Confirm Rural Outreach Courses are adding value	Review delivery of where and frequency of these courses	December 2005	Demand is met within available resources
3.7	New diabetes premises are available for occupation	Have moved into new premises	May 2006	Move completed
4. PRIMARY CARE				
4.1	Maintain and strengthen links with primary care providers	Work with primary care providers to: ▪ Minimise inappropriate utilisation of hospital acute services ▪ Improve elective services referral practices ▪ Ensure health services are delivered in the most appropriate setting	As per agreements with Pegasus Health and the Nurse Maude Association As per ToR and project plans for Acute Demand Management Group and Elective Services Working Group	Number of meetings and completed projects Undertake two projects to change service delivery setting

5. WORKFORCE				
5.1	Develop improvements to recruitment and selection systems and processes	HR Consultant to undertake review of processes Improvement areas identified	July 2005 December 2005	Processes defined across CDHB and mapped Methodology/approach developed to coordinate labour supply, internally and externally to minimise expenditure
5.2	Promote Key Behaviours	Through an evolutionary process integrate Key Behaviours into systems and processes, communication activity, and leadership	June 2006	Key Behaviours reflected in: Communication activity, Leadership development programs and in Recruitment and selection activity
5.3	Install a local HR Information System/develop workforce planning tools to apply at all levels	Review of current systems Project Scope completed	July 2005 December 2005	Provider identified Project activity defined
5.4	Improve Change Management processes	Develop guidelines and tools to support staff and managers in managing change	July 2005 December 2005	Guideline booklet for Managers circulated Guideline and supportive framework developed to assist staff in draft

OTHER PROJECTS		**INDICATORS/TARGETS**
1.	Continue implementation of Patient Flow/Patient Journey project	Focus on efficient use of resources Fund any reconfiguration within existing resources Complete implementation of capacity planning and demand forecasting Achieve optimal average length of stay
2.	Plan for Day Surgery Theatres	Maximise efficiency of Day Surgery Achieve rates of day surgery similar to those of other New Zealand peer hospitals by June 2006.
3.	Explore the options for introducing electronic prescribing	Electronic prescribing paper options and costing to be completed by December 2005.

MENTAL HEALTH SERVICES

Annual Objectives		Approach	Milestones	Indicators / Targets
1. HE KOROWAI ORANGA				
1.1	Promote a culturally responsive Mental Health Service	Maintain and build on the strength of Te Korowai Atawhai as the umbrella for bi-cultural develop-ment within the service by: ▪ Working in partner-ship with Iwi, whanau and tangata whaiora ▪ Ensuring appropriate resources for cultural assessment, specialist advice and teaching ▪ Ensure accurate data relating to service access ▪ All MHS staff to receive cultural training ▪ Ensuring core training for Pukenga Atawhai in Psychiatric Care and Cultural Development	Ongoing	Numbers of Pukenga Atawhai employed Numbers of MH staff completed baseline Cultural Competency training Numbers of Pukenga Atawhai who have completed training in core competencies in MH Numbers of clinical staff employed who identify as Māori
1.2	Improve ethnicity data collection throughout the hospital	Participate in ethnicity data collection policy consultation process Participate in ethnicity data collection	Ongoing	Ethnicity data updated in each admission Emphasis on the need to collect accurate ethnicity data identified and reinforced through the cultural training programme for staff This will be covered also at orientation for new staff
2.1	To assist the MHS to move towards its vision as a specialist MHS by developing Clinical Pathways with NGOs and Primary Care which ensure right skills, right place, right time	Review pilot of "Clinical Management" with Pathways Trust and 40 clients in Residential Rehab Service Negotiate and develop key Case Management relationships with NGOs and Primary Care Implement outcomes /directions of Canterbury Mental Health System plan as it relates to Specialist MHS Implement relevant recommendations of the Sth Is Regional Mental Health and Addiction Plan	Ongoing March 2006 Ongoing Ongoing	Integrated Care Co-Ordinator in place Formal pilot nearing completion July 2005 Levels of contact and satisfaction for all parties being monitored and evaluated Case Management criteria agreed with P&F and NGO, Primary Care Sector. Understood by all staff in SMHS Agreed actions implemented as per project plans

2.2	To understand the needs of those individuals who have enduring mental illness	Identify people in Specialist Mental Health Service (SMHS) with enduring mental illness (using the KPP framework) Identify services funded to meet needs of those with enduring mental illness Develop model for support / management including: ▪ Improving access to appropriate services ▪ Addressing interfaces between DHB funded and services available from other providers	Ongoing	Implement the KPP framework in an identified service Evaluate the outcome for consumers Include teaching of the principles of KPP framework in orientation sessions for new staff
2.3	To improve coordination of information collection systems	Ensure accurate, timely information recorded into Mental Health National Info Collection (MHNIC)	Ongoing	MHNIC data 100% accurate Participate in the MH_SMART/MHINC Project
3. WORKFORCE				
3.1	To ensure that Clinical staff have identified learning needs met to assist the Service's movement to a Specialist MHS	Model of needs identification established and implemented	Ongoing	All Clinical staff receive annual Performance Appraisal June 2005 Training plan developed, focus on staff achieving essential training – CPR / Calming and Deescalation / Risk Assessment and Formulation / outcome measures and specialist focused education
3.2	Compliance with HPCA expectations	Process for credentialling all clinical staff in place	Ongoing	- Current job descriptions - Credentialling of all applicants for positions - All have current Annual Practising Certificate

OTHER PROJECTS		**INDICATORS/TARGETS**
1	Access Canterbury Projects - Shared Care - Discharge planning - GP liaison	Develop future of project in light of other PHO and Mental Health initiatives
2	Participation in the Ministry of Social Services Pilot of the PATHS Model	Involvement in the planning and implementation stages. Numbers of Mental Health consumers re-entering the workforce and no longer on Sickness or Invalids Benefits
3	Accreditation Action Plans implemented	Put in place processes to ensure maintenance of accreditation status and readiness for re-survey December 2007
4	Participate in Mental health Standard Measures of Assessment & Recovery (MH_SMART) Project	Training of staff and undertaking of the outcome measures this year
5	Complete Project on improving responsiveness of Mental Health Services to Pacific Peoples	Project completed and agreed recommendations to be implemented

SERVICE RECONFIGURATIONS		BRIEF COMMENTARY
1	Implement agreed outcomes of Intellectual disability service review	Project plans are established for agreed outcomes of review and progress made against timeline for implementation
2	Implement agreed outcomes of Priorities for Action within Mental Health Services. Area of focus is Access & Responsiveness which effects the following services: - Family Mental Health - Child, Adolescent & Family - Adult Community MH	Project plans are established for agreed outcomes of these projects; may include internal management of change process and re-configuration of service delivery
3	Exploration of a programme for clients with high and complex needs	Implement agreed outcomes from the project group which may include development / re-design of a facility for this client group

THE PRINCESS MARGARET HOSPITAL – OLDER PERSONS SERVICES

Annual Objectives		Approach	Milestones	Indicators / Targets
1.	**HE KOROWAI ORANGA**			
1.1	To progress the implementation of Te Korowai Oranga and the Māori Health action plan	Respond to needs of Māori patients/ whanau through ensuring that environment reflects bi-culturalism	Continue to roll the cultural corridor concept out through the Division	Corridors reflect cultural themes
		Reduce the barriers to Māori and whanau within the TPMH services	Continue bi-annual Hui for older people	Review frequency and feedback from Hui 08/05
			Introduction of the Whanau Room	Review usage of Whanau Room ~ 11/05
			Develop links for the Psych. Services for the Elderly with Te Korowai Atawhai	PSE Māori NASC role attends meetings with Te Korowai Atawhai
		Staff to attend cultural training	Establish appropriate training programme for staff	November 2005
1.2	To continue to improve ethnicity data collection throughout the Division	To continue to participate in ethnicity data collection and to ensure data collection accuracy meets identified targets	Audits of ethnicity data	- Targets established - Minimum of quarterly audits occur - Ethnicity data collection updated at each admission
2.	**NEW ZEALAND DISABILITY STRATEGY**			
2.1	To continue to progress the implementation of the NZ Disability Strategy	The Division continues their involvement in the Older Persons Health Strategy	Review of continued operational input of the COSE model in line with MoH Aspire research project	March 2006
			Ongoing participation in InterRAI research project	Ongoing
		Bi-monthly meetings with Planning and Funding	Meetings occur and minutes of each meeting are retained	Bi-monthly meetings attended
		Review introduction of the volunteer program on site	Formal review occurs Findings communicated	August 2005
		Improve the documentation of goal setting / treatment plans within the Division	Service Provision Framework audits include goal setting review - action plans developed if results fall below target	Minimum of six Service Provision Framework Audits per annum
		Continuation of staff participation in Elder Care Forums	A minimum of two staff attend relevant meetings and forums	Attendance at meetings and forums
		Consumer Participation continues to be a focus for the division	- Members to be included in relevant meetings and forums - Provide input into service direction minutes available as appropriate - Representation at Clinical Management Board meetings	Ongoing

3.	**MENTAL HEALTH BLUEPRINT**			
3.1	To progress the Mental Health Blueprint utilising the Quality Health NZ Accreditation Standard as a tool	Following the Quality Health NZ Accreditation Survey in June 2004 an action plan is developed	Plan Developed	October 2005
		Initial training of recovery model implemented within Psych. Services for the Elderly	Initial training completed	December 2005
		Process for implementation of recovery model assessment tool (HONOS 65+) identified	Implementation completed as per plan - PSE representation on working plan	June 2006
		Respond to Older Persons initiatives identified under Mental Health Plan	Implementation plans developed for identified service changes	Attendance at Older Persons Psych. Service and Planning Forums
4.	**WORKFORCE**			
4.1	To ensure availability of an appropriately skilled workforce by promoting TPMH as a positive place to work	Division identifies and continues to implement positive staffing initiatives	Nursing New Graduate Programme has two intakes per year	Retention of New Graduates within the service
			Staff Wellness Day	Staff Wellness Day occurs annually
			Formation of a Professional Development Group re staff training, conferences and ongoing development	Group established Maintenance of staff training database
			Support of student Nursing Assistant Programme	Ongoing
		Support child friendly initiatives within the workplace	Availability of on site School Holiday Programme	Ongoing
4.2	To develop Senior Clinical Nursing positions within the Division	Implement a minimum of one senior clinical nursing position	Review of Specialist Continence Nurse position	August 2005
			Appointment of further two part time Nurse Specialist positions	June 2005
4.3	Clinical Leadership	Division reviews its approach to Clinical leadership across the disciplines	Discussion to be held with Clinical Leaders to determine issues relating to leadership	Discussion held and documented
			Formulate Terms of Reference for review of Clinical Leadership model	Terms of Reference formulated and distributed
			Develop programme of support for new graduates of all disciplines within the service	May 2006
4.4	Compliance with HPCA Expectations	Process for credentialling all clinical staff in place	Ongoing	Credentialling of all applicants for positions through Health Professional Advisors

OTHER PROJECTS		INDICATORS / TARGETS
1	Memory Assessment Service	Number of patients utilising Memory Assessment Service captured Memory Service implementation reviewed Benefits of Memory Service to patients documented
2	Community Stroke Service	Potential for Community Stroke Service Scoped and presented to Executive Management Team
3	Alcohol and Drug Services for Older People	Requirements for services scoped by August 2005 Potential pathways for funding identified
4	Quality Health NZ Action Plan	Following Quality Health NZ Survey Actions implemented as per action plan

SERVICE CONFIGURATIONS		BRIEF COMMENTARY
1	Reconfigure service delivery in line with the National Direction for School and Community Dental Services (MoH Review) – October 2004	Project coordinator will need to be assigned. Funding for project to be ascertained Review of clinic facilities completed Stakeholder consultation completed and scoping of service reconfiguration options completed
2	Community Services	Review role and functioning of Community Therapy Service

WOMEN'S AND CHILDREN'S HEALTH SERVICES

Annual Objectives		Approach	Milestones	Indicators / Targets
1. HE KOROWAI ORANGA				
1.1	Further improve ethnicity data collection throughout the Division	Provide information to women/patients/ families and staff as to why collection of ethnicity data is relevant Ensure forms seeking ethnicity data assist the process	Staff awareness of importance of data collection is high and information given by staff to patients and family is relevant and supportive of the objective	Women/Patients/ Families feel able to answer admission questions including identification of ethnicity Staff approach is comfortable and informed
2. NEW ZEALAND DISABILITY STRATEGY				
2.1	Continue to promote a non disabling culture as per the CDHB Disability Strategy Action Plan	Utilise the Disability and Support Advisory Committee as an advisory group to ensure new facilities, workforce training and employment practices promote a non disability environment Adopt DHB Elder-Friendly Guidelines	As HR policies are updated they reflect EEO principles Staff are encouraged and supported to attend relevant training opportunities As Policies and Guidelines are updated, Elder Friendly Guidelines are included, and incorpored into ongoing regular staff education	Staff attendance at training in disability issues occurs Feedback from patients, families and staff is positive Knowledge and application of Guidelines are comprehensive
3. ELECTIVE SERVICES AND RADIOTHERAPY WAITING TIMES				
3.1	Further progress on managing Elective Services (and Radiotherapy) Waiting Times	Manage the referral interface with a focus on patients remaining with their primary care provider and only accessing secondary or tertiary services at the optimal time for referral and treatment Monitor key performance indicators to ensure the most effective and efficient use of elective services resources and funding is occurring	Patient status (i.e. Certainty, Active Review or GP care) has been identified and the patient and their GP is aware of status Processes embedded to support adherence to CDHB and MOH policy in relation to Elective Services (and Radiotherapy) Waiting Times	Elective Services Performance Indicators (monthly) Internal Audit Reports (monthly and annually) Contracted volumes (per annum) re elective services are delivered (monthly) Crown Funding Agreement reporting (quarterly) District Annual Plan reporting (quarterly)
4. INEQUALITIES				
4.1	Reduce Health Inequalities	Identify relevant populations and target resources accordingly	Service and clinical plans reflect an awareness of and support for strategies which take into account the need to reduce health inequalities	Links to CDHB focus as a whole on reducing inequalities and relevant intersectoral groups can be seen in Planning

5. WORKFORCE				
5.1	To achieve a workforce which provides the right skills at the right place and time for best delivery and outcomes	Identify multidisciplinary workforce required to deliver healthcare taking into account new and emerging approaches and treatment HR practices support this objective	Service plans reflect multidisciplinary approach to healthcare and need to achieve an appropriate workforce to support efficient, effective healthcare delivery	Medical, Midwifery, Nursing and Allied Health Staff are engaged in healthcare activities which support best delivery and outcomes for patients needing the services offered by Women's and Children's Health

OTHER PROJECTS		INDICATORS/TARGETS
1	Adapting to New Christchurch Women's and Day Surgery Hospital	Post-move review completed and appropriately enacted
2	Maintenance of Baby-Friendly Hospital Status	Maintained following re-audit

SERVICE RECONFIGURATIONS		BRIEF COMMENTARY
1	Integration with Child Health Services on the Christchurch Hospital Site	Plans for effective integration will be complete and enacted

BRACKENRIDGE ESTATE

Annual Objectives		Approach	Milestones	Indicators / Targets
1. HE KOROWAI ORANGA				
1.1	All Brackenridge staff have received appropriate cultural awareness training	All Brackenridge staff to attend Treaty of Waitangi workshops	Evidence of new learning being used in workplace	80% of all staff have attended training by Dec 2005
1.2	Establish and maintain appropriate levels of Māori staff	target Māori recruitment	Target is 5% of Māori staff members	review 6 monthly
2. NEW ZEALAND DISABILITY STRATEGY				
2.1	All Brackenridge residents have lifestyle plans with ordinary life goals	Review all residents plans put in place revised plans and supports aimed at achieving an —rdinary Life"	Schedule 6 monthly reviews monitor objectives set in residents plans	Residents will be living an ordinary life with the necessary levels of support
3. WORKFORCE				
3.1	Develop internal training programme to complement IDCT Modules	Develop core set of competencies	Successful completion of training targets	All Staff demonstrates increased skill levels
3.2	All Staff Must Complete IDCT Modules As Base Training	Promote value of upskilling make it part of persons development plan	Measure attendance on regular basis to see target is reached	All Staff Have Attended IDCT Modules

OTHER PROJECTS		INDICATORS/TARGETS
1.	Certification	3 Year Certification Awarded October 2004
2.	Forest Park construction completed	Underway - Scheduled For Completion April 2005
3.	Resident Programme & Staff Structural Review Beginning March 2005	Completed July 2005

COMMUNITY AND PUBLIC HEALTH

Annual Objectives		Approach	Milestones	Indicators / Targets
1. PUBLIC HEALTH				
1.1	Improving the provision of information on health status and determinants and effective population health responses	Forming Public Health Intelligence Team (PHIT) Work plan for PHIT PHIT relationship and communication plan	Appointment of manager to PHIT Team Plan developed Plan developed	PHIT formed PHIT operating effectively as per Workplan and Communication Plan
1.2	Promote and support a focus on population health approaches and determinants of health by our DHBs in our region	Identify and promote opportunities for DHBs' provider arms to become more health promoting Develop relationships at all levels in DHB's in order to support their planning and strategic processes Support DHBs to provide training in public health approaches Involve Ministry of Health as a partner in this process	Development of Programmes Collaborative and supportive relationships developed	A minimum of two programmes running Ongoing Training provided Ongoing
1.3	Work with other organisations to promote and support a focus on population health approaches and determinants of health	Develop relationships with organisations that identify common goals Support the strategic development of existing collaborative ventures, and initiate/develop new ones Advocate for healthy policies in other agencies	Development of intersectoral initiatives focusing on priority health gain areas.	Ongoing positive relationships developed and maintained
1.4	Maximise the strategic and operational effectiveness of C&PH	Realign Management PHP functions and establish PHIT to support emphasis on Public Health Intelligence and external environment Develop change management and comms plans to engage staff in new direction and ensure contracts reflect approach Upskill staff to meet needs of new environment	Review organisational processes to reflect direction Prioritise and re-orient resources to reflect needs of new direction	Review undertaken and direction realigned Change management and communication plans developed Upskilling of staff ongoing

OTHER PROJECTS		INDICATORS/TARGETS
1	Support implementation of PHO promotion plans	Work with DHB's to identify requirements and contribute to these projects - lead as relevant
2	Child Health Strategy Implementation	Continued implementation of identified initiatives.

4. MANAGING FINANCIAL RESOURCES

4.1 Managing Within Operating Budget

The overarching impact on Canterbury DHB's financial planning is the level of baseline funding advised by the Minister of Health and estimated revenue from other health and non-health sources. In addition there are key factors and/or constraints which need to be taken into account. These include the Mental Health Funding Ring-fence, level and type of services to be funded and provided (including IDFs), the Core Directions impact, and the requirement to achieve a stable financial performance of a break-even' result.

The Canterbury DHB is budgeting for a break-even position for 2005/2006, an objective consistent with the Minister of Health's expectation of the Canterbury DHB's financial performance. In arriving at the break-even budget, a number of key assumptions were made, in particular, that the financial impact of the further devolvement and changes to Older People's Health Services will be fully funded. In particular, this relates to the changes to the income and asset testing regime and changes to Disability Support Service (DSS) boundaries. The budget is also dependent on the achievement of additional efficiencies and the need to undertake a number of infrastructure and service reconfigurations to align services to the funding.

The budget has taken into account the depreciation implication of the new $77M Christchurch Women's Hospital (CWH) and Day Surgery Unit which has been fully operational since April 2005.

The following sets out the summary budget estimations for 2005/2006:

	$M (GST excl)
Overall net increase in funding & revenue (incl non Base funding)	61.5
Less:	
Net increase in expenditure for external and CDHB provided services	(62.0)
Incremental depreciation/interest – new CWH & Day Surgery Unit	(3.5)
Other additional specific increases	(2.5)
Estimated 2005/06 Operating Gap	**(6.5)**
Efficiencies/revenue enhancement required to break-even	6.5
Budgeted Net Result	***Nil***

Note: Specific additional cost increases include but not limited to cancer drug mix and blood products

4.1.1 Outyears Scenario

The introduction of PBF has resulted in the Canterbury DHB receiving a graduated lower funding increase from 2004/2005 until its funding is at a level consistent with its population. As an over-funded DHB, the Canterbury DHB's funding will be subject to a reduction in transitional funding until its funding is in line with its population share.

The move to funding equity between DHBs will see the Canterbury DHB receiving a smaller funding increase over the next few years. The projected financial scenario over the next three years under PBF, is as follows:

Table 1

2004/05 $M		2005/06 $M	2006/07 $M	2007/08 $M
19.6	Estimated Increase in Annual Funding (incl non MOH funding)	61.5	32.5	21.0
Nil	Less: Deficit Reduction Required (assume breakeven in 2004/05)	Nil	Nil	Nil
19.6	Net Funds Available per annum	61.5	32.5	21.0
(27.9)	Less: Projected Annual Cost Increase (include nurses 'pay jolt')	(68.0)	(39.5)	(33.0)
(8.3)	**Annual Operating Shortfall**	**(6.5)**	**(7.0)**	**(12.0)**
(8.3)	**Cumulative Operating Shortfall From 2004/05**	**(6.5)**	**(13.5)**	**(25.5)**
8.3	Cumulative Efficiencies Required to Meet Shortfall	6.5	13.5	25.5
Breakeven	**Budget Net Result After Efficiencies**	**Breakeven**	**Breakeven**	**Breakeven**

Notes:

- *A significant portion of the additional funding in 2005/06 relates to top-up funding for 'cost-neutral' items such as nurses 'pay jolt' and changes to income & asset testing regime.*
- *2006/07 and 2007/08 figures exclude the financial impact of an additional one weeks leave effective April 2007 per the Holidays Act.*

The estimated annual operating shortfall between funding increase and expenditure growth is between $6M to $7M for the next two years, rising to about $12M in 2007/08, based on a planning assumption of 2% funding growth in out-years. Efficiencies and revenue enhancement initiatives will be required to meet this gap in order for the DHB to achieve a financial to breakeven result.

4.2 Key Assumptions and Risks

In addition to the need for efficiencies, revenue enhancement and/or service reconfigurations, other key assumptions to achieve the breakeven budget for 2005/2006 include:

- Baseline funding as per Minister of Health's funding advice
- Net Inter-District flow volumes and revenue will be fully realised
- Financial impact associated with the changes to income and asset testing regime is cost neutral to the DHB
- Financial impact associated with changes to DSS boundaries and any further contract/services being devolved by MoH is cost neutral to the DHB
- Collective employment agreements are settled within the Treasury's forecasted labour index, on average. Additional costs to move to national rates per government directive, if any, will be cost neutral to the DHB
- No significant change to previous year's service contract volumes, except where additional funding has been provided to the DHB (e.g. Mental Health ring-fence funding and/or Orthopaedic Initiative)
- Pharmac budget for community referred spending is as per agreed by DHBs and forecast savings on stats dispensing and other initiatives are achieved
- Interest rates are within Treasury's forecast
- Average increase in non-employee expenditure is within overall CPI
- Growth in acute medical and acute mental health volumes within sector average
- Cashflow relating to increased depreciation from asset revaluation (FRS3) is available for debt facility reduction or equity repayment
- Change in price/volume mix of NZ Blood Service products is within CPI or as agreed between DHBs and NZBS and there is no significant growth in South Island patients requiring blood products
- New government/MoH policies and initiatives that have financial impact on the CANTERBURY DHB will be fully offset by increased funding from the MoH
- Projected proceeds from approved sale of surplus assets are realised as planned

The over-riding risk to achieving the financial performance relates to the key assumptions above not holding true and the risks around staff pay increase expectations following the national NZNO nurses MECA settlement. In addition the flow-on impact of this pay settlement on to the NGO provider sector will present a significant risk in terms of price increase expectations and/or sustainability of the community services. Other risks include the inability to implement identified service reconfiguration and/or facility realignment, according to planned timeframes and the inability to achieve efficiencies and address cost over-runs internally.

4.3 Fixed Asset Valuations

In June 2003, the Canterbury DHB's assets were revalued as part of the FRS3 requirements. The revaluation resulted in a write-up of asset value of approximately $77M. The forecast financial statements include the increased capital charge ($8.5M) and depreciation expenses ($10.8M) resulting from the revaluation and the corresponding revenue from the Crown to off-set these expenses in each of the years. The continuing funding of this $19.3M in out-years is a critical assumption to achieve a break-even result.

DHBs are required to revalue their assets every five years and the next revaluation is expected in 2008. Therefore the 2007/08 financial forecasts outlined in this document may be affected.

4.4 Business Cases

The expected business cases requiring the Minister of Health's approval is for the disposal of the existing Christchurch Women's Hospital site. This site will be vacant following the move of services from the existing Christchurch Women's to the new Women's Hospital on the Christchurch Hospital site. There will be possible service reconfigurations and facilities realignment outlined in this plan.

Business cases relating to information technology and other significant capital projects will include Regional Capital Committee, MoH and National Capital Committee review and endorsement, where appropriate. The likely business case is for the replacement of the outdated legacy rostering, payroll, and human resources information system (HRIS).

4.5 Capital Expenditure

The estimated capital expenditure budget for 2005/2006 is $44.2M and consists of:

- $21.5M for Burwood Hospital Stage II Redevelopment.
  This incorporates the additional facilities required to deliver on the additional major joints volumes, as part of the government funding initiative
- $22.7M for normal asset replacement and priority new equipment.
  Details for the $22.7M will be established following an internal prioritisation process involving clinicians and management. This process is expected to be completed in late June 2005. Some of the key items are outlined in the draft Asset Management Plan.

Estimated funding for the capital expenditure will be:

- $9M additional credit facility for the Burwood Hospital Stage II Redevelopment
- $25M from operating cashflow
- $10M from approved surplus assets sale proceeds.

The proposed disposal of significant surplus assets over the next three years includes Canterbury DHB owned sites at Hanmer Springs, Hillmorton Hospital and the existing Christchurch Women's Hospital. Both the Board and the Minister of Health's approval has been received for the Hanmer and Hillmorton site disposals and a business case will be put forward for the proposed disposal of the Christchurch Women's Hospital site as part of the due process. The financial assumptions include the estimated proceeds from surplus asset sale/s expected in 2005/2006.

Investment in new technology systems within the capital expenditure funding is likely to include expansion of the Picture Archiving and Communications System (PACS) into the remaining hospital

sites, where appropriate, new clinical equipment and cook-chilled food. A replacement linear accelerator and CT were approved in 2004/2005 and these will be commissioned during 2005.

4.6 Debt and Equity

The Canterbury DHB's estimated total debt will increase from approximately $97M as at June 2005 to $100M as at June 2006. It is assumed that the available cashflow from FRS depreciation funding will be applied to loan facility reduction, thus reducing the balance as at June 2007 to approximately $92M. The increase in term loan in 2006 is primarily to fund the residual payment associated with the recently completed Christchurch Women's Hospital and Day Surgery Unit and the Burwood Hospital Stage II Redevelopment project, which is currently in the process of being formally approved by the Minister of Health.

The current approved credit facility available through the Crown Financing Agency is approximately $121M and this is expected to increase to $130M in 2005/06, on the assumption that the $9M additional facility for the Burwood Hospital Stage II Redevelopment project is approved by the Minister. In addition working capital of approximately $50M is financed from a private bank.

The Canterbury DHB is complying with the banking covenants required of its loans. The key covenants together with forecast ratios for 2005/2006 based on the forecast financial statements are:

	Required	Forecast Ratio
• Interest cover ratio:	>2.75 times	Approx7.5 times
• Debt/Debt plus Equity ratio:	<50%	Approx 32.7%

4.7 Efficiencies and Service Reconfigurations

In budgeting for break-even results, the Canterbury DHB will be planning to implement and achieve a number of efficiencies and/or service reconfigurations to meet the $6M to $12M operating gap. These have been outlined earlier in this plan in Section 3.2.7. Examples of the initiatives to be undertaken include:

- Ongoing HSS Non-clinical Support Services Reviews and Consolidations
- Implementation of 'Improving the Patient Journey' and 'Patient Flow' Projects
- Hospital and Community Laboratory Services Review
- Review and Alignment of Hospital Sites to Service Needs
- Integration of Womens' and Childrens' Services
- Clinical and Non-clinical Consumables Usage Review
- Review of processes by which new treatment regimes could be introduced
- Collaborative arrangement with external providers on elective services
- Review and streamline non acute patient transfers
- Improving access to and quality of Elective Surgery.

In addition, gain on sale from the disposal of surplus assets, as approved by the Minister, is an integral part of the efficiency target. Some of the initiatives are longer term and are only expected to generate major savings in future years. Early planning is essential to ensure the implications of the reduction in transitional funding (1% or approximately $8M per annum) in out-years are adequately addressed.

The initiatives will have input from clinicians, where appropriate, to ensure patient safety and related issues are adequately considered and factored in the decision making process.

4.8 Forecast Financial Statements - Years Ending 30 June 2005/06 to 2007/08

4.8.1 Forecast Group Statement Financial Performance

	2003/04 Actual $'000	2004/05 Forecast $'000	2005/06 Forecast $'000	2006/07 Forecast $'000	2007/08 Forecast $'000
Operating Revenue					
MoH Revenue	811,362	893,161	953,435	985,219	1,004,923
Patient Related Revenue	24,462	27,562	27,670	28,224	28,788
Other Revenue	13,060	9,140	11,276	11,501	11,729
Total Operating Revenue	848,884	929,863	992,381	1,024,944	1,045,441
Operating Expenditure					
Employee Costs	346,910	359,978	380,322	397,404	409,052
Treatment Related Costs	90,207	98,363	102,285	105,331	107,491
External Providers & IDF	299,921	355,703	387,073	398,676	405,150
Strategic Investment Fund		1,000	1,000	1,000	1,000
Non Treatment Related & Other Costs	53,689	51,316	53,459	54,531	55,075
Total Operating Expenditure	790,727	866,360	924,139	956,942	977,769
Result before Interest, Depn & Cap Charge	58,157	63,503	68,242	68,002	67,672
Interest, Depreciation & Capital Charge					
Interest Expense	(4,035)	(5,550)	(6,143)	(5,903)	(5,573)
Interest Received	595	172	172	172	172
Donation and Trust Funds	-	838	22	22	22
Capital Charge Expenditure	(23,306)	(23,400)	(23,230)	(23,230)	(23,230)
Depreciation	(32,652)	(35,563)	(39,063)	(39,063)	(39,063)
Total Interest, Depreciation & Capital Charge	(59,398)	(63,503)	(68,242)	(68,002)	(67,672)
Net Operating Results	**(1,241)**	**-**	**0**	**0**	**(0)**

Notes:

1. *Revenue include Ministry of Health 25 February 2005 funding advice*
2. *The significant increases in 2005/06 and 2006/07 relate to top-up funding associated with the nurses 'pay jolt'*
3. *The financial impact of an additional weeks annual leave effective 01/04/07, resulting from the Holidays Act, had **not** been factored in for the 2006/2007 and 2007/2008 years.*
4. *Potential change arising from asset revaluation in 2008 had not been considered.*
5. *Figures in expenditure categories may change following further internal budget refinement, however the net result will remain at 'break-even'.*

4.8.2 Forecast Group Statement Financial Position

	30/06/04 Actual $'000	30/06/05 Forecast $'000	30/06/06 Forecast $'000	30/06/07 Forecast $'000	30/06/08 Forecast $'000
Public Equity					
Opening Equity	211,585	199,344	199,344	199,344	199,344
Equity Repayment	(11,000)				
Net Result for the period	(1,241)	-	0	0	(0)
Total Public Equity	**199,344**	**199,344**	**199,344**	**199,344**	**199,344**
Current Assets					
Cash & Bank (OD)	(835)	(6,331)	(2,702)	(439)	(376)
MoH Debtor	14,074	7,000	7,000	7,000	7,000
Other Debtors & Other Receivables	12,849	10,000	10,000	10,000	10,000
Prepayments	553	600	500	500	500
Stocks	6,806	7,200	7,000	7,000	7,000
Total Current Assets	33,447	18,469	21,798	24,061	24,124
Current Liabilities					
Creditors & Accruals	63,736	69,284	69,000	69,000	69,000
Capital charge payable	5,810	5,819	5,819	5,819	5,819
GST	4,581	4,500	4,500	4,500	4,500
Provision for Income Tax	17	17	17	17	17
Interest Accrual	209	500	500	500	500
Staff Entitlement	52,757	54,000	54,000	54,000	54,000
Short Term Borrowings	42,600				78,700
Total Current Liabilities	169,710	134,120	133,836	133,836	212,536
Working Capital	(136,263)	(115,651)	(112,038)	(109,775)	(188,412)
Investments	292	292	292	292	292
Restricted Assets - Trust Fund	7,779	7,779	7,779	7,779	7,779
Fixed Assets	384,437	408,874	408,261	397,998	386,935
Total Non Current Assets	392,508	416,945	416,332	406,069	395,006
Term Staff Entitlement	(4,851)	(4,900)	(4,900)	(4,900)	(4,900)
Deferred Tax	(50)	(50)	(50)	(50)	(50)
Term Loans	(52,000)	(97,000)	(100,000)	(92,000)	(2,300)
Total Non Current Liabilities	(56,901)	(101,950)	(104,950)	(96,950)	(7,250)
Net Assets	**199,344**	**199,344**	**199,344**	**199,344**	**199,344**

Movement in Public Equity

	30/06/04 Actual $'000	30/06/05 Forecast $'000	30/06/06 Forecast $'000	30/06/07 Forecast $'000	30/06/08 Forecast $'000
Public Equity					
Opening Equity	211,585	199,344	199,344	199,344	199,344
Add/(Less):					
Equity Injection / (Repayment)	(11,000)	-	-	-	-
Net Result for the period	(1,241)	-	0	0	(0)
Total Public Equity	**199,344**	**199,344**	**199,344**	**199,344**	**199,344**

4.8.3 Forecast Group Statement Cashflow

	2003/04 Actual $'000	2004/05 Forecast $'000	2005/06 Forecast $'000	2006/07 Forecast $'000	2007/08 Forecast $'000
Cashflows from Operating Activities					
Cash provided from:					
MOH Receipts	845,726	900,235	953,435	985,219	1,004,923
Other Receipts	32,062	40,389	34,968	35,747	40,539
	877,788	940,624	988,403	1,020,966	1,045,463
Cash applied to:					
Employee Costs	335,069	358,686	380,322	397,404	409,052
Supplies & Expenses	450,264	501,275	543,801	559,538	568,717
Capital Charge Payments	21,166	23,391	23,230	23,230	23,230
Finance Costs	4,345	5,259	6,143	5,903	5,573
Taxes Paid	(1,897)	81	-	-	-
	808,947	888,692	953,496	986,075	1,006,572
Net Cashflow from Operating Activities	**68,841**	**51,932**	**34,907**	**34,891**	**38,891**
Cashflows from Investing Activities					
Cash provided from:					
Sale of Assets	2,132	-	9,750	11,200	
Interest Received	595	172	172	172	172
	2,727	172	9,922	11,372	172
Cash applied to:					
Advance to JV/Trust Investments	299	-	-	-	-
Purchase of Assets	52,029	60,000	44,200	36,000	28,000
	52,328	60,000	44,200	36,000	28,000
Net Cashflow from Investing Activities	**(49,601)**	**(59,828)**	**(34,278)**	**(24,628)**	**(27,828)**
Cashflows from Financing Activities					
Cash provide from:					
Equity Injection					
Loans Raised	52,000	2,400	3,000	-	-
	52,000	2,400	3,000	-	-
Cash applied to:					
Loan Repayment	56,780			8,000	11,000
Equity re Depn on Revaluation	11,000				
	67,780	-	-	8,000	11,000
Net Cashflow from Financing Activities	**(15,780)**	**2,400**	**3,000**	**(8,000)**	**(11,000)**
Overall Increase/(Decrease) in Cash Held	3,460	(5,496)	3,629	2,263	63
Add Opening Cash Balance	(4,295)	(835)	(6,331)	(2,702)	(439)
Closing Cash Balance	**(835)**	**(6,331)**	**(2,702)**	**(439)**	**(376)**

5.0 MEASURING SUCCESS

5.1 Consolidated List of Indicators of DHB Performance (IDP)

The MoH has established a set of DHB Accountability Indicators to focus DHBs on priority health objectives identified in the NZ Health Strategy, monitor activity and compare DHB performance, and to hold DHBs accountable. The Canterbury DHB is committed to performance improvement, both as a funder of services and as a provider of services. Progress toward achieving the Accountability Indicator targets will be reported as part of Canterbury DHB's quarterly performance reports.

Accountability Indicators
The accountability indicators reflect the accountability that Canterbury DHB has for securing improved health status for its population. As responsibility for funding some services is yet to be devolved to DHBs, there are indicators where the DHB's ability to influence the outcome is not through direct funding but through influencing other funders.

Due to the evolving nature of DHBs and their responsibility for funding, the actions taken by the Canterbury DHB to influence the direction of performance in relation to specified targets is of as much importance as the match between actual performance and the indicator itself.

Qualitative Accountability Indicators
Performance against the qualitative indicators will be measured on the basis of reporting deliverables rather than numeric targets. Performance will be assessed not only on provision of reports that meet the stated content requirements but also compliance with the reporting timeframes.

Quantitative Accountability Indicators
The majority of the quantitative indicators are aimed at measuring DHB performance in addressing cardiovascular disease, diabetes, oral health and well child services – four priority areas within the New Zealand Health Strategy.

For each of the quantitative indicators set out in this plan targets have been set for the 2005/2006 year. The setting of those targets has been based on:

- Expectations expressed by the MoH
- The latest national data
- The latest Canterbury DHB specific data

It should be noted that for many indicators historical data is poor. Consequently there are some indicators for which a target is unable to be set at this stage. It is the intention of the Canterbury DHB to gather the required baseline data to allow for targets to be set for future plans. It is noted that the MoH will be using results outside 90% or 99% confidence intervals to trigger further analysis for a number of indicators.

Indicator results and targets have been stated for three population groupings, Māori, Pacific People and other. The overall targets for the Canterbury DHB reflect these ethnic specific results and the demographic characteristic of the Canterbury region.

The intent of this section is to recognise that Canterbury DHB understands the need to look at the health of the Canterbury DHB population although many factors effecting health care directly is outside its control.

The Canterbury DHB's Accountability Indicators for 2005/2006 follow and are in addition to:

- Existing reporting requirements under service contracts; and
- Information requirements contained in the Operational Policy Framework; and
- The Balanced Scorecard for the Provider Arm; and
- Monthly financial reporting to the MoH's DHB Funding and Performance Directorate.

IDP No.	Description	Target / Deliverable	Frequency
HE KOROWAI ORANGA			
HKO-01	Local Iwi / Māori engagement and participation in decision-making and the development of strategies and plans for Māori health gain.	A qualitative report providing the following information; ▪ A copy of the Memorandum of Understanding (MoU) between the DHB and its local Treaty partner(s), and report achievements against key objectives in the MoU ▪ A progress report that demonstrates how local Iwi/Māori are engaged in decision-making, implementation, monitoring and evaluation, with respect to prioritaisation, service delivery and planning documents, including the following: - District Strategic Plan (DSP) - District Annual Plan (DAP) - Health Needs Assessment - Māori Health Plan ▪ Description of any specific initiatives achieved as an outcome of DHB engagement with their local Treaty partner(s) ▪ Description of when Treaty of Waitangi training has, or will, take place for Board members, and what percentage of Board members have undertaken the training ▪ Description of achievements against key deliverables in the implementation of the DHB's Māori Health (Strategic) Plan (or more detailed Māori Health Action Plan) ▪ Confirmation that the above reports have been endorsed by the local Treaty partner(s).	Six monthly in the 2nd and 4th quarters
HKO-02	Progress in the development of Māori health workforce and Māori health providers.	A qualitative/quantitative report that provides the best data possible for the following information: 1) a copy of the DHB Māori Health Workforce Plan, or the timeframe to complete the Plan 2) achievements based on key deliverables in the DHB Māori Workforce Plan, or if the Plan is being developed, describe at least 2 key DHB Māori health workforce initiatives that the DHB has achieved 3) Report the number of (i) management FTEs, (ii) clinical FTEs, (iii) administrative FTEs and (iv) other FTEs held by Māori out of the total numbers of (i) management, (ii) clinical (iii) administrative and (iv) other FTEs in the DHB.	Six monthly in the 2nd and 4th quarters
HKO-03	Improving Mainstream Effectiveness	A qualitative report that provides the following for the DHB's provider arm: ▪ A report that describes the reviews of pathways of care that have been undertaken in the last 12 months that focussed on ways of improving access to effective services for Māori. ▪ A report on an example(s) of actions taken to address issues identified in the reviews	Annually in the fourth quarter

PACIFIC HEALTH AND DISABILITY ACTION PLAN			
PAC-01	Progress towards implementation of priority areas identified in the Pacific Health & Disability Action Plan.	A qualitative report that responds to the following key points: Pacific child and youth health What initiatives have been implemented and progressed to improve and protect the health of Pacific children (0-14 years)? What initiatives have been implemented or progressed to improve the health of Pacific youth (15-25 years) Promoting Pacific healthy lifestyles and wellbeing What initiatives have been implemented or progressed to encourage and support health lifestyles? Pacific primary health care and preventative services What initiatives have been implemented or progressed to ensure that there are locally available Pacific primary health providers that effectively meet the needs of their local Pacific communities? A. The Pacific Health and Disability Workforce Development Plan What initiatives have been implemented or progressed to develop a competent and qualified Pacific health and disability workforce that will meet the needs of Pacific peoples? B. Pacific Provider Development What initiatives have been implemented or progressed to develop and support Pacific health providers capacity and capability to effectively deliver health services? Promote participation of disabled Pacific peoples what initiatives have been implemented or progressed to deliver disability support and health services that will enable disabled Pacific peoples to participate fully in their communities? Pacific health and disability information and research What initiatives have been implemented or progressed to inform policy, planning and service development?	6 Monthly in the 2nd and 4th quarters
PAC-02	Engagement and participation of Pacific peoples in DHB decision-making and the development of strategies and plans, which include goals for Pacific Health gain.	Report outlining the following: Description of how Pacific peoples are engaged and participate in DHB decision-making and the development of strategies and plans which include goals for Pacific Health gain. ▪ This will demonstrate that Pacific peoples are engaged and participate in DHB decision-making on equity, accessibility and resource allocation at a governance and management level in the DHB organisation. ▪ It will also give the number, purpose and outcomes of any fono (community participation) that have been, or are planned to be, conducted during the reporting period.	6 Monthly in the 2nd and 4th quarters
REDUCING INEQUALITIES IN HEALTH			
RIH-01	Progress towards raising awareness of inequalities and refocussing planning and funding activities to address inequalities in health	A qualitative/quantitative report that provides a description of (or reference to) the deliverable used to consider the DHB's population's health needs from an equity perspective using equity assessment tools (Health Equity Assessment Tool and Reducing Inequalities Intervention framework), considering:	Annually in the 3rd quarter

		▪ Health status ▪ Risk factors ▪ Access to services Demonstrate how this analysis has informed service reconfigurations and other actions that aimed to move outcomes towards equity.	
POPULATION PRIORITIES			
POP-01	Diabetes 1.1 Reduce diabetes contributory risk factors	The number of Health Promoting Schools as a percentage of the total number of schools within the DHB (as part of the Healthy Eating Healthy Action (HEHA)). ▪ **Targets:** 30% ≙ active' Health Promoting Schools *NB: The target for 2005/06 takes into account the effect of the MeZNB rollout.*	Annually in the 3rd quarter
	1.2 Improve diabetes recognition and follow up	The number of people with type I or II diabetes on a diabetes register who had a free annual check during the reporting period as a percentage of the expected number of Canterbury DHB residents with diabetes ▪ **Targets:** Māori 80% Pacific 120% Other 87% Total 84%	
	1.3 Improve diabetes management	The number of people with diabetes whose HBA1c was equal to or less than 8% as a percentage of the total number of people with diabetes ▪ **Targets:** Māori 39% Pacific 45% Other 20% Total 23%	
	1.4 Increase diabetic retinopathy screening	The number of people with diabetes that have had retinal screening or an ophthalmologist examination within the last two years as a percentage of the total number of people with diabetes ▪ **Targets:** Māori 45% Pacific 39% Other 80% Total 75%	
POP-02	Cardiovascular disease 2.1 Reduce CVD contributory risk factors 2.2 Increase early recognition and response to individuals with CVD	Confirmation statement: Are there smoke free policies in place across the DHB? The number of people in each target group who have had their absolute CVD risk recorded in the last 5 years as a percentage of the total number of people in that target group. **Target groups:** 1 Māori/Pacific & Indian subcontinent men >35 years of age 2 Māori/Pacific & Indian subcontinent women >45 years of age 3 European and other men >45 years of age 4 European and other women >55 years of age **Targets: will be agreed when data becomes available through PHO monitoring arrangements**	Annually in the 3rd quarter CDHB is in the process of developing a Heart Health plan. Part of the development and implementation of this plan will include putting in place the mechanisms needed to collect the information required for these indicators.

	2.3 Slow the rate of CVD progression, reduce incidence of avoidable CVD related complications. Strengthen self-management capability of individuals, family and whānau	The number of people with a 5-year absolute CVD risk of 15% and above who have a CV management/care plan which includes patient specific goals and follows best practice guideline advice, as a percentage of the Total number of people with a 5-year absolute CVD risk of 15% and above. **Targets: will be agreed when data becomes available through PHO monitoring arrangements**	Following this CDHB is currently unable to set targets for these measures but will work towards gaining the capacity to do so for future years.
	2.4 Increase co-ordination across providers, processes and community resources	The number of people who have suffered a CVD event who attend a cardiac rehabilitation outpatient programme as a percentage of the total number of people who have suffered a CVD event who were admitted and discharged from hospital. **Target: 50%** *This only includes people who access rehabilitation through hospital based programmes. In keeping with the goals of Canterbury DHB's Heart Health Strategy (2004), a pilot of cardiac rehabilitation programmes to people in their own homes will begin in February 2006. Future performance on this indicator will include these programmes but at present only hospital based clinics are able to be counted.*	
POP-03	Stroke 3.1 Reduce stroke contributory risk factors	As for 1.1 and 2.1 The number of people in each target group who have had their absolute CVD/stroke risk recorded in the last 5 years as a percentage of the total number of people in that target group.	Annually in the 3rd quarter
	3.2 Increase early recognition and response to individuals at risk of suffering a stroke	**Target groups:** 1. Māori/Pacific & Indian subcontinent men >35 years of age 2. Māori/Pacific & Indian subcontinent women >45 years of age 3. European and other men >45 years of age 4. European and other women >55 years of age **Targets: will be agreed when data becomes available through PHO monitoring arrangements**	As explained for POP-02 above, CDHB is currently unable to set targets for these measures.
	3.3 Reduce incidence of avoidable complications from strokes. Strengthen self-management capability of individuals, family and whanau	The number of people who have suffered a stroke event who have a management/care plan which includes patient specific goals and follows best practice guideline advice which specifically includes antiplatelet therapy and blood pressure lowering therapy, as a percentage of the total number of people who have suffered a stroke event and were admitted and discharged from hospital. **Targets: will be agreed when data becomes available through PHO monitoring arrangements**	
	3.4 Increase co-ordination across providers, processes and community resources	The number of people who have suffered a stroke event who have been admitted to organised stroke services and remain there for their entire hospital stay, as a percentage of the total number of people who have suffered a stroke event who were admitted and discharged from hospital. **Targets: unable to set for 05/06** **Baseline data not yet available**	

POPULATION PRIORITIES			
POP-05	Oral health: percentage of children caries free at age 5 years	**Targets** Māori: 51.2% Pacific: 51.2% Other: 51.2% Total: 51.2%	Annually in the 3rd quarter for the period 1 January to 31 December 2005
POP-06	Oral health: mean DMFT score at year 8 (Form 2)	**Targets** Māori: 1.6 Pacific: 1.6 Other: 1.6 Total: 1.6 **In regards to the oral health targets it should be noted that there is fluoridation of public water supplies in Methven only – population approximately 1200 people. Any changes affected now or in the near future will not show through in the MF rate of Form 2 children for another 7-12 years at the earliest. CDHB will endeavour to meet the target subject to the above constraint.* *The CDHB agreed a Position Statement on Fluoridation in 2003. This is available on the CDHB website.*	Annually in the 3rd quarter for the period 1 January to 31 December 2005
POP-07	Reducing Violence; planning and implementing Family Violence Intervention programmes	The DHB will report complete, comprehensive and timely information on the deliverable outlined in the Family Violence Programme (see Section 3.1.5 Other Population Health Activity).	6 Monthly in the 1st and 4th quarters
POP-08	Improving the health status of people with severe mental illness	Access to services: average number of people domiciled in the DHB region, seen each month for the three months being reported (the period is lagged by 3 months) for: - children and youth aged 0-19 years adults aged 20-64 years - for Māori, Other, and in total **Targets for 05/06:** 0-19 years 20-64 years 65 years + Māori: 0.65% 1.31% 0.28% Other: 0.65% 1.0% 0.19% Total: 0.65% 1.1% 0.19%	Quarterly
POP-09	Babies born in public hospital with low birth weight- rate per 1000 hospital births	**Targets for 05/06** Māori: 72 Pacific peoples: 49 Other: 61 Total: 62	6 Monthly in 2nd and 4th quarters
POPULATION PRIORITIES			
POP-10	Progress in implementing the Baby Friendly Hospital initiative in maternity services.	**Report:** Listing all maternity facilities in the DHB and the BFHI status of each facility and a commentary on progress of any issues identified in any audit reports (relating to BFHI). For those facilities not BFHI accredited a detailed timeline for progressing toward accreditation for each facility will be provided. In addition, a quantitative analysis, including the proportion, for each major ethnic group, of —hospital born" babies delivered in an accredited baby friendly hospital, will be included.	6 Monthly in 2nd and 4th quarters
POP-12	Progress towards implementation of the National Immunisation Register (NIR)	**Report describing:** 1) Implementation progress and time lines 2) Issues or risks, including staffing levels required 3) Budgets and risks	Quarterly

POP-13	Ambulatory sensitive admissions. Children and Older People. Discharge rate per 1000 population	**Targets** ***Children*** ***<5*** ***5-14*** ***15-24*** Māori: 65.0 15.0 11.0 Pacific peoples: 90.0 20.0 11.0 Other: 72.0 16.0 11.0 Total: 72.0 16.0 11.0 ***Older People*** ***65-74 years*** Māori: 90.0 Pacific peoples: 105.0 Other 55.0 Total: 55.0 CDHB is committed to reducing disparities. Actions for improving rates for Māori and Pacific people on this indicator are embodied within the DHBs Māori Health Plan *(Whakamahere Hauora Māori Ki Waitaha), Pacific Health Action Plan,* and Health of Older People Strategy (LinkAGE Strategy and Action Plan).	6 Monthly in 2nd and 4th quarters
POP-14	Residential Care/Home Care reative expenditure on long-term community support compared to expenditure on residential care	**Target** Targets will be agreed within 3 months of the data becoming available	Quarterly
POP-15	Implementing the Cancer Control Strategy	The DHB will provide a qualitative report on the key areas of progress achieved against the DHB's cancer control strategy implementation plan goals/areas for action.	6 Monthly in 2nd and 4th quarters
POP-16	Radiation oncology treatment waiting times.	Part 1: Monthly templates supplied on time and complete from each DHB (including provision of information by DHB of domicile and ethnicity). Part 2: A report updating progress towards ensuring all patients receive oncology megavoltage radiation treatment according to nationally agreed standards. This report is to be agreed with all the peripheral DHBs whose populations have used the service during the quarter	Part 1 monthly Part 2 quarterly
SERVICE PRIORITIES			
SER-01	Accessible and appropriate services in Primary Health Organisations	A ratio of the age-standardised rate of GP consultations per high need person to the age-standardised rate of GP consultations per non-high need person. **Target:** Targets will be agreed within 3 months of the data becoming available	Quarterly
SER-02	Participation by Māori in decision making in Primary Health.	Qualitative report that provides the following information, 1) A progress report that evidences active participation by Iwi/Māori in PHO planning, development, implementation, funding and delivery of services to meet the needs of Māori whanau more effectively 2) The names of PHOs with Māori Health Plans that have been agreed to by the DHB or, for newly established PHOs, a report on progress in the development of Māori Health Plans.	6 Monthly in 2nd and 4th quarters
SER-03	Continuous Quality Improvement- Elective Services.	The DHB will report complete, comprehensive and timely information on the deliverable outlined in the Elective Services Programme (see Minister of Health's Implementation Priorities 9A: Improving Elective Services and 9B: Improving Orthopaedic Services). **Target:** Full compliance with the 8 Elective Services Performance Indicators by the end of the 2005/06 year.	6 Monthly in 2nd and 4th quarters

SER-04	Accessible and appropriate services for people living in rural areas	The number of shared roster areas with on-call rosters of 1:1, 1:2, or 1:3. **Target:** 0 i.e.. All areas have on-call rosters of 1:4 or better	Quarterly
SER-05	Improved responsiveness of mental health services	Qualitative report that includes the following; 1. Frequency of consumer surveys and detail regarding changes that result from consumer feedback 2. Explanation of how the DHB would integrate the nationally consistent perception survey questions into current practice.	6 Monthly in 2nd and 4th quarters
QUALITY			
QUA-01	Quality systems.	Report providing the following information: 1) Confirmation that the quality requirements in new and renewed service agreements are consistent with the quality requirements in applicable national service frameworks. Provide a resolution plan for any exceptions. 2) Report confirming that appropriate procedures for managing and reporting adverse (sentinel and serious) incidents have been maintained and that all such events have been reported to the Ministry of Health. 3) The DHB funding arm demonstrates the capacity/resources to initiate issues based audits of both its provider arm and contracted providers as necessary, by reporting: A summary of audit activity of the provider arm and contracted providers, giving a list of all audited providers and the type of audit conducted (e.g., routine, issues based), and the action(s) to be taken to ensure progress for: *-Personal Health* *-Mental Health* 4) The DHB provider arm demonstrates an organisational wide commitment to quality improvement and effective clinical audit by reporting: A high level summary (list) of key quality improvement and Clinical audit initiatives and results, focusing on those that are effective and/or ineffective against the Goals in Improving Quality (IQ): A Systems Approach for the New Zealand Health and Disability Sector for: *-Personal Health* *-Mental Health* 5) DHBs to confirm that complete and timely information has been provided to: i) the following components of the balanced scorecard: Patient satisfaction Blood stream infections ii) the New Zealand Health Information Service for the Mental Health Information National Collection (MHINC).	Part 1-2: Annual in the fourth quarter Parts 3-5: Annual in the third quarter

INVESTING IN THE FUTURE			
INV-01	Information management initiatives/capabilities.	The DHB will provide the following report to demonstrate the degree of progress being made and where targets are agreed, provide additional commentary to explain variances: 1. The number and percentage of clinical FTEs, by major clinical grouping, that has access to which clinical knowledge bases (such as Cochrane and Medline). 2. The number and percentage of general practices using electronic decision support guidelines endorsed by the NZ Guidelines Group, particularly for cardio-vascular, diabetes and referrals. 3. The volumes and percentages of discharges, broken down by service area, eg orthopaedic, mental health, using electronic messaging software to notify primary care providers of relevant patient details on hospital discharge. The electronic means should be specified. 4. The number and percentages of DHB funded referring practitioners electronically generating laboratory order scripts, receiving laboratory results and electronically generating pharmaceutical scripts. 5. The extent to which DHBs have implemented and are complying with sector standards for security and privacy. This includes the Health Information Privacy Code 1994, the Health Network Code of Practice and any other related standards or practices formally agreed between the Ministry and DHBs	6 Monthly in 2nd and 4th quarters CDHB is unable to set targets for this indicator at this time. CDHB is currently working towards implementation of the WAVE strategy. Progress during the 2005/06 year will enable CDHB to set targets for this indicator in the future.
INV-02	Implementation of the Workforce Action Plan	The DHB will provide the following information: 1. Evidence that the DHB is supporting the implementation of HWIS by 30 June 2006. 1.1 DHB to provide a brief progress report (70 words or less) assessing their achievement of HWIS timelines up to 31 December, and the likelihood they will achieve the final implementation deadline. 1.2 As above, to 30 June 2006. 2. Report describing how the DHB is maintaining and achieving healthy workplaces. 2.1 DHBs to complete the stocktake project as identified in the 04/05 WAP. The main conclusions (including, where applicable, any remedial action considered necessary) are to be described (70 words or less). 2.2 30 June 2006. DHBs are to report briefly (70 words or less) on any remedial action or new initiatives implemented under Deliverable 2.1 in the period to 30 June 2006. The report should describe expected outcomes, and actual achievements, of the action.	1st quarter: 3.1 2nd quarter: 1.1, 2.1 3rd quarter: 3.2 4th quarter: 1.2, 2.2

<table>
<tr><td></td><td></td><td>3. Report including the following:

3.1 DHBs are to complete a review, or participate in a regional or national review, to assess what barriers may exist to the establishment of new roles in their organisations. The scope of the review is at DHBs' discretion—it could examine an occupational group or a specific operational area, for example. The conclusions of the review are to be reported (70 words or less).

3.2 Linked to the work of Deliverable 3.1, the DHB will implement, where practicable, cost-effective action to overcome, or endeavour to overcome, one or more of any barriers identified in Deliverable 3.1. The DHB will report on action taken and results (70 words or less).</td><td></td></tr>
<tr><td colspan="4">KEY RISKS AND NEW INITIATIVES</td></tr>
<tr><td>RIS-01</td><td>Responding to and resolving Service Coverage issues.</td><td>The DHB will report progress achieved during the quarter towards resolution of gaps in service coverage (not agreed as exemptions or exceptions through the DAP process) identified by the DHB or Ministry through:
▪ analysis of explanatory indicators
▪ media reporting
▪ risk reporting
▪ formal audit outcomes
▪ complaints mechanisms.</td><td>Quarterly</td></tr>
<tr><td>RIS-02</td><td>Targets to increase funding for Māori health and disability initiatives.</td><td>The DHB will report:
1. Actual expenditure on Māori Health Providers by GL code and by Purchase Unit
2. Actual expenditure for Specific Māori Services provided within mainstream services targeted to improving Māori health by Purchase Unit
3. Total actual expenditure for Iwi/Māori-led PHOs
4. Actual expenditure for mainstream PHO services targeted to improving Māori health
5. Total actual expenditure on DHB Māori Workforce or Provider Māori Workforce Development initiatives, which are not funded through the Māori provider development scheme
6. Where information is available, the DHB will report a comparison between expenditure for the above measures for 2004/05
Targets:
<table><tr><td></td><td>Actuals</td><td colspan="3">Targets</td></tr><tr><td>Measure</td><td>2004/05</td><td>2005/06</td><td>2006/07</td><td>2007/08</td></tr><tr><td>1</td><td>3,804</td><td>3,919</td><td>4,036</td><td>4,157</td></tr><tr><td>2</td><td>4,110</td><td>4,234</td><td>4,361</td><td>4,491</td></tr><tr><td>3</td><td>n/a</td><td>n/a</td><td>n/a</td><td>n/a</td></tr><tr><td>4</td><td>n/a</td><td>n/a</td><td>n/a</td><td>n/a</td></tr><tr><td>5</td><td>525</td><td>541</td><td>557</td><td>574</td></tr></table>NB: Expenditure is in $000 Actuals for 2004/05 where calculated from actuals for July-December and contract for January-June</td><td>6 Monthly in 2nd and 4th quarters</td></tr>
</table>

RIS-03	Progress towards the implementation of the Meningococcal B Immunisation project	Quantitative indicator ▪ Progress towards the target of 90% of 6 week-5 month olds receiving their 3rd dose of MeZNB vaccine OR ▪ Progress towards the target of 90% of 6 month - 5 year olds receiving their 3rd dose of MeZNB vaccine (depending on implementation of the programme) AND ▪ Progress towards the target of 90% of school enrolled children receiving their 3rd dose of MeZNB vaccine Qualitative indicator A report describing: 1. Implementation progress and timelines 2. Risks with priority greater than 12 in accordance with the Project Implementation Plan drafted by the DHB 3. Budget risks Targets: CDHB will meet the targets specified in our Meningococcal Project Implementation Plan	Quarterly

6. REFERENCES

The Canterbury DHB has developed key documents that have been referenced throughout this District Annual Plan. These documents can be accessed via the Canterbury DHB website www.cdhb.govt.nz or by contacting the Canterbury DHB's Planning and Funding Division on (03) 364 4159.

- Statement of Intent 2004/2007
- District Strategic Plan: *Towards a Healthier Canterbury, Directions 2006* (including the CDHB's Prioritisation Policy)
- Health Needs Assessment for Canterbury, September 2004
- Health Needs Assessment of People 65 and Over, February 2003
- Quality Strategic Plan 2004/2006
- Child Health and Disability Action Plan 2004/2007
- Māori Health Plan: *Whakamahere Hauora Māori Ki Waitaha 2002/2006*
- Pacific Health Action Plan, March 2002
- Canterbury Heart Health Strategy, September 2004
- Oral Health Strategy, September 2003
- Annual Report 2004/2005
- Rural Health Action Plan: *Rural Health in Canterbury DHB 2002*
- Diabetes Interim Plan, October 2002
- Disability Strategy Action Plan for Disability 2004/2007
- Mental Health and Addiction Strategy, May 2004
- LinkAGE Action Plan 2003
- CDHB Diabetes Actions 2004/2005: *Prevention and Management*

7. ATTACHMENTS

7A: Draft Volumes Schedules for Service Provision 2005/2006
7B: Service Coverage Expectations
7C: Revenue Reconciliation
7D: South Island Regional Mental Health Strategic Plan 2005/2006
7E: CDHB Information Services Strategic Plan *(very large document available on request)*

8. APPENDICES

Appendix 1 CDHB Population Projections
Appendix 2 Disability Population Projections/breakdown
Appendix 3 Older People's Services Strategy Project Plan
Appendix 4 Organisational Chart and Services Provision Table for CDHB HSS
Appendix 5 Glossary of Terms
Appendix 6 Review of Rural Health Services (Project Plan)
Appendix 7 Review of Ophthalmology Services (Project Plan)
Appendix 8 Māori Health Expenditure List
Appendix 9 Healthy Eating: Active Living Strategy

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

DISTRICT ANNUAL PLAN

2006 – 2007

July 2006

Our Vision – Ta Matou Matakite

To promote, enhance and facilitate the health and well-being of the people of the Canterbury District. Ki te whakapakari, whakamaanawa me te whakahaere i te hauora M te orakapai o ka takata o te rohe o Waitaha

DISTRICT ANNUAL PLAN
1 July 2006 – 30 June 2007

Produced in 2006 by
Canterbury District Health Board
PO Box 1600, Christchurch
Telephone (03) 364 4160

www.cdhb.govt.nz

ISSN: 1176 3124

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Note: All the Canterbury DHB documents referred to in this Plan can be found on the DHB's website: www.cdhb.govt.nz. All the Ministry of Health or national documents referred to in this Plan can be found on the Ministry's website www.moh.govt.nz. A reference guide and glossary have been attached for further information.

1 EXECUTIVE SUMMARY

Statement from Canterbury DHB Chair and Chief Executive

We are pleased to present this District Annual Plan for the Canterbury District Health Board (DHB) for the 2006/2007 financial year. It outlines the activities the Board will be undertaking to June 30th 2007.

This Plan reflects the Canterbury DHB's continued commitment to promoting, enhancing and facilitating the health and wellbeing of the people of Canterbury. In developing the Plan, the DHB recognises the national health priorities defined by the New Zealand Health Strategy and Disability Act 2000. The Plan also recognises local objectives: five Core Directions, five Strategic (Health Gain) Priorities and four Disease Priorities all selected through a comprehensive health needs assessment and community consultation process, undertaken in part when determining the long-term District Strategic Plan for the Canterbury DHB. This District Annual Plan provides a comprehensive overview of health priorities and associated projects to be pursued in 2006/2007.

In seeking to achieve ongoing strategic objectives and priorities, the single largest challenge is in maintaining financial viability. The operating environment is becoming increasingly challenging. DHBs are faced with capped budgets, have tightly placed limits on service delivery and are confronted with increasing economic and regulatory and compliance cost pressures. In the case of the Canterbury DHB, these cost pressures are further compounded by the transition to equity under Population Based Funding (PBF), which sees the Canterbury DHB receive lower funding increases than some other DHBs. PBF involves using a formula designed to distribute the available health and disability support funding between DHBs according to the relative needs of their population and the relative costs of meeting those needs. The Canterbury DHB is considered as overfunded on this basis.

The DHBs' ability to respond to pressures is restricted by the limited tools available that are acceptable to government. Service pressures are greatest in meeting the cost of growing volumes and treatment models in cancer services and cardiovascular services as well as growing acute demand. Measures to reduce these pressures are being worked on: but it will take time to put them in place. Workforce shortages and the expectations in Multi-Employer Collective Agreements (MECAs) will place additional stress on the sector in 2006/2007.

The magnitude of the challenge ahead can be considered in the context of the anticipated cost "gap" between the funding increases received by the Canterbury DHB and the potential cost growth indicated by some official forecasts of consumer (CPI) and labour cost growth.

The Ministry of Health's advice to DHBs in the 2006/2007 Planning Package[1], provides Forecast Funding Track of 2.93% in 2006/2007 and estimated increases of 2.9% and 2.1% in the 2007/2008 and 2008/2009 years respectively. In comparison to the index of New Zealands likely inflation[2], there is a significant gap between the likely costs faced by DHBs and current projected funding increases.

Given these cost pressures the Canterbury DHB will be required to make significant efficiency gains. Where actual cost growth exceeds the levels forecast in this Plan, further efficiency gains or service reductions will be needed to ensure breakeven.

The last few years have seen unprecedented levels of investment in some staff groups partly to cope with service pressures: partly to recognise anomalies and international wage rates. Past collective settlements for MECAs in the three most vital groups are already estimated to account for increases equivalent to FFT in 2006/2007. Yet those contracts will need to be re-negotiated with expectations of some increase, which, within the available funding is not affordable. Wage costs during the period 2002/2003 to 2005/2006 have increased significantly and this trend will need to be contained in future periods. The effect otherwise will be the reduction in patient services in order to pay additional levels of wages. This stark message needs to be recognised by Government, unions, staff and the people of Canterbury.

[1] The government provides DHBs with a rolling three-year indicative funding package at the end of each year. This advice informs the planning process by providing a future view of funding on which to base long-term plans.

[2] MoH Requirements and Guidelines for Using Financial Templates 2006/07, December 2005, Appendix 2.

More positively, our first objective is to use our considerable resource in the best manner possible for the health and disability needs of the people we serve. In doing this we are likely to deliver some current services in different ways and in different settings.

In the last year, the Canterbury DHB has achieved significant successes across a number of areas. Amongst the more notable examples were:

- Opening the new Christchurch Women's Hospital and Day Surgery Unit, a $78.9 million project delivered on time and budget;
- Establishment of the Improving the Patient Journey initiative aimed at improving the design and management of patient care throughout the continuum of care;
- The successful implementation of the Meningococcal B Immunisation programme;
- Launch of the Healthy Eating, Healthy Living Action Plan (an initiative encouraging healthy eating, physical activity and smokefree lifestyles) and the successful implementation of Smokefree Sites with all Canterbury DHB hospital sites now Smokefree; and
- Significant efficiency initiatives over past years have assisted the DHB to reduce its $21M deficit to a breakeven position.

Our motivation is to do the very best we can to ensure our Community gets the optimum services we can deliver with the funding available. The Canterbury DHB acknowledges the importance of providing adequate leadership and information to its stakeholders as it strives to improve the health status of our community. As such, we will continue to encourage innovation, information sharing and the development of health expertise to cope with future demand whilst promoting, enhancing and facilitating the wellbeing of the people of Canterbury.

Syd Bradley
Chairman

Gordon Davies
Chief Executive

Office of Hon Pete Hodgson
MP for Dunedin North
Minister of Health
Minister for Land Information

Mr Syd Bradley
Chair
Canterbury District Health Board
PO Box 1600
CHRISTCHURCH

Dear Mr Bradley

Canterbury District Health Board: 2006/07 District Annual Plan

This letter is to advise you that I have signed Canterbury District Health Board's (CDHB's) 2006/07 District Annual Plan (DAP) for the three years 2006/07-2008/09 and the Board has my support for the implementation of this plan.

I wish to express my appreciation to the Board, management and staff for all the effort that has gone into producing the plan and the efforts made to manage your services within the funding available.

I understand that you have set yourselves challenging plans requiring the achievement of significant cost savings and efficiencies. I acknowledge and commend your intention to maintain a break even position. However, in order to address the risks around achievement of your DAP, I request that you include in the commentary that you send to the Ministry with your monthly financial results:

- explanation of any adverse variances to budget on a line item basis, and
- actions that you will be taking to reverse the trend and achieve your plan.

The Ministry will also seek further information from you on your accounting methodology and treatment of fixed assets.

CDHB will continue to receive in 2006/07 the early payment arrangements that you benefited from in 2005/06, subject to the acceptable financial performance during the year.

Risks

I note the risks you have identified. I expect CDHB to continue to manage its financial risks and live within its allocated funding. Where your DHB identifies severe

Parliament Buildings, Wellington, New Zealand. Telephone: (04) 470 6558, Facsimile: (04) 495 8449

risks of any type I expect you to notify the Ministry of Health (the Ministry) of them along with your strategies for mitigating them.

Electives

Improving elective services is a priority in 2006/07. I realise there are many challenges inherent in the management of elective services, however it is important that there is transparency in the system. People have the right to know when they have been promised surgery that they will get it within a specified timeframe, or if they cannot be offered treatment what their options are. It is also important that we deliver services in cost effective ways, so that more people can receive treatment.

I am pleased that you have been able to agree a revised recovery plan with the Ministry that will enable you to achieve compliance with the Elective Service Performance Indicators across all services by 30 September 2006 at the latest. Thank you for your commitment. The Ministry will keep me informed of your progress.

Mental Health

I note that you have received additional blueprint funding for 2006/07 and via the DAP process have outlined the proposed use of this funding. It is important that the planned use of this funding occurs and in the timeframes outlined in the DAP so service growth can be progressed and funding applied to building and strengthening mental health and addiction services for your population.

Getting ahead of the curve – The Chronic Disease Burden

I am pleased your DAP addressed the prevention and management of long-term conditions. As you are aware, the burden of chronic or long-term conditions bears most heavily on Māori, Pacific and high deprivation groups and delivers unequal health outcomes including premature death. We need to get better at preventing and managing long-term conditions among these groups. The Primary Health Care Strategy and Healthy Eating Healthy Action provide you with the basic tools to do this. I encourage you to include in your planning for 2007/08 explicit links between your plans around long term conditions prevention and management with your efforts to reduce inequalities and activity in primary care/community settings.

Capital

Please note that sign off on the 2006/07 DAP does not mean approval for any capital projects requiring equity or new lending, or self-funded projects that require the support of the National Capital Committee. Approval of such projects is dependent on both the 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 managed through the annual capital allocation round also.

Service Configurations

My approval of your DAP also does not constitute approval of proposals for service changes or service reconfigurations. I expect you to comply with the requirements of the Operational Policy Framework and advise the Ministry where any proposals may require my approval.

This letter should be attached to the copy of the signed plan held by the Board and a facsimile of the letter should be attached to all copies of the Plan made available to the public or any other third party.

Yours sincerely

Hon Pete Hodgson
MINISTER OF HEALTH

2 INTRODUCTION

Who are we?

DHB were established in January 2001, under the New Zealand Public Health and Disability Act 2000. There are twenty-one across the country and their prime responsibility is to improve, promote and protect the health and independence of their populations. Funded by government, DHBs work with their communities to decide what health services are needed and how to best use the limited funding they receive. DHBs must also note government policies, particularly: the New Zealand Health Strategy 2000, New Zealand (NZ) Disability Strategy 2002 and the NZ Māori Health Strategy 2002[3].

The Canterbury DHB is the second largest of NZ's twenty-one DHBs by population and the largest by geographical area. The catchment covers rural communities from Kekerengu in the North, Rangitata in the South and Arthur's Pass in the West and comprises the Territorial Local Authorities (TLAs) of Kaikoura, Hurunui, Waimakariri, Christchurch City, Banks Peninsula, Selwyn and Ashburton.

The Canterbury DHB, through its Planning and Funding division, holds more than 800 contracts with health and disability service providers; funding most of the disability services (for older people), mental health services, Māori health, personal and family health services provided in the Canterbury district.

There are fourteen public hospitals in Canterbury, which provide hospital and specialist personal health, mental health, disability support, alcohol and drug and community health services. These are managed by the Canterbury DHB through its Provider-Arm (Hospital and Specialist Service division).

The Canterbury DHB also promotes community health and well being through population health programmes, health promotion and health protection programmes (including the services of the Medical Officer of Health), primarily through its Community and Public Health division.

As the largest funder and provider, of health and disability services in Canterbury, the DHB also encourages all health and disability support providers in the district to work in collaboration to make care more efficient and effective and to address inequalities of access to health and disability services.

2.1 Strategic Directions

2.1.1 Vision and Values

Our Vision – Ta Matou Matakite	
To promote, enhance and facilitate the health and well-being of the people of Canterbury	
Ki te whakapakari, whakamaanawa me te whakahaere i te hauora Mo te orakapai o ka takata o te rohe o Waitaha	
Our Values – A Matou Uara	
Care and respect for others	Manaaki me tekotua i etahi atu
Integrity in all we do	Hapai i a matou mahi katoa i ruka i te Pono
Responsibility for outcomes	Kaiwhakarite i ka hua
Our Way of Working – Ka Huari Mahi	
Be people and community focused	Arotahi atu ki ka takata meka
Demonstrate innovation	Whakaatu whakaaro hihiko
Engage with stakeholders	Tuu atu ki ka uru

[3] These documents can be found on the Ministry of Health website www.moh.govt.nz.

2.1.2 Decision Making Principles

The majority of the health and disability services that the Canterbury DHB needs to fund are set out in government polices and directives. For those services for which there is a greater level of funding discretion the DHB has developed a Prioritisation Framework, identifying a set of principles to assist in making choices about funding services in the future. When making decisions about which services to provide, and at what level, the following five principles are be considered:

Effectiveness	The extent to which the health or disability service improves (benefits) quality of life by the reduction of pain, the maintenance of lifestyle, the promotion of independence or the prevention of premature death. The services that produce the most benefit are likely to be of greater priority. The level of benefit takes into account both the benefit per person and the total number of people benefiting.
Cost	The total cost of services are compared to the effectiveness of those services. This is done to ensure available funding is used to achieve the maximum possible gain.
Equity	The effectiveness of the service in improving the health of disadvantaged groups is considered. Disadvantaged groups include those on low incomes, Māori, Pacific and refugee communities, those with multiple diagnosis and those in remote areas with limited access to services.
Māori Health	In making funding decisions the Treaty of Waitangi is acknowledged and Māori participation in providing services is encouraged. Services must be appropriate and accessible to Māori.
Acceptability	The diverse expectations and values of New Zealanders are also considered when making prioritisation decisions on which services to provide and at what level.

2.1.3 Planning Assumptions

A number of planning and financial assumptions have been made within this Plan, which if not deliverable may limit the Canterbury DHB's ability to improve the health of its community or may lead to adverse financial outcomes. The financial assumptions made are outlined in the financial section of this document (Section 5) the planning assumptions are highlight below:

Operating Environment	Our short and mid-term direction and environment remains similar and current government health and funding policies remain the same.
Baseline Funding	Baseline and outyears funding increase as per funding advice from the Ministry of Health (MoH). As an over-funded DHB it is assumed that the Canterbury DHB will only receive a net increase equivalent to the annual FFT. It is assumed that any changes to the PBF formula, including funding that currently sits outside the PBF formula, will not impact adversely on future funding levels nor the period of transition to equity.
Inter-District Flows	Net Inter-District Flow revenue can be fully realised. Net Inter-District Flow volumes remain stable and do not decline significantly.
Planning Assumptions	The DHB has the ability to shift funding, where appropriate, from hospital and specialist services to community services and vice versa. Where such transfers occur, it is assumed that the provider can reasonably achieve equivalent reduction in cost.
Implementation of Strategies	The DHB is able to implement identified service reconfiguration and/or facility realignment, according to planned timeframes.
Efficiency Realisation	Where savings from efficiency gains or service re-configurations are not sufficient to achieve breakeven, that acceptable service reductions can be identified and realised in a timely manner.
New Policies and Initiatives	Any new government or MoH policies or initiatives that will result in increase expenditure are fully offset by increased funding. Any financial impact associated with changes to Disability Support Service (DSS) boundaries between age related and non-age related services and any further contract/services being devolved by MoH is cost neutral to the DHB.
Regional Workforce Flow-on	National and regional employment relations and workforce development activity will not impact negatively on regional and provider workforce outcomes or service delivery.
Salary and Wages	Increases (including auto increments and increases already committed) can be achieved within FFT (2.93%).
Non-Government Organisations (NGOs)	Contracts with NGO providers will be settled within FFT (2.93%) on average.

Age Residential Care and Home Based Support Services	Any cost increases resulting from the Aged Residential Care price review in excess of FFT will attract additional government funds. Income and Asset Testing will be funded.
Workforce Retention	The DHB can retain the appropriate number of health workers needed to provide the level and scope of services required.
Acute Demand for Hospital Services	Growth in acute medical and surgical health volumes can be managed at levels below the sector average and any increases in demand for services can be met through reducing delivery in other service areas.
Demand Driven Services	Growth of expenditure in demand driven services can be managed below the sector average and any increases in demand for services can be met through reducing delivery in other service areas.
Pharmaceutical Expenditure	Pharmac budget for community referred spending is as per agreed by DHBs and forecast savings on stats dispensing and other initiatives are achieved.
Pharmac	Pharmac budget is agreed on the basis of forecast actual 2005/2006 expenditure plus FFT.
Pandemic Drug Costs	It is assume that any increased drug costs associated with a pandemic will be nationally funded.
Impact of Income and Asset Testing	Any financial impact associated with the changes to the income and asset testing regime continue to be cost neutral to the DHB.
Lifestyle Changes	Health education and promotion initiatives can influence change in the lifestyles of our community.
Access Improvements	Improving access to primary and community care and improving chronic disease management will result in reduced hospital admissions.
Inter-Sectoral Support	Other government departments, agencies and schools are also working to improve the community's health and make it easier to stay healthy.
Sustainable Health and Disability Services	Service Providers continue to maintain an acceptable level of quality and appropriate levels of service delivery within the available resources.
Sustainable Provider-Arm Services	The DHBs Provider-Arm continues to maintain an acceptable level of quality and appropriate levels of service delivery are maintained within the available resources. Savings through service innovations are realised and the DHB achieves efficiencies and address' cost over-runs internally.
Stakeholder Satisfaction	The DHB is able to maintain a reasonable level of public and media satisfaction with regard to expectations of health service provision or service quality.

2.1.4 Ongoing Challenges

The Canterbury DHB has identified a number of long-term challenges which it will need to address over the next five to ten years in order to continue to provide health and disability services and to improve the health of its community:

Working with Funding and Financial Pressures
DHBs are funded on the basis of the PBF formula which is designed to distribute the available health and disability support funding between DHBs according to the relative needs of their population and the relative cost of meeting those needs. The Canterbury DHB is considered overfunded against this formula and will receive lower increases than other DHBs over the next few years, until its funding is equitable. At the same time we need to continue providing the required volume and range of services in our district. This pressure will be our greatest challenge.

Meeting Increasing Demand for Services
A number of factors contribute to the increasing demand on health services in Canterbury; an ageing population, the changing demographics of our community, the pressures of mental health or addiction issues, rising chronic disease levels and the changing expectations of our population. Continuing to fund a wide range of community and hospital services and investing in new health technology and resources all within our limited funding is going to be difficult. We will need to look to our community and to other DHBs for support in responding and coping with this increasing demand.

Workforce Capacity
A high performing health service is dependent on the skill and hard work of those working in the system. The challenge for the Canterbury DHB is to provide an environment which supports innovation and career development. We also need to consider wider workforce issues; the issues rural areas have in recruiting and retaining key staff and the scope we have to develop health care

beyond traditional boundaries and constraints. We will be working on a coordinated approach to building the capacity of Canterbury's health workforce.

Reducing Inequalities
Although recent statistic show that the health status of Māori and Pacific people is improving, a gap still remains. Improving the quality of ethnicity data collection is an ongoing issue. When ethnicity data collection is robust we will be better able to accurately measure whether progress is occurring in improving the health status of high-needs and high-risk groups in Canterbury. The challenge is to better understand the gaps in health status and to accurately and effectively target resources to reduce those inequalities.

Improving Access to Health Care
The Canterbury DHB will work in a number of areas over the coming years to reduce barriers to accessing health and disability services; working with Primary Health Organisations (PHOs) to improve access to primary care services and with rural service providers to address issues of equitable access for rural communities. We will also work to ensure emergency services are efficient and effective, focusing on acute demand management and avoidable hospital admissions. Managing the waitlists for elective surgery will be an ongoing process; meeting government expectations on provision of certainty for patients and for national equity to elective services. A major challenge will be the development of clinical and facilities master plans to ensure services are provided not only at the right time, but also in the right place and by the right provider.

Reducing the Impact of Lifestyle Diseases
Lifestyles influence a number of diseases including cancer, diabetes, heart disease and respiratory disease. The Canterbury DHB's challenge in working to reduce the impact of these diseases centres around health promotion, education, screening and early intervention. Much of our work will be focused on healthy eating, active living, continuing smokefree and tobacco control education and injury prevention as well as working closely with other organisations outside the health sector to address to determinants of health such as housing, income, education, transport and recreation.

Addressing the Health Issues of an Ageing Population
By 2021 nearly 20% of the Canterbury population will be over 65 years of age. Pressure on health funding will increase as more people become subject to problems of ageing; older people particularly those aged over 75 consume a significant amount of health resources. Community support demand will increase along with demand for a number of aged related services such as orthopaedics, cataracts, incontinence and dementia. We will need to look at alternative models of care and innovative service development to meet the future demands of our ageing population.

Focusing on Effective and Quality Services
The Canterbury DHB will implement the Improving the Patient Journey project over the next five years. One of the goals of this project is to reduce unnecessary waits and delays for patients by focusing on patient orientated processes, reducing variations in treatment, and encouraging collaboration between health providers; all within the resources available. As demand for services increases, along with our ageing population with multiple health issues, the continuum of care between services will become increasingly essential.

Managing Community and Staff Expectations
Advances in technology mean new levels of care are available but often at higher costs. It is always a challenge to balance the expectation and demand for new treatments. We also need to maintain positive relationships and morale in a constrained funding environment and manage salary and wages expectations from our own staff and the impact of the expectations of the community workforce. Communication, collaboration and consultation will be important tools in the coming years.

Increasing Productivity in the Hospital and Specialist Service (HSS) Division
Alongside the financial pressure associated with the move to PBF the increasing demand for services in Canterbury means that our HSS division must increase its productivity while still managing expenditure. The Improving the Patient Journey project will play a large part in meeting this challenge by streamlining and integrating services. However, this will still be a challenge for our services.

Working with Other South Island DHBs
Closer clinical and non-clinical collaboration is going to be essential for the Canterbury DHB in the future, particularly around sustainable clinical services, access to specialist services, recruitment and

retention of staff and shared savings from bulk capital investments. Maintaining close partnerships with other DHBs and working on shared planning will be an important focus.

Developing Infrastructure
The Canterbury DHB will be required to update its property and must maintain its Information Technology infrastructure. Parts of our property infrastructure are ageing and will need to be replaced to meet new building codes. In addition our ability to evaluate service models, health outcomes and measure success depends on the provision of good quality, timely information and the sharing of that information through secure and stable information systems. We will need to ensure that our infrastructure investment is sustained and effective and that the best use is made of available funding.

2.2 Priorities for 2006/2007

2.2.1 Our Core Directions and Health Gain Priorities

The Canterbury DHB undertook a strategic planning process in 2005 producing, in consultation with the Canterbury community and stakeholders, an updated District Strategic Plan; *A Healthier Canterbury: Directions 2010*. This District Strategic Plan (DSP) describes the Canterbury DHB's direction, challenges, priorities and long-term goals over the next five years. Each DHB is also required to produce Statements of Intent and District Annual Plans, which present more detail on how progress will be made in achieving the directions, priorities and long-term goals set out in their DSPs[4].

In the development of its DSP the Canterbury DHB identified five Core Directions which it believes will be essential to addressing the challenges it faces and providing a foundation for achieving our priorities and long-term goals. These Core Directions will also enable the DHB to make changes and improvements in all areas of ongoing work and to meet key national and ministerial expectations over the coming years:

- Improve the Health and Wellbeing of our Community;
- Find Better Ways of Working;
- Work Together;
- Develop Our Health Workforce; and
- Be a Leader in Health.

Five Strategic 'Health Gain' Priorities were also chosen for special attention. These were based on a Health Needs Assessment (HNA) for the Canterbury district (completed in 2004), key government health strategies such as the NZ Health Strategy, Māori Health Strategy and the NZ Disability Strategy and on feedback received during consultation on the Canterbury DHB's DSP. The agreed Health Gain Priorities for focus over the coming five years are:

Three Population Priorities:

- Child and Youth Health;
- Older People's Health; and
- Māori Health.

Two Service Priorities:

- Primary Health; and
- Disease Prevention and Management.

The Canterbury DHB also identified four Disease Priorities during this process to which additional focus will be given over the next five year:

- Cancer;
- Cardiovascular (Heart) Disease;
- Diabetes; and
- Respiratory Disease.

[4] The Canterbury DHB's Accountability Documents can be found on its website www.cdhb.govt.nz.

2.2.2 The Minister of Health's Priorities and Expectations

The Government objectives for DHBs are set out in the NZ Public Health and Disability Act 2000 (NZPHD Act), NZ Health Strategy, Māori Health Strategy, the NZ Disability Strategy and other National Health Strategies. In developing its DSP the Canterbury DHB considered these overarching strategies, ensuring that its own objectives were aligned with that of the health and disability sector as a whole.

In considering the actions and activities required in 2006/2007 to progress its local Core Directions and Health Gain Priorities outlined in its DSP the Canterbury DHB also considered the Minister of Health's national Expectations, Priorities and Ongoing Priorities signalled as part of the 2006/2007 Planning Package. The Minister's Expectations and Priorities for 2006/2007 are:

Expectations of progress on National Health Strategies[5] (focusing on reducing inequalities and improving quality and safety) particularly the:

- Māori Health Strategy 2002;
- Mental Health Strategy 2005;
- Health of Older People Strategy 2002; and
- Primary Care Strategy 2001.

Priorities:

- Getting Ahead of the Curve with emphasis on progressing the Healthy Eating Healthy Action, Cancer Control and the Tobacco Control Strategies;
- Child and Youth Health Services with emphasis on hearing test for neonates, increased well child checks for preschoolers, child and adolescent mental health services, oral health services, and free primary care services for those under 6 years;
- Primary Health Care emphasis on reduced costs, focus on prevention, early detection, and broadening the range of health professionals involved in the continuum of care;
- Health of Older People emphasis on supporting older people in their own homes and continuum of care models to better support people moving from their homes to residential care, assessment treatment and rehabilitation and primary services;
- Infrastructure with a focus on the Health Information Strategy and progressing the various work-streams on health workforce issues; and
- Cost Effectiveness with emphasis on value for money and productivity gains.

Ongoing Priorities:

- Improving Elective Services including progressing the Orthopaedic and Cataract Initiatives;
- Collaborating Across Agencies focusing on minimising family violence;
- Performance Assessment and Management emphasising local initiatives that contribute to equity and access, efficiency and value for money, effectiveness, quality and intersectoral focus; and
- Building Relationships and intersectoral collaboration.

2.2.3 Treaty of Waitangi - Priorities for Māori Health

The Canterbury DHB recognises and respects the principles of partnership, participation and protection embedded in the Treaty of Waitangi. We also acknowledge the expectations of the NZPHD Act and the Crown Funding Agreement and are committed to reducing disparities and improving health outcomes for Māori and to ensuring Māori involvement in planning for these.

The Canterbury DHB has agreed a regular meeting schedule with Ngāi Tahu, as manawhenua of the district, through Manawhenua ki Waitaha; a representative group which comprises the seven Ngāi Tahu rūnanga. We also meet quarterly with Te Rūnanga o Ngā Maata Waka representatives and the Māori community and engage in numerous other formal and informal interactions with Māori providers, services and community organisations. The outcomes of these meetings feed directly into the DHB's planning processes.

A review of Canterbury DHB's current Māori Health Plan *Whakamahere Hauora Māori* was undertaken over the past year. This involved a series of community consultation forums, one-on-one

[5] Copies of national strategies can be found on the Ministry of Health's website.

meetings with Māori providers, advice and feedback from internal DHB staff and forums, and the involvement of Iwi Māori in developing the review process. The key priorities for 2006/2007 include:

- Implementation of a Memorandum of Understanding with Manawhenua ki Waitaha;
- Implementation of Ethnicity Data Collection projects at all Canterbury DHB hospital sites;
- Development of a forum for whanaungatanga and cultural development for staff and establish a cultural training programme for DHB contract managers and Board members;
- Setting of expenditure targets for all Māori health services and service-related initiatives and establish a monitoring programme that meets internal and external accountabilities for the community and the Canterbury DHB;
- Application of clinical, cultural and priority-need frameworks to ensure responsiveness to Māori;
- A review of Māori health policy and quality frameworks, within the DHB and across its community providers and support for Māori providers participation in quality improvement programmes; and
- Collating Māori health workforce data to identify project areas, developing a workplan to implement an HR strategic directional plan for Māori health workforce needs and working with the education sector to promote Māori health careers and develop recruitment strategies.

2.2.4 Key Focus 2006/2007

The key challenge for Canterbury DHB going forward is to balance the fiscal pressures faced by the DHB against the need to improve health outcomes for our population. Given the significant financial pressure faced as we transition to equity under PBF, the identification of savings to allow the ongoing achievement of breakeven will be a greater focus than in the past.

To ensure that we have the funds to meet increasing future costs, we must identify better ways of working within the funding available. The Canterbury DHB's preferences for sources of savings (in descending order) are through:

- Efficiency gains (delivering the same service in more efficient ways);
- Service re-configuration (delivering the same outcomes but delivering services in other ways); and
- Service reductions through reduced access or full cessation.

During 2006/2007 we will continue to focus on achieving budget without the need for service reductions, however consideration will be given to the identification of potential service reductions in the out years, should these become necessary to achieve budget.

Coupled with the increased fiscal focus above, the DHB will continue to focus on the reduction of inequalities in health care and support the development of new services in those areas where new government funds have been supplied, such as mental health services and PHO development.

In achieving its objectives the DHB notes a number of regulatory or contractual compliance issues that are either already generating significant fiscal pressure or are likely result in future pressure, namely:

- Current and future MECAs and in particular the compounding effect of annual “step” increases coupled with expectation of FFT based increases;
- Potential impact of the Holidays Act, Electrical Regulatory Compliance and Fire Compliance Upgrades;
- The impact of the Restraint Policy and its impact on staffing levels; and
- Other ad hoc requirements that propose a solution to high profile cases but have ongoing cost implications in their implementation.

While addressing these compliance issues through a national coordinated approach is a worthwhile goal, the cost and benefit to DHB populations is not well measured and impacts on the ability of DHBs to maintain financial viability, while addressing local priorities. A better understanding of the impact of these compliance and contractual requirements is needed so that appropriate signalling of the relative priority within any new funds available to the sector can be made.

3 ENVIRONMENT

In September 2004 the Canterbury DHB completed its second comprehensive Health Needs Assessment (HNA) bringing together information describing the Canterbury population and the health status of its residents. More detailed information from that assessment (than that which is presented here) can be found on the Canterbury DHB website www.cdhb.govt.nz.

3.1 Overview of the Canterbury Population

Canterbury's usual resident population, at the 2001 Census, was 427,089. Statistics NZ predicts that this will rise to 464,700 by 30 June 2005 (base 2000) and to 504,700 by 30 June 2021. Māori make up 6.7% of Canterbury's usual resident population, Asian people 4.4% and Pacific people 2.0%. Most people identifying as Māori, Asian or Pacific live in Christchurch City.

Just over a quarter (26%) of Canterbury's population lives outside the urban Christchurch boundary. There are differing degrees of rurality but approximately 7,000 Cantabrians live in remote areas and have to drive for more than an hour for primary health care services.

The health status of residents in most areas in Canterbury is the same as, or better than, the national health status. We have the highest life expectancy at birth of all the DHB regions (77.8 years).

Poorer health status is linked with high degrees of deprivation and Canterbury has around 80,000 people living in NZ Deprivation Deciles 8, 9 and 10 (the highest levels of deprivation). The percentage of Māori and Pacific people living in these areas is higher with 43% of Pacific and 30% of Māori in deciles 8, 9 and 10 (Level 10 being the highest level of deprivation) compared to 17% of Asians and 15% of Pakeha.

Around 15% of Canterbury's population are aged between 15 and 24 years. This is the same as the national figure. As with the national population, increasing number of our child and youth populations are Māori, Asian and Pacific. These ethnic groups have younger populations in general and approximately 50% of the Māori and Pacific populations are under 25 years old.

The 2001 Census shows 13% of the total Canterbury population is aged over 65 years. This is a slightly higher proportion of elderly, relative to the NZ population as a whole. Some rural areas, namely Kaikoura and Ashburton, have particularly high proportions of their populations aged over 65 (15.3% and 16.4% respectively). The percentage of the total population in Canterbury aged over 65 is predicted to increase to almost 20% by 2021.

Addressing the health needs of our ageing population is one of the Canterbury DHB's key challenges over the next ten years and is one of the five Health Gain Priorities identified in our DSP. Child and Youth Health and Māori health have also been identified as Health Gain Priorities where a focus over the next five years will help to improve the health of our community.

3.2 Key Health Trends for Canterbury

In order to address the health needs of our community it is important to understand our health status and the conditions and illnesses which are prevalent in the Canterbury district.

The total number of deaths for all ages in Canterbury is almost exactly as expected, given the age and socioeconomic deprivation of the region. The primary causes of death in Canterbury are diseases of the circulatory system (ischaemic heart disease, stroke, heart attack), cancers and respiratory system diseases; particularly for males.

Diabetic complications (such as heart disease, blindness and kidney failure) are major contributors to the burden of disability experienced by people from middle age, particularly Māori and Pacific people who are at higher risk of diabetes and associated complications.

The prevalence of these diseases is reflected in the Canterbury DHB's choice of Cancer, Cardiovascular Disease, Diabetes and Respiratory Disease as its identified Disease Priorities for the next five-ten years.

A number of conditions which result in death or disability are attributable to risk factors: smoking tobacco, not being physically active, eating foods that are not healthy, drinking too much alcohol or using recreational drugs. The 2002/2003 NZ Health Survey[6] reveals that most New Zealanders believe they have very good health. However, more than half of all adults are overweight, half do not get thirty minutes of exercise a day and 20% of people aged over 45 have been diagnosed with heart disease.

Tobacco smoking is a major risk factor and preventable cause of death. Canterbury's average smoking rates (23%) are lower than that of NZ as a whole, where the average rate is 25% for most age groups. However, nearly 9,000 people over the age of 35 are admitted to hospital in Canterbury every year with smoking related illnesses costing our region's hospitals around $23 million yearly.

Canterbury's hospitalisation rates for childhood asthma are high as is our notified rate of pertussis (whooping cough). The rate of tooth decay in five-year-old children has also increased since 1996. Māori and Pacific children (an increasing percentage of our child population) have higher rates of hospitalisation for vaccine-preventable diseases, and higher rates of tooth decay and glue ear.

Disease prevention and management is another of the Canterbury DHB's five Health Gain Priorities with emphasis on healthy eating, active living, smoking cessation and intersectoral collaboration. Primary Health is the last of the five identified Health Gain Priorities, focusing on the role of PHOs, ensuring equity of access to primary care, sustainability of services and the development of chronic care continuums.

Timely and consistent primary health care can help prevent disease development, complications and hospitalisations. In Canterbury, socioeconomically deprived people are hospitalised with potentially preventable conditions at almost twice the rate of those less-deprived. PHOs are an important resource in working with low income and high-need populations to reduce the barriers to accessing health and disability services and the health inequalities associated with socioeconomic status.

3.3 Organisation Structure

The Board of the Canterbury DHB consists of eleven members and is the governance body responsible for the operation of the DHB established in 2000 under the NZPHD Act. The Board has a delegation policy, approved by the Minister of Health, to delegate decisions on management matters to the Chief Executive. It also has the following sub committees comprised of a mix of both Board members and community representatives:

- Hospital Advisory Committee;
- Community and Public Health Advisory Committee;
- Disability Support Advisory Committee; and
- Finance, Audit and Risk Committee.

The first three are Statutory Committees, required under the NZPHD Act and the last is a Committee specific to the Canterbury DHB established by its Board in January 2001. In general, all meetings where the Board or any of its Statutory Committees make decisions are open to the public to attend, as observers. In accordance with the NZPHD Act, public notice of the date, time and venue of the meetings are available on the Canterbury DHB's website. Further information on the membership and function of all the Committees can also be found here.

The Chief Executive has delegated management responsibility for the organisation of which there are three primary divisions: Planning and Funding (P&F), Community and Public Health Services (CPH) and Hospital and Specialist Services (HSS – the Provider-Arm of the Canterbury DHB).

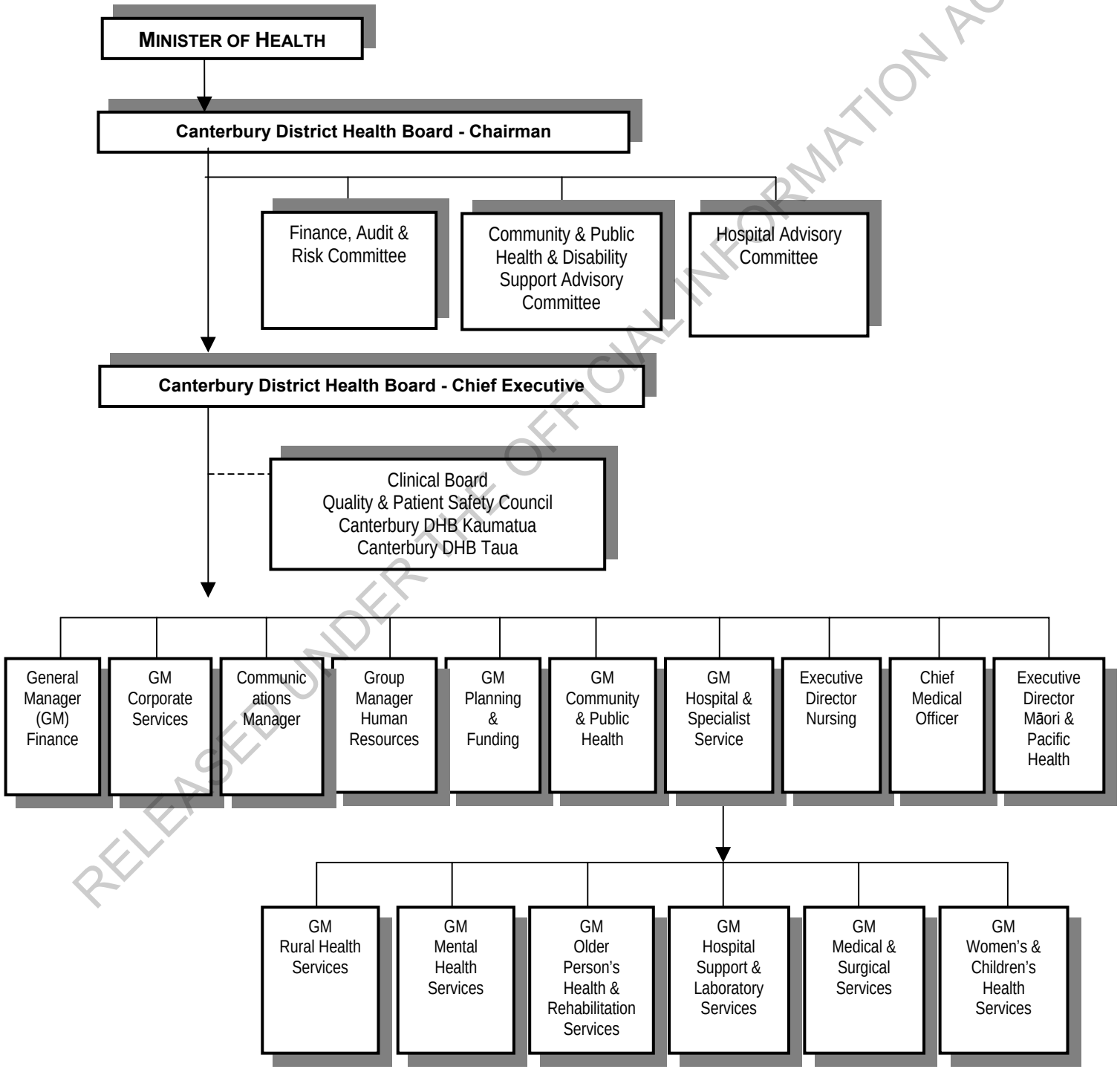
Previously the HSS had several separate (site based) operating units however its new structure (implemented in 2004) sees a number of new divisions structured along clinical lines; with a move towards a service focus rather than a site-based model. The service focused divisions are: Rural Health Services, Mental Health Services, Women's and Children's Health Services, Older Person's Health and Rehabilitation Services, Medical and Surgical Services and Hospital Support and Laboratories Services.

[6] The NZ Health Survey can be found on the MoH Website www.moh.govt.nz

The Canterbury DHB also has two fully owned subsidiaries, Canterbury Laundry Services Limited and Brackenridge Estate Limited, and has joint controlling interest in the South Island Shared Services Agency Limited (SISSAL) all of which it intends to keep operating in the medium term.

Support for these divisions is provided by the Finance, Human Resources, Corporate Services and Communications divisions. At this executive management level the Canterbury DHB also has an Executive Director of Māori and Pacific Health, an Executive Director of Nursing and a Chief Medical Officer who provide clinical and cultural leadership to all areas of the organisation and also provide oversight of patient safety and quality.

Figure 1 - Organisational Chart of the Canterbury DHB



4 ENSURING SERVICES FOR THE CANTERBURY DHB'S POPULATION

4.1 Providing Health and Disability Services

The Canterbury DHB has a number of non-negotiable obligations and responsibilities under key national health strategies, the NZPHD Act, the Treaty of Waitangi, the Crown Funding Agreement, the Minister of Health's yearly and ongoing Expectations and Priorities and its own accountability to the Canterbury community.

The DHB's vision of promoting, enhancing and facilitating the health and wellbeing of the people of Canterbury is closely aligned with key priorities identified in the NZ Health Strategy and the Minister of Health's yearly and ongoing Expectations and Priorities.

The five chosen Core Directions will provide the Canterbury DHB with the foundations to ensure it is able to meet its obligations and responsibilities and work towards its ultimate goal of promoting, enhancing and facilitating the health and well-being of its community.

The chosen Health Gain Priorities are where the Canterbury DHB will target activity to make improvements in the delivery of services. As highlighted earlier in the document, the Priorities are a mixture of population, service and disease based approaches and represent the areas where the Canterbury DHB believes there is the biggest potential for change and development.

The Board, Chief Executive and senior management have collectively determined key focus and strategies to achieve outcomes in line with each of the Canterbury DHB's five Core Directions and its mixed Health Gain Priorities over the next year. This document also outlines the Canterbury DHB's focus and strategies to progress ministerial expectations and priorities over the next year.

The approach in all of these areas will be consistent, in particular, working collaboratively with the primary care sector, our community and HSS to ensure an integrated approach to patient care and the development of chronic disease continuums. Working with providers and external stakeholders to promote messages related to lifestyle choices, physical activity, healthy eating, obesity and smoking cessation. Working to ensure services are culturally appropriate and working with providers and community agencies to reduce inequalities and increase access and uptake of services.

However, as an overfunded DHB we must be mindful of moving to equity over the coming years and living within our budget. The focus on financial, service and demand pressures have also been highlighted earlier in the document and progress on these will be central to achieving the long-term goals outlined in the Canterbury DHB's DSP. Work has already begun in a number of these areas (much under a number of the Core Directions) and ongoing work will also progress outside the scope of this District Annual Plan (DAP).

The Canterbury DHB will be looking in the coming year at the way in which it delivers and evaluates services and will be aiming to do things better within available resources. Health Services Planning and looking at the picture of health in our community and our communities' needs in the future will be central as we move forward.

Progress on the Core Directions and Health Gain Priorities will be reported to the Board and appropriate Statutory Committees throughout the year.

4.1.1 Improve the Health of Our Community - Reducing Disparities and Inequalities

The health of Canterbury residents is on average the same as or better than the national health status and Canterbury has the highest life expectancy of any DHB region. However, the changing demographics of Canterbury's population also needs to be considered in future health planning; growing Māori, Pacific and refugee communities and the increasing age of our population will mean a change in the number of high needs and high risk groups in the make-up of our population.

The Canterbury DHB is aware of the inter-relationships that exist between socio-economic status, education, employment, housing and health and will continue to work intersectorally, through groups like Strengthening Families, Healthy Christchurch and PHOs, to target and reduce inequalities and to address the determinants of health.

Reducing disparities, addressing inequalities and improving access is a focus for the Canterbury DHB and are expectations of the Minister of Health this year. The challenge will be not just identifying gaps through improved data collection but actually targeting resources towards those high needs and high-risk groups and effecting changes in health status.

During 2006/2007 we will be focusing on the following activity and intervention to reduce disparities and inequalities, building further on the foundations already put in place in the past year particular on the work done in Ashburton around rural health services and equitable access for rural communities:

What	Improve our understanding of the health needs of our community - Knowledge and Analysis.
Who	Executive Director Māori and Pacific Health
How	Progress the collection of ethnicity data throughout the Canterbury DHB and amongst community providers and use that data to evaluate access issues and better target resources: ▪ Extend the collection of Ethnicity Data through all Canterbury DHB sites and including PHOs; ▪ Develop and implement systems and process for analysis of that information; and ▪ Communicate this information to key stakeholders to enable analysis of service gaps and development of innovate models to address these gaps.
When	Presenting analysis of Ethnicity Data for at least one Health Gain Priority in 2006/2007.

What	Raise the focus on lifestyle disease prevention, lifestyle choice and pathways to change.
Who	General Manager Community and Public Health
How	▪ Provide an effective and efficient health education resource distribution service to multiple outlets (e.g. PHOs, service centres, libraries). ▪ Influence public health action in other sectors through intersectoral engagement, and provision of public health advice and advocacy. ▪ Provide relevant public health input relating to inequalities and determinants of health to all DHB strategies
When	Ongoing throughout 2006/2007

What	Optimising access and utilisation to rural hospitals and community health services – ensuring rural services are accessible, sustainable and clinically viable.
Who	General Manager, Hospital and Specialist Services General Manager, Rural Health Services (HSS) General Manager, Planning and Funding
How	Implementation of the recommendations of the Review of Health Services in Ashburton (Ashburton Integrated Model of Care Project December 2005) focusing on the development and implementation of six projects over the coming year: ▪ Collaboration and Integration with primary, community and public health services; ▪ Core Services and Specialist Led Services; ▪ Investing in Workforce Development; ▪ Health Information and Technology Systems;

	▪ Health Promotion; and ▪ Site Redevelopment and Ancillary Services. Implement the recommended activities from the Review of Rural Health Services (November 2005): ▪ Continued accreditation of Ashburton Hospital and all Rural Health Service Hospitals; and ▪ Ongoing support for Rural PHOs.
When	▪ Workforce Strategy developed for Ashburton Health Services Q1. ▪ 'Model of Care' for Kaikoura developed in consultation with the Community Q2. ▪ Waiting times for rural access to Child and Family Mental Health Service are reduced as a result of service reconfigurations Q1. ▪ Additional visiting specialist services from Christchurch available at Ashburton Hospital Q3.

Child and Youth Health

Child health and youth health are priority areas for the Canterbury DHB. Keeping our child and youth population healthy provides them better opportunities for becoming healthy adults. The Canterbury DHB aims to improve outcomes for children and youth in Canterbury, particularly those with high needs, those at risk and those in environmentally disadvantaged situations.

In 2004, the Canterbury DHB developed a Child Health and Disability Action Plan *Mahere o te Hauora Tamariki me te Hauātanga* based on the principles and key directions of the national Child Health Strategy and local community priorities. A Child Health Strategy Group was established to oversee the implementation of the Canterbury DHB's Action Plan.

Ten priorities for improving children's health are identified: access to services, child health information, hearing, immunisation, injury prevention, mental health, nutrition and physical activity, oral health, parenting and smokefree environments. In addition, more than sixty actions are outlined to improve child health outcomes, a number of these commenced in the past year including:

- Establishment of a Child and Youth Mortality Committee focused on reducing the numbers of preventable deaths;
- A pilot in twelve Early Childhood Centres designed to improve health and wellbeing; and
- A project to obtain better information about the Strengthening Families collaborative case management process in order to improve the outcomes for families/whanau who live in high risk environments.

The Canterbury DHB also successfully:

- Rolled-out the Meningococcal B Vaccination Programme and established the National Immunisation Register (NIR) in Canterbury, providing an accurate way of measuring the percentage of children who are vaccinated for each of the childhood immunisation events;
- Opened the new 134-bed Christchurch Women's and Children's Hospital and Day Surgery Unit on the Christchurch Hospital site and successfully transferred patients and staff.

Emphasis over the next year will be on the continued implementation of the Child Health and Disability Action Plan and on developing a local Youth Health Plan; developing ways to best meet the needs of young people in Canterbury:

What	Continue to implement the Child Health and Disability Action Plan, working to reduce inequalities in the health status of children and to ensure child health services are provided in an equitable and timely manner – through a coordinated community approach.
Who	Child Health Project Manager (Community and Public Health) Portfolio Manager Personal Health (Planning and Funding) General Manager Women's and Children's Division (HSS)
How	▪ Work to improve child health information systems, making them clinically useful, appropriate, up-to date and available. ▪ Work with providers to coordinate health promotion, prevention and early intervention, especially hearing screening and immunisation. ▪ Increase awareness of injury prevention in progressing Priority 5 of the Action Plan. ▪ Promote healthy eating and exercise, support effective parenting programmes, smoke-free environments and the OK Kids Project focusing on reducing childhood obesity.

	▪ Support and facilitate the adoption of healthy supporting policy measures within schools participating in the Fruit in Schools Programme. ▪ Provide tools to schools to assist them to identify and access quality health education and other health service programmes, resources and information to support health promotion in schools. ▪ Continue to promote WellChild Checks in progressing Priority 1 of the Action Plan. ▪ Participate in, and implement additional initiatives for child and youth (when funded nationally) such as: the MoH's Family Violence Guidelines on child and partner abuse and Universal Newborn Hearing Screening Programme.
When	Ongoing 2006/2007.

What	Ensure a coordinated community approach to youth health services to promote access, early intervention, reduction in risk activity and a population-based approach to continuums of care.
Who	Portfolio Manager Personal Health (Planning and Funding) General Manager Women's and Children's Division (HSS) General Manager, Community and Public Health
How	Develop a comprehensive local Action Plan for Youth Health and begin implementation of that Plan. In developing the Plan consider: ▪ Youth services particularly in the areas of: primary health, mental health, sexual health and school-based youth health; ▪ Māori and Pacific youth issues and inequalities in health status of Canterbury youth; and ▪ Focus on keeping youth safe and reducing risk activity and collaborating with other intersectorial agencies in working towards improving the health status of Canterbury youth.
When	Presentation of the Youth Health Plan, October 2006.

What	Increase immunisation rates of two year olds, working toward achieving target 95% fully immunised.
Who	Portfolio Manager Personal Health (Planning and Funding)
How	▪ Continued refinement of the NIR administrative processes to ensure timely and accurate newborn enrolment. ▪ Establishment of an NIR Governance Group to monitor immunisation rates and provide advice to improve immunisation coverage rates in specific ethnic, deprivation or geographical areas that have lower coverage rates. ▪ Development of strategies that maximise the use of the NIR to support providers and ensure effective utilisation of the NIR as a tool for improving immunisation rates within Canterbury.
When	Ongoing 2006/2007 The national immunisation coverage survey indicates that DHBs in the Southern region are performing better than average with an estimated 91% of children receiving DTaP dose 3 measured at one year of age and 88% of children receiving MMR vaccine dose 1 measured at 18 months of age. Consolidation of current performance and incremental improvements are anticipated for 06/07.

What	Improve school based dental health services for children and youth in Canterbury and promote good oral health practice.
Who	General Manager Older Persons Health and Rehabilitation (HSS) General Manager, Community and Public Health
How	▪ Use relevant Canterbury DHB Action Plans and contracts to ensure that oral health education is incorporated and promoted along with other 'healthy lifestyle' messages and participate in national MoH and local CPH programmes such as Healthy Eating Healthy Action (HEHA) and Healthy Eating Active Living (HEAL). ▪ Support ongoing workforce development and ensure an ongoing relationship with external education providers to support recruitment and training and address workforce issues. Continue with the current pilot project offering a refresher course for dental therapists, aimed at encouraging a return to work. ▪ Actively participate (as funding allows) in the outcomes and recommendations of the MoH School and Community Dental Clinic Review.

	▪ Carry out a health promotion project in Canterbury to improve awareness of role and value of fluoride in oral health.
When	Ongoing 2006/2007.

Health of Older People

In 2002 the MoH's national Health of Older People Strategy (HOP) was released. The primary aim being to promote wellness, improve and maintain health functioning and independence and ensure the development of an integrated continuum of care so that older people needing support can access the right services at the right time, in the right place and from the right provider. The emphasis is on flexible, holistic, quality needs based care in the community

In October 2003 the MoH devolved the funding responsibility for age related services to DHBs. DHBs are now responsible for planning and funding health and disability services for older people including residential care services, assessment, treatment and rehabilitation services, homes based support and other community services for the elderly.

The Canterbury DHB has laid a strategic platform to implement the national HOP Strategy at a local level and over the past year has:

- Developed its own local Aged Care Strategy *Healthy Ageing, Integrated Support* through full consultation with key stakeholders and the wider community and with the unanimous approval of its Board;
- Successfully transitioned rest home beds to hospital level beds to meet changes in demand;
- Begun reviewing day care options for older people with the view to increasing capacity;
- Successfully increased respite capacity and funding;
- Begun the piloting of the InterRAI assessment tool in Older Person's Health;
- Begun piloting Medication Management for 'at-risk' in the community, including older people;
- Begun building a database to assist with future capacity planning and monitoring the progress of service and funding shifts within aged care;
- Successfully developed an older people's reference group;
- Begun piloting Specialist Complex Wound Care Support in a residential care; and
- Begun a SupportCare End-of-Life and SupportCare Severe Medical Illness initiative in the community and in residential care to increase equity of access, efficiencies and quality of care.

Priorities for 2006/2007 are primarily around phasing the implementation of actions from the Older People's Services Strategy and focusing on providing care for the elderly in the community and away from institutional care:

What	Begin implementation of the Canterbury DHB Older People's Services Strategy *Healthy Ageing, Integrated Support*.
Who	Portfolio Manager, Aged Care (Planning and Funding) General Manager Older Person's Health and Rehabilitation (HSS)
How	▪ Build the capacity of home based support services to phase shifting services and funding from inpatient and residential care to community based services. ▪ Remodel and build the capacity of day care provision for the elderly including dementia and general services. ▪ Develop a holistic seamless model of care in the community - including increasing flexible medium-high packages of care in the community and the introduction of Coordinator of Services for the Elderly (COSE) services into primary care settings. ▪ Build an information infrastructure - particularly around increased analysis and accountability. ▪ Reduce access points for residential care and raise entry criteria - build the capacity of Needs Assessment Service Coordinator (NASC) services in the hospitals and community for timely assessments and increased reassessments and consider the roll-out of InterRAI comprehensive assessment tool. ▪ Begin a process of integration and coordination of community services with key stakeholder participation and maximise efficiencies for best health outcome. ▪ Heighten intersecotrial focus, relationship building and shared vision for holistic elder care

	services. ▪ Focus on Health Promotion and services - including falls prevention, strategic communication and dissemination and associability of elder friendly information on available community services and care options. ▪ Work with primary care to maximise quick response to older person's needs and challenges. ▪ Explore development of an institutional transitional care model for short-term rehabilitation. ▪ Build on and strengthen palliative care provision and promote informed choices. ▪ Identify continence issues in relation to entry into residential care and address needs.
When	Ongoing throughout 2006/2007: ▪ Home based support services strengthened through facilitating decasualisation of the home based support work force, supporting education initiatives, recruitment and retention; ▪ Multi care provision promoted with rehab focus; ▪ Service provision of stand alone general and dementia day care services in the community built up and residential care day care provision redefined; ▪ Work underway with providers to put in place a holistic seamless care model in the community; ▪ Number of older people receiving flexible medium to high care packages in community increased, numbers reflecting a reduction in residential care placement; ▪ Planning and funding information infra-structure complete and utilised to analyse progress; ▪ NASC capacity in Christchurch Hospital and COSE in the community increased; ▪ More timely regarding assessments to track care package outcomes being conducted; ▪ Support use of a comprehensive assessment tool for older people in hospitals and community; ▪ Services and potential integration of services mapped with key stakeholders; ▪ Current older person's contracts and services reviewed; ▪ Collaborative relationships with intersectorial organisations built and a common plan to help older people in the community developed; ▪ Volumes for Stay on Your Feet services increased; ▪ Work commenced with ACC with view to increasing usage of hip protectors; ▪ Commence health promotion around falls, continence and hip protectors targeting older people; ▪ SupportCare service specifications reviewed and palliative community support built up; ▪ Support the residential care sector to develop a transitional model of care to support older people staying in the community; and ▪ Work with residential care sector to promote respite care as a support to home based care.

Māori Health - He Korowai Oranga

On average Māori have the poorest health status of any group in NZ and are twice as likely to develop diabetes as European people, have a significantly shorter life expectancy and are over-represented for injuries, heart disease, Sudden Infant Death Syndrome (SIDS) and a myriad of other health status measures. A number of strategies are in place to address these concerns, both nationally and locally, and the Canterbury DHB continues to work closely with the Māori community and Māori health providers to make progress in improving the health status of Māori.

The Canterbury DHB adopted its local Māori Health Plan *Whakamahere Hauora Māori ki Waitaha* in 2002 and this was reviewed and revised in early 2006[7]. The Plan recognises the Canterbury DHB's Treaty obligations within the framework of the NZPHD Act and is consistent with the directions outlined in the national Māori Health Plan *He Korowai Oranga* and Action Plan *Whakatātaka*. Over the past year a number of achievements have been made in the area of Māori Health:

- Implementation of the Ethnicity Data Collection Pilot project at The Princess Margaret Hospital producing excellent results with a roll-out of that project now underway at all Canterbury DHB site;
- The establishment of a Māori Health Team at Christchurch Hospital to work within Paediatrics and Oncology – two high needs areas for both Māori and Pacific people. The team supports staff within these units to facilitate relationships and achieve better health outcomes for patients;
- A Whanau room opened at The Princess Margaret Hospital following the success of the Whanau room on the Christchurch Hospital site; and

[7] The draft revised Māori Health Plan is attached to this document as Appendix 2.

- Approval from the Christchurch Polytechnic Institute of Technology for the Māori mental health qualification *Tikaka Hauora*, seeking greater participation of qualified Māori in the health sector.

The key focus for 2006/2007 centres on the implementation of recommendations from the revised Māori Health Plan and around progression of plans and foundations put in place over the past year:

What	Implement the revised Canterbury DHB Māori Health Plan.
Who	Executive Director Māori and Pacific Health Portfolio Manager, Personal Health (Planning and Funding)
How	▪ Implement the Canterbury DHB Māori Model of Service Delivery providing clinical, cultural and priority-need frameworks to ensure mainstream services responsiveness to Māori ▪ Support the development of Māori Health providers through the Māori Provider Development Scheme (MPDS) and evaluate the impact of that scheme; ▪ Increase support for Māori provider capacity and capability through mental health funding and cooperation with the other South Island DHBs in Te Herenga Projects (lead by the NMDHB). Reinforce key messages: Quality, Sustainability, Collaboration, Cooperation; ▪ Maintain relative investment in Māori Health, implement expenditure targets for all Māori health services and service-related initiatives and establish a monitoring programme that meets internal and external accountabilities for the community and the Canterbury DHB; ▪ Review Māori health policy and quality frameworks, within the DHB and its community providers and support Māori providers participation in quality improvement programmes; ▪ Continue to enact, in consultation with Māori, appropriate processes to engage with the Māori community and Māori providers. Formalise the relationship that exists with Ngāi Tahi and Manawhenua ki Waitaha through the development of a Memorandum of Understanding at governance level; and ▪ Progress the Ethnicity Data Collection project to ensure that all Canterbury DHB sites collect ethnicity data and introduce processes and systems to analyse that data to determine and formalise access levels and access issues for Māori. ▪ Implement Te Puawaitanga, Māori Mental Health National Strategic Framework, and other mental health frameworks, as well as continued implementation of Mental Health Blueprint and Tuutahitia te Wero (Mental Health Workforce Development Plan).
When	Ongoing throughout 2006 in accordance with the revised Māori Health Plan Timeframes.

What	Ensuring a coordinated, population based, community approach to reducing disparities and fostering Māori community participation at all levels throughout the DHB.
Who	Executive Direction Māori and Pacific Health General Manager, Community and Public Health
How	▪ Continue collaboration around national and local strategies that promote health in areas of priority for Māori such as healthy nutrition and increased physical activity (HEHA and HEAL). ▪ Ensure Māori input into key Canterbury DHB strategies, PHO process and other integration initiatives particularly in key areas for Māori ie Child Health, Diabetes, and Cardiovascular Disease and focus on pathways of care that will lead to better outcomes for Māori. ▪ Continue regular Māori community consultation hui and participate in intersectoral Māori networking forums and initiatives that positively affect Whânau Ora. ▪ Identify and support Māori-led community development in priority areas. ▪ Continue current involvement in the activities of groups such as: Christchurch Social Policy Integration Network, the Housing Network and Strengthening Families and foster relationships with Te Puni Kokiri, Ministry of Education and the Ministry of Social Development to address environmental disparities that effect health status. ▪ Improve Māori health status by promoting smokefree lifestyles, as articulated in Auahi Kore initiatives and the Aukati Kai Paipa programme.
When	Ongoing 2006/2007.

What	Further develop the Māori health and disability workforce and work to improve the cultural responsiveness of Canterbury health services.
Who	Executive Director Māori and Pacific Health Group Manager Human Resources

How	▪ Continued development of the Canterbury DHB Māori Workforce Development Plan. The main aim is Whânau Ora with the key focus being the implementation of *He Korowai Oranga*. ▪ Develop a forum for whanaungatanga and cultural development for staff, establish a cultural training programme for contract managers and ensure Board members are also offered training. ▪ Collate Māori health workforce data to identify baseline and project areas and develop a workplan to implement a strategic directional plan for Māori health workforce needs. ▪ Work with HSS to promote Māori health knowledge and training for non-Māori staff. ▪ Work with the education sector to promote Māori health careers and to develop a Māori recruitment strategy.
When	Ongoing throughout 2006/2007: Ensure at least two cultural training days are run during 2006/2007.

Current Funding Allocations

The Māori health expenditure stocktake that the Canterbury DHB undertook during 2005/2006 identified expenditure of $8.2M for the year through a combination of Māori community providers, mainstream community providers and the Canterbury DHB's HSS. This funding included $300k of one-off funding specifically targeting Māori under the Meningococcal B Immunisation Programme.

The Māori health expenditure target for the 2006/07 financial year is set at $8.6M. Forecast targets for 2007/2008 and 2008/2009 are $8.9M and $9.1M respectively.

Progressing the New Zealand Disability Strategy

In June 2004 the Canterbury DHB approved the updated version of its Disability Strategy Action Plan 2004/2007 (Action Plan for Disability). This Plan sets out the Canterbury DHB's objectives and priorities for implementing the NZ Disability Strategy at every level of the DHB. A monitoring report on progress against the Action Plan goes to the Disability Support Advisory Committee (DSAC) every six months.

In the past year the Canterbury DHB has worked to promote and provide a non-disabling culture:

- A NZ Disability Strategy Survey of Canterbury DHB' HSS divisions was completed which outlined the key areas of progress under the NZ Disability Strategy Objectives; and
- Work is underway to conduct a survey of users of Canterbury DHB inpatient and outpatient services to better understand how the services can meet the needs of patients and consumers.

The Canterbury DHB recognises that it cannot address every barrier over night, but can take a step by step approach to practical and attitudinal changes that will benefit everyone. The Canterbury DHB sees the NZ Disability Strategy as a 'whole of government strategy' of which the Canterbury DHB forms only a part. During 2006/2007 the Canterbury DHB will work to achieve the Strategy's objectives in the areas it is able to influence through its own local Action Plan for Disability:

What	Ensure that the health concerns and needs of people with disabilities are known at a service and planning level – Knowledge and Analysis.
Who	Executive Direction of Nursing Quality Manager, Corporate Quality and Risk Chief Information Officer, Information Services
How	▪ Update the patient admission form to provide information on a patient's disability, which will include type of disability, severity, particular needs and any other information the patient deems relevant. ▪ Survey consumers with impairments who have been either inpatients or outpatients as part of the ongoing monthly consumer satisfaction surveys to assist in determining what consumers of health services want in order to improve their experience. ▪ Ensure the DSAC workplan is informed by the Disability Strategy Action Plan and the results of the Canterbury DHB's NZ Disability Strategy Questionnaire.
When	Ongoing through 2006/2007.

What	Work intersectorally with other agencies in Canterbury to eliminate barriers that New Zealanders with impairments face in their daily lives and ensure that HSS are providing accessible services and ensuring equitable access to services.
Who	General Manager Hospital and Specialist Services General Manager Corporate Services General Manager Community and Public Health
How	▪ Continue to work towards more coordinated services for people with disabilities and to work with other agencies such as Christchurch City Council and Healthy Christchurch on health and disability issues. ▪ Implement actions from the Canterbury DHB's Māori Disability Strategy Development Project to help meet disability needs of Māori, as funding allows. ▪ Continue to ensure all site redevelopment conforms to current standards of accessibility through adherence to the Canterbury DHB's Accessibility Plan. ▪ Continue to provide 24-hour interpreter services, including those for Deaf people, in all major hospitals and comply with the requirements of the NZ Speech language Bill when enacted into law, as funding allows. ▪ Participate in the scoping of a project to address issues pertaining to assessment and referral of children with disabilities. ▪ Maintain links with the community to assist disabled people to return to the community including liaison with ACC, Lifelinks, domiciliary care, equipment access etc.
When	Ongoing through 2006/2007.

4.1.2 Find Better Ways of Working – Integrated Continuums of Care

The Canterbury DHB faces the challenge of growing demand, while at the same time working within funding and financial pressures. The DHB intends to expand how it plans, funds and delivers health care in Canterbury to ensure the most effective resource utilisation and to deliver the best possible health outcomes within the limited funding allocated.

The Canterbury DHB needs to ensure that health resources are protected, sustainable and supported long-term and a focus for the coming year is to progress future health services planning through the development of clinical services plans, chronic care continuum frameworks and service models and facilities masterplans. This will mean new thinking around best provider, best location, best service but will enable us to ensure ongoing provision of health and disability services and to provide services which are better integrated and configured and that operate seamlessly across geographical, professional and service boundaries.

Improving the patient journey through the hospital system is a important part health service planning and the Improving the Patient Journey Project, already underway within the Canterbury DHB, will be rolled out to further divisions and to sectors beyond as part of the focus on effective chronic disease management continuums. This will enable us to ensure more consumer focused services and will assist the DHB to build capacity, capability and to improve productivity.

Success already evident through the work on Improving the Patient Journey includes significantly reducing CT Radiology Waiting Times. A focus of the coming year will be on capturing the degree of movement, operational and strategic impact of the Improving the Patient Journey activity. The development of Key Performance Indicators clearing stating organisational objectives are one measure of success and the development of these will be activity supported. Given the financial pressures faced by the Canterbury DHB it will also be important to measure some form of financial flow impact. Collecting, analysing and disseminating clinically and organisationally useful information will also enhance monitoring and drive performance improvement.

What	Work on the development of frameworks for Chronic Disease Management Continuums – Right Place, Right Time and Right Provider.
Who	General Manager Planning and Funding General Manager Hospital and Specialist Services
How	Link closely with Core Direction 'Working Together' (4.1.3) and enhancing partnerships with primary and community care providers working on a framework for services.

	▪ Collaborate with the wider health sector to develop and implement Chronic Disease Management Continuums focusing on Respiratory Disease, Cardiovascular Disease and Diabetes and including the range of services from self management to specialised complex care. ▪ Progress integration pilots and programmes to incorporate PHOs and General Practitioners (GPs) as key partners in the management of demand on hospital and specialist service ▪ Enhance referral guidelines and education to improve appropriate utilisation of speciality and emergency services.
When	Ongoing throughout 2006/2007.

What	Continue to implement the Improving the Patient Journey Project – Effective integrated care and improved productivity.
Who	Executive Director of Nursing Chief Medical Officer General Manager Hospital and Specialist Services General Manager Planning and Funding
How	Re-orientate and focus the Improving the Patient Journey team to concentrate its limited resources into the areas of greatest strategic and operational impact, in line with the HSS Annual Workplan. Progress the following key streams of the Improving the Patient Journey Project over the coming year: ▪ Emergency Department – refining length of stay; ▪ Acute Assessment Unit developed – process and structure; ▪ Radiology Review; ▪ Theatres Review; ▪ Out of Hours Services Review; ▪ Developing Measures for Success – Key Performance Indicators (KPIs); and ▪ Avoiding Unnecessary Hospital Admissions (driven by Planning and Funding).
When	Ongoing throughout 2006/2007: ▪ Strategy for Emergency Department length of stay in place; ▪ Daily performance tools installed for Radiology; ▪ Operational model agreed for Operating Theatres, detailed implementation plan complete; ▪ Night Team Coordinator in place and measures identified for Out of Hours service; and ▪ Measures of success defined and implemented.

What	Work to ensure optimum use of resources and investment – Future Health Services Planning.
Who	General Manager Corporate Services General Manager Hospital and Specialist Services General Manager Planning and Funding
How	The focus of future health services planning is to optimise the future use of capital within the DHB. Over the coming year work will be undertaken on: ▪ Health Services Plans – through a governance structure, including Steering Group and Project Team, Health Services Plans will be developed for departments through the DHB; ▪ Facilities Masterplan – the Health Services Plans will inform the development of a Facilities Masterplan for the Canterbury DHB; and ▪ Asset Management Plan – development of this Plan will continue, moving into greater detail and alignment with Health Services and Facilities Masterplans.
When	Ongoing throughout 2006/2007: ▪ Updated Asset Management Plan completed Q2; and ▪ Health Services Plans to inform Facilities Masterplan developed Q4

Primary Health Care

Primary care is often the first point of contact with health services and reducing barriers to accessing care helps people to stay well. Costs may be a barrier for some people; hospitalisation rates for people on lower incomes are higher than the Canterbury average. It is the intension of the NZ Primary Health Care Strategy 2001 that every New Zealander has the same ability to access Primary Care Services.

The Canterbury DHB will support the ongoing implementation of the national Primary Health Care Strategy and will aim to enhance population health by improving access to primary care and public health programmes designed to suit local needs. In the past two years a number of successes have been achieved in Canterbury through the implementation of the national Strategy:

- Establishment of five PHOs covering 98% of Canterbury, all participating in Care Plus;
- Implementation of a number of 'Services to Improve Access' programmes including: longer GP consultations, school health clinics and community nursing services;
- Implementation of a number of health promotion programmes including service mapping, smoking cessation programmes, youth oral health programmes, physical activity and nutrition programmes;
- Collaboration between the DHB and PHOs on targeted projects such as Service Maps and Winter Warming;
- Collaboration with PHOs to ensure at least a third of the PHO Boards are made up of community representatives to promote community engagement and responsiveness to community needs;
- Improved collaboration and coordination of community based services such as Home Based Support Services; and
- Review of Laboratory Services to ensure appropriate level of accessibility to services for the people of Canterbury.

In 2006/2007 the Canterbury DHB will work with the primary care sector to ensure the continued implementation of a number of projects that are currently underway. These projects will make inroads to progressing the primary care interface with hospital services and improving the coordination of primary and community services.

The DHB will also continue to work collaboratively with PHOs, pharmacy, laboratory, oral health services and home based support services to improve access to primary and community services and to improve coordination of these services:

- Continued implementation of the Mental Health Demonstration Models within primary care;
- Annual Planning for PHOs – engaging in collective stewartship and sharing of mutual ideas including community governance and the promotion of community representatives on PHO Service to improve Access (SIA) and Health Promotion (HP) Committees;
- Implementation of the Healthy Eating Active Lifestyle Project;
- Review and 24 hour cover and work with GPs and PHOs to develop an After Hours Plan for the Canterbury district; and
- Review Canterbury's rural services, incorporating rural primary care issues, supporting 24 cover, access to primary care specialist services and addressing rural workforce issues.

What	Streamline primary health care services and work with the sector to reduce the number of avoidable admissions to hospital.
Who	Portfolio Manager, Primary Care (Planning and Funding)
How	Work with PHOs, continuing to implement the NZ Primary Care Strategy; focusing on reducing the current inequalities within primary care service provision and providing support for GPs to allow them to manage the care of their enrolled populations by: ▪ Reducing co-payments for the 45-64 year old age group; ▪ Implementing PHO Health Promotion Plans; ▪ Implementing PHO Services to Improve Access Plans; ▪ Have all Canterbury PHOs enrolled in the PHO Performance Management Programme; ▪ Undertaking a review of Primary Mental Health Services and of Acute Demand Service provision.
When	Ongoing throughout 2006/2007.

What	Implement recommendations of the Canterbury DHB's Community Laboratory Services Review.
Who	Portfolio Manager, Primary Care (Planning and Funding)
How	Complete the Laboratory Services Review and implement the recommendations: ▪ Undertake a Request for Proposals (RFP) to implement the changes required; ▪ Aim to achieve the reconfiguration of service provision, increased accessibility and better data sharing of Laboratory services; and ▪ Aim to achieve increased testings and an overall reduction in hospital admissions.
When	May – September 2006.

What	Ensure access to Pharmacy Services within Canterbury.
Who	Portfolio Manager, Primary Care (Planning and Funding)
How	▪ Reduce the co-payments for 45-64 year olds enrolled within Canterbury PHOs. ▪ Work with the pharmacy sector to implement relevant addition services such as a Medicine Management Programme to improve the management of pharmaceutical needs within the Canterbury community.
When	Ongoing throughout 2006/2007.

What	Ensure that Home Support Services are targeted at the population of most need and work to ensure a streamlined, effective and efficient approach to service provision through improved coordination of services.
Who	Portfolio Manager, Primary Care (Planning and Funding) Portfolio Manager, Older Peoples Health (Planning and Funding) General Manager, Older People's Health and Rehabilitation Services (HSS)
How	▪ Implement the recommendations of the Canterbury DHB's Aged Care Strategy, *Healthy Ageing, Integrated Support.* ▪ Work with providers to develop strategies to assist in the retention and recruitment of carers to ensure a workforce that is flexible and available to provide the services required. ▪ Review the role of District Nurses within the community and determine the need for 24-hour nursing cover. ▪ Consider the possible development of Acute Care Teams to assist with targeting of services to high needs groups and reducing avoidable admissions to hospital.
When	Ongoing throughout 2006/2007.

Disease Prevention/Management

Population health programmes are key to achieving healthier people and communities. There is a need for an increased focus on programmes that target healthy eating, physical activity and smokefree lifestyles, especially among high needs groups.

Smoking contributes to a number of preventable illnesses resulting in a large burden of disease and is currently the single major cause of preventable death in NZ. However inactivity, poor nutrition and rapidly rising obesity rates are beginning to rival tobacco as the leading cause of preventable disease. All give rise to cardiovascular disease, diabetes, poor psychosocial outcomes and reduced life expectancy. In the past year all Canterbury DHB sites successfully achieved Smokefree status

A complex range of environmental influences affect the lifestyle choices of our community. Hence, a comprehensive multi-sector approach is needed to promote change and influence improved health status. A number of successes over the past year have contributed to a solid foundation for moving forward in the promotion of health, including the implementation of the HEAL Plan.

The Canterbury DHB has chosen four Disease Priorities; Cancer, Cardiovascular Disease, Diabetes and Respiratory Disease. All of these are influenced by lifestyle choice and public health education can make a difference in the health status of our community in all of these areas. As the Canterbury DHB moves towards a focus on chronic disease management continuums it will be important to

ensure that a public health and education focus is incorporated into those continuums. Priorities for 2006/2007 will focus on a number of areas that will assist in improving the health of our community:

What	Assist our community to make healthy choices through supportive physical, social, economic and policy environments and commitment to improved health and wellbeing.
Who	General Manager Community and Public Health
How	Contribute to and advocate for the development of standards, policies and practices which will create safer and healthier environments in the primary and community health sector, the NGO sector, the housing sector and in DHBs (Healthy Hospitals). Work collaboratively with Territorial Local Authorities (TLAs), Healthy Christchurch, Healthy Inangahua, Early Childhood Centres and with Māori and Pacific health organisations and intersectorial agencies. Develop and distribute health information and resources relating to health and wellbeing issues through intersectoral partners. Identify and work with other intersectoral agencies to explore the extent that public health/health promotion issues are being addressed and the opportunity for these issues to be placed on their policy/strategy agenda. Participate in the development, implementation and monitoring of intersectoral action plans to deliver social environment initiatives that address the determinants of health in geographic localities.
When	Ongoing throughout 2006/2007.

What	Promote a population-based approach to improving screening and awareness of risk activity and disease prevention activity across the DHB's four Disease Priorities.
Who	General Manager Community and Public Health
How	▪ Reduce the incidence of cancer through primary prevention, supporting PHOs to implement smokefree and QUIT smoking programmes. ▪ Continue to support programmes focusing on improving nutrition, smokefree lifestyles, limiting alcohol intake, increasing exercise and sun protection campaigns. ▪ Provide advice and expertise to facilitate the implementation of the Smokefree Environments Act 1990 and amendments to the legislation and strengthen community awareness and action to address retail sales and supply of tobacco to minors. ▪ Support the implementation and maintenance of Smokefree environments in schools within the context of Health Promotion in Schools. ▪ Work in partnership with other organisations, to develop programmes that encourage smokefree environments in the Māori community including homes, Marae and Kura Kaupapa Māori. ▪ Promote both local and national smoking cessation programmes, including cessation programmes targeting the Māori population (Aukati Kai Paipa smoking). ▪ Work in partnership with other organisations, developing, implementing and supporting public education, media and social marketing campaigns to raise public awareness of the health risks of tobacco use and to promote Smokefree lifestyles. ▪ In collaboration with other sectors, support and facilitate the development and implementation of nutrition and physical activity policies in key settings including preschools/schools, Kura Kaupapa Māori, Māori and Pacific settings, high need settings and within DHBs. ▪ Work with the education sector (through supporting Health Promotion in Schools, Fruit in Schools and other initiatives) to improve access to healthy food in preschools/schools, Kura Kaupapa Māori, particularly those with high levels of highest need. ▪ Identify and use opportunities to increase the profile of healthy food choices and physical activity in media, advertising and promotion. ▪ Support existing and (as appropriate) new community based education programmes aimed at increasing knowledge of community members, about nutrition and physical activity. ▪ Strengthen and develop networks between primary health care and public health to promote nutrition and physical activity issues ensuring effective participation from high needs groups. ▪ Develop and maintain district-level alliances and networks between health agencies and TLAs to inform and influence district planning.
When	Ongoing throughout 2006/2007.

Cancer

The Canterbury DHB works very closely with community providers to promote health initiatives that reduce cancer, such as improving nutrition, promoting smoke-free lifestyles and increasing exercise. Over the past year this collaborative work with other agencies had led to a number of success:

- Cancer Society/Laural Whitford Charitable Trust Information and Learning Centre established at Christchurch Hospital; providing on-site support and information to cancer patients and their families along with professional development resources for health professionals;
- Launch of the Cancer Society's Colossal Colon to help educate the public on the importance of a healthy lifestyle in preventing bowel cancer;
- Beginning collaborative work with the Cancer Society and Otago School of Medicine to help the Tissue Bank become financially self-sufficient; and
- All Canterbury DHB worksites, facilities and grounds are now smokefree.

The Canterbury DHB's approach to cancer builds on a number of national policies and strategies as well as focusing on issues raised in its Palliative Care Strategy (2003) and the review of Oncology Services (2002). Primarily, the Canterbury DHB is committed to implementing the NZ Cancer Control Strategy (2005-2010) and meeting the priorities outlined in that document[8].

In 2005 the South Island DHB General Managers (P&F) commissioned a stock take of cancer services in the South Island with the aim to bench mark existing services and then develop knowledge and skills to assist in the implement of the NZ Cancer Control Strategy. This regional plan works towards implementing and achieving the actions outlined in goals two through to five of the NZ Cancer Control Strategy by building upon existing cancer control strategies within DHBs through the provision of shared learning and providing the opportunity for consistency across regions.

This project will inform the actions taken over the coming year to progress the NZ Cancer Control Strategy. Treatment availability and cost are continuing challenges and together with community providers and agencies we will also be looking at ways to improve patient flow from diagnose through treatment to cure or palliative care. The Canterbury DHB's priorities for the 2006/2007 year are:

What	Work with other South Island DHBs to identify options for improved collaboration in delivering cancer treatment services and to progress the NZ Cancer Control Strategy.
Who	General Manager Planning and Funding General Manager Hospital and Specialist Services
How	▪ Reduce inequalities between DHB populations and within DHB populations. ▪ Align DHB and regional cancer services with the National Cancer Strategy. ▪ Work to ensure consistent DHB service development, with the ability to meet local needs. ▪ Work to ensure efficient use of resources in the development and planning of cancer services. ▪ Share information and ideas through regional collaboration (Regional Collaboration Network). ▪ Achieve radiation therapy waiting times. ▪ Establish service standards and develop multi-disciplinary teams to ensure effective diagnosis and treatment of cancer – through treatment advisory groups and tumour boards.
When	Ongoing throughout 2006/2007: ▪ A report outlining the current activity being undertaken within goals 2-5 of the NZ Cancer Control Strategy provided to all South Island DHBs 2006; and ▪ Recommendations for future alignment of DHB and regional cancer services with the NZ Cancer Strategy service development provided 2007.

What	Review Palliative Services in Canterbury.
Who	Portfolio Manager, Personal Care, Planning and Funding
How	▪ Undertake a review of all Palliative Services ensuring duplication/gaps identified and remedied. ▪ Implement the SupportCare packages of care into the community.
When	Ongoing throughout 2006/2007.

[8] The NZ Cancer Control Strategy is available on the Ministry of Health website www.moh.govt.nz.

Cardiovascular (Heart) Disease

The incidence of Cardiovascular Disease (CVD) is likely to increase as our population ages and is usually linked with diabetes and strongly influenced by lifestyle choice. Māori and Pacific have higher rates of CVD than other ethnicities.

A plan for minimising the effects of CVD on Canterbury's population was approved by the Canterbury DHB Board in 2004. The Canterbury Heart Health Strategy was developed in consultation with Canterbury DHB's Cardiovascular Steering Group consisting of both provider and user representatives and recommended a number of actions to improve heart health in Canterbury. The Strategy highlighted the importance of population-based strategies for reducing the impact and incidence of CVD and the importance of improving rehabilitation and community treatment after acute heart events.

Over the past year the Canterbury DHB has worked collaboratively to make gains in CVD and introduced a memorandum of understanding with the National Health Foundation as a means of examining ways to work together to improve heart health in Canterbury. Other successes over the past year will provide a good foundation for change and improvement over the coming year:

- Being chosen as one of five pilot sites for the National Health Foundation's *Heart Guide Aotearoa,* a home-based phase two rehabilitation programme scheduled to begin this year. The programme will be delivered by practice nurses in six large practices in Christchurch and the surrounding area and enables the Canterbury DHB to work collaboratively with general practice linking patients back into primary care for ongoing CVD management; and
- Beginning a primary care based CVD risk assessment project in Rangiora. Looking at the health status of the whole population as determined by their GPs. Information will be gathered in a standardised way over the coming year and will help shape the health promotion needs of the whole community.

In addition to these pilot programmes, challenges for the coming year include curbing and stabilising childhood obesity rates through community, school and early childhood centre programmes. There will also be a focus on increasing the numbers of partnerships, collaborations and alliances across the health sector in order to develop future initiatives to reduce the risk of heart disease:

What	Implement the actions associated with the *Canterbury Heart Health Strategy* , covering the continuum from health promotion, disease prevention, treatment, rehabilitation and palliative care.
Who	General Manager, Community and Public Health Portfolio Manager, Secondary Care (Planning and Funding) General Manager, Hospital and Specialist Services
How	▪ Develop a comprehensive approach to reducing the incidence and impact of CVD including progressions of HEAL and HEHA. ▪ Support strategies to address heart health in Māori and Pacific communities especially through primary and community care. ▪ Continue to review current interventions being used for CVD and introduce specific interventions to meet indicator targets for cardiac surgery and angioplasty. ▪ Continue to work with key stakeholders and health promotion providers to promote messages related to physical activity, healthy eating, weight reduction, smoking cessation. ▪ Work to ensure services are culturally appropriate and work with Māori and Pacific communities to support prevention, early detection, and service uptake. ▪ Continue to work with primary care and hospital services to ensure and integrated approach to patient care and support the development of chronic disease management continuums. ▪ Coordinate actions with national guidelines on management of cardiovascular risk, stroke, and diabetes.
When	Ongoing throughout 2006/2007.

Diabetes

Diabetes is a Health Gain Priority area for the Canterbury DHB, with the incidence of both type 1 and type 2 diabetes increasing in Canterbury. The Canterbury DHB will work closely with community and

primary care providers over the coming year to progress a coordinated community approach, to ensure access to services and to promote timely intervention.

The Canterbury DHB continues to support the Local Diabetes Team (a representative group of health professionals, community providers and consumer representatives) which provides advice and information to the DHB and reports on annual diabetes screening and management targets.

Work also continues on population-based interventions to promote healthy eating and increase physical activity with the teams from Nutrition and Physical Activity (CPH), Diabetes Life Education and Pacific Health Promotion merging their services at the end of 2005 in order to maximise their resources and effectiveness.

Future plans for the Canterbury DHB's Diabetes Services include the construction of new premises adjacent to the Christchurch Hospital. This new facility will house the Diabetes Centre, Home Dialysis Training Centre, meeting and education rooms and enlarged clinics to improve patient facilities.

In 2004 the Diabetes Action Plan *Disease Prevention and Management: CDHB Diabetes Actions,* updated progress on recommendations made in the 2002 Interim Diabetes Plan and proposed further areas for focus. There were a number of successes over the past year:

- Access to community podiatry services was promoted for high risk feet through a funded podiatry service in primary care;
- A Paediatric Diabetes Endocrinologist was appointed to increase consultant availability and improve timing of transition to adult services;
- The Canterbury DHB's HEAL Plan was introduced and activities were successfully linked with the MoH's national HEHA Strategy;
- Activities were also successfully linked with Cardiovascular Disease and Heart Health Plans; and
- Construction began on a new Diabetes and Dialysis Centre.

A number of local Canterbury DHB action plans and national health strategies incorporate actions that contribute to improved outcomes for diabetes including HEHA and HEAL, Māori health strategies and Pacific health strategies. The Canterbury DHB will continue to progress these over the coming year and will work closely with the Local Diabetes Team to focus gains in this area. The key priorities for the coming year are:

What	Coordination of services within the community to improve access and intervention.
Who	Portfolio Manager Personal Health (Planning and Funding) Portfolio Manager Primary Health (Planning and Funding)
How	▪ Progress work with all diabetes providers to ensure a sustainable coordinated approach. ▪ Continue to work in collaboration with the Local Diabetes Team to raise diabetes awareness and to progress shared goals and initiatives. ▪ Progress work with primary care teams to identify people with type 2 diabetes earlier to ensure early treatment. ▪ Support PHOs to provide health promotion in physical activity and healthy eating and to increase the number of people with diabetes getting annual checks and the number of patients with adequate glycaemic control. ▪ Continue to work with Māori and Pacific providers and communities to support prevention, early intervention and ongoing uptake of services. ▪ Work with community podiatry services on access for those with uncomplicated high risk feet. ▪ Progress a coordinated approach to access to community podiatry and retinal screening. ▪ Work to ensure all annual review data is collected for regional/national databases.
When	Ongoing throughout 2006/2007: ▪ Publication of the Local Diabetes Annual Report by the Local Diabetes Team; and ▪ Establishment of a single database under a 'lead' PHO for improved diabetes data collection.

Respiratory Disease

Diseases of the respiratory system are a leading cause of death in both Canterbury and in NZ. Chronic respiratory diseases, particularly asthma and smoking related diseases such as chronic obstructive pulmonary disease (COPD) and emphysema, represent a significant public health problem.

Nationally, asthma hospitalisations are higher for Māori than non-Māori despite asthma prevalence being similar in Māori and non-Māori children. Asthma self-management can significantly reduce hospital admissions. Over the past year the Canterbury DHB has laid foundations to reduce the incidence of respiratory disease:

- Completion of the 'Baxter Bear' programme (in conjunction with the Canterbury Asthma Society) aimed specifically at children in the community with asthma. This programme was funded through the Canterbury DHB's Strategic Health Investment Fund; and
- Role-out of CarePlus through Canterbury PHOs, Respiratory Disease is one of the Chronic Diseases that will be targeted over the coming year.

Priorities for 2006/2007:

What	Addressing risk activity that impacts on respiratory disease.
Who	General Manager, Community and Public Health
How	▪ Continue with Smokefree Activities and smokefree cessation promotion. ▪ Work collaboratively with intersectorial agencies on the 'Warm Homes' project – to ensure adequate home heating for older people to keep them healthy in their own homes. ▪ Improve the self management of respiratory disease through enhanced provision of education and support to patients, families/whanau and caregivers.
When	Ongoing throughout 2006/2007.

What	Improve the health status of Canterbury's residents who are at risk of developing respiratory disease, provide appropriate and timely treatment and work to improve the quality of life for those with respiratory disease.
Who	General Manager Hospital and Specialist Services General Manager Planning and Funding
How	▪ Provide links to the development of Chronic Disease Management Continuums to ensure that the treatment of Respiratory Disease is considered when the framework around continuums is developed. ▪ Utilise Health Round-table Benchmarking and International Comparisons to recognise clinical best practice and measure the Canterbury DHB against other DHBs to assist in improving patient care and ensuring best practice standards are met. ▪ Scope and develop an Acute Medical Assessment Unit to assist with the assessment and management of short-term stay patients.
When	Ongoing throughout 2006/2007.

Cost Effectiveness, Efficiency and Value for Money

The Canterbury DHB is committed to continuous efficiency improvement. We have a responsibility to seek to improve the efficiency of the services we provide, while maintaining or improving service delivery. This has been highlighted through the DSP process as one of the DHB's greatest challenges.

The Canterbury DHB has an ongoing process to review its infrastructure costs and, where appropriate, initiatives are implemented to manage and/or reduce these costs. Efficiency initiatives over past years have resulted in the Canterbury DHB having a low administration component relative to the size of the organisation and assisting with improving productivity. The DHB has successfully made substantial improvements in its financial management and achieved in excess of $50m in efficiency gains since its inception.

In developing new strategies and initiatives or undertaking reviews the Canterbury DHB will continue to identify areas where integration, efficiencies, re-configuration or earlier intervention can produce

better value and outcomes from available funding. We are committed to ensuring that opportunities of this nature continue to be identified and acted upon to realise health gains for our community. We will also be looking at the benefit associated with efficiency gains or service re-configurations which may equally reflect improved service quality, adoption of best practice, improved or increased service delivery and long-term service sustainability.

What	Continue to review and evaluate employee cost control processes.
Who	General Manager Hospital and Specialist Services
How	Review and develop a full range of approvals and monitoring systems for: ▪ Recruitment advertisements; ▪ Replacement staff, additional staff, bureau and relief staff and academic appointments; ▪ Overtime; ▪ The management of leave and sick leave; and ▪ Service costs. Continue to develop and implement training programmes for staff on 'Workforce Management Rostering Systems' (WMRS).
When	Ongoing throughout 2006/2007.

What	Continue to review and evaluate nursing workforce costs.
Who	General Manager Hospital and Specialist Services Executive Director of Nursing
How	▪ Analysis of the use of nursing workforce to develop an understanding of the dynamics of staff cost drivers and use of bureau staff. ▪ Review of social nurses and models of care. ▪ Consideration and investigation of MECA compliance costs.
When	Ongoing throughout 2006/2007.

What	Continue to review and evaluate treatment-related costs.
Who	General Manager Hospital and Specialist Services
How	▪ Analysis and understanding of the costs of clinical supplies beginning with Oncology and discussions through the Clinical Board on frameworks and next steps. ▪ Review clinical practice in other centres and DHBs including benchmarking and best practice. ▪ Review clinical guidelines. ▪ Review approval and purchasing processes.
When	Ongoing throughout 2006/2007.

What	Continue to review and evaluate new technology.
Who	General Manager Hospital and Specialist Services Chief Medical Officer
How	▪ Approval processes to be formally enhanced and required. ▪ Communicate with key clinical leaders and staff and work with the Canterbury DHB's internal Health Technology Assessment Committee in establishing frameworks.
When	Ongoing throughout 2006/2007.

What	Continue to review and evaluate annual leave reduction plans.
Who	General Manager Hospital and Specialist Services
How	▪ Overall objective to approve level up-front and review alternatives – not catching effects/sites.

	▪ Enhance utilisation of Workforce Management and Rostering Systems (WMRS). ▪ Monitor top 100 annual leave users and develop, implement and monitor targeted personal annual leave reduction plans.
When	Ongoing throughout 2006/2007.

The Planing and Funding division of the Canterbury DHB currently manages over 800 contracts with health and disability services providers and over the 2006/2007 year ongoing review will be undertaken on these contracts to ensure opportunities for efficiencies and streamlining processes are taken.

Specific operational efficiency initiatives for the HSS for 2006/2007 are centred on their Strategic Workplan which outlines HSS focus and priority projects. Regular progress reports are provided to the Board's Hospital Advisory Committee[9] on these various HSS projects along with financial reports on expenditure and volumes.

What	Implement operational efficiency initiatives in line with the HSS Strategic Workplan.
Who	General Manager Hospital and Specialist Services
How	There are a number of sub-projects within the following areas designed to improve efficiency and effectiveness and to optimise cost control and revenue enhancement over the coming year: ▪ Improving Financial Rigour; ▪ Changing Clinical and Patient Processes; ▪ Review of Clinical Services; ▪ Infrastructure Improvement; and ▪ Improving Organisational Fitness and Training of Managers
When	Ongoing throughout 2006/2007.

Elective Services, Orthopaedic and Cataract Initiatives

Meeting demand for elective services is a primary focus for the Canterbury DHB and a high priority nationally for the Minister of Health. The DHB's Elective Services Steering Committee continues to monitor compliance against national Elective Services Performance Indicators (ESPIs) which are reported regularly to the MoH. The key objectives with regard to elective services are to:

- Deliver services within contracted volumes and improve capacity within existing resources;
- Communicate to patients and referrers of the likelihood of service;
- Continue to develop strategies to deliver elective services within current resources and improve milestones;
- Continue to collect information to identify future demand/need; and
- Identify and develop new initiatives.

The Canterbury DHB is also committed to implementing government initiatives around electives in particular areas with national projects currently underway in both Orthopaedic and Cataract services. Over the past year the DHB has made a number of significant achievements:

- ESPI Recovery Plan in place for all elective specialties;
- Contract volumes achieved in elective services;
- New elective services initiative funding projects implemented;
- ESPI Recovery Plan milestones achieved for both Orthopaedic and Cataract initiatives;
- Volume targets achieved for both the Orthopaedic and Cataract initiatives;
- Access threshold for cataract surgery lowered;
- Continue Quality Improvement (CQI) reporting compliance in Orthopaedic Service achieved and CQI Patient Flow Reports now provided to Orthopaedic clinicians to inform consistent patient selection; and

[9] The HSS Workplan and papers from the HAC meetings are available on the Canterbury DHB website.

- Clinicians now involved in CQI compliance and setting of promise levels for Cataract Initiative.

Productivity and Efficiency Successes:

- 'Did Not Attend' policy in place and monitored monthly;
- Guidelines and booking system reviewed for diagnostics;
- ESPI reports available to staff;
- Day Surgery and Day of Surgery Admission percentages increased;
- Process mapping informed a complete redesign of model of care from referral to pre-admission. 'Bottlenecks' quantified and solutions identified for Orthopaedic Initiative;
- Orthopaedic GP Liaison appointed;
- Orthopaedic operating theatre utilisation up 30%;
- Nurse led Orthopaedic admissions commenced, agreement for Nurse led pre-admission to commence 2006/2007;
- Both General Practitioners and Optometrists now pre-screening and scoring Cataract patients with training provided to up-skill General Practitioners in eye treatment and procedures;
- Nurse led follow up Glaucoma clinics commenced; and
- Process map of elective Cataract patient journey completed.

In addition to progressing the commitment to projects already underway the priorities for Elective Services 2006/2007 are to:

What	Work to improve access to First Specialist Assessments (FSAs) and aim to provide 100% of patients their first specialist assessment within six months.
Who	General Manager, Medical and Surgical Division (HSS) General Manager, Women's and Children's Health (HSS)
How	▪ 100% of first specialist assessments seen within six months in surgical, medical and gynaecology. ▪ Continue to improve the matching of promises to capacity in all services. ▪ Work to continue with primary sector to further develop alternative options in the community. ▪ Utilisation of clinical time to be monitored. ▪ Continue monitoring "did not attend" rates to reduce wastage of clinical time. ▪ Further develop nurse led initiatives. ▪ A review of sleep studies with alternative treatment being implemented in the community. ▪ Ongoing development of improved primary access to diagnostics. ▪ Reduce the number of follow-ups required in targeted specialties. ▪ Review of induction and training process for new staff working with booking system. ▪ Discharge follow-ups back into the community in a timely manner. ▪ Prioritise recommendations from outpatient audit.
When	Ongoing throughout 2006/2007: ▪ ESPI management Q1; ▪ Matching priority is integrated into all service function Q2; ▪ Implement recommendation from outpatient audit Q2; ▪ Increase nurse led initiatives Q3; and ▪ Monitor clinical utilisation Q4.

What	Implement systems to improve access to elective surgery across all population groups – Improving the Patient Journey, Theatre Module.
Who	General Manager, Medical and Surgical Division (HSS)
How	▪ Reviewing theatre utilisation and future requirements in regard to acute/elective sessions. ▪ Analyse "bottlenecks" and "delays". ▪ Increase the utilisation of pre-admission clinics. ▪ Examining theatre staff roster and shift patterns. ▪ Measuring time of admission to time to theatre.

	▪ Maximising the current resourced theatre time with the ability to increase the resource in the future. ▪ Increase day surgery percentages and day of surgery admission percentages. ▪ Review the skill mix required for each theatre session. ▪ Continue to monitor recruitment and retention of skilled theatre staff.
When	Ongoing throughout 2006/2007: ▪ Benchmark Australia and New Zealand theatre staffing models Q1; ▪ Allocate theatre scheduled sessions in line with contracted volumes Q2; ▪ Improve patient pathway from admission to theatre Q2; ▪ Implement pre-admission procedures for all specialties to increase day of surgery admission and day surgery Q3; ▪ Implement alternative staff rosters and shifts where applicable Q4; and ▪ Increase capacity for orthopaedic and cataract initiatives Q4.

What	Achieve consistent prioritisation for patients in all services with a focus on the link between assignment of priority and treatment decisions by clinicians.
Who	General Manager, Medical and Surgical Division (HSS)
How	▪ Work with surgeons to further delineate patient need and ability to benefit. ▪ Collaborate with the Clinical Priority Assessment Criteria (CPAC) review consortium to implement effective score tools in general and vascular surgery. ▪ Identify opportunities for local score tool develop and implement where there is no national tool. ▪ Regularly review consistency of prioritisation through Ministry of Health scatter plots and give feedback to clinicians.
When	Ongoing throughout 2006/2007: ▪ Review scatter plots Q1; ▪ Implement a monthly monitoring system for clinicians and managers Q1; ▪ Engage in decision making with clinicians and consortium team Q2; and ▪ Develop and implement local score tools where appropriate Q4.

What	Progress and implement the national Orthopaedic initiative within the Canterbury DHB.
Who	General Manager, Older Persons Health and Rehabilitation (HSS)
How	Maintain ESPI compliance and continue to improve the matching of promises to capacity for both outpatient and in-patient treatment: ▪ GP Liaison to focus on the referral gateway and communication with primary care. Build additional public sector capacity for hip and knee replacement to meet the target intervention rate by 2007/2008: ▪ Timely completion of Stage Two Redevelopment of the new Burwood Hospital surgical ward/ theatres /PACU/ day surgery and admitting unit with a supporting workforce plan in place. Achieve consistent prioritisation for patients with focus on link between assignment of priority and treatment decision by clinicians: ▪ Work with surgeons to further delineate patient need and ability to benefit; and ▪ Ensure that matching priority given to a patient with the order in which patients are treated, at an individual clinician level, becomes an integrated function within the service. Work alongside primary care and the Canterbury DHB's Planning and Funding division to support and monitor a greater range of options to help manage demand on secondary services. Focus on Nurse led pre admission and develop competency framework to support all nurse led Elective Orthopaedic activity.
When	Ongoing throughout 2006/2007: ▪ Completion of Burwood Hospital redevelopment Q4; ▪ Matching priority is integrated into service function Q4. Streamlining programmes underway to help manage demand on secondary services: ▪ ESPI Management Q1; ▪ Pre Admission and Discharge Planning redesign Q2;

	▪ Optimise Outpatient Capacity and Capability Q3; ▪ Burwood Theatre Planning and Utilisation Q4; and ▪ Workforce Utilisation and Planning Q4.

What	Progress and implement the national Cataract Initiative within the Canterbury DHB.
Who	General Manager Medical and Surgical Services (HSS)
How	100% of FSA and In-patient treatment list patients seen within six months and additional capacity for cataract surgery built to meet the target intervention rates by 2007/2008: ▪ Continue to improve the matching of promises to capacity; and ▪ Facilitate interim solutions to current capacity issues while concurrently developing longer term plans for increasing public sector Ophthalmology capacity in Canterbury. Achieve consistent prioritisation for patients with a focus on the link between assignment of priority and treatment decisions by clinicians: ▪ Provide clinicians with regular information showing scoring patterns and links between priority and treatment decision. Focus on streamlining the Cataract Patient Journey from referral to pre-admission: ▪ Analyse "bottlenecks" and identify solutions; and ▪ Further development of Nurse led initiatives.
When	Ongoing throughout 2006/2007: ▪ Clinicians will be provided with scoring pattern information Q2; ▪ Interim solutions to capacity issues implemented Q4; and ▪ Solutions to bottlenecks identified Q4.

Progressing the Mental Health Strategy and Mental Health Blueprint

Completion of the Canterbury DHB Mental Health and Addictions Strategy in May 2004 provided a local framework for managing access to and delivery of a 'System of Care' model based on advancing recovery for service users. Two directions have been established and these are:

- Improving access for people experiencing mental illness, alcohol and other drug problems; and
- Introduce an improved 'System of Care' that is integrated, responsive and available in the consumer's chosen community.

The Canterbury DHB's Mental Health and Addictions Strategy is consistent and complimentary to existing work at national and regional levels (particularly the Government's Mental Health Strategy; *Te Tahuhu* Improving Mental Health 2005-2010) and is clear that service reconfiguration must occur within resources. Its vision is 'Improving the health and well-being of people experiencing mental illness and alcohol and other drug problems'.

The Canterbury DHB was allocated $2.8 million additional Blueprint funding in 2005/2006. This provided an opportunity for significant investment in new services for the Canterbury District. The following services have been, or are in the process of being established as a result of this additional funding:

- Māori Mental Health Services for Child and Youth (MHCS.39)
  The Kaupapa Māori Mental Health Services Review identified a need for additional Youth Services, and Child and Youth Services are identified as a priority area for Canterbury DHB. An increasing percentage of Māori are under the age of 30; therefore, there is an increasing need for youth services in Canterbury. Quarterly statistics have shown that access rates to mental health services for Māori Children and Youth are disproportionately low relative to population. The Canterbury DHB will contract with a Kaupapa Māori NGO to provide clinical child and youth services, the resource for this proposal is equivalent to four Full-Time Equivalents (FTEs).
- Addiction Treatment Options for Women (MHCS.01.A)
  AOD providers report significant difficulty accessing treatment options for women, that are flexible enough to meet the needs of women re child care etc, therefore resource was allocated to increase addiction treatment options for women in Canterbury (up to $100,000).
- Alcohol and Other Drug (AOD) Advocacy / Peer Support (MHCS.21.A.*consumer*)

Ensuring that mental health services are recovery oriented is a requirement of Te Tahuhu – the national Mental Health Plan. The Recovery philosophy recognises that service users lead their own recovery, have personal power and have a valued place in their whanau and community. service users must also have formalised positions within the mental health system to assist with the systemic development of recovery focussed and responsive services. The resource for this service is equivalent to two FTEs

- Pacific Mental Health Services for Child and Youth (MHCS.21.7)
  Child and Youth Services are a priority area for Canterbury DHB. Quarterly statistics have shown that access rates to mental health services for Pacific Children and Youth are disproportionately low relative to population. The resource for this service is equivalent to four FTEs.
- Respite Services for Adults(MHRE.01.*planner*) (MHRE.01.*crisis*)
  A shortage of community respite beds was reported as a significant contributing factor to this increased demand for inpatient services, therefore resource was allocated to increase respite services. The resource for this service is equivalent to six beds.
- Specialised Areas of Mental Health (MHCR.09)
  Community Support Workers provide non-clinical support to assist service users to maximise and maintain recovery within the community. Some service user groups have specific needs that require more intensive support than what providers of generic Community Support Workers can offer. The resource for this service is equivalent to five FTEs.
- Community Integration Service (MHWD.01)
  The purpose of these service is to work with individuals in existing residential services and inpatient services and facilitate the move on to more independent arrangements by building packages of care around individuals that do not 'fit neatly' into traditional services. This service will include a Transition Fund that will be managed by the Community Integration Service staff in partnership with the DHB's Contract Manager. This fund is available to fund one-off expenses that will assist a service user to move into more independent accommodation. The resource for this service is equivalent to five FTEs, with additional resource for a Transition Fund.
- Peer Support Services (MHCD.21.1)
  Service user run services are a key component of a recovery oriented mental health system. The DHB will contract for a programme where service users support other users in their recovery and the resource for these services is equivalent to three FTEs.
- Mobile Medication Service (MHWD.01)
  This is a demonstration mobile outreach service that operates outside normal business hours and targeted to those who have been most difficult to engage in mainstream service delivery. The resource for this service is equivalent to two FTEs.
- Primary Mental Health Initiatives (MHCS06A)
  Development of Mental Health Liaison Worker positions that are based in primary care, supporting GPs and liasing with mental health services.
- Pyschogeriatric Services (MHCS.06.A.PSE)
  Resource was allocated to a memory clinic. This service provides early assessment and support for dementia.
- Increased Maternal Mental Health Services (MHCS.06.B)
  An additional 0.5 FTE Consultant Psychiatrist for Maternal Mental Health.

Many of these services have been established as demonstration programmes for a period of 18-24 months. During this time qualitative and quantitative information will be collected by service providers which will be used to develop future contracts. This will ensure that planning and funding decisions regarding future service or sector reconfigurations will be aligned to the needs of service users and their families and their required mental health outcomes.

The coming year will also provide opportunities for service expansion with a further $1.6m additional Blueprint funding allocated to Canterbury. This investment will focus on developing Peer Support Services ($500,000) (MHCD.21.1), supporting Primary Care ($260,000) (MHCS06A) and the remainder providing flexible mental health support options based on the experience of the demonstration programmes in 2005/2006.

Despite this additional funding a number of providers of mental health services are under some financial pressure. These pressures include pay equity demands as a flow on effect of the nurses' salary agreement, difficulties with recruitment and retention in a highly competitive environment and infrastructure/technology issues. In order to respond to these issues the Canterbury Mental Health Sector, led by P&F, must closely examine the current range and mix of mental health services to better understand effectiveness, efficiency and how responsive services are to the needs of service users and their families.

National Mental Health Workforce Development Programmes and Centres provide numerous resources and opportunities for mental health providers, service users and whanau. The Canterbury Mental Health Sector will continue to participate in and support these national and regional initiatives that are relevant to local issues and support participation by local providers.

The Canterbury DHB will also continue to pursue the goals of Te Puawaitanga and progress cultural responsiveness of mainstream mental health services and the development of the Kaupapa Māori Mental Health Sector.

What	Improve and support flexibility and responsiveness in mental health services.
Who	Portfolio Manager, Mental Health (Planning and Funding) General Manager, Mental Health Services (HSS)
How	Fund demonstration services that improve service flexibility and accessibility for service users: ▪ Assess the outcomes of these demonstration services; ▪ Identify improvements that can be attributed to funding approaches; and ▪ Select the demonstration services that will continue. Provide information to the mental health sector about the ways of working that are expected to be achieved through the aforementioned demonstration services and in general to support the flexibility of mental health services. Continue to support Te Korowai Hinengaro Oranga Ki Waitaha as a key mechanism for developing and strengthening the Kaupapa Māori Mental Health Sector, and supporting regional initiatives like Te Roopu Awhiowhio to improve the responsiveness of mainstream services. Implement the recommendations of the Child and Adolescent Family Mental health Services Review and the Review of the Model of Care in Adult General Mental Health Services, to promote improvements in the patient journey and increased flexibility and responsiveness.
When	Ongoing throughout 2006/2007: ▪ Assessment of demonstration services in Q1 and Q2. Services selected as effective (eg, because of consumer outcomes) will then be funded on an ongoing basis; and ▪ Regular meetings with mental health providers for information sharing and discussion to ensure clarity of expectations and remedy any difficulties.

What	Support cohesiveness and collaboration between mental health providers and stakeholders.
Who	Portfolio Manager, Mental Health (Planning and Funding)
How	Ensure all providers with Canterbury DHB contracts have information about and opportunities to discuss how the System of Care model is intended to work.
When	Ongoing throughout 2006/2007: ▪ Q2 and Q3 hold regular provider meetings with mental health service providers where P&F will provide information and direction; and ▪ Use provider specific clauses in contracts, as required, to clarify responsibilities and key linkages within the System of Care model.

What	Continue to support and develop recovery orientation in the mental health sector.
Who	Portfolio Manager, Mental Health (Planning and Funding)
How	Include recovery specification in provider specific clauses of contracts. Use information from the Recovery Systems Project led by the SISSAL to inform funding decisions.
When	Ongoing throughout 2006/2007: ▪ Q2 specification included on renewal or variation of mental health provider contracts.

Progressing the Health Information Strategy

Significant Information Services activity is already underway throughout the Canterbury DHB. In addition to the implementation of both the Information Services Strategic Plan (ISSP) and the Health Information Strategy NZ (HIS-NZ), significant changes are being made to Information Services infrastructure and regional collaboration is a primary focus.

This year's activities build on the considerable investigation and analysis work from 2004/2005 and the foundation work undertaken in 2005/2006. Some of that work undertaken in the past year includes:

- Successful signing of South Island Telecommunications Contract with facilitation of contract price and service level being made available for all South Island DHBs;
- Successful upgrade of Oracle Financial Business Systems which provide improved financial management and reporting for the organisation;
- First step upgrade of Stargarden HR and Payroll systems successfully completed, ensuring the technology platform is appropriately supported throughout the DHB;
- Successful implementation of information technology infrastructure on the new Christchurch Women's Hospital and Day Surgery site. This included some innovation technology to improve voice communications in the clinical setting;
- Voice and Data Networks across the DHB successful upgrade to streamline communications, reduce costs and allow improved internal communication links; and
- Successful implementation of NIR system and school based vaccination systems.

The Canterbury DHB's ISSP re-enforces the objectives outlined in national strategies and our Information Services are committed to working closely with stakeholders (locally, regionally and nationally) to implement solutions that satisfy clinical and business requirements. The focus over the coming year will be delivering projects that have been in planning for the last year:

What	Continued implementation of the Canterbury DHB's ISSP and delivery of a robust infrastructure framework.
Who	General Manager Corporate Services Chief Information Officer, Information Services
How	Complete Infrastructure Stabilisation Programme of Work. Implement first stage Clinical Information System: ▪ Implement a clinical portal to give an aggregated view of clinical information including a Patient Master Index, National Provider Index integration and Electronic Discharge Summaries; and ▪ Formulate a strategy to move to a single Patient Administration System. Progress the upgrade of HR Payroll and Rostering systems. Support the implementation of an Oral Health information System. Complete the implementation of MH-SMART. Implement National Non-admitted Patient Collection (NNPaC).
When	▪ Complete implementation of data capture forms for MH-SMART Q1. ▪ Implementation of NNPaC Q1. ▪ Infrastructure Programme complete Q4. ▪ Clinical Information System roll-out underway Q4. ▪ HRIS and Rostering Business Case and implementation Planning Study complete Q1-Q4.

What	Actively participate in HIS-NZ, the development of standards defined in HIS-NZ projects.
Who	General Manager Corporate Services Chief Information Officer, Information Services
How	▪ Progress collaborative networks to address information system needs at local, regional and South Island levels (Action Zone 1 – National Network). ▪ Actively participate in NHI promotion and work on the continuous improvement of data quality (Action Zone 2 – NHI Promotion). ▪ Implement single South Island Regional Network to provide access to clinical information at other DHBs and to other significant health or health service providers (Action Zone 1).

	▪ Provide access to PACs services (where they exist) at other South Island DHBs for Canterbury DHB staff treating tertiary referred patients (Action Zone 1). ▪ Provide access to Clinical Information Systems (where they exist) at other South Islands DHBs for Canterbury DHB staff treating tertiary referred patients (Action Zone 1). ▪ Implement 'Client' Health Practitioner Index (HPI) (Action Zone 3 – HPI Implementation). ▪ Lead in the implementation of phase one of the National Non-Admitted Patient Collection (NNPaC) (Action Zone 9 – National Outpatient Collection).
When	▪ Active participation in at least three National Action Zones. ▪ Regional DHB Network set up within South Island by Q1. ▪ NNPaC implemented (Phase1) by Q1. ▪ Discharge Summaries implemented at Christchurch Hospital by Q3. ▪ NHI Promotion ongoing monitoring of data quality and targeted training to improve. ▪ Implementation of 'Client' HPI at Canterbury DHB by Q3. ▪ Each DHB is able to retrieve PACS images from other DHBs by Q3. ▪ Each DHB has access to the clinical information systems at other DHBs by Q3.

4.1.3 Work Together

The Canterbury DHB realises that its vision will not be achieved through its efforts alone. By looking outside of our organisation, establishing partnerships with other agencies and with other sectors, as well as with our community and consumers, the DHB can work to influence the determinates of health and enhance the continuum of care needed to achieve improved health outcomes.

The Canterbury DHB plans to continue to emphasise the importance of working collaboratively with its own workforce and to encourage work across professional and organisational boundaries to optimise the use of combined health resources and to challenge traditional roles to improve health outcomes for patients and consumers.

The Canterbury DHB will also begin to work on the development of a Framework for Primary and Community Care over the next year. The intention is that this framework will be used to assess service or funding proposal as to their 'fit' within the direction of service development. The framework will look at the continuum in the community from 'wellness' at one end to 'unwellness' at the other and work to 'recentre' the health sector onto primary care as the first line and consistent tread throughout the patient journey. The expected outcomes are early detection and intervention, continuity and coordination of care, better and more timely information and workforce changes.

What	Share responsibility for quality health outcomes with our community.
Who	General Manager, Community and Public Health
How	Maintain an intersectoral focus continuing ongoing work with external agencies to address the determinants of health and to share vision for improving outcomes: ▪ Support for the Canterbury Intersectoral Physical Activity and Nutrition Group; ▪ Development of PHOs Health Promotion Plans; ▪ Continue involvement in the Poverty Project with Healthy Christchurch; ▪ Involvement in the development of Long Term Community Council Plans (LTCCPs); ▪ Continued involvement in the Housing Forum; ▪ Support for Health Impact Assessments (HIAs); ▪ Continued involvement in the Regional Land Transport Committee; ▪ Support the development of an Urban Development Strategy for Greater Christchurch; ▪ Continued involvement in and support for Healthy Christchurch; and ▪ Continued involvement in and support for Pandemic Planning.
When	Ongoing throughout 2006/2007.

What	Enhance partnerships between our clinical workforce and management - considering the changing mix of skills required for future service provision and changing models of care.
Who	Chief Medical Officer Executive Director of Nursing
How	Work to challenge the roles and mix of health care workers and the models of services delivery for the benefit of patients, consumers and service users: ▪ Continue current work at Burwood Hospital looking at the changing role of health professionals. Successfully admitting patients to hospital for elective surgery without direct RMO involvement; and ▪ Continue working on the development of a 'Night Team' to improve the quality of care, improve the work experience and training of RMOs and to change the role of health professionals at night. Review sustainability of services in rural services and specific workforce issues: ▪ As part of Review of Health Service in Ashburton (Ashburton Model of Care Project) develop and implement initiatives around the replacement of traditional RMO roles with generalist medical officers including some uptake of responsibility by nurses. Continue to develop and implement professional development and recognition programmes.
When	Ongoing throughout the 2006/2007 year.

What	Enhance partnerships with primary and community care providers – working on the development of a Framework for Primary and Community Services to ensure long-term capacity.
Who	General Manager Planning and Funding
How	▪ Collaborate with the wider health sector to develop and implement Chronic Disease Management Continuums focusing on Respiratory Disease, Cardiovascular Disease and Diabetes and including the range of services from self management to specialised complex care. ▪ Progress integration pilots and programmes to incorporate PHOs and GPs as key partners in the management of demand on hospital and specialist service. ▪ Enhance referral guidelines and education to improve appropriate utilisation of speciality and emergency services.
When	Implementation of changes to be ongoing throughout 2006/2007.

4.1.4 Develop our Health Workforce

A sustained, skilled and flexible health care workforce is central to the Canterbury DHB's ability to provide effective quality services and meet the challenge of improving our community's health. We aim to maintain our workforce capacity by supporting flexibility and innovation, encourage training and skills development and providing recognition and leadership opportunities within the organisation.

The Canterbury DHB has endorsed, in principle, District Health Board New Zealand's (DHBNZ's) Future Workforce 2005-2010 Strategy.[10] The Strategy identifies the following eight priority areas: fostering supportive environments and positive cultures; enhancing people strategies; education and training; models of care; primary health workforce; Māori health workforce; Pacific health workforce and non-regulated and voluntary health and disability workforce.

In Promoting a healthy workplace environment the Canterbury DHB will also encourage its workforce to lead by example in terms of healthier lifestyles and practices. In October 2006, Canterbury will host the DHB Health and Safety Conference, themed *'Working Well Together'* profiling the importance of a shared responsibility for safety and wellness. This builds on the success of the popular Wellness Days and the development of a Health and Safety management system. Other successes include:

- Centralisation of the Human Resources Group and establishment of key positions responsible for Workforce and Strategy Portfolios;
- A centralised accident reporting and recording system;
- ACC Partnership Programme for the management of workplace injuries;

[10] Refer to *Future Workforce 2005 – 2010* by DHBNZ Workforce Development Group for more detail.

- A dedicated Rehabilitation Advisor to support staff return to work from non-work injuries and health related events;
- Establishment of an Occupational Health Service for staff;
- Development and commencement of the HR competency development programme;
- Dedicated Organisational Development Framework (ODF) projects to improve recruitment and selection practices, remuneration practices, performance reviews, change management and management and leadership development; and
- Review of HR systems to improve workforce data and reporting capability.

Over the following year the key priorities for the Canterbury DHB with regard to developing its health workforce and maintaining workforce capacity are a combination of local and national priorities:

What	Encourage a flexible approach to reflect the changing needs of our community.
Who	Group Manager, Human Resources
How	Identify the likely impacts of future models of care on the health workforce to enable strategic workforce planning and development: ▪ Re-establish the Canterbury DHB Workforce Steering Group (WSG) to identify future activities as appropriate; ▪ Support and participate across identified year 1 Future Workforce projects as per the national *Future Workforce* programme; and ▪ Support and Participate in 2006/2007 employment relations priorities and projects (pay and employment equity review, bargaining activity and negotiations) as determined by DHBNZ project scopes.
When	Q2: Reconvene Workforce Steering Group. Throughout 2006/2007 the Canterbury DHB will participate in national initiatives and projects in accordance with the project plans and timeframes provided national, where appropriate: – As per *Future Workforce* Year 1 Project Plans; and – As per project scopes provided by DHBNZ for WAP.

What	Develop a workforce providing the 'right skills' for the best health outcome to ensure long-term capacity for service provision.
Who	Group Manager, Human Resources
How	Continue to work with education providers to develop programmes for a changing health environment and encourage enrolment particularly amongst under represented groups: ▪ Continue support for the development of Māori Workforce through the Tikaka Hauora initiative. Improve workforce information and data collection to assist with workforce development and capacity planning: ▪ Participate as a key stakeholder in the DHB-wide Human Resources Information System (HRIS) project, contributing to system configuration and process design, and to the development of change management approach for implementation, as required; ▪ Develop and enhance in-house HR business systems to facilitate the use of workforce data and reporting; and ▪ Support the identified priority areas for the 2006/07 HWIP, including specific workforce forecasting, modelling and analysis initiatives.[11]
When	Q3: Implement the Tikaka Hauora Development Programme. Q4: Implementation of regional e-recruitment solution. Q2: Streamlining of HR reporting frameworks.

What	Ensure Canterbury's health sector is a 'good place to work'.
Who	Group Manager, Human Resources
How	Provide leadership and career opportunities for our health care workforce and support career

[11] Refer to Health Workforce Information Programme by DHBNZ Workforce Development Group for more detail

	development: ▪ Development and implementation of identified management and leadership programmes; ▪ Implementation deliverables of the Performance Review project; ▪ Investigate and scope projects for succession planning and reward and recognition; ▪ Consideration and alignment of identified Workforce Steering Group activity – incorporating local tertiary providers and collaboration through established forums; ▪ Development and implementation of the DHB's collaborative Leadership Framework Model; and ▪ Participate and support Health Sector Branding Initiative as per the project scope from DHBNZ.
When	Ongoing throughout 2006/2007 as per the ODF project scopes and as per the project scopes provided by DHBNZ.

What	Create a safe and health-promoting environment to support and retain staff.
Who	Group Manager, Human Resources
How	Continue the ongoing progression of Health and Safety management practices and culture: ▪ Progress the local healthy workplace and employee wellbeing programme. Develop and implement one hazard management system: ▪ Host the 2006 National DHB Health and Safety Conference; and ▪ Participate and support identified national initiatives arising from the national Health and Safety Managers Forum. Support, participate and collaborate in national activity related to the Healthy Workplace Stocktake[12].
When	Ongoing throughout 2006/07. Occupational Health Service implemented and operating. Q2: Health and Safety Conference programme developed and conference successfully hosted.

4.1.5 Be a Leader in Health

In order to affect change the Canterbury DHB needs to provide leadership to its community and develop a stable infrastructure to support the improvements it plans to make. The DHB will continue supporting expertise in health, encouraging innovation and promoting quality health care service delivery.

One of the challenges in making improvements in the health status of our community is influencing people and organisations to listen and learn from one another. The Canterbury DHB will work on encouraging debate and sharing information with our community to foster creative solutions to cope with future demand and improve the health of our community.

What	Enhance Clinical Governance process and systems.
Who	Chief Medical Officer
How	▪ Review the financial and clinical implications of new technology and new therapies or high cost treatments and support the work of the Clinical Review Committee in reviewing the evidence for cost effective clinical improvements. ▪ Work towards the development of frameworks for use of new technology and therapies and benchmarks for treatment-related costs. ▪ Extend the role of the Canterbury DHB's Health Technology Assessment Committee to cover all Canterbury DHB services and to become a procedural requirement.
When	Ongoing throughout 2006/2007.

What	Encourage innovation, development and research.
Who	General Manager, Planning and Funding Chief Medical Officer

[12] Refer to DHBNZ Healthy Workplace Stocktake 2005 report & Summary of Responses

	Executive Director of Nursing
How	▪ Review the Canterbury DHB's Strategic Investment Funding to ensure allocation of investment funding to advance projects around integration and innovative change to improve access to health services. ▪ Continue to hold the Canterbury DHB Quality and Innovation Awards Annually and to review and develop the awards programme.
When	Regular updates to the Executive Management Team - Quarterly.

What	Increase the level of community action amongst health sector and intersectoral partners to improve the knowledge and skills base to implement a population health approach.
Who	General Manager Community and Public Health
How	▪ Provide health promotion and public health training for the sectors influencing health and community groups, and organisations to ensure they have the capacity to enable them to develop community based public health action. ▪ Influence public health action in other sectors through intersectoral engagement, provision of public health advice and advocacy.
When	Ongoing throughout 2006/2007

Quality and Safety

The Canterbury DHB has a strong commitment to the provision of high quality health care services. We strive to ensure we provide an integrated service that strongly encourages evidence based clinical care and is responsive to consumer needs.

We have a DHB-wide Quality and Patient Safety Council which takes a coordinated approach to considering quality and patient safety. The Council is supported by the Canterbury DHB Quality and Risk Team and its primary goal is to provide leadership in improving quality and patient safety in the health services covered by the Canterbury DHB.

The Quality Strategic Plan is the Council's key document providing a framework that promotes leadership as the underlying driver of quality improvement and quality improvement as a continuum. Developed within the context of the MoH document Improving Quality (IQ): *A Systems Approach for the NZ Health and Disability Sector*; the Plan presents ten initiatives grouped into five goal areas. These areas are: community participation/community involvement, initiating organisational change and development, clinical risk management, instituting mechanisms for effective reporting and accountability and knowledge management for clinical services and quality.

The Council monitors the implementation and progress towards the quality initiatives and promotes quality improvement. There have been a number of key successes over the past year including:

- The development and promotion of key quality and patient safety policies including the Culture of Patient Safety and No-Blame Incident/Accident Reporting policies;
- Significant success in Quality and Innovation Awards Programmes, winning State Services Sector award in the 2005 BearingPoint Innovation Awards, two finalists in the Champion Canterbury Awards 2005, 2005 Individual Award Winner and 2005 Organisations Highly Commended Award in the 2005 New Zealand Health Innovation Awards, finalist in the Quality Health New Zealand/Baxter Quality Improvement Awards 2005 and a highly commended for Excellence in the Use of Information Technology at the Computerworld Excellence Awards 2005;
- The continued development of the Canterbury DHB's own Quality and Innovation Awards Programme, promoting a systematic approach to project work throughout the organisation by encouraging people to write up projects and by running Applicant Information Sessions. By encouraging our staff to record their quality improvements and innovations we have also fostered the sharing of information both internally and externally. Roadshows have also been run to facilitate the sharing and learning gained from the applicants project activities;
- The CDHB Restraint Approval Monitoring Group (now into its second year) developed and implemented a common restraint register within the HSS and developed HSS procedures for the use of bedrails. A new Restraint Clinical File Audit tool was introduced and implemented. A self-learning package for use of physical restraints was developed for staff; and

- A Root Cause Analysis training programme was hosted by DHB, with very positive feedback. This was an initiation of the National Quality and Risk Managers group with training delivered through the NSW Clinical Excellence Commission.

What	Continue to implement the Canterbury DHB's Quality Strategic Plan – reviewing and realigning the Quality Strategic Plan with the DSP for 2006-2010.
Who	Executive Director of Nursing Chief Medical Officer Quality Manager, Corporate Quality and Safety
How	▪ The new Quality Strategic Plan and Quality and Patient Safety Council's workplan is implemented with cohesive quality and risk management structures in place across the DHB. ▪ Continue to develop quality and patient safety policies. ▪ Hold the Canterbury DHB Quality and Innovation Awards Annually and continue to review and develop the awards programme. ▪ Progressing the work on developing a set of quality indicators and implementing regular reporting to the Board. ▪ Select and implement a new incident management software system for the HSS with a view to offering this system to our community based providers in the future.
When	Develop an open disclosure policy and education programme for staff in the HSS. Pilot a new component to the current Quality and Innovation Awards programme. Consider the needs of the HSS and gauge Community Based Providers interest in a new incident management software system and: – Initiate, oversee and evaluate tender process; – Select software option that best suits our requirements; and – Implementation of new software across the HSS.

Consultation and Community Participation

A number of initiatives may warrant formal consultation, such as reconfiguration of services. The Canterbury DHB will identify consultation needs in each instance and meet its obligations in this regard. The NZPHD Act specifies consultation in relation to the following matters:

- The District Strategic Plan;
- Changes to the Annual Plan; and
- The disposal of land.

The Canterbury DHB works closely with Māori and Pacific communities, meets regularly with Manawhenua ki Whaitaha and pacific community groups and holds regular consultation hui to ensure input into the development of strategies and initiatives to improve health care access and delivery. In addition the Canterbury DHB works closely with the ACC on areas such as the development of the Orthopaedics Initiative and the development of an Occupational Health Service and the feedback from this work also feeds into the District Annual Plan.

One of the Canterbury DHB's key objectives is to continue facilitating increased community participation in the assessment, planning and funding of health and disability services in Canterbury.

Regional and National Health Emergency Planning

In the past year the Canterbury DHB has successfully taken part in a number emergency exercises, placing particular emphasis on the involvement and preparation of community health providers. A number of PHOs and community health providers being involved in exercises during 2005.

The Canterbury DHB continues to participate in the South Island Regional Health Emergency Plan in conjunction with the Ministry of Health, St John Ambulance and the other South Island DHBs. This Plan covers a multi-DHB response to any emergency. The Canterbury DHB also maintains its own major incident and emergency plans identifying how essential health services will continue to be delivered in the event of a national health-related emergency.

In response to National Pandemic Planning the Canterbury DHB has taken part in a cooperative planning process involving:

- Public Health
- Primary Care
- Hospital Services
- Rural Health Services
- Community Nursing Services
- Civil Defence Emergency Services
- Information Services
- Local Territorial Authorities and other relevant agencies.

The Canterbury DHB Influenza Pandemic Plan is under development (as at 1 March 2006) and includes cooperation and input from the above organisation. When complete the Plan will be based on a commitment by the participants that they can achieve the aims and objectives at a practical level.

4.2 Funding Health and Disability Services

4.2.1 Service Coverage

Within available resources, the Canterbury DHB will:

- Facilitate timely and equitable access to appropriate health services, in accordance with Crown Funding Agreement requirements
- Undertake service development to ensure that the health service outcomes, as outlined in the NZ Health Strategy and the NZ Disability Strategy, are taken into consideration
- Fund in 2006/2007 a range of services similar to those funded in 2005/2006.
- Ensure, where appropriate, that the Nationwide Service Framework is applied when entering into service agreements, including utilising nationally consistent service specifications and/or prices.
- Ensure that the service coverage requirements of the Operational Performance Framework and Service Coverage Schedule requirement are met (refer to Attachment E for Exceptions).
- Ensure that ring-fenced mental health funding is spent funding mental health services (including alcohol and other drug services).

The Canterbury DHB is working to foster the development of Māori capacity for meeting the health needs of Māori. As with other DHBs, Canterbury provides Māori health and disability services via a mixture of explicit Māori health funding and funding allocated to mainstream services. A process is underway to revise indicators of performance as part of the revision of the DHB's Māori Health Plan.

The Canterbury DHB is working within national and regional arrangements relating to the funding impact of Inter-District Flows (IDFs).

4.2.2 Service Delivery

Volume Schedules for services to be provided in 2006/2007 are detailed in Attachment D.

4.2.3 Service Monitoring and Evaluation

Financial management of the Canterbury DHB is organised into three sections:

- Overall Canterbury DHB financial management (including subsidiaries);
- Funding; and
- In-house provider.

The purpose of the above separation is to provide transparency between the financial performance of the two key functions of the Canterbury DHB (the funding and the in-house provider) while keeping an overall view of the whole organisation and related subsidiaries. Separate financial and activity reports are prepared for each of the above three sections monthly, to facilitate monitoring at management level as well as to the Board's Finance Audit and Risk Committee (FARC).

A comprehensive Risk Register has been developed to identify the financial and non-financial risks for both the Canterbury DHB in-house provider and externally funded providers. The Canterbury DHB continues to enhance systems to manage both financial and non-financial service risks.

The Canterbury DHB will actively monitor and assess the quality of services provided by both the Canterbury DHB in-house provider (HSS) and the externally funded providers; via service agreements. Monitoring includes appropriate procedures for reporting adverse incidents as well as routine reporting against standards (such as Health and Disability Safety Standards 2001) and processes. In addition, the Canterbury DHB monitors provider service quality through a programme of routine quality audits, service reviews and issues-based audits.

Activity in HSS Mental Health Division will continue to have a focus on quality of service delivery including specific interventions for service users such as: regular review of treatment and support processes (including risk management plans), individual crisis plans for long term patients, relapse prevention plans and consumer outcomes.

The Canterbury DHB's ethnicity data collection methods are the subject of work particularly at Christchurch Hospital, The Princess Margaret Hospital and with PHOs, and relates to the policy and implementation work noted earlier in this and previous DAPs.

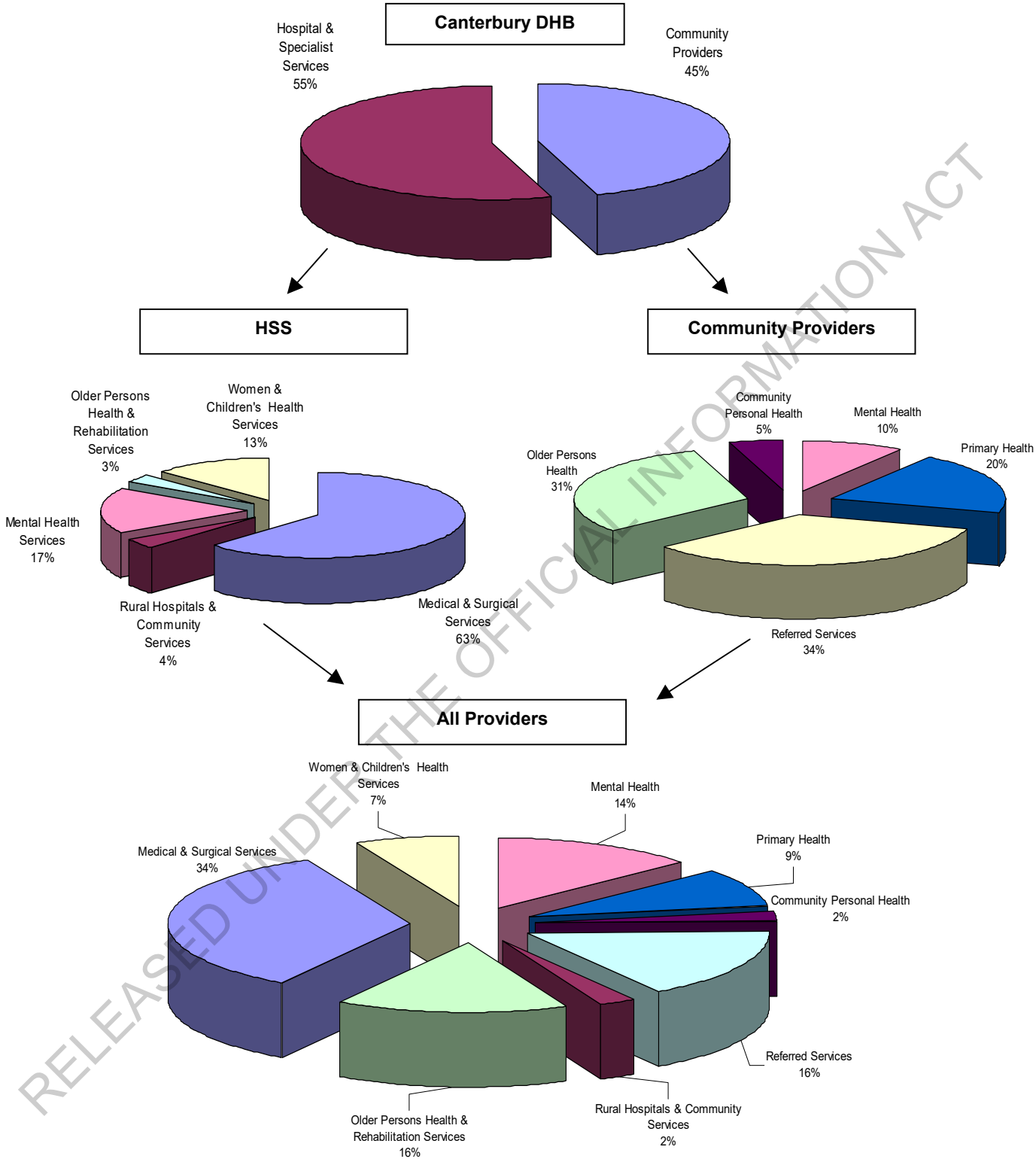
Collaboration with the SISSAL, and Health Payments Agreements and Compliance (HealthPAC) in collecting, summarising and analysing contract information is vital to the ongoing success of the Canterbury DHB in providing relevant information for decision making.

Service monitoring is in line with individual contractual arrangements, and new requirements contained in the Crown Funding Agreement, Service Coverage Document and Operational Policy Framework, will be worked into new service agreements over time.

As in 2005/2006 a Service Level Agreement will be put in place between the Canterbury DHB's Planning and Funding (P&F) and HSS divisions to monitor internal performance of DHB funded service agreements. The performance of the HSS is the subject of a monthly report by P&F to the Hospital Advisory Committee (HAC).

4.2.4 Current Funding Allocations

Together with contracting processes including the use of Request for Proposal processes the Canterbury DHB works hard to treat provider arm and NGO providers equitably. The following diagram indicates how current funding is allocated by the Canterbury DHB:



4.2.5 Additional Funding Responsibilities

The major funding changes expected in 2006/2007 will be limited to an additional $1.6m in new Blueprint funding for Mental Health Services. The MoH has not identified any other additional funding for the Canterbury DHB for health services in 2006/2007.

4.2.6 Future Funding Pressures

The factors driving funding pressures faced by the Canterbury DHB are similar to those faced by other DHBs, namely reflecting the pressure to increase both volumes and prices paid to providers. However with the Canterbury DHB's current funding being estimated at above its 'equitable' funding share, the Canterbury DHB will receive a lower than average DHB sector funding increase from which these pressures must be managed. With lower than average funding increases the Canterbury DHB will face significantly greater funding pressures than those experienced by some other DHBs.

With PBF, benchmark pricing is used in the funding of providers. The Canterbury DHB's current over-target funding is considered to be primarily reflective of higher volume delivery rather than over pricing.

During the transition to PBF equity the Canterbury DHB as a funder of health services will need to continue to:

- Constrain growth in prices to less than the levels indicated by the MoH Consumer Price Index (CPI) adjustments; and
- Re-allocate volumes between discretionary and non-discretionary services to meet demand driven growth, while providing incentives to providers to minimise and manage growth in demand.

As a provider of health services the Canterbury DHB will need to continue to:

- Constrain the growth in the cost of service delivery to enable the provider to deliver the desired mix of services within the available funding; and
- Manage growth in demand for acute hospital services via the ongoing development of the interfaces with primary care and other providers. This will include the ongoing management of the introduction of new treatment regimes and technologies.

The DHB works as part of national forums such as the national pricing programme and on the aged residential care agreement to find better ways of dealing with funding issues.

Summary of HSS Issues

The Canterbury DHBs HSS has a number of specific funding and pricing issues:

- Clinical Training Agency prices do not cover the total cost of training and prices do not take into account nor keep pace with the National staff collective awards increases.
- Brain Injury Rehabilitation Pricing - the DHB's concerns have been raised with the MoH and we are currently preparing to escalate the matter. This largely relates to patients under 65 years of age and therefore is an issue for the HSS and the MoH.
- New Cancer Drug - Impact of new cancer drug has not been included in 2006/2007 IDF charging/washup. This issue will be discussed with the other DHBs.
- MoH support for initiatives such as Late Effects Programme - funding for three years and then exiting. Clinicians and MoH expect DHB to then pick up the funding. The Canterbury DHB will not have the funds nor would it rate this in top five priorities.
- Intellectual Disability/Mental Health - significant issues with DSS MoH re inappropriate placements in Mental Health Services and also inadequate response regarding appropriate placement of Intellectually Disabled patients in community settings.

4.2.7 Service Reconfigurations 2006/2007

As discussed throughout this document, while we continue to receive increases in funding, the level of those increases will be less than the sector average until our funding is seen to be in line with our population share (transition to equity). The increases we receive are considered to be insufficient to meet projected inflationary pressures and the increasing costs of demand driven services and hence productivity gains have been key in ensuring financial breakeven. Preferences for sources of savings (in descending order) are through:

- Efficiency gains (delivering the same service in more efficient ways);
- Service re-configuration (delivering the same outcomes through the delivery of services in different ways); and
- Service level reductions in access or rate of service delivery.

Service reconfigurations anticipated in 2006/2007 are:

- Implementation of ministerial or national reviews, initiatives or reconfigurations to ensure consistency in systems and process, equity of access and improved health outcomes such as:
  - Review of School Dental Clinics and Dental Services Model of Care;
  - Implementation of Cataract and Orthopaedic Initiatives;
  - Implementation of the NZ Cancer Control Strategy;
  - Continued implementation of the Government's Primary Health Care Strategy; and
  - Ongoing review and allocation of Mental Health Blueprint Funding.
- Implementation of Canterbury DHB reviews, initiatives or re-configurations to address fitness of the organisation, ensure efficiency, best practise, quality and safety, improved health outcomes and sustainability of service delivery. In addition to those already reflected in the document, these would include:
  - Review the interface between General Practice and the Hospital Emergency Department to ensure patients are managed in the most appropriate setting. This would include review of the current Acute Management Project;
  - Continued implementation of the Improve the Patient Journey project to review patient processes, reduce unnecessary waits and delays and to improve patient flows;
  - Implementation of the Healthy Ageing Integrated Support Strategy;
  - Implement the recommendations of the Child and Adolescent Family Mental Health Services Review;
  - Implement the recommendations of the Review of the Model of Care in Adult General Mental Health Services;
  - Implementation of the Review of Health Services in Ashburton (Ashburton Model of Care Project);
  - Progression of the Primary Health Care Strategy;
  - Completion and implementation of the Community Laboratory Review, including changes to funding mechanisms and demand management;
  - Completion and implementation of the Palliative Care Review;
  - Reconfiguration of service delivery models to match the best location for the provision of treatment and care with a full health service review which will information the completion of a facilities master plan; and
  - Review of support services processes to align to best practices eg: warehousing, distribution and purchasing processes.
- Consideration of service reconfigurations or service level reductions to achieve a breakeven position beyond 2008/2009:
  - Work with other DHBs to reduce the costs to our organisation on a national and regional level
  - Consider the provision of services to allow hospitals to focus only on emergency and serious illness
  - Consider models of care where services are (or could be) provided in the community
  - Consider the clinical and financial sustainability of some rural and metropolitan services
  - Review staff skill mix in obstetric services and consider alternative models of care
  - Consider reductions in non-essential services to levels in line with other DHBs and manage these costs
  - Identify those services that are least cost effective and consider alternative models of care.
  - Establish service benchmarks with other DHBs to identify services not funded by other DHBs.

Some reviews will be implemented in 2006/2007, while others will be in preparation for changes and developments in the 2007/2008-year and beyond. Further detail with regard to operational efficiency and productivity initiatives is provided in the Canterbury DHB's DSP.

Service reconfigurations will involve consultation with hospital or community based service providers, to determine appropriate solutions that best meet the needs of the Canterbury DHB's community. These solutions will then be actioned to meet the Canterbury DHB's adjusted funding levels. Where service reconfigurations are in the area of Mental Health the ringfence requirements will be maintained and reconfiguration processes will comply with Section 5 of the Operational Policy Framework.

5 MANAGING FINANCIAL RESOURCES

5.1 Managing Within Operating Budget

Canterbury DHB will receive a net funding increase of approximately 2.9% for 2006/2007 from the government. The funding increase has an efficiency factor built in. This means that, all things being equal, DHBs are required to be more efficient so as to operate within the funding received.

Canterbury DHB faces significant financial pressures each year and the coming years present additional pressures as the flow-on implication of the nurses pay settlement on other Canterbury DHB's occupational groups and community providers are expected. The significant increase in cost of cancer drugs, regulatory and legislative compliance costs, rising emergency department attendances together with ongoing service demands both in the community and hospital settings are financial risks facing the DHB.

The Canterbury DHB is budgeting for a deficit of $2.5M in 2006/2007 as a result of additional funding for the out-years financial impact of PSA MECA being paid 'in advance' to the DHB in 2005/2006. The Canterbury DHB will need to recognise this 'advance' funding in its 2005/2006 accounts, while the cost will only be incurred or recognised in out-years accounts. Hence the DHB will be expecting to report a 'surplus' for 2005/2006 equivalent to this 'advance' funding and accordingly will be budgeting for a deficit for 2006/2007 of a similar amount – the impact being $2.5M. Once this mis-matching between revenue and expenditure is taken into account the Canterbury DHB is in effect budgeting for a 'breakeven' position - an objective expected by the Minister of Health.

Break-even has been achieved through partial funding of the financial impact of legislative changes eg holiday's Act and FRS3, but some risk remain in 2006/2007. The Canterbury DHB will seek to engage in discussions with the MoH to ensure any further directives or guidelines issued can be implemented in a fiscally sustainable manner. The budget is also dependent on the achievement of additional efficiencies, the need to undertake a number of infrastructure and service reconfigurations to align services to the funding and realisation of 'gain on sale' from the approved disposal of surplus assets.

The following sets out the summary budget estimations for 2006/2007:

Table 1.

	$M (GST excl)
Overall Net Increase in Funding/Revenue (include non-Base)	42.8
Less:	
Increase in Expenditure (external and CDHB Provider service)	(49.9)
Incremental Interest, Depreciation and Capital Charge	(10.2)
Estimated 2006/07 Operating Shortfall	**(17.3)**
Estimated Annual Efficiencies/Revenue Enhancement	14.8
Budget Net Result After Efficiencies - Surplus/(Deficit)	**(2.5)**

5.1.1 Outyears Scenario

As an overfunded DHB it is expected that the increase in funding Canterbury DHB will receive over the next few years will be minimal. The MoH has signalled that the expected funding increase for

Canterbury DHB for outyears will be 2.9% for 2007/2008 and 2.1% for 2008/2009. The gap between funding increase and expected 'normal' expenditure growth to maintain existing services is significant.

In the past two years Canterbury DHB had relied on 'gain on sale' from approved surplus assets to address some of the financial operating gap and this will continue for 2006/2007 and 2007/2008. Whilst the DHB's first approach will be to continue to seek to re-configure services and change how services are delivered these are unlikely to yield a level of efficiencies to eradicate the operating gap. Hence the DHB may need to reduce services to enable a breakeven position in 2008/2009 as outlined in Table 2.

Table 2. Outyears Financial Scenario with service reductions to meet funding shortfall

	2006/07 $M	2007/08 $M	2008/09 $M
Estimated Net Annual Funding/Revenue Increase	42.8	27.5	19.0
Less: Estimated Net Annual Cost Increase	(60.1)	(37.0)	(36.5)
Estimated Annual Operating Shortfall	**(17.3)**	**(9.5)**	**(17.5)**
Estimated Annual Efficiencies	14.8	9.5	10.1
Estimated Annual Value of Incremental Service Reductions	-	-	7.4
Annual Budget Financial Results after Service Reductions	**(2.5)**	**-**	**-**

Notes: Table 2 includes forecast financial impact of asset revaluation and the partial funding for increased capital charge and depreciation arising from the asset revaluation. The "Estimated Annual Projected Costs" take into account service reductions are likely to occur in a 'phased' manner.

A full health service review is to be undertaken, with a view to completing our facilities master plan. There will be a need for further consultation with our community as DAPs are reshaped to make efficiency gains and where appropriate service reductions.

The Canterbury DHB has also developed a draft Asset Management Plan (AMP)[13] which outlines its capital intentions over the next ten years. Financial implications of the AMP, if any, have been included in the financial statements of the Canterbury DHB's DSP. This includes the need to consider options for the replacement of the Riverside Block of Christchurch Hospital in the latter years of this Strategic Plan period.

5.1.2 Key Financial Assumptions and Risks

The key assumptions to achieve the breakeven budget for 2006/2007 include the following:

- Baseline funding as per Minister of Health's funding advice;
- Net Inter-District flow volumes and revenue will be fully realised;
- Financial impact associated with the changes to legislative, regulatory and compliance policy changes is cost neutral to the DHB;
- Financial impact associated with changes to DSS boundaries and any further contracts/services being devolved by MoH is cost neutral to the DHB;
- Collective employment agreements are settled on average at the funds available after step and committed wage increases have been deducted from the 2006/2007 inflation funding received. Additional costs to move to national rates per government directive, if any, will be cost neutral to the DHB;
- No significant change to previous year's service contract volumes, except where additional funding has been provided to the DHB (e.g. Mental Health ring-fence funding and/or Orthopaedic Initiative);

[13] The Canterbury DHB's draft Asset Management Plan will be updated in October 2006 in accordance with MoH regulations.

- Pharmac budget for community referred spending is as per agreed by DHBs and forecast savings on stat dispensing and other initiatives are achieved;
- Interest rates are within Treasury's forecast;
- Average increase in non-employee expenditure is within CPI recognising efficiencies that will be required in this area, including blood products;
- Spending of national haemophilia pool will be similar to amounts as advised to the DHBs;
- Growth in acute medical and acute mental health volumes will be minimal;
- Costs associated with pandemic planning, including additional stock and/or obsolescence and capital charge will be fully funded by the Crown;
- Efficiency initiatives, and service reconfigurations are achieved as planned;
- Projected proceeds from approved sale of surplus assets are realised as planned;
- Capital charge will not apply to assets donated after 1 July 2005 and will remain at 8%; and
- The reduction in funding transitional funding pool is equivalent to demographic funding increases.

The over-riding risk to achieving the financial performance relates to the key assumptions above not holding true and the risks around wage increase expectations for the health sector, both internal staff and external providers, following the national employment collective settlements. Other risks include the inability to implement identified service reconfiguration, facility realignment or service reductions, according to planned timeframes and the inability to achieve efficiencies and address cost over-runs internally.

5.1.3 Property Valuations

In June 2003, the Canterbury DHB's properties were revalued as part of the Financial Reporting Standards Number 3 (FRS3) requirements. The revaluation resulted in a write-up of asset value of approximately $77M.

We have assumed that Canterbury DHB will undertake a revaluation of its property related assets as at 30 June 2006 and an estimated financial impact has been incorporated in the forecast financial statements. We have also assumed that the additional capital charge and depreciation arising from this revaluation exercise will only be partially funded in accordance with the methodology as advised to DHBs by the Ministry of Health. The partial funding methodology is likely to result in the need for additional efficiencies by the DHB to meet its financial target.

5.1.4 Business Cases

With the need to operate within the available funding, service reconfigurations and facility realignments are likely to take place and service reductions may need to be included to ensure breakeven in the outyears. The Minister of Health's approval will be obtained in accordance with the government's guidelines.

Business cases relating to information technology and other significant capital projects will include Regional Capital Committee, Ministry of Health and National Capital Committee review and endorsement, where appropriate. Business cases that will be presented in 2006/2007 include the replacement of the outdated legacy rostering, payroll, and human resources information system (HRIS) and some of the initiatives outlined in Section 4.2.7.

5.1.5 Capital Expenditure

The estimated capital expenditure budget for 2006/2007 is $36M and consists of:

- $11M for balance of Burwood Hospital Stage II Redevelopment.
  This capital project was approved by the Minister early in 2005 and commenced in mid 2005.
- $25M for normal asset replacement and priority new equipment.
  Details for the $25M will be established following an internal prioritisation process involving clinicians and management. This process is expected to be completed in late June 2006. Some of the key items are outlined in the draft AMP.

Estimated funding for the capital expenditure will be:

- $9M additional credit facility for the Burwood Hospital Stage II Redevelopment
- $27M from operating cashflow

Detailed requirements of recent Building Act changes are yet to be finalised by Territorial Local Authorities and these may alter the priority and scope of future projects. Current 2008/2009 estimates include building replacement as part of that legislative compliance and the estimated capital expenditure for 2008/2009 is $85.5m. Several projects will require internal resourcing and prioritisation as well as regional and national prioritisation. Funding for these significant projects will be discussed with the Ministry of Health when the full implications of legislative requirements are known.

The proposed disposal of significant surplus assets over the next three years includes the Canterbury DHB owned sites at Hanmer Springs, Hillmorton Hospital and the old Christchurch Women's Hospital. Both the Board and the Minister of Health's approval has been received for the Hanmer and Hillmorton site disposals and a business case will be put forward for the proposed disposal of the Christchurch Women's Hospital site as part of the due process. The financial assumptions include the estimated proceeds from surplus asset sale/s expected in 2006/2007 and outyears.

5.1.6 Debt and Equity

The Canterbury DHB's estimated total term debt is expected to remain at $79M as at June 2006 and increase to $105M by June 2009. It is assumed that the available cashflow from depreciation funding will be applied to fund capital expenditure, thus deferring the need to increase loans until the major property rebuilding projects in 2008/2009 and out years.

The current approved credit facility available through the Crown Health Financing Agency is approximately $130M. In addition working capital of approximately $50M is financed from a private bank.

The Canterbury DHB is complying with the banking covenants required of its loans. The key covenants together with forecast ratios for 2006/2007 based on the forecast financial statements are:

Required		**Forecast Ratio**
Interest cover ratio:	**>2.75 times**	**Approx 7.2 times**
Debt/Debt plus Equity ratio:	**<50%**	**Approx 27.2%**

5.1.7 Efficiencies and Service Reconfigurations

In budgeting for break-even results, Canterbury DHB will be planning to implement and achieve a number of efficiencies and/or service reconfigurations to close the operating gap. These have been outlined earlier in this plan. Examples of the initiatives to be undertaken include:

- Ongoing HSS non-clinical support services reviews and consolidations;
- Implementation of 'Improving the Patient Journey' and 'Patient Flow' projects;
- Hospital and community laboratory services review;
- Review and alignment of hospital sites to service needs;
- Clinical and non-clinical consumables usage review;
- Review of processes by which new treatment regimes could be introduced;
- A full health services review and completion of facilities masterplan matching best location for the provision of treatment and care; and
- Collaborative arrangement with external providers on elective services.

In addition, gain on sale from the disposal of surplus assets, as approved by the Minister of Health, is an integral part of the efficiency target. Some of the initiatives are longer term and are only expected to generate major savings in future years. Early planning is essential to ensure the implications of the reduction in transitional funding in outyears are adequately addressed.

The initiatives will have input from clinicians, where appropriate, to ensure patient safety and related issues are adequately considered and factored in the decision making process.

5.1.8 Accounting Policies

The accounting policies adopted are consistent with those in the prior year. A full statement of accounting policies is contained in the Canterbury DHB's 2006/2009 Statement of Intent.

5.2 Forecast Financial Statements - Years Ending 30 June 2006/07 to 2008/09

5.2.1 Forecast Group Statement Financial Performance

	2004/05 Actual $'000	2005/06 Forecast $'000	2006/07 Forecast $'000	2007/08 Forecast $'000	2008/09 Forecast $'000
Operating Revenue					
MoH Revenue	900,187	960,049	994,542	1,024,171	1,046,124
Patient Related Revenue	27,851	28,445	29,298	29,884	32,036
Other Revenue	14,475	18,295	25,754	23,003	17,857
Total Operating Revenue	942,513	1,006,789	1,049,595	1,077,058	1,096,017
Operating Expenditure					
Employee Costs	369,683	388,217	417,600	438,660	446,273
Treatment Related Costs	98,947	104,216	101,748	101,740	102,757
External Providers & IDF	352,053	400,596	410,229	420,726	423,710
Strategic Investment Fund	1,000	1,000	1,000	-	-
Non Treatment Related & Other Costs	54,905	51,411	52,477	51,522	51,517
Total Operating Expenditure	876,588	945,440	983,054	1,007,648	1,024,257
Result before Interest, Depn & Cap Charge	65,925	61,349	66,540	69,410	71,760
Interest, Depreciation & Capital Charge					
Interest Expense	(4,188)	(5,653)	(6,696)	(7,446)	(8,196)
Capital Charge Expenditure	(21,862)	(15,348)	(18,072)	(16,892)	(16,892)
Depreciation	(39,519)	(37,848)	(44,272)	(45,072)	(46,672)
Total Interest, Depreciation & Capital Charge	(65,564)	(58,849)	(69,040)	(69,410)	(71,760)
Net Operating Results	**361**	**2,500**	**(2,500)**	**(0)**	**(0)**

5.2.2 Summary of Revenue and Expenses by Output Class

Funding Arm

	2004/05 $'000	2005/06 $'000	2006/07 $'000	2007/08 $'000	2008/09 $'000
Revenue					
MoH revenue	869,927	926,517	954,565	982,248	1,002,875
Total Revenue	869,927	926,517	954,565	982,248	1,002,875
Expenditure					
Other - Personal Health	627,125	658,612	679,711	699,424	714,112
Other - Mental Health	102,896	108,219	110,452	113,655	116,042
Other - Disability Support	135,272	154,170	160,538	165,193	168,661
Other - Public Health	341	1,778	-	-	-
Other - Maori Health	883	406	432	444	454
Other - Governance & Admin	3,291	3,332	3,432	3,532	3,606
Total Expenditure	869,808	926,517	954,565	982,248	1,002,875
Net Surplus/(Deficit)	**119**	-	-	-	

Governance & Funder Admin

	2004/05 $'000	2005/06 $'000	2006/07 $'000	2007/08 $'000	2008/09 $'000
Revenue					
MoH revenue	3,291	3,332	3,432	3,532	3,606
Total Revenue	3,291	3,332	3,432	3,532	3,606
Expenditure					
Personnel	2,085	2,369	2,436	2,507	2,560
Depreciation	16	18	24	24	24
Interest & Capital charge					
Other	875	945	972	1,001	1,022
Total Expenditure	2,976	3,332	3,432	3,532	3,606
Net Surplus/(Deficit)	**315**	-	-	-	-

Provider Arm

	2004/05 $'000	2005/06 $'000	2006/07 $'000	2007/08 $'000	2008/09 $'000
Revenue					
MoH revenue	543,724	555,121	579,881	599,913	618,808
Patient Related Revenue	27,851	28,445	29,298	29,884	32,036
Other	14,475	18,295	25,755	23,003	17,857
Total Revenue	586,050	601,861	634,934	652,800	668,701
Expenditure					
Personnel	367,598	385,848	415,164	431,153	443,713
Depreciation	39,503	37,830	44,248	45,048	46,648
Interest & Capital charge	26,045	21,001	24,768	24,338	25,088
Other	152,977	154,682	153,254	152,261	153,252
Total Expenditure	586,123	599,361	637,434	652,800	668,701
Net Surplus/(Deficit)	**(73)**	**2,500**	**(2,500)**	-	-

In House Elimination

	2004/05 $'000	2005/06 $'000	2006/07 $'000	2007/08 $'000	2008/09 $'000
Revenue					
MoH revenue	(516,755)	(524,921)	(543,336)	(561,522)	(579,165)
Total Revenue	(516,755)	(524,921)	(543,336)	(561,522)	(579,165)
Expenditure					
Other	(516,755)	(524,921)	(543,336)	(561,522)	(579,165)
Total Expenditure	(516,755)	(524,921)	(543,336)	(561,522)	(579,165)
Net Surplus/(Deficit)	-	-	-	-	-

Consolidated

	2004/05 $'000	2005/06 $'000	2006/07 $'000	2007/08 $'000	2008/09 $'000
Revenue					
MoH revenue	900,187	960,049	994,542	1,024,171	1,046,124
Patient Related Revenue	27,851	28,445	29,298	29,884	32,036
Other	14,475	18,295	25,755	23,003	17,857
Total Revenue	942,513	1,006,789	1,049,595	1,077,058	1,096,017
Expenditure					
Personnel	369,683	388,217	417,600	433,660	446,273
Depreciation	39,519	37,848	44,272	45,072	46,672
Interest & Capital charge	26,045	21,001	24,768	24,338	25,088
Other	506,905	557,223	565,455	573,988	577,984
Total Expenditure	942,152	1,004,289	1,052,095	1,077,058	1,096,017
Net Surplus/(Deficit)	**361**	**2,500**	**(2,500)**	-	-

5.2.3 Forecast Group Statement Financial Position

	30/06/05 Actual $'000	30/06/06 Forecast $'000	30/06/07 Forecast $'000	30/06/08 Forecast $'000	30/06/09 Forecast $'000
Public Equity					
Opening Equity	199,344	251,705	243,205	226,205	211,705
Equity Repayment		(11,000)	(14,500)	(14,500)	
Net Result for the period	361	2,500	(2,500)	(0)	(0)
Total Public Equity	**199,705**	**243,205**	**226,205**	**211,705**	**211,705**
Current Assets					
Cash & Bank (OD)	10,109	(269)	3	(715)	(43)
MoH Debtor	8,522	8,522	8,522	8,522	8,522
Other Debtors & Other Receivables	7,312	8,000	8,000	8,000	8,000
Prepayments	507	600	600	600	600
Stocks	6,594	7,000	7,000	7,000	7,000
Total Current Assets	33,044	23,853	24,125	23,407	24,079
Current Liabilities					
Creditors & Accruals	71,653	74,509	69,509	59,509	66,509
Capital charge payable	7,371	4,500	4,500	4,500	4,500
GST	2,632	3,000	3,000	3,000	3,000
Interest Accrual	369	400	400	400	400
Staff Entitlement	66,929	67,914	67,914	59,624	59,624
Short Term Borrowings					
Total Current Liabilities	148,954	150,323	145,323	127,033	134,033
Working Capital	(115,910)	(126,470)	(121,198)	(103,626)	(109,954)
Investments	311	311	311	311	311
Restricted Assets - Trust Fund	8,405	8,405	8,405	8,405	8,405
Fixed Assets	391,767	446,609	430,337	408,265	424,593
Total Non Current Assets	400,483	455,325	439,053	416,981	433,309
Term Staff Entitlement	(6,218)	(7,000)	(7,000)	(7,000)	(7,000)
Term Loans	(78,650)	(78,650)	(84,650)	(94,650)	(104,650)
Total Non Current Liabilities	(84,868)	(85,650)	(91,650)	(101,650)	(111,650)
Net Assets	**199,705**	**243,205**	**226,205**	**211,705**	**211,705**

5.2.4

Movement in Public Equity

	30/06/05 Forecast $'000	30/06/06 Forecast $'000	30/06/07 Forecast $'000	30/06/08 Forecast $'000	30/06/09 Forecast $'000
Public Equity					
Opening Equity	199,344	199,705	243,205	226,205	211,705
Add/(Less):					
Equity Injection / (Repayment)	-	(11,000)	(14,500)	(14,500)	-
Revaluation of Property		52,000			
Net Result for the period	361	2,500	(2,500)	(0)	(0)
Total Public Equity	**199,705**	**243,205**	**226,205**	**211,705**	**211,705**

Forecast Group Statement Cashflow

	2004/05 Actual $'000	2005/06 Forecast $'000	2006/07 Forecast $'000	2007/08 Forecast $'000	2008/09 Forecast $'000
Cashflows from Operating Activities					
Cash provided from:					
MOH Receipts	905,739	960,049	994,542	1,024,171	1,046,124
Other Receipts	46,670	39,452	46,053	47,887	49,893
	952,409	999,501	1,040,595	1,072,058	1,096,017
Cash applied to:					
Employee Costs	354,144	386,450	417,600	441,950	446,273
Supplies & Expenses	498,730	554,866	570,455	583,988	570,984
Capital Charge Payments	20,301	18,219	18,072	16,892	16,892
Finance Costs	4,023	5,622	6,696	7,446	8,196
Taxes Paid	1,934	(368)	-	-	-
	879,132	964,789	1,012,822	1,050,276	1,042,345
Net Cashflow from Operating Activities	**73,277**	**34,712**	**27,772**	**21,782**	**53,672**
Cashflows from Investing Activities					
Cash provided from:					
Sale of Assets	70	7,110	17,000	10,000	
Interest Received	1,268	3,000	-	-	-
	1,338	10,110	17,000	10,000	-
Cash applied to:					
Advance to JV/Trust Investments	645	-	-	-	-
Purchase of Assets	47,076	44,200	36,000	28,000	63,000
	47,721	44,200	36,000	28,000	63,000
Net Cashflow from Investing Activities	**(46,383)**	**(34,090)**	**(19,000)**	**(18,000)**	**(63,000)**
Cashflows from Financing Activities					
Cash provide from:					
Equity Injection					
Loans Raised	-	-	6,000	10,000	10,000
	-	-	6,000	10,000	10,000
Cash applied to:					
Loan Repayment	15,950				
Equity Repayment re FRS-3		11,000	14,500	14,500	-
	15,950	11,000	14,500	14,500	-
Net Cashflow from Financing Activities	**(15,950)**	**(11,000)**	**(8,500)**	**(4,500)**	**10,000**
Overall Increase/(Decrease) in Cash Held	10,944	(10,378)	272	(718)	672
Add Opening Cash Balance	(835)	10,109	(269)	3	(715)
Closing Cash Balance	**10,109**	**(269)**	**3**	**(715)**	**(43)**

6 MEASURING SUCCESS

6.1 Consolidated List of Indicators of DHB Performance (IDP)

The MoH has established a set of DHB Accountability Indicators to focus DHBs on priority health objectives identified in the NZ Health Strategy, monitor activity and compare DHB performance, and to hold DHBs accountable. The Canterbury DHB is committed to performance improvement, both as a funder of services and as a provider of services. Progress toward achieving the Accountability Indicator targets will be reported as part of Canterbury DHB's quarterly performance reports.

Accountability Indicators
The accountability indicators reflect the accountability that Canterbury DHB has for securing improved health status for its population. As responsibility for funding some services is yet to be devolved to DHBs, there are indicators where the DHB's ability to influence the outcome is not through direct funding but through influencing other funders.

Due to the evolving nature of DHBs and their responsibility for funding, the actions taken by the Canterbury DHB to influence the direction of performance in relation to specified targets is of as much importance as the match between actual performance and the indicator itself.

Qualitative Accountability Indicators
Performance against the qualitative indicators will be measured on the basis of reporting deliverables rather than numeric targets. Performance will be assessed not only on provision of reports that meet the stated content requirements but also compliance with the reporting timeframes.

Quantitative Accountability Indicators
The majority of the quantitative indicators are aimed at measuring DHB performance in addressing cardiovascular disease, diabetes, oral health and well child services – four priority areas within the New Zealand Health Strategy.

For each of the quantitative indicators set out in this plan targets have been set for the 2006/2007 year. The setting of those targets has been based on:

- Expectations expressed by the MoH;
- The latest national data; and
- The latest Canterbury DHB specific data

It should be noted that for many indicators historical data is poor. Consequently there are some indicators for which a target is unable to be set at this stage. It is the intention of the Canterbury DHB to gather the required baseline data to allow for targets to be set for future plans. It is noted that the MoH will be using results outside 90% or 99% confidence intervals to trigger further analysis for a number of indicators.

Indicator results and targets have been stated for three population groupings, Māori, Pacific People and Other[14]. The overall targets for the Canterbury DHB reflect these ethnic specific results and the demographic characteristics of the Canterbury region.

The intent of this section is to recognise that Canterbury DHB understands the need to look at the health of the Canterbury DHB population although many factors affecting health care directly is outside its control.

The Canterbury DHB's Accountability Indicators for 2006/2007 follow and are in addition to:

- Existing reporting requirements under service contracts;
- Information requirements contained in the Operational Policy Framework;
- The Balanced Scorecard for the Provider Arm; and
- Monthly financial reporting to the MoH's DHB Funding and Performance Directorate.

[14] For more information on Ethnic Groupings, refer to the MoH, Ethnicity Data Protocols for the Health and Disability Sector, 2004.

IDP No.	Description	Target/Deliverable	Reporting Period
EFFECTIVENESS			
HKO-01	Local Iwi/Māori are engaged and participate in DHB decision-making and the development of strategies and plans for Māori health gain	A quantitative report providing: 1 The number of PHOs with Māori Health Plans (MHPs) that have been agreed to by the DHB as a percentage of the total number of established PHOs. **Target:** 100% of PHOs will have MHPs 2 Total number of DHB Board members that have undertaken Treaty of Waitangi training as a percentage of the total number of DHB members A qualitative report describing: 3 Achievements against the MoU between a DHB and its local Iwi/Māori health relationship partner, including other initiatives achieved that are an outcome of engagement between the parties and a copy of the MoU. 4 How (mechanisms and 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 (including a section on PHOs). *Either* 5 How MHPs are being implemented by the PHOs and monitored by the DHB (include a list of the names of the PHOs with MHPs) *Or* 6 Progress in the development of MHPs for newly established PHOs, including a list of the names of these PHOs. All newly established PHOs will have Māori Health Plans 7 When Treaty of Waitangi training (including any facilitated by the Ministry) has taken, or will take place for Board members.	Six-monthly in Q2 and Q4.
POP-12	Progress towards the national target of 95% of two year olds fully immunised	**A) DHB NIR Enrolled Populations** 1. The number of newborns born and enrolled during the reporting period as a percentage of the number of children born during the reporting period*. 2. The number of newborns born and enrolled during the reporting period of each ethnicity as a percentage of the number of children born during the reporting period of each ethnicity (Māori, Pacific, Asian, Other). 3. The number of newborns born and enrolled during the reporting period of each level of deprivation as a percentage of the number of children born during the reporting period of each deprivation quintile. 4. The number of children on the NIR less than two years of age with an 'Opt-Off' status as at the report date as a percentage of the number of children less than two years of age on the NIR as at the report date. **Target:** The DHB will report actual performance during 2006/2007 for A1-4. Targets will be established from 2006/2007 baselines. **B) Progress towards the national target of 95% of two year olds fully immunised** The DHB will identify a four to six percent improvement in overall immunisation coverage, if its current annual immunisation coverage is less than 90 percent. The DHB will report coverage quarterly using (where possible) the following two reporting periods: a) The most recent quarter b) The previous 12 months.	The indicator will be measured quarterly and annually.

		NIR Immunisation coverage at 6, 12, 18 and 24 months of age: 1. The number of children on the NIR up-to-date with immunisation on the day they turned a specified age (6, 12, 18, 24 months) during the reporting period as a percentage of the number of children on the NIR who turned a specified age (6, 12, 18, 24 months) during the reporting period. **Target:** 6&12 months 86-91% 18&24 months 85-88% 2. The number of children on the NIR of each ethnicity (Māori, Pacific, Asian, Other) up to date with immunisation on the day they turned a specified age (6, 12, 18, 24 months) during the reporting period as a percentage of the number of children on the NIR of each ethnicity who turned a specified age (6, 12, 18, 24 months) during the reporting period. **Target:** Ethnicity not currently reliably identified 3. The number of children on the NIR of each deprivation quintile up to date with immunisation on the day they turned a specified age (6, 12, 18, 24 months) during the reporting period as a percentage of the number of children on the NIR of each deprivation quintile who turned a specified age (6, 12, 18, 24 months) during the reporting period. **Target:** Ethnicity not currently reliably identified 4. The number of children on the NIR up-to-date with MMR immunisation on the day they turned 18 months during the reporting period as a percentage of the number of children on the NIR who turned 18 months during the reporting period. **Target** 85-88%% Note: This target is within the 'achieved' rating as advised within the IDPs.	
SER-02	Care Plus Enrolled Population	The number of each PHO's Care Plus enrolled population as a percentage of each PHO's expected Care Plus enrolled population. This indicator applies only to persons enrolled in PHOs, and excludes casual visits (Data Source: MoH via HealthPAC). CarePlus + High Use Health Card enrolled population is 5% **Target:** 100% of the eligible population enrolled	Quarterly. PHOs are required to report quarterly.
SER-03	Primary Health Organisations participating in the PHO Performance Management Programme	The number of PHOs participating in the PHO Performance Management Programme as a percentage of the total number of PHOs that have been operational for more than one quarter. Data Source: MoH via HealthPAC. **Target:** 100%	Six-monthly at the end of Q2 and Q4.
PAC-02	Engagement and participation of Pacific peoples in DHB decision-making and the development of strategies and plans that include goals for Pacific health gain	A qualitative report demonstrating: 1. How Pacific peoples are engaged and participate in DHB decision-making, on equity, accessibility and resource allocation, at a governance and management level in the DHB organisation. 2. The development of strategies and plans which include goals for Pacific health gain. 3. The number, purpose and outcomes of any community participation activities that have been conducted during the reporting period. The report includes, as appropriate, information about how Pacific people are engaging with decision-making about the implementation, monitoring and evaluation of service delivery and planning documents, including the following: • DSP, DAP, HNA; • District Pacific Health (DPH) and Disability Action Plan; • DPH and Disability Workforce Development Plan; and • Pacific Provider Development Fund Purchasing Strategy.	Six-monthly in Q2 and Q4.

<table>
<tr><th colspan="4">EQUITY AND ACCESS</th></tr>
<tr><td>HKO-02</td><td>Development of Māori health workforce and Māori health providers</td><td>A quantitative report which completes Table 1 below providing:

1. The number of (i) management, (ii) clinical, (iii) administrative and (iv) other FTEs held by Māori divided by the total numbers of (i) management, (ii) clinical, (iii) administrative and (iv) other FTEs in the DHB respectively.

Table 1.
FTEs Management Administration Clinical Other
Māori workforce #
Non-Māori workforce #
Total workforce #

A qualitative report which includes:
2. A copy of the DHB Māori Health Workforce Plan (or agreed regional Māori Workforce Plan), or the timeframe to complete the Plan.
Either
3. A report on achievements based on key deliverables in the DHB (or Regional) Māori Workforce Plan;
Or
4. If the Plan is being developed, a description of at least two key DHB Māori health workforce initiatives that have been achieved.

If possible, a reporting template based on the key points above will be developed.</td><td>Six-monthly in Q2 and Q4.</td></tr>
<tr><td>HKO-04</td><td>DHBs will set targets to increase funding for Māori Health and disability initiatives</td><td>A report which completes Table 2 below which includes:

1. Actual expenditure on Māori Health Providers by GL code.
2. Actual expenditure for Specific Māori Services provided within mainstream services targeted to improving Māori health by Purchase Unit (PU).
3. Total actual expenditure for Iwi/Māori-led PHOs.
4. Actual expenditure for mainstream PHO services targeted at improving Māori health
5. Total actual expenditure on DHB Māori Workforce or Provider Māori Workforce Development initiatives, which are not funded through the Māori Provider Development Scheme.
6. Where information is available, a comparison between expenditure for the above measures for 2005/06 (in addition to mandatory reporting against 2006/07 expenditure).

Table 2: DHB Māori Expenditure
Measure GL Code PU 2005/06 Actual 2006/07 Actual Variance
Māori health providers
Specific Māori services
Iwi/Māori-led PHOs
Mainstream PHO services
Māori workforce or provider funding
Total expenditure
Projected $8.2m $8.6m</td><td>DHBs to undertake six-monthly reports to the Ministry (not part of the monthly financial reporting template).</td></tr>
<tr><td>POP-01
POP-02
POP-03</td><td>Diabetes
Cardiovascular disease
Stroke</td><td>Outcome 1: Reduced development of contributory risk factors
Indicator: Risk reduction – Obesity
How to measure:
The number of schools using the health promoting schools framework as a percentage of the total number of schools within the DHB (as part of the Healthy Eating Healthy Action strategy).
Target: 33%

Indicator: Risk reduction - Smoking
How to measure:
The number of enrolled persons aged over 14 years with smoking status on record as a percentage of the total number of enrolled persons aged over 14 years. Data source: PHO Performance Monitoring.

Outcome 2: Increased early recognition and response to individuals with chronic conditions</td><td>Annually in Q3.</td></tr>
</table>

		Indicator: CVD Risk recognition **How to measure:** The number of people in each target group who have had their five-year absolute CVD risk recorded in the last five years as a percentage of people in each respective target group. Target groups: 1 Māori/Pacific & Indian subcontinent men >35 years of age 2 Māori/Pacific & Indian subcontinent women >45 years of age 3 European & other men >45 years of age 4 European & other women >55 years of age. Indian subcontinent are defined as level 2 codes 43 Indian and 44 Other Asian as per the ethnicity data protocols for the H&D Sector. Data Source: PHO monitoring framework. **Outcome 3: Slowed rate of progression, reduced incidence of avoidable complications** **Indicator:** Diabetes follow-up **How to measure:** The number of unique individuals with type I or type II diabetes mellitus on a diabetes register, whose date of their free annual check is during the reporting period as a percentage of the expected number of unique individuals to have type I or type II diabetes mellitus, as at the end of the reporting period (Data sources: LDT Annual Report & MoH). **Target:** Māori 80% Pacific 120% Other 84% Total 84% **Indicator:** CVD follow-up - Statins **How to measure:** The number of persons where CVD risk is greater than or equal to 15% where statins have been prescribed in the past year as a percentage of the total number of persons where CVD risk is greater than or equal to 15 % (Data source: DHBs via PHO Performance Monitoring). **Outcome 4: Increased co-ordination across providers, processes and community resources** **Indicator:** Diabetic retinopathy screening **How to measure:** The number of people with type I or type II diabetes mellitus on a diabetes register that have had retinal screening or an ophthalmologist examination in the last two years, and the date of the free annual check is during the reporting period as a percentage of the number of people with type I or type II diabetes mellitus on a diabetes register whose date of their free annual check is during the reporting period (Data source: LDT Annual Report). **Target:** Māori 45% Pacific 38% Other 80% Total 75% **Indicator:** Cardiac Rehabilitation Programme **How to measure:** The number of people who have suffered a CVD event who attend a cardiac rehabilitation outpatient programme as defined below as a percentage of the number of people who have suffered a CVD event who were admitted and discharged from hospital. A CVD event is defined in patients with coronary heart disease, specifically those following an acute myocardial infarction/unstable angina), coronary artery bypass surgery and angioplasty. (2002 NZGG cardiac rehabilitation guidelines) [ICD 10 – 120-125]. **Target:** 50% **Indicator:** Organised Stroke Services **How to measure:** The number of people who have suffered a stroke event who have been admitted to organised stroke services and remain there for their entire	

		hospital stay as a percentage of the number of people who have suffered a stroke event. Stroke event is defined as *'a clinical syndrome typified by rapidly developing signs of focal or global disturbance of cerebral function, lasting more than 24 hours or leading to death, with no apparent cause other than of vascular origin'*. (Stroke Guidelines Nov 2003) [ICD 10 – 161, 163, 164]. **Target:** 100% **Outcome 5: Strengthened self-management capability of individuals, family and whanau** **Indicator:** Diabetes Management **How to measure:** The number of people with type I or type II diabetes mellitus on a diabetes register that had an HBA1c equal, to or less than, 8% at their free annual check during the reporting period as a percentage of the number of people with type I or type II diabetes mellitus on a diabetes register whose date of their free annual check is during the reporting period (Data Source: LDT Annual Report – note they report HBA1c > 8%). **Target:** Māori 39% Pacific 45% Other 20% Total 23%	
POP-05	Oral health – Percentage of children caries free at age five years	The total number of caries free children at the first examination after the child has turned five years, but before their sixth birthday, examined by the DHB School Dental Service as a percentage of the total number of children who have been examined in the age five group, in the year to which the reporting relates. This will be reported by ethnic group (Māori, Pacific, Other) and by fluoridation status of the school area the child attends. Data source: SDS and other oral health providers. **Target**: 51%	Annually in Q3 for the period 1 January to 31 December 2006.
POP-06	Oral health – Mean DMFT score at year eight	The total number of permanent teeth of Year eight children, Decayed, Missing (due to caries) or Filled at the commencement of dental care, at the last dental examination, before the child leaves the DHB SDS divided by the total number of children who have been examined in the Year eight group, in the year to which the reporting relates. This will be reported by ethnic group (Māori, Pacific, Other), fluoridation status of the school area the child attends and mean components of the DMF index (ie. D-teeth, M-teeth, F-teeth). Data source: SDS and other oral health providers. **Target:** 1.6	Annually in Q3 for the period 1 January to 31 December 2006.
POP-08 (a)	Improving the health status of people with severe mental illness (Total)	Access to services The average number of people domiciled in the DHB region, seen per year rolling every three months being reported (the period is lagged by three months) for: • Children and youth aged 0-19 • Adults aged 20-64 • Older people aged 65+ Specified for Māori, Other and in Total, as a percentage of the projected population of DHB region by age and ethnicity. Target: Māori Other Total 0-19 2 2 2 20-64 2.5 2.5 2.5 65+ Targets not established for over 65 as service historically funded by DSS.	Quarterly.
POP-08 (b)	Reducing repeat acute mental health admissions	Methodology	Six-monthly Q2 and Q4.
POP-13	Ambulatory sensitive admissions - Children and older people - discharge rate per 1000 population	A report providing the total number of hospital discharges considered being ambulatory sensitive per 1000 current census populations, projected to 2005/06 using medium projection as at the end of the reporting period.	Six-monthly in Q2 and Q4. Results

		Age bands reported on are children <5, 5 to 14, 15 to 24 and older people 65 to 74. Ethnicity groups Māori, Pacific peoples, Other and in total for all age groups. **Target:** Māori Pacific Other Total 0-4 6.3 8.8 7.0 7.0 5-14 1.4 1.8 1.5 1.5 15-19 1.1 1.1 1.1 1.1 65-74 8.8 9.3 5.4 5.4 Where the DHB region and ethnic rate is significantly greater than the total NZ (all ethnicity rate) national rate (99% confidence interval) the DHB will provide information on the current and planned initiatives likely to influence future outcomes specifically for the effected population group(s).	based on most complete previous 12 months' data.
POP-14	Radiation oncology and chemotherapy treatment waiting times	*Part 1:* Monthly templates that measure the interval between the patient's referral from a medical practitioner to the oncology department, and the beginning of radiation/chemotherapy treatment, are supplied on time and complete from each DHB (or from cancer center for contributing DHBs as agreed). (Including provision of information by DHB of domicile.) **Target:** Start on time – Gp A 100%, Gp B 100% Gp C 98% 2% Gp C wait 4-8weeks 0% Gp A,B, or C wait 8-12 or >12 weeks *Part 2:* Each of the six cancer centre DHBs (Auckland, Waikato, MidCentral, Capital and Coast, Canterbury and Otago) provide a report updating on progress towards ensuring all patients receive oncology megavoltage radiation treatment and chemotherapy treatment according to nationally agreed standards. This report is to be agreed with all the peripheral DHBs whose populations have used the service during the quarter. In the fourth quarter, this report should include information that demonstrates the cancer center has undertaken a data audit of its waiting time data and is satisfied that high quality data is being provided. Interpretation issues: As 2006/07 will be the first year of collection of chemotherapy waiting times at a national level, targets in relation to waiting times will be set, and 2006/07 will act as the year for the establishment of baselines. Expectations in relation to chemotherapy will relate to supply of data.	Part 1 Monthly. Part 2 Quarterly.
RIH-01	Progress toward further incorporating health inequalities concepts and actions into overall policy, planning, funding and service provision	A qualitative report that shows: 1. Key areas of inequalities that are identified within its HNA; and 2. Actions/steps taken to address the identified inequalities using an appropriate equity tool (eg the Reducing Inequalities Intervention Framework, the Health Equity Assessment Tool, etc).	1: Q1. 2: Q33.
RIS 01	Service Coverage	A report providing the following information: Progress achieved during the quarter towards resolution of gaps in 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 MoH through: *Analysis of explanatory indicators, media reporting, risk reporting, formal audit outcomes, complaints mechanisms or sector intelligence.*	Quarterly.
SER-01	Accessible and appropriate services in Primary Health Organisations	The ratio of the age-standardised rate of GP consultations per high need person to the age-standardised rate of GP consultations per non-high need person. This indicator applies only to persons enrolled in PHOs, and excludes casual visits. Data source: MoH via HealthPAC. **Target :** 1.2 to 1	Quarterly.
SER-04	Low or reduced cost access to first level primary care services	The ratio of the number of PHO practices that demonstrate that all increased subsidies translate into low or reduced cost access for eligible patients to the number of PHO practices in a DHB region. This indicator	Quarterly.

		applies only to persons enrolled in PHOs, and excludes casual visits. Data source: DHBs quarterly fee reporting. Demonstration is achieved by compliance with the government policy for access and interim PHOs across all groups, where the subsidies apply and where this is approved by the DHB and the MoH.	
PAC-01	Progress towards the implementation of priority areas identified in the Pacific Health and Disability Action Plan	A report providing information on the following key points: 1. Pacific child and youth health Initiatives that have been implemented and progressed to improve and protect the health of Pacific children (0-14 years) Initiatives that have been implemented or progressed to improve the health of Pacific youth (15-25 years) 2. Promoting Pacific healthy lifestyles and wellbeing Initiatives that have been implemented or progressed to encourage and support healthy lifestyles 3. Pacific primary health care and preventative services Initiatives that have been implemented or progressed to ensure that there are locally available Pacific primary health providers that effectively meet the needs of their local Pacific communities 4a. The Pacific Health and Disability Workforce Development Plan Initiatives that have been implemented or progressed to develop a competent and qualified Pacific health and disability workforce that will meet the needs of Pacific peoples 4b. Pacific Provider Development Initiatives that have been implemented or progressed to develop and support Pacific health providers capacity and capability to effectively deliver health services 5. Promote participation of disabled Pacific peoples Initiatives that have been implemented or progressed to deliver disability support and health services that will enable disabled Pacific peoples to participate fully in their communities 6. Pacific health and disability information and research Initiatives that have been implemented or progressed to inform policy, planning and service development? *(Note that this component of the indicator only applies to the seven DHBs with relatively high numbers of Pacific peoples in comparison to other regions in the country: Capital and Coast, Hutt, Canterbury, Waikato, Counties Manukau, Auckland and Waitemata DHBs.)*	Six monthly, in Q2 and Q4.
INTERSECTORAL FOCUS			
POP-01 POP-02 POP-03	Diabetes Cardiovascular disease Stroke	Risk reduction – Obesity Risk reduction – Smoking	
QUALITY			
HKO-03	Improving mainstream effectiveness	A report on the following information for the DHB's provider arm: 1 Describing the reviews of pathways of care that have been undertaken in the last 12 months that focused on improving access to effective services for Māori. 2 Example of actions taken to address issues identified in the reviews. If possible, develop a reporting template based on the key points above.	Six monthly, in Q2 and Q4. Annual in Q3.

[15] Reporting should exclude HealthPAC audits.

		The DHB provider arm demonstrates an organisational wide commitment to quality improvement and effective clinical audit by reporting: A high level summary (list) of key quality improvement and clinical audit initiatives and results, focusing on those that are effective and/or ineffective[15] against the Goals in *Improving Quality (IQ): A Systems Approach for the New Zealand Health and Disability Sector*. ***Table 1 - Reporting template - quality improvement and clinical audit initiatives*** *Note - The template below provides guidance on how to map a range of current initiatives to the IQ goals it does not encompass all possible initiatives, and is not intended to restrict the range of initiatives reported. All initiatives undertaken by the DHB should be reported.* **Goal** **Describe personal health initiatives** **Describe effectiveness of initiative** 1.There are more effective service outcomes for Māori by acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi and applying the principles of participation, partnership and protection. *Include…ethnicity data audits.* 2. There is a shared vision towards safe and quality care that is engendered through committed leadership at all levels, which supports constant maintenance and improvement in service quality, and takes into account Māori aspirations and priorities. *Include…Quality committee initiatives and Initiatives to implement/improve structures and processes.* 3. People are encouraged and supported to participate in the planning, delivery and assessment of health and disability services and programmes, including the active participation of Māori. *Include… H&D code of rights, Pacific caucus and consumer feedback activities.* 4.There is widespread awareness, understanding and commitment to a quality improvement culture at all levels of the health and disability sector. *Include… High level policy development, Awards systems for quality improvement/innovation and Involvement in local or national quality initiatives.* 5. There is evolutionary redesign of systems of care to support delivery of quality services. *Include…Prioritisation activity, Discharge planning, Specific service based clinical development, eg, BFHI, Clinical audits, Infection control activity and Patient flow activity.* 6. Unexpected adverse outcomes are managed in an open and supportive manner that build trust and confidence in the system and are fair to all participants. *Include… Internal health and safety activity such as hazard identification, Mortality/morbidity meetings, Risk registers and risk management initiatives, Energy audits and Medical waste audits.* 7. There is effective and open communication, co-ordination and integration of service activities that recognise the value of teamwork. *Include… Service/sector wide forums and meetings, Improvements in organisation- wide processes, eg, debriefing processes across services and Career pathway development.* 8. There is a supportive and motivating environment that provides the workforce with appropriate tools, including cultural competency tools, for continuous learning and ongoing improvement in planning, delivery and assessment of health and disability services.	

		Include… Staff and workplace safety activities, Systems for maintenance of clinical quality, eg, credentialing, Competency up-skilling and Activities to implement magnet initiatives. 9. Useful knowledge and information, including Māori satisfaction information and clinical evidence, is readily available and shared to support a quality-conscious culture. *Include… Information audits, Clinical records audits and Documentation audits.* 10. Regulatory protections that assure safe care are in place to support people and service providers. *Include…All 3rd party audits, Accreditation and certification activity, Labs and pharms audits andFood hygiene regs audit.*	
QUA 01 (b)	Results for People with enduring severe mental illness	A report providing: 1. The number of adults (20 – 64 years) with enduring serious mental illness (two years or more in treatment*, since the first contact with any mental health service. (* in treatment = at least one provider arm contact every three months for two years or more.) 2. The number (and percentage) of long-term clients with up-to-date crisis prevention plans (NMHSS criteria 16.4) and describe how this is assured. **Target:** 98% 3. The number (and percentage) of long-term clients in full time work (> 30 hours). **Target**: 2.5% 4. The number (and percentage) of long-term clients with no paid work. **Target:** 85% 5. The number (and percentage) of long-term clients undertaking some form of education e.g. University, Polytechnic.	Annual in Q2.
SER-06	Continuous Quality Improvement – Elective services.	A quantitative report providing: Standardised Discharge Ratios (SDRs) for 11 elective procedures as published on the MoH website each quarter (excluding hip and knee replacements and cataracts covered by separate initiatives). A qualitative report demonstrating: 1 For any SDR that is more than 5% below the national average of one, ie, a rate of less than 0.95, the analysis that has been undertaken to review the appropriateness of its rate. 2 The reason that the DHB considers the rate to be appropriate for its population, or an action plan as to how it will address its relative under delivery of that procedure.	Six monthly, based on Q2 and Q4 results.
EFFICIENCY AND VALUE FOR MONEY			
SER-05	The proportion of laboratory test and pharmaceutical transactions with a valid NHI	1 The number of government subsidised community pharmaceutical items dispensed by pharmacies in the DHB district with a valid NHI submitted as a proportion of the total number of government subsidised community pharmaceutical items dispensed by pharmacies in the DHB district. **Target:90%** 2 Laboratory tests: The number of tests carried out by community laboratories in the DHB district with a valid NHI submitted as a proportion of the total number of tests carried out by community laboratories in the DHB district. **Target:92%** Data source: MoH via HealthPac.	Quarterly.

7 REFERENCES

The Canterbury DHB has developed key documents that have been referenced throughout this District Annual Plan. These documents can be accessed via the Canterbury DHB website www.cdhb.govt.nz or by contacting the Canterbury DHB's Planning and Funding Division on (03) 364 4159.

- District Strategic Plan: *A Healthier Canterbury: Directions 2006.*
- Canterbury DHB Statement of Intent 2006/2009.
- Health Needs Assessment for Canterbury, 2004.
- Canterbury DHB Quality Strategic Plan 2004/2006.
- Rural Health Action Plan: *Rural Health in Canterbury DHB 2002.*
- Child Health and Disability Action Plan 2004/2007.
- Canterbury DHB Aged Care Strategy: *Healthy Ageing, Integrated Support 2005.*
- Disability Strategy, Action Plan for Disability 2004/2007.
- Healthy Eating, Active Living Plan 2005/2010.
- Canterbury DHB Information Strategy Strategic Plan 2005.
- Canterbury Heart Health Strategy, September 2004.
- Oral Health Strategy, September 2003.
- Pacific Health Action Plan, March 2002.
- Diabetes Strategy Action Plan (Interim), 2002.
- Mental Health and Addiction Strategy, May 2004.

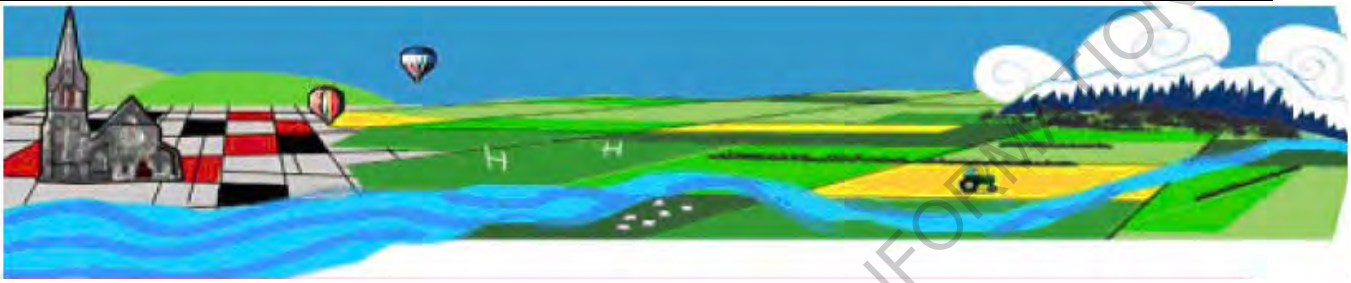
8 APPENDICES

Appendix 1.	Glossary of Terms.
Appendix 2.	Revised Canterbury DHB Māori Health Plan (draft).

9 MOH ATTACHMENTS

Attachment A.	DAP Financial Template.
Attachment B.	Mental Health Plan Template.
Attachment C.	Revenue Reconciliation.
Attachment D.	Volumes Schedules for Service Provision 2006/2007.
Attachment E.	Service Coverage Expectations.

District Annual Plan 2007/2008



Canterbury District Health Board

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

DISTRICT ANNUAL PLAN
1 July 2007 – 30 June 2008

Produced in 2007 by the
Canterbury District Health Board
PO Box 1600, Christchurch

www.cdhb.govt.nz

ISSN: 1176-3124 (Print)
ISSN: 1177-9500 (Online)

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1 EXECUTIVE SUMMARY

Statement from the Chairman and Chief Executive Officer

We are pleased to present our District Annual Plan (DAP) for the 2007/08 financial year. This document reflects our continued commitment to promoting, enhancing and facilitating the health and wellbeing of the people of Canterbury.

In 2004 the Canterbury District Health Board (DHB) chose five Core Directions, five Strategic Health Gain Priorities and four Disease Priorities. These local strategic priorities are coupled with national and regional objectives and expectations to set our long-term direction and goals. The following DAP document outlines the activity we have planned in 2007/08 that will contribute to achieving the long-term objectives and goals that we have set.

Over the past year the Canterbury DHB has achieved some excellent outcomes and results against both national and regional expectations as well as local DHB priorities. These achievements provide an excellent foundation for making further progress in meeting national objectives and local priorities in 2007/08 and include:

- Implementing the 'Improving the Patient Journey' Programme and various patient flow projects aimed at reducing patient delay and duplication, improving access and utilisation of critical resource and improving continuums of patient care;
- Opening the new Diabetes and Home Dialysis Training Centre and completion of the Burwood Hospital (Stage 2) Re-development, delivered on time and within budget;
- Successful challenging of traditional health care roles and implementing nurse-led services and a dedicated night team;
- The securing of additional electives funding for the majority of elective services;
- The establishment of the Acute Medical Assessment Unit at Christchurch Hospital;
- Implementation of our *Healthy Ageing, Integrated Support* Strategy and completion of the trial of a geriatric assessment tool aiming to improve coordinated clinical assessment;
- A review of Acute Demand and After Hours Cover in Canterbury with the establishment of collaborative recommendations to address acute demand growth; and
- Successful implementation of the 'Fruit in Schools' Programme promoting healthy eating, physical activity, sun protection and smokefree environments.

In seeking to achieve both national and local objectives, our single largest challenge continues to be maintaining financial viability in a climate of increasing demand and public expectation. As in previous years the DHB is committed to planning for, and delivering, a breakeven financial outcome. Although we are confident that this can be delivered in 2007/08 we are concerned that due to growing external factors we will face increasing difficulty in achieving this result in future years. Much will depend on receiving sustainable funding and ensuring that secondary service DHB's are able to continue to provide current services including night and weekend services. It will also depend on ensuring funded community services are well integrated, work well together and work effectively on issues such as chronic conditions and long term illness.

We are committed to working collaboratively with the Ministry, other DHBs, other health service providers, our workforce and our community to find ways to overcome the issues and risks we face and will seek support for joint problem solving, prioritisation and for implementing necessary services changes.

To date a key focus in maintaining our breakeven position has been efficiency gains made across our organisation. However in light of our ageing population, the increasing burden of chronic illness, wage and salary pressures and increasing cost pressures, we must accelerate change in order to maintain this position. We are looking at all aspects of our business to determine how we can be more cost effective while continuing to achieve our goals and priorities. Trade-offs and prioritisation will be increasingly required during this period to ensure that our commitments are realised and the way forward includes a range of efficiency initiatives, service change and innovation and service reconfigurations.

In maintaining a breakeven position, and therefore ensuring financial viability, our motivation is to do the best we can to ensure our community gets optimum service delivery for the funding available. The accelerated pace of change required to meet our commitments will require us to work collaboratively and across sectors to alleviate acute demand and service pressures, reduce inequalities and reduce the incidence and impact of chronic illness. In doing this we are likely to deliver some current services in different ways and in different settings. Implementation of our 'Improving the Patient Journey' Programme, our established local health strategies and the recommendations from the Acute Demand and After Hours Cover Review will provide significant opportunities to make real improvements to the health status of Canterbury residents.

A robust approach to managing chronic and long-term conditions must be developed and during the next year we will be establishing a framework to initiate an organised system of care that will cross all of our identified strategic and disease priority areas. The biggest difference is that the new system is likely to involve self-management and be community based rather than hospital centred. Instead of the hospital and its specialist services being the prime port of call, management of chronic conditions will be handled through a close working partnership between GP services, relevant community health services and the DHB. The team approach is vital in keeping people well-managed and out of hospital and also, of course, entails people understanding their condition, having practical training on how to manage that condition and being involved in the development of their care plan.

The DHB will continue to have a strong focus on the health of older people and primary health care development which we are hopeful will continue to constrain acute demand. We are committed to the continued implementation of our local *Healthy Ageing, Integrated Support* Strategy and the national Primary Care Strategy with a focus on reducing inequalities and removing barriers to accessing support and primary care services.

Child and Youth health and Maori health will also be a focus for the DHB with emphasis on reducing risk factors such as smoking, poor nutrition and obesity. We are committed to the implementation of the national *Healthy Eating, Healthy Exercise* (HEHA) Strategy which we are hopeful will contribute to a reduction in the risk factors across identified disease priorities.

The longer-term issue of sustainability and capacity is of particular interest to the DHB. In this regard we need to promote debate at a local level with emphasis on long-term service planning and demand management. A focus for the DHB in 2007/08 is improved planning and service development to better meet the needs of our population. We will be looking to establish a direction for future health service delivery in Canterbury through our Health Services Planning Programme. We look forward to developing this work and anticipate establishing new models of care to cope with future demand and developing strategic facilities and workforce plans to make the best use of our limited resources.

Alongside this long-term work we acknowledge the importance of providing adequate leadership and information to stakeholders as we strive to make improvements in the health status of our community. As such, we will continue to encourage innovation, information sharing and the development of health expertise to cope with future demand whilst promoting opportunities for improved quality and patient safety and improving the way we currently address health issues, from the management of episodic events to the complete patient journey.

The coming year will be a challenging one for the DHB as we confirm our vision for the future with the plan for that vision being a catalyst for the development of a master site plan for the next twenty years. We will look to our stakeholders, clinical teams, consumers and community to help determine and implement that vision and work towards a healthier Canterbury in 2010 and beyond.

Signatories

Syd Bradley
Chairman

Gordon Davies
Chief Executive

Approval Letter from the Minister of Health

Office of Hon Pete Hodgson
MP for Dunedin North
Minister of Health

9 JUL 2007

Mr Syd Bradley
Chair
Canterbury District Health Board
PO Box 1600
CHRISTCHURCH

Dear Mr Bradley

Canterbury District Health Board: 2007/08 District Annual Plan

I am pleased to advise that I have signed Canterbury District Health Board's (CDHB) 2007/08 District Annual Plan (DAP) for three years, and that the Board has my full support for implementing this plan.

This year your Board and management have put tremendous effort into successfully managing what was a challenging 2006/07 plan. I can see from your 2007/08 plan that you intend to continue this effort. I am really appreciative of this.

Service Change and Reconfiguration
May I remind you that my 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 where any proposals may require my approval.

Health Targets
The introduction of the new Health Targets was designed to provide an increased focus on my continuing priorities. They provide the sector with a solid platform for measurable progress in the coming year. I am delighted with the emphasis that your Board plans to give to these priorities. I look forward to receiving updates from you as the year progresses.

Reducing Burden of Chronic Disease
Although variable across DHBs, many DAPs this year are showing an increasing commitment to health promotion and illness prevention strategies. Healthy Eating Healthy Action (HEHA) initiatives are developing well and the progress the sector plans on oral health and tobacco control is very pleasing. CDHB's extension of HEHA into a Healthy Eating Active Living (HEAL) plan for your local population is particularly interesting to me. Keep up the good work on establishing the cancer

Parliament Buildings, Wellington, New Zealand. Telephone: (04) 470 6558, Facsimile: (04) 495 8449

control regional networks. The work you are doing on cancer services is so important because it impacts on the lives of so many New Zealanders.

Primary Care
This year I will be looking for the progress you signal in primary care. Primary Health Organisations (PHOs) are not new anymore. You should be expecting a solid contribution from them towards both your promotion and prevention strategies (especially for children and youth), and in their management and support of patients with chronic disease.

Primary care has a tremendous contribution to make to the management of elective services. I encourage you to continue to give full support to your General Practitioner (GP) liaisons so that we can achieve real improvement in the interface between primary and secondary services. I am looking forward to hearing of your progress on your integrated referral management gateway for patients. Consider reviewing your processes within both primary and secondary care where tremendous gains can still be made.

Electives
Meeting Elective Service Patient Flow Indictors (ESPI) remains an area of high priority. I do realise the challenges inherent in the management of elective services but will reiterate my message to you from last year. People have a right to know when they have been promised surgery that they will get it within a specified timeframe, or if they cannot be offered treatment what their options are. Could you as a Board, please ensure that you have mechanisms (such as "buffers" and robust internal reporting systems) in place to ensure that your ESPI compliance is maintained and that your commitment to additional volumes is achieved.

Achievement of increased elective volumes could be a tangible demonstration of productivity gains and a contribution to value for money strategies. Please frequently review your productivity levels as the year progresses.

Health of Older People
Your plans to advance the implementation of the Health of Older People strategy shows a strong commitment to this age group in your community. I am very pleased to see the work you plan on developing community based services and on supporting workforce enhancements.

Mental Health
I note that again you have taken up the opportunity of Blueprint funding. I am keen to see that you have in place mental health services, using this funding (and as much as possible of your previous mental health surpluses) as early as possible in the new year.

As a nation we still need to make more progress in building and broadening services to support people with mental health or addiction illnesses. This year I am expecting to see real improvements in services for children and young people.

Financial and Risk Management
I hardly need to remind you of the need to continue to manage your services within your allocated funding. I note the risks outlined in your DAP and the mitigation

strategies you have identified have my support. I expect robust financial performance and that you continue to keep the Ministry of Health (the Ministry) informed of emerging risks.

Capital
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 National Capital 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.

Monitoring Intervention Framework
I am pleased to note that CDHB has maintained the status of standard monitoring on the Monitoring and Intervention Framework (MIF). This is a reflection of your ongoing positive performance and is rewarded by the benefit of receiving early payment of your funding. I am confident that you will be working to retain your MIF status throughout 2007/08.

Inequalities
Lastly, but most importantly, there remains within our community population groups whose health and well being is significantly lagging behind the majority. I ask that you continue to focus on reducing inequalities.

In conclusion I know that as you enter this new year you and your Board will have in the front of your minds improving service quality, meeting fiscal imperatives and managing industrial challenges. All this in the context of impending Board elections. It is a tremendous contribution that you are making to the lives of New Zealanders. Thank you. Best wishes with the implementation of your 2007/08 DAP.

Could I ask 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. Pete Hodgson
MINISTER OF HEALTH

2 INTRODUCTION

2.1 The Canterbury DHB - Who are we?

DHBs were established in January 2001, under the New Zealand Public Health and Disability Act 2000 (NZPHD Act)[1]. There are twenty-one DHBs spread across the country and their prime responsibility is to work (within the funding allocated to them) to improve, promote and protect the health and independence of the population of their region.

The Canterbury DHB is the second largest of the twenty-one DHBs in New Zealand (NZ) by population and the largest by geographical area. Our catchment covers Kekerengu in the North, Rangitata in the South and Arthur's Pass in the West and comprises the six Territorial Local Authorities (TLAs) of Kaikoura, Hurunui, Waimakariri, Christchurch City, Selwyn and Ashburton.

- We *plan,* in consultation with stakeholders and our community, the strategic direction for health and disability services in the Canterbury region.
- We *fund* most of the health and disability services provided in Canterbury and hold more than 800 service contracts with health and disability service providers.
- We *provide* health and disability services encompassing women's and children's services, medical and surgical services, mental health, older person's health, and rural health services, laboratory and hospital support services and rehabilitation services.
- We *promote* community health and well-being through population health programmes, health promotion, health education and health protection programmes.
- We are also the largest employer in the South Island with over 8000 staff. Working closely with tertiary providers and clinical training agencies we aim to build the capability of our health workforce, provide leadership and career development and ensure a good, safe working environment for our staff.

THE CANTERBURY DHB - 'ON AN AVERAGE DAY'

$3 million is spent	197 people are admitted to a public hospital 12 admissions were potentially preventable	225 people are seen in ED 3067 people are seen in general practice	15 babies are born 0.9 have low birth weight 2 are born to teenage mothers	34 people are admitted for elective surgery 90% are satisfied with their care

2.2 Our Vision and Values

OUR VISION TA MATOU MATAKITE	**OUR VALUES** A MATOU UARA	**WAYS OF WORKING** KA HUARI MAHI
To promote, enhance and facilitate the health and well-being of the people of Canterbury. Ki te whakapakari, whakamaanawa me te whakahaere i te hauora Mo te orakapai o ka takata o te rohe o Waitaha.	Care and respect for others. Manaaki me tekotua i etahi atu. Integrity in all we do. Hapai i a matou mahi katoa i ruka i te Pono. Responsibility for outcomes. Kaiwhakarite i ka hua.	Be people and community focused. Arotahi atu ki ka takata meka. Demonstrate innovation. Whakaatu whakaaro hihiko. Engage with stakeholders. Tuu atu ki ka uru.

[1] *The NZPHD Act can be found on the Ministry of Health website www.moh.govt.nz.*

2.3 Our Organisation Structure

DHBs have three key output 'arms' or roles: the *Governance* of health and disability services, the *Planning and Funding* of services and the *Provision* of services.

GOVERNANCE

The governance structure of DHBs is set out in the NZPHD Act (the Act which established DHBs). Each DHB has an eleven member Board, the members of which are responsible to the Minister of Health for the overall performance (or governance) of the DHB. Seven board members are elected by the DHB's community and four are appointed by the Minister of Health. The Board's role is to:

- Set long-term strategic direction, consistent with government objectives;
- Ensure compliance with the law, accountability requirements, relevant Crown expectations and the requirements of the NZPHD Act;
- Monitor the financial and non-financial performance of the DHB;
- Appoint the Chief Executive and maintain that employer relationship; and
- Maintain appropriate relationships with the Minister of Health, Parliament, Maori communities and the public (or population) of its region.

Each Board is required to have three Statutory Committees (comprised of a mix of both Board members and community representatives)[2]:

- *Hospital Advisory Committee (HAC)* - monitors the financial and operational performance of the hospitals the DHB owns, as well as assessing strategic issues relating to the provision of hospital and specialist services.
- *Community and Public Health Advisory Committee (CPHAC)* - provides the Board with advice on the health and disability needs of the resident population and how the services funded and/or provided by the DHB, along with the policies it adopts, will impact on that population.
- *Disability Support Advisory Committee (DSAC)* – provides advice on the disability support needs of the population and aims to ensure that the services provided/funded, and the policies adopted by the DHB, promote the inclusion and participation of people with disabilities and maximise their independence.

Our Board also has an additional sub-committee specific to the Canterbury DHB, the *Finance, Audit and Risk Committee (FARC),* established to enhance the Board's governance function by providing advice on the financial operation of the DHB.

While the responsibility for DHB performance rests with the Board, it has a delegation policy, assigning operational and management matters to the Chief Executive Officer (CEO). Our Board and CEO ensure that their strategic and operational decisions are fully informed through appropriate involvement and support at all levels of the decision making process.

Executive support is provided by the Executive Management Team (EMT) which includes General Managers of Planning and Funding, Hospital and Specialist Services, Community and Public Health and Corporate Services divisions (refer to Appendix 1 for an Organisational Chart).

At this EMT level we also have an Executive Director of Maori and Pacific Health, an Executive Director of Nursing and a Chief Medical Officer who provide clinical and cultural leadership and oversight of patient safety and quality. The CEO also receives advice and input from the DHB's Clinical Board, Quality and Patient Safety Council and Te Kahui Taumata (senior Maori staff group).

PLANNING AND FUNDING HEALTH AND DISABILITY SERVICES

The Planning and Funding division of the DHB is responsible for determining what health and disability services are needed in Canterbury and how best to use the funding the DHB receives. This involves analysing the region's health needs and, in consultation with our stakeholders and community, deciding on the mix, range and volume of services to be provided.

Using the funding available from government, the DHB (through the Planning and Funding division) then contracts with the organisations or individuals who can best provide the services our community needs.

[2] *In accordance with the NZPHD Act, meetings where the Board or any of its Statutory Committees make decisions are open to the public to attend as observers. Notice of the meetings is available on the DHB's website www.cdhb.govt.nz.*

Service contracts are held with a wide range of health and disability service providers including a mix of private, religious, welfare, government and Non-Government Organisations (NGOs). The services contracted include primary care services (general practice and nursing services, community, pharmacy and laboratory services), mental health, public health, child health, oral health, family health and maternity services, services for older people, disability and rehabilitation services, residential support and rest home services, Maori and Pacific health services and hospital and specialist services.

Our Planning and Funding division manages the service contracts or agreements, initiates specific health improvement projects and builds partnerships with our community, our providers and with other DHBs to develop integrated continuums of care, promotes innovation, develops services to meet any identified gaps in service delivery and improves health outcomes for our community.

This division is also responsible for ensuring Canterbury residents have access to specialist services that are not delivered in our region and for monitoring and managing the flow of funds for these 'out of district' services.

The division's core activities are:

- Determining the health and disability status and needs of our population;
- Planning, prioritising and operationalising national strategies in relation to those needs;
- Involving stakeholders and the community through consultation and participation;
- Funding health and disability services by undertaking service contracting; and
- Monitoring and evaluating service delivery, including audits, and accounting to the Ministry of Health (Ministry) for the DHB's performance.

PROVIDING HEALTH AND DISABILITY SERVICES

The Provider-arm of the Canterbury DHB is referred to as the Hospital and Specialist Service (HSS) division. This division provides inpatient and outpatient services, community services and day programmes, across its six service divisions (refer to Appendix 2 for an overview of the services provided by each division).

The level and variety of services provided by DHBs depends on their relative size, with some DHBs providing more specialist and tertiary level services than others. Because of the size of the Canterbury DHB our HSS division provides an extensive range of specialist secondary and tertiary level services.

The Canterbury DHB owns 14 hospitals in the Canterbury region, which are managed by the HSS division and while the majority of HSS services are provided from these hospitals, some specialist services are delivered from community bases or through out-reach clinics. A significant proportion of our HSS mental health services are provided in community settings.

HSS are primarily funded through our Planning and Funding division (who hold a service contract with the HSS division just as they do with all service providers - referred to as the Price Volume Schedule (PVS[3])). However, the HSS division also has service contracts with external purchasers, such as the Accident Compensation Corporation (ACC), and also provides funded services as required by contracts with those external purchasers.

Our services are also provided to patients from outside the Canterbury region, coming from DHBs where more specialist services are not available. Those other DHBs are responsible for meeting the costs of the services provided to their patients by our HSS division; referred to as 'inter-district' services or Inter-District Flows (IDFs). These IDFs are closely monitored to ensure our ability to provide for our own resident population is not effected by the flow of patients from other regions.

SERVICE DIVISIONS WITHIN HSS

Medical and Surgical Services	Mental Health Services	Rural Health Services	Women's and Children's Services	Older Person's Health and Rehabilitation Services	Hospital Support and Laboratory Services

[3] *The PVS is the contract between the DHB's Funder and its Provider specifying the service volumes to be delivered and the prices to be paid for those volumes.*

2.4 About this District Annual Plan

The NZPHD Act sets out the statutory objectives, functions and responsibilities of a DHB and outlines how they will develop District Strategic Plans (DSPs) to describe their objectives and long-term goals. Our DSP, *A Healthier Canterbury: Directions 2010,* was developed in 2005 and outlines the strategic direction of health services in Canterbury for the period 2006-2010.

The DSP is aligned to the government's health and disability strategies and is influenced by the revenue available to the DHB and the specific health needs of the DHB's resident population. In 2004 we undertook a Health Needs Assessment (HNA) of our population and an extensive public consultation process to gather feedback from our community. The outcome of these processes was recognition of the specific local needs of Canterbury residents and the subsequent establishment of five Core Directions, five Strategic Health Gain Priorities and four Disease Priorities where we will place additional focus to better meet the needs of our resident population. We are committed to improving health outcomes in these selected priority areas as well as implementing national objectives that will improve the health status of our community.

CORE DIRECTIONS	HEALTH GAIN PRIORITIES	DISEASE PRIORITIES
Improve the Health and Wellbeing of our Community	Child and Youth Health	Cancer
Find Better Ways of Working	Older People's Health	Cardiovascular Disease
Work Together	Māori Health	Diabetes
Develop our Healthcare Workforce	Primary Health	Respiratory Disease
Be a Leader in Health	Disease Prevention/ Management	

All DHBs are also required to produce District Annual Plans (DAPs) and Statements of Intent (SOIs). These documents, in essence, detail how the DHB will achieve the long-term goals and objectives set in their DSPs. The DAPs are action focused and outline activity planned for the coming year that will assist the DHB not only to achieve its long-term goals but also to meet its immediate challenges and fulfil the expectations and requirements of the Minister of Health. The SOI is a high-level summary of the DAP and includes performance measures and targets for a three-year period.

Because the DAP is closely aligned to the DSP and SOI, it should be read in conjunction with those documents, all of which can be found on the DHB's website www.cdhb.govt.nz.

The DAP, which follows, is designed to show:

- Our intended activity and outputs for 2007/08 and how these relate to our DSP;
- The funding proposed for those intended activities and outputs;
- Our expected capital investment;
- Financial and non-financial performance forecasts; and
- How performance will be monitored, measured and reported.

2.5 Our Decision Making Principles

The majority of the health and disability services that DHBs fund are set out in government polices and directives which outline the services that must be provided by the DHB, at what level they will be provided and what funding will be provided for those services.

DHBs must also note government strategies when making funding decisions, particularly: the NZ Health Strategy 2000, NZ Disability Strategy 2002 and the NZ Maori Health Strategy 2002[4].

For those services for which there is a greater level of discretion the Canterbury DHB has developed a Prioritisation Framework, identifying a set of principles to assist in making choices and decisions about which services to fund/provide in the future and at what level.

[4] *These national strategies as with all national health strategies referred to in this document can be found on the Ministry's website ww.moh.govt.nz.*

The DHB is also guided in its decision making process by the Strategic Priorities established during the development of our DSP. When making decision on which health services to fund/provide the DHB's choice is also heavily influenced by the specific health needs of different groups within its population.

CANTERBURY DHB DECISION MAKING PRINCIPLES	
Effectiveness	The extent to which the service improves quality of life by the reduction of pain, the maintenance of lifestyle, the promotion of independence or the prevention of premature death. The level of benefit takes into account both the benefit per person and the total number of people benefiting.
Cost	The total cost of a service is compared to the effectiveness of that service to ensure available funding is used to achieve the maximum possible gain.
Equity	The effectiveness of the service in improving the health of disadvantaged groups is considered. Disadvantaged groups include those on low incomes, Maori, Pacific and refugee communities, those with multiple diagnoses and those in remote areas with limited access to services.
Maori Health	In making funding decisions the Treaty of Waitangi is acknowledged and Maori participation in providing services is encouraged. Services must be both appropriate and accessible to Maori.
Acceptability	The diverse expectations and values of New Zealanders are considered when making prioritisation decisions on which services to provide and at what level.

2.6 Collaboration, Partnerships and Community Participation

While we have set out our long-term objectives and goals we realise that our vision will not be achieved through the DHB's efforts alone. By looking outside our organisation, establishing partnerships with other agencies and with other sectors, as well as with our community and consumers, the DHB can work to influence the determinants of health and enhance the continuum of care needed to achieve improved health outcomes.

We have inter-agency relationships with a wide range of government agencies including: the Ministry, the Mental Health Commission, Child, Youth and Family, Police, Housing NZ, the Ministries of Justice, Education and Social Development, ACC and the Department of Corrections.

We work collaboratively with the Christchurch City Council (CCC), Environment Canterbury and the five TLAs in the wider Canterbury area along with Canterbury schools, the NZ Diabetic and Cancer Societies, the Heart Foundation, the regional Sports Trust and many other NGOs in the Canterbury region. We also actively support a number of collaborative ventures including Healthy Christchurch, Push Play, the Healthy Heart Awards and the Canterbury Intersectoral Physical Activity and Nutrition Group (CIPANG) which endeavour to improve the health of our population.

Our relationships with the five Primary Health Organisations (PHOs) in Canterbury are important to us and we work closely on acute demand management, after hours care and health promotion and population health initiatives. These partnerships also involve many NGO health and disability service providers in the region and we work hard to build collaborative relationship with all our external providers through regular provider meetings, reference groups and issue based forums.

We work with a number of educational institutions in particular the Christchurch School of Medicine, Christchurch Polytechnic Institute of Technology (CPIT) and the Clinical Training Agency (CTA). This work supports the growth of the capability and capacity of our health workforce.

At a national level we work closely with the Ministry, participating in national projects including national benchmarking exercises and national pricing projects. We support DHBNZ[5] and participate in DHBNZ activities in areas including primary health, industrial relations, prioritisation tools, workforce development and information sharing.

We participate in a number of regional initiatives with other DHBs such as working with South Island DHBs on the Cancer Control Network and the implementation of national information systems. We also have a Memorandum of Understanding (MoU) with the West Coast DHB which assists in the development of closer clinical collaboration.

[5] *DHBNZ is the national representative body for all twenty-one DHBs.*

The Canterbury DHB is also a shareholder in the South Island Shared Services Agency Limited (SISSAL), which is wholly owned by the six South Island DHBs: Nelson Marlborough, West Coast, Southland, Otago, South Canterbury and the Canterbury DHB. The purpose of SISSAL is to support DHBs to meet their objectives by providing health information, service planning and external audit functions as well as coordination and analytical support and some benchmarking of services.

Directions agreed in our key accountability documents and local health strategies ensure our continued involvement in collaborative projects both nationally and regionally.

Community Participation

Interaction with our community occurs on a number of levels. At a governance level, seven of the Board's members are elected by our community and additional community members are appointed to the Board's Statutory Committees. In the past year a representative of Ngai Tahu has been invited to attend Board meetings as an observer[6].

We actively engage with providers of health services working with them in a cooperative way for the benefit of our population. In important areas of policy development or for significant projects we seek input from our community and our providers. This may be in the form of providing opportunities for input on early development of papers/ideas or to have involvement in working parties.

A number of initiatives or policy changes a DHB proposes may warrant formal consultation. The NZPHD Act specifies DHB consultation in relation to developing or changing the DSP, changes to the DAP and the disposal of any Crown land. We would also expect to consult on any major reconfiguration of services and will identify any consultation needs in each instance and meet our obligations in this regard (including consulting with the Minister of Health).

We have established, or are involved with, a number of consumer and community reference groups, working parties and advisory groups which provide advice and input on the development of strategy, policy and direction for the Canterbury DHB. We also work closely with Maori and Pacific communities. We meet regularly with Manawhenua ki Whaitaha[7], Maata Waka and several Pacific community groups to ensure Maori and Pacific input into the development of strategies, policy and initiatives to improve health care access and delivery and reduce inequalities in health status.

Over the 2006/07 year we have undertaken considerable consultation on a number of key strategies and plans including most notably: the development of frameworks for heath services planning and the management of chronic conditions, the review of acute demand management and after hours cover, the development of a youth health position paper, the revision of our Maori Health Plan, the development of a model of delivery for community services for older people and a model of care for Ashburton and Kaikoura and a stakeholder forum on home based mental health services.

This consultation has involved stakeholders, staff and the public through a number of different processes including reference groups, hui and fonos, public and stakeholder meetings, staff focus groups and working groups. It is important to us that the long-term direction being set through these key strategies are relevant to, and supported by, users, our community and our staff and that any change will have a positive impact on the health status of our community. Our commitment to collaborative participation in setting direction and policy is outlined in our DSP and actions in our DAP demonstrate this continued commitment.

Pandemic and Emergency Planning

The Canterbury DHB continues to take part in emergency exercises, placing particular emphasis on institutional and public health readiness for emergencies and assisting community health providers in their preparedness. We participate in the South Island Regional Health Emergency Plan in conjunction with the Ministry, St John Ambulance and the other South Island DHBs. This Plan covers a multi-DHB response to any emergency.

We comply with all aspects of Ministry emergency planning requirements including training, planning, exercises and risk reduction. All DHB staff are orientated to Canterbury's hazard environment and a number of staff have attended NZ Qualifications Authority's Coordinated Incident Management System Training which is the benchmark for NZ emergency planning.

During the winter months we activate our Snow Plan to ensure that any disruption to patient care is minimized. Other important work is also underway regarding earthquake preparedness planning.

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[6] *Although this member has no voting rights their contribution to discussions is valued input for the DHB's Board.*

[7] *Manawhenua ki Waitaha is a representative group which comprises the seven Ngāi Tahu Rūnanga.*

We also maintain our own major incident and emergency plans identifying how essential health services will continue to be delivered in the event of a national health-related emergency. Our pandemic planning is well advanced and is based on the scenario developed by the Ministry. Projects are being undertaken in conjunction with a wide range of health providers including primary and private providers, key community groups, other emergency services, civil defence emergency management groups, Maori community groups and neighbouring DHBs.

In 2007/08 our main emergency planning activity will be 'Exercise Cruickshank' a whole of government emergency exercise being led by the Ministry. We will coordinate the response of the health sector within the Canterbury region as well as providing expert support to Civil Defence and law enforcement agencies and leadership for the South Island response. The DHB will also have particular responsibility for managing 'border control' and for managing the 'cluster control' aspects of the exercise.

3 OUR ENVIRONMENT

This section provides background on the environment in which we operate. It outlines our geographical location and population profile, identifies health issues for the Canterbury district and describes how our operating environment influences the choices we make[8].

In September 2004 we completed our second comprehensive HNA bringing together information describing the Canterbury population and the health status of our residents. The HNA document can be found on our website (www.cdhb.govt.nz).

3.1 Overview of the Canterbury Population

Canterbury's usual resident population, at the 2006 Census, was 466,416 with Statistics NZ predicting that this would rise to 504,900 by 2016.

There has been some change in the ethnic mix in Canterbury over the past five years, with the latest 2006 figures showing Maori making up 7.2% of the Canterbury population, Asian people 6.1% and Pacific people 2.2%[9]. Most people identifying as Maori, Asian or Pacific live in Christchurch City.

In the 2001 census, Ngai Tahu was the largest identified iwi in Canterbury, followed by Nga Puhi and Ngati Porou. The main Pacific ethnic groups are Samoan, Tongan, Cook Island Maori and Niuean.

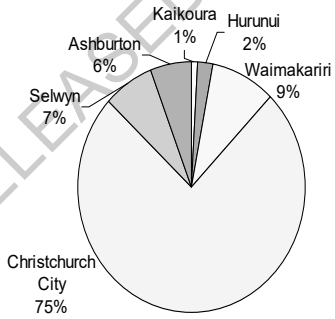
The 2006 Census indicates that just over a quarter (27%), of our population live outside the urban Christchurch boundary. There are differing degrees of rurality but approximately 7,000 of our population (1.5%) live in remote areas and have to drive for more than an hour for primary health care services.

Latest 2006 figures show around 14% of our population is aged between 15 and 24 years. This is similar to the national figure. As with the national population, an increasing number of our child and youth populations are Maori, Asian and Pacific. These ethnic groups have younger populations in general and latest figures show that while 34% of the total Canterbury population is under 25 years old - approximately 55% of our Maori population is aged under 25. Around 60% of the Pacific population in Canterbury are under 30 years of age. There are proportionately almost twice as many Pacific children as non-Pacific children under the age of 10 in our region.

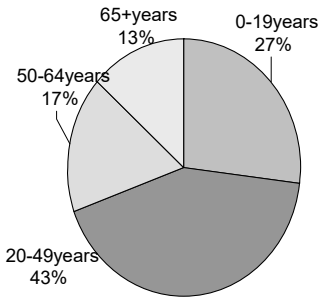
The 2006 Census shows 13% of the total Canterbury population are aged over 65 years. This is a slightly higher proportion of elderly, relative to the NZ population with latest national figures showing 12% of the country's population are aged over 65. Two of our rural areas, Kaikoura and Ashburton, continue to have even higher percentages of their populations aged over 65 (15% and 16% respectively). The 2001 Census predicted the percentage of the Canterbury population aged over 65 would increase to almost 20% by 2021.

THE CANTERBURY DHB POPULATION – 2006 CENSUS

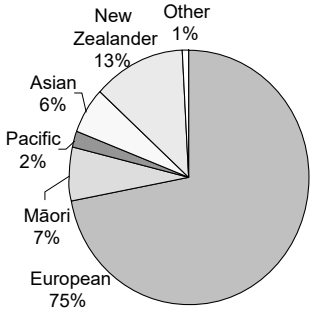
Population by TLA*



Population by Age



Population by Ethnicity



[8] *Detailed analysis of the 2006 Census has yet to take place. Most figures used in this document are taken from the 2001 Census (www.stats.govt.nz). Where updated information has been made available we have referred to this.*

[9] *Allows for double counting where individuals identify with more than one ethnic group.*

While there are fewer older Maori and Pacific people in New Zealand, with the lower life expectancy due in part to higher morbidity rates through diabetes, stroke and cardiovascular disease, the percentage aged over 65 is projected to increase with the number of Maori over 65 expected to increase from 1.3% in 2001 to 3% by 2021.

Addressing the health needs of our ageing population is one of our key challenges over the coming years and is one of the five long-term strategic priorities identified in our DSP.

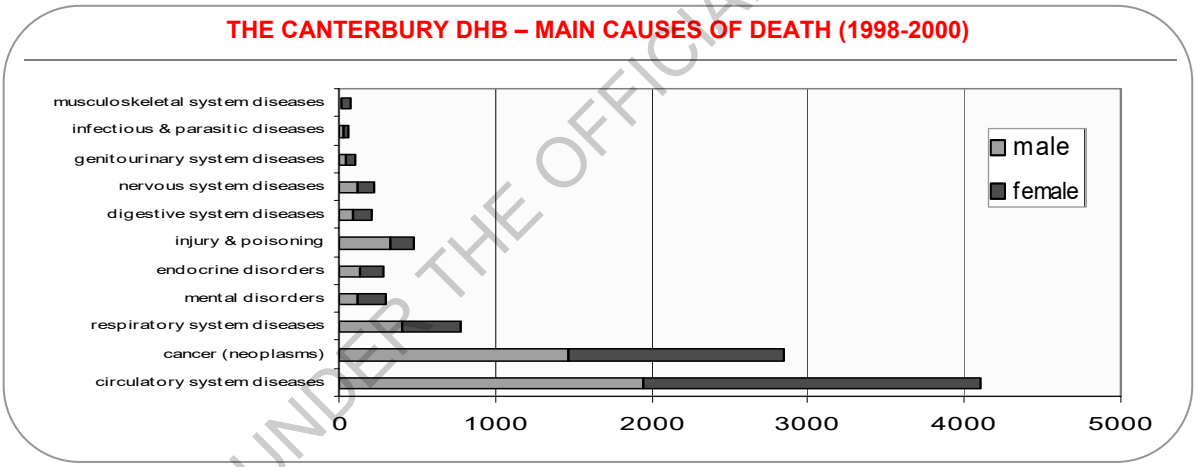
Poorer health status is linked with high degrees of deprivation and the 2001 Census showed Canterbury had around 80,000 people living in NZ Deprivation Deciles 8, 9 and 10 (the highest levels of deprivation). The percentage of Maori and Pacific people living in these areas was higher with 43% of Pacific and 30% of Maori in deciles 8, 9 and 10 compared to 17% of Asians and 15% of Europeans. 18% of Canterbury's under 15 age group were living in deciles 8, 9 or 10.

3.2 Key Health Trends for Canterbury

In order to address the health needs of our community it is important for us to understand the health status of our population and the conditions and illnesses, which are prevalent in our region. This understanding has assisted the Canterbury DHB in selecting our long-term Strategic Health Gain Priorities where we believe additional focus will improve our community's health status.

The health status of residents in most areas in Canterbury is the same as, or better than, the national health status. We have the highest life expectancy at birth of all the DHB regions (77.8 years).

The total number of deaths for all ages in Canterbury is also almost exactly what is expected, given the age and socio-economic deprivation of our residents. The primary causes of death in Canterbury are diseases of the circulatory system (ischaemic heart disease, stroke, heart attack), cancers and respiratory system diseases.



Diabetic complications (such as heart disease, blindness and kidney failure) are major contributors to the burden of disability experienced by people from middle age, particularly Maori and Pacific people, who are proportionately at higher risk of diabetes and associated complications.

The prevalence of these diseases is reflected in our choice of Cancer, Diabetes, Heart Disease and Respiratory Disease as our four identified Disease Priorities for the next five-ten years.

A number of conditions which result in death or disability (including diabetes) are attributable to risk factors: smoking tobacco, not being physically active, eating foods that are not healthy, drinking too much alcohol or using recreational drugs. The 2002/03 NZ Health Survey reveals that most New Zealanders believe they have very good health[10]. However, more than half of all adults are overweight, half do not get thirty minutes of exercise a day and 20% of people aged over 45 have been diagnosed with heart disease.

Tobacco smoking is a major risk factor and preventable cause of death. Canterbury's average smoking rates (23%) are lower than that of NZ as a whole, where the average rate is 25% for most

[10] *The NZ Health Survey can be found on the Ministry website, www.moh.govt.nz.*

age groups. However, nearly 9,000 people over the age of 35 are admitted to hospital in Canterbury every year with smoking related illnesses costing our region's hospitals around $23 million yearly.

Disease prevention and the management of chronic and long-term illness is one of the Canterbury DHB's five Strategic Priorities with emphasis on healthy eating, active living, smoking cessation, intersectoral collaboration and the development of integrated continuums of care.

Timely and consistent primary health care can help prevent disease development, complications and hospitalisations. Ambulatory sensitive admissions to hospital are those which result from diseases and conditions which are sensitive to interventions delivered through primary care. It is considered that a good percentage of these admissions are avoidable. Nationally ambulatory sensitive admission rates are rising, from 25% per 1000 people in 1995 to 28% per 1000 in 2001.

Canterbury's ambulatory sensitive admission rates, for the years 1998-2002, show a slight decrease in overall rates and lower rates than the national average. However, in Canterbury, socio-economically deprived people are hospitalised with potentially preventable conditions at almost twice the rate of those less-deprived. Canterbury's hospitalisation rates for childhood asthma are high, as are our notified rates of pertussis (whooping cough). Maori and Pacific children (an increasing percentage of our child population) also have high rates of hospitalisation for vaccine-preventable diseases, and higher rates of tooth decay and glue ear than other Canterbury children.

Primary Health is also one of our identified Strategic Priorities and through Primary Health Care Organisations (PHOs) the DHB intends to focus on earlier intervention, improving equity of access to health services, the management of chronic conditions and addressing acute demand.

The oral health status of Canterbury five-year-olds has declined since 1996. For 12-year-olds oral health status declined between 1999 and 2002 and is now back to where it was in 1996. Water fluoridation can reduce dental decay in children by as much as 50% - only 4% of Canterbury children receive fluoridated water compared to 96% of Wellington children.

Beginning in 2007/08 the DHB will be implementing the Ministry's oral health reform – including a move away from traditional school dental clinics towards modern community oral health services with an increased emphasis on prevention. This work has been identified under our Strategic Priority; Child and Youth Health.

Suicide rates in Canterbury are no higher than the national average but continue to be of concern especially for males. Although not a priority area for the DHB at this time we continue to implement national and local solutions for improved mental health services and equity of access for consumers.

Maori and Pacific Profile

Maori admission rates for Pertussis are 2.7 times higher than that of Europeans and 3.2 times higher than Pacific people. Maori are twice as likely to develop diabetes and on average develop diabetes nine years earlier than their counterparts of other ethnicities. Maori children also have high discharge rates for asthma, particularly in Canterbury where rates for children under five are higher than national rates.

Pacific people are more likely than other ethnicities to be admitted to hospital for diseases of the skin and subcutaneous tissues and conditions related to pregnancy. The high rate of tobacco smoking amongst Pacific youth aged 15-24, (39% for males and 45% for females), is a particular concern and much higher than the average rates in Canterbury.

Maori and Pacific health improvements are critical in Canterbury, as throughout NZ, given that on average these ethnic groups have the poorest health status. Nationally and regionally a range of health strategies acknowledge the importance of improving Maori and Pacific health outcomes in order to reduce and eventually eliminate health inequalities that negatively effect these ethnic groups. To add local focus we have included Maori Health and Child and Youth Health amongst our Strategic Priorities.

3.3 Demand Pressures

The Canterbury DHB, like most DHBs across the country, is facing an environment of increasing demand for its services. Our ageing and growing population and the increasing burden of chronic conditions are amongst factors which have contributed to this rising demand.

Christchurch Hospital Emergency Department (ED) visit volumes remained relativity static until 2004 when growth began to increase at around 5% a year; this equates to an additional 3,944 visits. Relative to the DHB's population, ED attendances have increased from 142 attendances per 1000 people to 150 attendances per 1000 people. The additional volumes over this period are primarily people under 30 years of age who make up nearly 64% of the growth observed over 2004/05.

In 2005/06 there were 64,000 discharges from our hospitals, 60,000 were Canterbury residents. The total number of discharges is also increasing over time as demand for our services grows. There are two types of hospital admissions: acute (or emergency) services for patients who are very ill and require immediate treatment and elective services for patients who have conditions that do not require immediate hospital treatment. The number of discharges for acute services has grown faster than growth in our population.

Over the coming year the DHB is undertaking a number of initiatives focused on reducing the demand for acute services and reducing unnecessary or 'avoidable' admissions to hospital, including implementing the recommendations of the Acute Demand and After Hours Cover Review and developing a framework for managing chronic conditions. However, these initiatives will take time to impact on the levels of demand and hence in the short term we are likely to continue to face increasing demand for hospital services.

The DHB will continue with its commitment to improving elective services management and implementing its Improving the Patient Journey Programme across all services in acute settings to reduce inpatient delay, increase the ability of our services to cope with growing demand and improve access to theatres and services by reducing process delays and improving our utilisation of critical resources (such as staff and beds).

4 OUR STRATEGIC PRIORITIES AND DIRECTION

4.1 Our Core Directions and Health Gain Priorities

As highlighted in Section 2.4, five Health Gain Priorities and four Disease Priorities have been identified for special attention or focus by the DHB. The selection of these Strategic Priorities was based on a HNA for the Canterbury region (completed in 2004), the directions of key government health strategies and on feedback received during public consultation on our DSP in 2005.

In addition to these Health Gain and Disease Priorities we also identified five Core Directions which will assist the DHB to build the foundations essential to addressing the challenges we face and ensuring we are able to meet our obligations and responsibilities and work towards our ultimate goal of promoting, enhancing and facilitating the health and well-being of our community.

CORE DIRECTIONS	HEALTH GAIN PRIORITIES	DISEASE PRIORITIES
Improve the Health and Wellbeing of our Community	Child and Youth Health	Cancer
Find Better Ways of Working	Older People's Health	Cardiovascular Disease
Work Together	Māori Health	Diabetes
Develop our Healthcare Workforce	Primary Health	Respiratory Disease
Be a Leader in Health	Disease Prevention/ Management	

The following section of this document (Section 5) outlines the goals and objectives the DHB has identified for each Core Direction, Health Gain Priority and Disease Priority and the actions we intend to undertake over the coming year to achieve the long-term vision set out in our DSP.

4.2 The Minister of Health's Priorities and Expectations

When determining the actions and activity required in 2007/08 to progress our Core Directions and identified Priorities we also consider the Minister of Health's national expectations and priorities, which are signalled as part of the Ministry's annual Planning Package delivered to all DHBs.

The Planning Package ensures that the Ministry and DHBs have agreed guidelines for accountability documents and, by clearly outlining annual expectations and priorities, provides parameters for DHB planning. The Package also ensures that the requirements of relevant legislation are met and, together with policy direction, helps to maintain national consistency across the sector.

For 2007/08 the Minister of Health has signalled expectations around substantial and measurable progress on national health strategies (focusing on quality and safety, innovation and further reductions in health inequalities).

The Minister is also looking to instil a 'Common Purpose' promoting partnerships and supportive relationships, both within and beyond the health system, and collaboration on common strategies and priorities.

The Minister of Health's specific Priorities for 2007/08 are:

- *Chronic Disease.* With emphasis on progressive implementation of the Healthy Eating Healthy Action (HEHA) Strategy, Cancer Control Strategy and the Tobacco Control Strategy. Focus is also on programmes which assist early diagnosis and management of conditions such as diabetes or depression;
- *Child and Youth Services.* Emphasis on progressing improvements in oral health services, child and youth mental health services and adolescent sexual health services. Continued development and implementation of the 'ready for school' health and wellness checks, free primary health care for under sixes, newborn hearing screening and early intervention;
- *Primary Health.* Emphasis on the maturation of PHOs - the development of new models of service, the involvement of a broader range of professionals, an improved primary/secondary interface and a focus on the population health lens;

- *The Health of Older People.* Emphasis on continued change in service delivery and the implementation of new assessment tools, new models of supportive care for those choosing to live longer at home and renewed attention on workforce training in the sector;
- *Infrastructure.* Emphasis on continued investment in improvements to the health information system and cooperation and coordination across the sector. Focus will also be placed on progressing the national Future Workforce Initiative; and
- *Value for Money.* While good gains continue to be made in cost effectiveness there will be further emphasis on opportunities to improve organisational efficiency and ensure value for money.

Ongoing Priorities:

- Progress the objectives of the NZ Disability Strategy;
- Progress the objectives of the NZ Mental Health and Addiction Action Plan;
- Reduce inequalities particularly for those groups with the poorest health (those of low socio-economic status and Maori and Pacific people) and those with disabilities;
- Improve the quality and safety of health and disability services;
- Improve elective services including progressing the Orthopaedic and Cataract Initiatives; and
- Collaborate across agencies to reduce family violence and implement the Ministry's Family Violence Intervention Guidelines.

Because of our consideration of national priorities in developing our local approach and our DSP a number of our Core Directions and identified Strategic Priorities are the same as those identified nationally by the Minister of Health and our direction is very much aligned with the 'Common Purpose' expected by the Minister.

Where the Minister's priorities for the coming year are additional to those priorities specifically identified by us, the action and activity we have planned to meet the Minister's expectations has been identified in Section 6 of this document.

4.3 Key Focus 2007/08

While managing their three roles in health (Governance, Planning and the Funding and the Provision of health and disability services), DHBs face a number of challenges. In our DSP we identified the Canterbury DHB's challenges as:

- Working with funding and financial pressures;
- Meeting increasing demand for services;
- Workforce capacity;
- Reducing inequalities;
- Improving access to health care;
- Reducing the impact of lifestyle diseases;
- Addressing the health issues of an ageing population;
- Focusing on effective and quality services;
- Managing community and staff expectations;
- Increasing productivity in the provider-arm (HSS);
- Working with other South Island DHBs; and
- Developing our infrastructure.

In the coming year we will continue to address the challenges we face that would otherwise hamper our long-term progress. Much of the activity under our Core Directions is planned to assist with addressing these barriers to success and over the past year work has already begun which will provide the foundations to enable the DHB to change its culture and practice and allow us to create opportunities to change the way we fund and deliver health services in Canterbury.

Our Board and CEO have identified and confirmed the key focus for the DHB over the coming year to provide us with the best opportunity to improve health outcomes for our population.

- Defining New Ways to Provide Services:
  - Health Services Planning;

- Integrated Care and the Management of Chronic Conditions; and
- Patient Centred Care and Improving the Patient Journey.

- Ensuring the Supportive Infrastructure to Make Changes:
  - Information Technology and the Interchange of Information;
  - Quality and Patient Safety; and
  - Future Workforce Development.
- Ensuring Change is Supported:
  - Relationships to Improve Environments;
  - Partnerships to Improve Service Delivery and Manage Demand;
  - Improved Productivity, Efficiency and Effectiveness; and
  - Community Engagement.

The table that follows summarises how the focus for 2007/08 will help us to address the challenges we face and progress change in our region. The table also demonstrates how our focus for 2007/08 relates to the long-term priorities and directions of the DHB.

FOCUS FOR 2007/08	CHALLENGE	DHB PRIORITY
Defining New Ways to Provide Services		
Develop a Health Service Plan	▪ Working with funding and financial pressures ▪ Meeting increasing demand for services	▪ Finding Better Ways of Working
Develop a framework for managing chronic conditions	▪ Reducing the impact of lifestyle diseases ▪ Addressing the needs of an ageing population	▪ Disease Prevention and Management
Continue to implement the Improve the Patient Journey Programme	▪ Meeting increasing demand for services ▪ Focusing on effective and quality services ▪ Increasing productivity in the provider-arm	▪ Finding Better Ways of Working
Ensuring the Supportive Infrastructure to Make Changes		
Support the establishment of a Clinical Portal and the implementation of our Information Services Strategic Plan (SSP).	▪ Focusing on effective and quality services ▪ Increasing productivity in the provider-arm ▪ Developing our infrastructure	▪ Being a Leader in Health
Continue the development and implementation of the DHB's Quality Strategic Plan.	▪ Focusing on effective quality services ▪ Managing community and staff expectations	▪ Being a Leader in Health
Develop a strategic workforce vision and challenge traditional roles in health.	▪ Workforce Capacity ▪ Increasing productivity in the provider-arm ▪ Focusing on effective quality services	▪ Working Together ▪ Developing our Health Workforce
Supporting Change		
Collaborate on implementing the HEHA Strategy to raise health awareness and reduce risk factors.	▪ Reducing the impact of lifestyle diseases ▪ Reducing inequalities	▪ Disease Prevention and Management ▪ Child and Youth Health
Implement acute demand work streams with an emphasis on reducing Ambulatory Sensitive Admissions.	▪ Meeting increasing demand for services ▪ Improving access to health care ▪ Reducing inequalities	▪ Improving the Health of our Community ▪ Primary Care
Improve resource utilisation focusing on freeing space and resource for elective services.	▪ Increasing productivity in the HSS ▪ Meeting increasing demand for services ▪ Improving access to health care ▪ Managing community and staff expectations	▪ Improving the Health of our Community ▪ Finding Better Ways of Working
Support community provider development and community input into decision making.	▪ Reducing Inequalities ▪ Managing community and staff expectations ▪ Improving access to health care	▪ Improving the Health of our Community ▪ Maori Health

5 ISSUES, ASSUMPTIONS AND RISKS

5.1 Key Risks and Mitigation Strategies

The complex nature of a DHB's activity and responsibilities exposes the organisation to a variety of risks. Broadly speaking, the DHB faces three types of risk: internal risks which can be managed directly by the DHB; risks to services run by contracted providers where the DHB must work with the providers to minimise risks; and external or environmental risks that are faced across the region or by the DHB sector as a whole. We can only manage these external risks by working jointly with the primary and community sectors, government agencies, other DHBs and with the Ministry.

The Canterbury DHB has adopted an organisation-wide approach to risk management and risk reporting, which deals with all potential areas of risks, including clinical, operational, financial and organisational for all services funded by the DHB. A comprehensive Risk Management process has been developed to identify and track the treatment of these risks.

Major risks are regularly reported to our management teams including: the Board's advisory committees (FARC and HAC), the DHB's Clinical Board, our CEO, EMT, HSS General Managers and quality teams.

The risk management system accords with the guidelines in the current Australian and NZ Standard: Risk Management AS/NA 4360:2004 and with our obligations under the Ministry's Operational Policy Framework.

Internal reviews and audits are undertaken across the DHB to provide assurance that the controls to mitigate and reduce risk are in place and are effective. Training and assistance is provided to ensure the risk identification and management process is consistent across the DHB and is of a high standard. We continue to enhance systems to manage both financial and non-financial service risks that we face.

When considering the achievement of our long-term goals and objectives the biggest risks facing the DHB going into 2007/08 relate to financial sustainability including increasing compliance costs, unforeseen price increases and wage increase expectations for the health sector and the increasing demand resulting from the growing burden of chronic conditions.

5.2 Assumptions Made in Developing this Plan

Given the significant challenges and risks we face as a DHB a number of planning and financial assumptions have been made in developing this Plan. These assumptions highlight the risks that are, in the main, outside of our control. If these assumption do not hold true this may limit the DHB's ability to improve the health of our community or may lead to adverse financial outcomes.

Assumptions have been made that the DHB operating environment will not change dramatically and that funding advice provided to the DHBs will hold true.

PLANNING AND FINANCIAL ASSUMPTIONS – *it is assumed that …*	
Operating Environment	- Our short and mid-term direction and environment will remain similar and current government health and funding policies will remain static. - Interest rates will remain within Treasury forecasts.
Baseline Funding	- Baseline and out-years funding will increase as per funding advice from the Ministry. - Any future changes to the Population Based Funding (PBF) formula will not impact adversely on future funding levels[11]. - Demographic funding will be received in future years.
Demand for Services	- The growth in demand for services can be managed within the available resources or any increases in demand can be met through reducing delivery in other service areas.
Price Increases	- Contracts with NGO providers will be settled (on average) within baseline Future Funding Track (FFT)[12] including any increases in demand for services. - The introduction of new drugs or technology will be within the technology adjuster funding provided to the DHB.

[11] *PBF is the Ministry funding system - using a formula to allocate each DHB a fair share of the available resources.*

	- Average increase in non-employee related expenditure can be kept within baseline FFT. - Capital charge will not apply to donated assets and will remain at 8%.
Inter-District Flows	- Net Inter-District Flow (IDF) revenue can be fully realised and IDF volumes will remain stable and not decline significantly. - Neighbouring DHBs will not alter referral patterns without adequate advance notification.
Efficiencies	- Planned savings through service innovations are able to be realised and the DHB has the capability and capacity to achieve efficiencies and address cost over-runs.
Elective Services	- The DHB will remain ESPI compliant enabling it to retain early payment status as well as receive additional elective funding. Loss of early payment would reduce interest income by around $3M which could further reduce elective services. - National industrial action does not result in financial penalty to the DHB and/or the DHB can recover contract volumes after cancelled elective surgeries as a result of any action.
Compliance Costs	- The financial impact associated with any new government or Ministry legislative, regulatory or compliance policy/initiative will be fully offset by increased funding or within any funding received. - Any financial impact associated with changes to Disability Support Service boundaries between age related and non-age related services and any further contracts or services devolved by the Ministry are cost neutral to the DHB. - Any impact of future asset revaluation under FRS-3[13] will be cost neutral to the DHB.
Wage and Salary Costs	- Collective employment agreements will be settled within the baseline FFT increase, inclusive of automatic step movements and flow-on impact from previous year's employment settlements.
Capacity and Capability	- The DHB is able to recruit and retain staff in key clinical positions.
Gain on Assets	- Projected proceeds from approved sale of surplus assets can be realised as planned.
Pharmaceutical Expenditure	- The Pharmac budget for community referred pharmaceuticals is as agreed by the DHB (on the basis of forecast actual expenditure plus baseline FFT) and any forecast savings are achieved.

5.3 Funding Envelope 2007/08

For the first time since the formation of DHBs population forecasts have been realigned to the latest Census figures, funds available to DHBs have been increased and the PBF formula has been revised. When we prepared our long-term vision and DSP in 2005 the Canterbury DHB was considered to be receiving more than its fair share of health funding (for its population) under the PBF formula. While we were to receive increases in funding for demographic changes, the level of this increase was to be reduced until our funding was in line with our population share.

The latest 2006 Census results and PBF review have resulted in the Canterbury DHB reaching funding equity under the PBF formula. What this means in funding terms is that in the future we will receive our full share of the funding increase for demographic funding for any increases in our population levels.

In 2007/08 the Canterbury DHB expects to receive $952M in revenue through its Crown Funding Agreement and $80M for provision of services to residents of other DHBs (IDFs).

In addition to this we expect to receive a further $32M from separate contracts with the Crown in 2007/08 (for example $7M for additional Elective Services, $5.3M for the Orthopaedic and Cataract initiatives and $420K for the implementation of the national HEHA Strategy) giving a total of $1.064B to operate the DHB and fund services for Canterbury residents within the Canterbury region.

5.4 Pressures on Expenditure

While our return to equity reduces some pressure on the DHB in the future, the additional baseline funding provided for 2007/08 is expected to be absorbed by cost pressures as the baseline funding falls short of projected cost increases. Additionally, our population is predicted to increase by 1% over the coming year which will increase demand for existing services.

[12] *FFT is the annual percentage price increase to DHBs from the Ministry.*

[13] *FRS-3 is the Property, Plant and Equipment Accounting Standards*

In seeking to achieve ongoing strategic objectives and priorities, it is a challenge to maintain financial viability. Cost and demand growth makes this a significant challenge. DHBs are faced with capped budgets, have tightly placed limits on service delivery and are confronted with increasing economic, regulatory and compliance cost pressures. As our population ages service needs increase and increasing technology developments (including pharmaceuticals) provide newer, better, but more expensive interventions. DHBs also face key pressures to increase the volume of services funded and prices paid for those volumes and increasing expectations around wage and salary growth.

A number of these issues, or pressures, have been highlighted as 'risks' to the DHB's performance and the magnitude of the challenge ahead can be considered in the context of the anticipated cost 'gap' between the funding increases we will receive and the potential cost growth indicated by some official forecasts of the Consumer Price Index (CPI)[14] and the Labour Cost Index (LCI)[15].

Health sector non-wage costs tend to rise faster than CPI and recent health sector wage settlements have been well above the rate of growth shown in the LCI (although the Ministry has provided special 'pay jolt' funding to meet some of these costs). The last few years have seen unprecedented levels of investment in some staff groups partly to cope with service pressures and partly to recognise anomalies and international wage rates. Wage costs have been increasing significantly and this trend will need to be contained in future periods. The effect otherwise will be the reduction in patient services in order to pay additional levels of wages.

We also highlight the cost pressures of national regulatory or contractual compliance issues. These are often ad hoc requirements that propose a solution to high profile cases but have ongoing cost implications in their implementation. While addressing these compliance issues through a national coordinated approach is a worthwhile goal, the cost and benefit to DHB populations is not well measured and impacts on our ability to maintain financial viability, while addressing local priorities. A clearer picture of the impact of these compliance and contractual requirements is needed so that their implementation costs and priority can be measured when new funds are available to the sector.

Although the pressure to achieve breakeven has been eased by our equity position after the recent review of the PBF formula, when we compare the funding increases provided and the anticipated cost growth there still remains a clear cost gap which the DHB will need to address and manage.

AS A FUNDER WE WILL NEED TO:	AS A PROVIDER WE WILL NEED TO:
Constrain the price growth to within baseline FFT. Re-allocate volumes between discretionary and non-discretionary services to manage demand driven growth, while providing incentives to providers to minimise/manage growth in demand.	Constrain the growth in the cost of service delivery to enable delivery of the desired mix of services within the available funding including managing the introduction of new treatment regimes and technologies. Collaborate with primary care and community based providers to manage demand for acute hospital services.
KEY PRESSURES ON EXPENDITURE	
▪ Labour Costs - cost of national settlements set through national processes of which we are only one player. Current and future employment agreements and in particular the compounding effect of annual "step" increases coupled with expectation of CPI based increases. ▪ Increasing Demand – cost of the increasing demand for services exceeding additional funding for population growth (demographic adjustment). ▪ NGO Expectations - pressure to meet wage growth pressures and cost growth. ▪ DSS Aged Care Services – with an ageing	▪ Employee Costs - job sizing, union expectations, locums and bureau costs, the real 'full costs of employment' including the costs of allowances and the costs of additional conditions of employment. ▪ Industrial Action - service delivery risks, inability to meet contract due to strike action and meeting the costs of contingency planning. ▪ Demand Higher than Budget Volumes - both volume driven due to changes in demographics and the increasing chronic disease burden. ▪ IDF - casemix higher than IDF and prices not adjusted to meet the costs. ▪ Treatment Costs and New Drugs - the impact of cancer drugs (increase demand and new drugs) has

[14] *CPI – An inflationary indicator that measures the change in the cost of a fixed basket of products and services, including housing, electricity, food, and transportation.*

[15] *LCI - Measures changes in labour costs. These costs are base salary and ordinary-time wage rates, overtime wage rates and non-wage labour-related costs including annual leave and statutory holidays, superannuation, ACC employer premiums, medical insurance, motor vehicles available for private use and low-interest loans.*

population there is an increase demand for long-term support services.	not been included in IDF charging/washup. ▪ National Policy - potential impact of the Restraint Policy, Holidays Act, merger of Medsafe and TGA, Electrical Regulatory Compliance and Fire Compliance Upgrades; ▪ Clinical Training Costs - prices do not cover the total cost of training and do not take into account or keep pace with national collective award increases. ▪ ACC Changes - employer programme cost increases.

5.5 Allocation of Funds - Service Coverage 2007/08

Together with contracting processes including the use of Request for Proposal (RFP) processes we work hard to treat our internal and external providers equitably. Within our available resources, the Canterbury DHB will:

- Facilitate timely and equitable access to appropriate health services, in accordance with Crown Funding Agreement requirements;
- Undertake service development to ensure that the health service outcomes, as outlined in the NZ Health Strategy, NZ Maori Health Strategy and the NZ Disability Strategy, are taken into consideration;
- Fund in 2007/08 a range of services similar to those funded in 2006/07;
- Ensure, where appropriate, that the Nationwide Service Framework is applied when entering into service agreements, including utilising nationally consistent service specifications and/or prices;
- Ensure that the service coverage requirements of the Operational Performance Framework and Service Coverage Schedule requirement are met;
- Ensure that ring-fenced mental health funding is spent funding mental health services (including alcohol and other drug services)[16].

Maori Health Funding

Like all DHBs, we are working to foster the development of Maori capacity for meeting the health needs of Maori and reducing inequalities in access and outcomes. As with other DHBs, we provide Maori health and disability services via a mixture of explicit Maori health funding and through funding allocated to mainstream services. A Maori health expenditure stock-take, undertaken by the DHB, identified expenditure of $9.4M through a combination of Maori community providers, mainstream community providers and our HSS division for the year ending June 2006.

Our Maori health expenditure target for the 2007/08 financial year is expected to be set at $10.4M and forecast targets for 2008/09 and 2009/10 are $10.7M and $11.0M respectively. An outline of the proposed direction for Maori health in Canterbury is provided in Section 6.2.3.

Mental Health Blueprint

In 2007/08 the additional Blueprint Funding that we will receive is $680,000. We intend to invest this funding in expanding a number of services which are outlined in Section 7.1.2.

Additional Electives Funding

The Canterbury DHB has been allocated an additional $7M in 2007/08 for Elective Services and this funding will be devolved to appropriate HSS service divisions as part of the DHB's PVS negotiations whereby the Planning and Funding and HSS divisions determine the area of greatest need for our population, and where there is HSS capacity to increase volumes. These negotiations will determine where the additional electives funding will be allocated. Added to this the DHB has received $5.3M for the continued implementation of its Orthopaedic and Cataract initiatives and this funding will be used to increase volumes in both service areas. An outline of the direction and activity in these areas is given in Section 7.1.5.

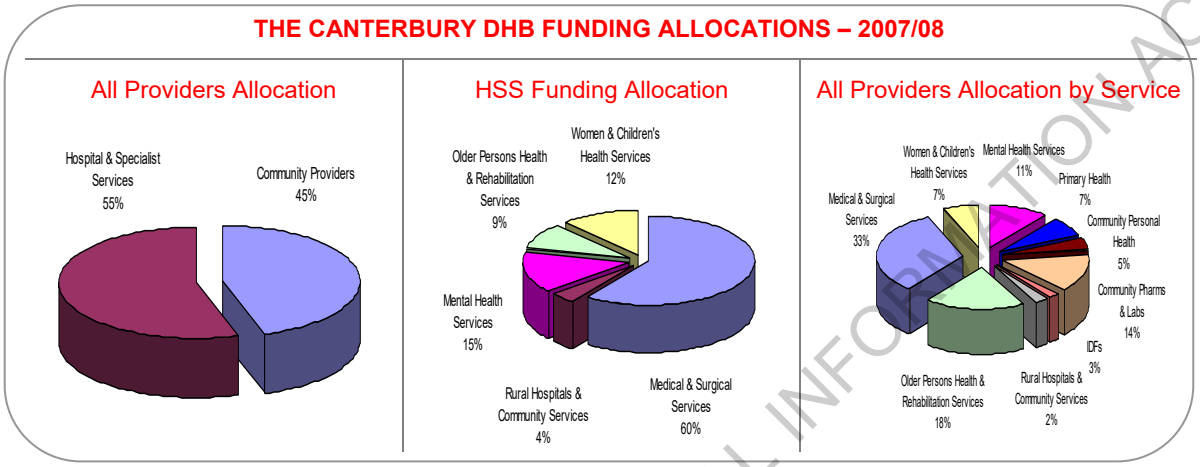
[16] *The Crown Funding Agreement, National Service Framework, Operational Policy Framework and Service Coverage Agreement are all accountability documents between the Ministry and DHB, under which DHBs operate.*

HEHA Funding

In 2007/08 we have also been allocated $420K specifically for the implementation of the national HEHA Strategy in the Canterbury region, an outline of the activity planned to drive this implementation is provided under our Health Gain Priority, Disease Prevention and Management, Section 6.2.5.

Current Funding Allocations

The following diagrams indicate how the Canterbury DHB's current funding is allocated:



5.6 Capability, Capacity, Productivity and Value for Money

The Canterbury DHB is committed to building health sector and workforce capability and capacity through provider relationships, cross-sector collaboration and leadership, an ongoing commitment to quality and safety, improving knowledge and information management and increasing the participation of Maori and high needs groups in service planning.

However, with funding constraints and increasing demand, the need for service planning, service reconfiguration and the development of innovative models of care and robust prioritisation mechanisms is becoming increasingly evident. To achieve our long-term objectives and goals we need to determine the most appropriate and affordable mix of services to meet the needs of our population. While we completed a HNA for the Canterbury region (in 2004), health services planning is at various stages of development within different divisions and different services of the DHB. A standard scoping exercise was seen as imperative and we began an extensive Health Services Planning Project in 2006/07. We have also begun scoping and developing a framework for managing long-term illness and chronic conditions within the Canterbury region.

The objectives of these projects are to:

- Develop key directions that will provide a framework for decision making regarding health investment, that includes facilities and human resources over the next 5-10 years;
- Optimise health outcomes and encourage innovation while 'living within our means';
- Develop and consolidate health care services in appropriate locations/settings, that provide sustainable levels, range, access and quality of services delivered;
- Ensure services located in hospital settings will complement community based services;
- Support a patient-centred focus for health services rather than a episodic care focus and promote the patient as leader in their own care;
- Provide a equitable distribution of services, based on the needs of our population; and
- Minimise barriers to access to services, co-locating where possible and undertake service re/development in locations that are accessible.

Once completed, this planning will present a framework which will directly support a Facilities/Site Master-Plan enabling the DHB to undertake any major facility redevelopment in an informed manner

and to reconfigure service delivery models to match best location for the delivery of services. We will also be able to better prioritise capital expenditure and funding applications and develop a Strategic Workforce Plan through improved understanding of the future direction, the setting and the location of future service delivery.

We also need to ensure that the investments we have made are returning value for money, that our operations are effective and efficient and that we are being as productive as possible.

As such the DHB remains committed to ensuring all services funded are evidence based, and to give priority to interventions that give the most benefit relative to the resources used. We will continue to focus on the reduction of inequalities in health care and support the development of new services in those areas where funding will produce changes in health status for our community.

As already discussed, where we have some discretion with regards to investment and funding the DHB has developed a Prioritisation Framework (refer Section 2.5). As we consider the allocation of funding the principles of this Framework assist in our decision making along with the Strategic Priorities identified in our DSP and through our HNA.

When considering the investments we have already made a variety of productivity measures and benchmarking are used to assess and promote service quality and efficiency and these will continue to be developed and applied in 2007/08. These measures include caseload and consultation evaluations, consumer satisfaction and complaints and timeliness. We monitor overall productivity of the DHB through resource utilisation and the value of services provided compared to the costs of providing those services.

The DHB has an ongoing process to review its infrastructure costs and, where appropriate, initiatives are implemented to manage and/or reduce these costs. Efficiency initiatives over past years have resulted in our low administration component relative to the size of our organisation and have assisted in improving productivity. Effectiveness, productivity and quality programmes such as the Improving the Patient Journey Programme have enabled the DHB to reduce over-crowding and wait-times in ED, despite an overall growth in volumes. The opening of our Acute Medical Assessment Unit is credited as making a significant difference, along with improvements in bed management systems such as daily bed meetings.

We will be seeking to further improve productivity and effectiveness in this manner in the coming year. While we work on longer-term initiatives, our priorities centre on maintaining service provision, ensuring equity of access to services and ensuring effectiveness while maintaining quality standards. We plan to undertake a number of programmes, initiatives and/or service reconfigurations in 2007/08 to improve our productivity and to ensure that our process and systems allow us to maximise outcome for investment and value for money. The initiatives to be undertaken include:

- Continued implementation of the Improving the Patient Journey Programme;
- Continued review of clinical and non-clinical consumables usage and supply chain processes particularly around inventory and purchasing;
- Continued review of the introduction of any new treatment regimes;
- Ongoing HSS non-clinical support services reviews and consolidations;
- Continued implementation of operational efficiency initiatives including improving the financial rigour of HSS services and improving organisational fitness through appropriate management training and the development of HSS Business Plans;
- Continued review and evaluation of HSS employee cost control processes, nursing workforce costs, treatment-related costs, the costs of new technology and review of leave management and roster activity;
- Development and implementation of a framework for managing chronic conditions.
- Implementation of the recommendations from the Community Laboratory Review;
- Implementation of the recommendations of the review of Acute Demand and After Hours Cover including collaborative arrangement with external providers on elective services and acute demand management;
- Review provider contracts, both those with external providers and those with HSS to determine whether we are achieving the best outcomes possible for the public funding invested;
- Continued work within HSS Mental Health Services to streamline the patient journey through a single point of entry;
- Continued work within the HSS Older Person's Health Services to implement the *Healthy Aging Integrated Support* Strategy and the CARE Team Model;

- Continued review of service delivery models to improve access, reduce duplication, provide for a better use of resources and increase the range of treatment options; and
- Implementation of any reviews, reconfigurations or initiatives arising from the completion of a Health Services Plan for the Canterbury DHB – matching best location and best provider to treatment and delivery.

In undertaking this work we will also be looking at the associated benefits, including improved service quality, adoption of best practice and long-term service sustainability. All initiatives to ensure and achieve value for money will have input from clinicians, where appropriate, to ensure patient safety and related issues are adequately considered and factored in the decision making process.

A considerable focus for our provider-arm centres on improving future capability and capacity to manage the increasing demand for health and disability services from our ageing community.

One of the more obvious areas has been in the development of sufficient facilities in which physically to provide both existing and new services including the development of a Diabetes Centre, the new Christchurch Women's Hospital and Day Surgery Unit and Stage II of the Burwood Hospital Redevelopment. Development of a clinical portal will offer clinicians useful electronic 'real time' information and a de-facto electronic medical record to enable improved patient care.

Inevitability staffing resource is the most complex area to improve capability and capacity. We have embraced moves towards national and regional recruitment initiatives to fill positions where there are international shortages and have moved towards more cost effective and internet based recruitment models. Our approach to learning and development continues, with an extensive internal organisational development programme which encompasses the professional, organisational, leadership and cultural dimensions required of our staff.

The DHB has taken a progressive, innovative approach to examining how patients and clients are cared for in our system and the roles and relationships between different health professional groupings. It is clear that greater interdisciplinary learning and process review are vital to reduce the fragmented care that is provided in some situations. We are committed to progressing our Improve the Patient Journey Programme, to the development of a framework for managing chronic conditions to improve the integration of care and to the implementation of recommendations from the Review of Acute Demand and After Hours Cover.

The focus of capacity planning work within HSS over the next year will be linked to the DHB's Health Services Planning Programme. The DHB is taking a constructive, transparent and collaborative approach to determining the health and disability needs of our future population and what that will mean in terms of service models, facilities and workforce. The development of business plans for our HSS divisions is an integral part of this planning with workforce plans sitting alongside this work.

The majority of the key actions and activity of HSS service divisions are covered off in this document under the DHB's Strategic Priorities. However building capability and capacity within Women's Health Services is not specified and actions to enhance services for women and children across the DHB will be a focus in the coming year. The DHB will raise national discussion around the underlying pressures and drivers of increasing demand on Neonatal Services. A number of reviews are also planned, along with the intended development of a Maternity Plan for the DHB.

Aim	Enhance Women's and Children's Health Services within HSS and across the DHB.
Sponsor	GM Women's and Children's Health GM Planning and Funding GM Community and Public Health
Actions	**Neonatal Services** ▪ Work to ensure a coordinated and sustainable neonatal transport service focusing on a muti-disciplinary team approach to maintaining training, rostering and data collection and undertake assessment of equipment and resources. ▪ Identify key positions within the HSS neonatal service required to maintain a robust nursing workforce and skills and training need to maintain those positions. ▪ Work with the Ministry on planning to achieve the first phase of the Newborn Hearing Screening Programme implementation. Support the national Implementation Advisory Group in the development of critical components of the national programme and, as funding allows, move to a state of readiness to implement the programme. **Gynaecology:**

	▪ Respond to the changes to the Ministry agreement for provision of Cervical Screening Services with centralisation of the Cervical Screening Register in Wellington in 2007. ▪ Provide a HSS based Gynaecology GP Advice Service implementing patient referral criteria/proformas for specific gynaecological conditions for use by GPs and implement follow up plans for GP follow up intervention. ▪ Provide medical management treatment options for pregnancy loss, working with colleagues to embrace alternative treatment options, develop policy/procedures and provide education to Lead Maternity Carers (LMC) and GPs to ensure appropriate utilisation of the service. **Maternity:** ▪ Develop a Maternity Plan for the DHB. ▪ Scope the development of a Diabetes Midwifery Clinic to enhance care for women with diabetes in pregnancy and alleviate pressure on Obstetric and Physician clinics. ▪ Continue to implement Smokechange Pregnancy Services, with continued education and study days for staff[17]. ▪ Review Community Midwifery Services, analysing service coverage by independent providers, and if appropriate develop a proposal for change for consultation and implement any recommendations from that consultation. ▪ Maintain Baby Friendly Hospital Initiative (BFHI)[18] accreditation, continuing education and study days and consult with Maori and other key community groups on breastfeeding policy. ▪ Implement a planned approach to the provision of caesarean sections where the procedure is clinically appropriate and to occur prior to the commencement of labour. Plan for procedures, scope staffing levels and implement an audit loop (reviewing the clinical threshold for caesarean section as a planned procedure). ▪ Working with the Ministry the Community and Public Health (CPH) division will identify data and resource requirements to implement the National Universal Routine Antenatal HIV Screening Programme in the community.
Outputs	**Neonatal Services** ▪ Staff skill levels and personnel required to provide a 24-hour 7 day-a-week neonatal transport services are maintained. Available equipment and resources are appraised. ▪ Identification of key positions assists the nursing workforce to develop skills to manage neonates with complex medical conditions. ▪ Planning for the implementation of the Newborn Hearing Screening Programme is supported and the DHB is in a state of readiness to implement the programme. **Gynaecology:** ▪ The change management process associated with the change to Cervical Screening Services are complete and a new infrastructure for service provision is implemented. ▪ The implementation of proforma use/follow up plans is complete and GPs are provided with comprehensive information for management plans, specialist knowledge and education. ▪ The number of surgical Dilation and Curettage (D&C) procedures are reduced. **Maternity:** ▪ A Maternity Plan for the DHB is approved and implementation is commenced. ▪ Continuity of care is provided for diabetic women. ▪ Women who smoke in pregnancy are referred to smoke change services. ▪ Community Midwifery Services are reviewed with recommendations underway. ▪ Baby Friendly Hospital Initiative (BFHI) accreditation is maintained. ▪ A planned approach to the provision of caesarean sections is developed and implemented. ▪ Using regional expertise from established programme, CPH will develop and seek Board approval for a plan to implement the HIV Antenatal Screening Programme which, within available funding, meets the standards for screening and includes development of data capture standards and systems for evaluation.

[17] *Smokechange is a Ministry funded smokefree pregnancy service providing an early intervention programme.*

[18] *The BFHI is a Ministry initiative which focuses on the promotion of choice and provisions of support for all women in feeding their baby and ensuring that the choice is made from a position of knowledge, having been fully informed of the options and the benefits to the baby.*

5.7 Anticipated Service Changes 2007/08

The past two years have been a period of development for the DHB, working under an updated DSP, and a number of service changes, reviews and efficiency initiatives have been scoped and developed over this time to improve capability, increase capacity and productivity and to introduce alternative service delivery models to improve effectiveness. Implementation is underway on a number of these initiatives, with activity continuing in the coming years, including:

- Implementing outcomes from the Child and Adolescent Family Mental Health Services Review;
- Implementing outcomes of the Model of Care in Adult General Mental Health Services Review;
- Implementing the reprovision of residential services for those with intellectual disability and psychiatric illness;
- Implementing the recommendations of the Review of Health Services in Ashburton;
- Implementing the recommendations from the Community Laboratory Review, including changes to funding mechanisms and demand management;
- Implementing the Improving the Patient Journey Programme and Patient Flow projects; and
- Implementing the outcomes of the *Healthy Ageing Integrated Support* Strategy for Older People.

Service Change in 2007/08

The increases in funding we will receive in the coming year will be insufficient to meet projected demand pressures and the increasing cost of service provision. Hence productivity gains will be key in meeting future demand whilst ensuring our continued financial viability.

We will still be looking to make efficiency gains by delivering the same service in more efficient ways. We will also be aiming to ensure value for money for our investment and evaluating possible service re-configurations (delivering the same outcomes through the delivery of services in different ways) that would provide a more effective or productive service for our community. These include those mentioned throughout this document, in the DHB's DSP and the following:

- Implementation of external ministerial or national reviews, initiatives or reconfigurations to ensure consistency across the sector, equity of access and improved health outcomes such as:
  - Implementation of national School and Community Dental Clinics Model of Care;
  - Review of the funding for laboratory tests by private specialists;
  - Continued implementation of the Cataract and Orthopaedic Initiatives;
  - Continued commitment to achieving compliance in all Elective Services Patient Flow Indicators (ESPIs) and implementation of additional elective services funding;
  - Implementation of the NZ Cancer Control Strategy, the national HEHA Strategy, Primary Care Strategy and Health of Older People Strategy; and
  - Implementation of national initiatives (as funding allows) such as screening services and Family Violence Guidelines; and
  - Ongoing review and allocation of Mental Health Blueprint Funding.
- Implementation of internal reviews, initiatives or re-configurations to improve capability, capacity, efficiency, quality and health outcomes, reflected throughout this document and including:
  - Implementation of the recommendations of the Review of Acute Demand and After Hours Cover and continued review of the interface between general practice and the ED to ensure patients are managed in the most appropriate setting;
  - Continued implementation of the Improve the Patient Journey Programme to review patient processes, reduce unnecessary waits and delays and to improve patient flows;
  - Continuation of the Health Services Planning Programme recommending reconfiguration of service delivery models to match the best location for the provision of treatment and care and informing the completion of a Facilities Master-Plan and Strategic Workforce Strategy;
  - Development and implementation of a framework for managing chronic conditions;
  - Continued review of staff and skill mix within services and consideration of alternative models of care to improve services delivery and the patient journey;
  - Continued implementation of our local health strategies including: our Youth Health Position Paper, *Healthy Ageing Integrated Support* Strategy, Maori Health Plan, Canterbury Heart Health Strategy, Mental Health and Addictions Strategy, Information Services Strategic Plan and our Quality Strategic Plan; and

  - Continued review of support services processes to align to best practice including warehousing, distribution and purchasing processes.

- Long-term consideration of service and delivery models to achieve value for money, better target inequalities in health status and lead innovation in health services delivery and to ensure sustainability of service delivery:
  - Work to reduce the costs to our organisation on a national and regional level;
  - Consider service provision to allow hospitals to focus on emergency and serious illness;
  - Consider the clinical and financial sustainability of some rural and metropolitan services;
  - Identify least cost effective services and consider alternative models of care; and
  - Consider reductions in non-essential services to levels in line with other DHBs and establish service benchmarks with other DHBs to address national consistency and equity of access.

Some reviews will be implemented in 2007/08, while others will be in preparation for changes and developments in the 2008/09-year and beyond. Further detail with regard to operational efficiency and productivity initiatives is provided in our DSP and in previous DAP and SOI documents.

Service reconfigurations will involve consultation with hospital or community based service providers, to determine appropriate solutions that best meet the needs of our community. Where service reconfigurations are in the area of mental health the ringfence requirements will be maintained. Any DHB service reconfiguration processes will comply with the Operational Policy Framework.

6 ADVANCING OUR STRATEGIC PRIORITIES

6.1 Our Core Directions

The pressure of financial and service demands has been highlighted earlier in this document and managing these demands will be central to achieving the long-term goals and objectives outlined in our DSP. Work has already begun on a number of projects and initiatives to address and alleviate the pressures we face, with significant work having already taken place in the past year, particularly around acute demand and electives services management and improving the patient journey.

The DHB will focus in 2007/08 on the way in which we deliver and evaluate services and will be aiming to do things better within available resources and to implement changes in models of care and delivery to enable these improvements. Health Services Planning - looking at the picture of health in our community and our community's future needs, will be central as we move forward and improve the way in which we deliver services. The DHB's HSS division is also working on the development of Business Plans for all its service divisions assisting in developing a clearer picture of future need, the impact of increasing demand and opportunities for integration of care.

The following section outlines the activity the DHB has planned under its Core Directions, looking primarily at address key challenges and building foundations to enable change.

CANTERBURY DHB - HEALTH GAIN PRIORITIES

Improve the Health of Our Community	Find Better Ways of Working	Work Together	Develop Our Health Workforce	Be A Leader in Health

6.1.1 Improve the Health of Our Community

Reducing disparities, addressing inequalities and improving access to health services is a focus for the Canterbury DHB and are expectations of the Minister of Health. We will aim not just to identify gaps through improved data collection, but to target resources towards high need and high-risk groups and to affect long-term changes in health status.

We are aware of the inter-relationships that exist between socio-economic status, education, employment, housing and health and will continue to work collaboratively to set goals and objectives for our community's health, to share data and research on health outcomes and to provide a healthy environment for our population.

One of the groups we work with, in an effort to build relationships with other organisations and develop a shared approach to the health of our community, is Healthy Christchurch[19]. This group began as an intersectoral initiative sponsored by the DHB, the CCC, Te Runanga O Ngai Tahu, He Oranga Pounamu, Pegasus Health, the Christchurch School of Medicine and the Ministry and now involves over 200 organisations who have signed the 'Healthy Christchurch Charter'. Its aims are:

- To forge a common vision for a healthy city.
- To foster healthy relationships between diverse agencies and sectors, from 'grassroots' groups to government agencies.
- To enable flexible, collaborative and prompt responses to emergent health issues.
- To ensure all policy incorporates a health perspective.

The initiative recognises that all sectors and groups have a role to play in creating a healthy city, whether their specific focus is recreation, employment, youth, transport or any other aspect of city life. Some of the projects to date include:

- Healthy Workplaces - developing a pilot programme for addressing workplace health issues, including stress, nutrition, relationships and employment law;

[19] *Information on Healthy Christchurch can be found at www.healthy.christchurch.org.nz*

- Healthy Homes - aimed at promoting awareness of environmental issues and their potential financial and health impacts among the Christchurch population with sessions focused on energy, transport, waste, gardening, water and shopping;
- Oral Health - proposed to address the adverse oral health impacts of the decision not to fluoridate the Christchurch water supply. One achievement included every Christmas food parcel distributed through the Methodist Mission containing a toothbrush and fluoridated toothpaste for each child – this reached around 800 children across the city; and
- City Harvest - a citywide celebration of growing your own food and eating healthily linked to the central themes of good nutrition, gardening/ harvesting and celebration.

During 2007/08 we will be focusing on the following activity to improve environments for our population in an effort to reduce disparities and inequalities and will build further on the foundations already put in place in the past year:

Aim	Share responsibility for quality health outcomes.
Sponsor	General Manager (GM) Community and Public Health
Actions	▪ Collaborate with external agencies, providers and community organisations to establish systems for collecting and analysing population based health data and establishing joint goals for improving health status of our community; ▪ Provide health promotion and public health training to improve the knowledge and skills of Canterbury organisations and their ability to implement a population health approach; ▪ Communicate health information to key stakeholders to improve dissemination of, access to or implementation of evidence for public health policy and practice; and ▪ Develop and distribute effective and efficient health education resources to support the development of innovate models of care and the reduction of inequalities.
Outputs	▪ Effective information systems are developed and provided that support planning, delivery, evaluation and reporting of public health interventions. ▪ An increased focus on health determinants and addressing health inequalities is reflected in the Long Term Community Council Plans (LTCCP) of Canterbury Councils and in the DHB's strategic and accountability documents. ▪ Population health outcome indicators are identified and incorporated into DHB DSP and DAP documents and into LTCCPs.

As part of the development of our DSP and long-term direction in 2005, the DHB concluded that it would need to optimise capability and capacity in its HSS division to cope with increasing demand in the coming years (refer Section 5.6). In considering the unique challenges faced by our rural services, a Review of Rural Health Services and a Review of Ashburton Health Services were undertaken in 2005. A specific strategy was developed and the resulting, Ashburton Integrated Model of Care project was begun.

The work begun in Ashburton involves the establishment of closer relationships between our HSS Rural Health Services, Rural Canterbury PHO, and NGO providers who will work together to ensure patients have a 'seamless journey' through a well-coordinated health system.

The overriding principles for integrated care are:

- The patient and family/whanau are at the centre of decision making;
- Right care, right place, right time, right people;
- Working together to provide safe and improved health services and quality of care;
- Integrated and coordinated care across primary, secondary and tertiary services;
- Adaptability and flexibility of health services that are affordable;
- Clinical procedures and services supported by technology;
- An appropriately skilled and available workforce; and
- Flexible environment that supports medical and rehabilitation in-patient services, day surgery with short stays, outpatient and community-based services and long-term care for the elderly.

The Integrated Model of Care for Ashburton is being developed through six projects and project teams, all of which include advisors from the community, the DHB, and other key health service providers. Key successes over the past year have included:

- An increase in Day/Short Stay treatments and additional elective surgery completed in Ashburton;
- Changes to Medical Officer workforce based in Ashburton to allow for greater flexibility in service delivery to better meet the needs of the smaller rural area; and
- Implementation of Picture Arching and Communication System, commissioning of a CT Scanner and establishment of a Urology Day Service to improve service delivery in the rural area.

Aim	Ensure rural services are accessible, sustainable and clinically viable.
Sponsor	GM, Rural Health Services (HSS)
Actions	Continue to implement the Ashburton Integrated Model of Care, focusing on the development and implementation of the following projects: ▪ Collaboration and Integration with Primary, Community and Public Health Services; ▪ Core Services and Specialist Led Services; ▪ Investing in Workforce Development; ▪ Health Information and Technology Systems; ▪ Health Promotion; and ▪ Site Redevelopment and Ancillary Services. Implement the recommended actions from the Review of Rural Health Services (November 2005): ▪ Continue accreditation of all Rural Health Service Hospitals; ▪ Provide ongoing support for Rural PHOs; and ▪ Develop a services plan for the Kaikoura region (as a pilot under Health Services Planning).
Outputs	▪ Establishment of an after hours primary care service using the resources of Ashburton GPs and Ashburton Hospital Medical Officers and in conjunction with the recommendations from the Canterbury DHB's Review of Acute Demand and After Hours Cover. ▪ Expansion of Ashburton based GP Liaison role. ▪ Review of primary maternity services in Ashburton. ▪ Development of an action plan for Older People's Services and for the management of chronic conditions specifically for the Ashburton district. ▪ New or expanded visiting specialist services based at Ashburton Hospital. ▪ Increased number of day and short stay procedures performed at Ashburton Hospital. ▪ Development of a workforce profile and projections for Ashburton and an action plan for workforce development for all health workers in the Ashburton region. ▪ Health promotion programmes more integrated across all providers in the region. ▪ Facility plans in place, based on projected future health service needs and accredited facilities for safe and efficient patient care. ▪ Sustainable health services plan completed for the Kaikoura region.
Measure	▪ Sustainable after-hours primary health care services in place. ▪ Sustainable maternity services in place along with services to meet the needs of older people. ▪ Increased access to specialist services in Ashburton, reducing the need for Ashburton residents to travel to Christchurch for treatment. ▪ Reduced length of stay. ▪ Sustainable medical workforce in place at Ashburton Hospital and in the Ashburton region. ▪ Health care facilities meet the needs of the population.

6.1.2 Find Better Ways of Working

If the DHB intends to ensure effective utilisation of resources and delivery of the best possible health outcomes within the funding allocated we need to ensure that health resources are protected, sustainable and supported long-term. A focus for the coming year is to progress planning for future health services through the development of health services models, the development of a framework for the management of chronic conditions and the development of integrated service models.

These developments will provide a strategic roadmap for changes in future funding models, the development of workforce strategies and the development of a Facilities Master-Plan. This will mean new thinking around the best way to provide care to our population, looking at the best location, the best service and the best provider. However this will enable us to ensure ongoing provision of health and disability services and to provide services which are better integrated and configured, and that operate seamlessly across geographical, professional and service boundaries.

As we continued our drive for a more consumer focused service our Improving the Patient Journey Programme, will assist us to develop more effective continuums of care, to build capability, capacity and to improve productivity – key streams of the Programme will be progressed over the coming year.

Aim	Work to ensure optimum use of resources and investment – Health Services Planning.
Sponsor	GM Planning and Funding
Actions	The focus of the Health Services Planning Programme is to optimise the future use of capital within the DHB. Over the coming year work will be undertaken on the development of a Strategic Health Services Plan. Through a governance structure, including Steering Group and Project Team, models of care will be developed for focus areas in a phased roll-out following the completion of models in four pilot areas: Child Health, Respiratory Health, Eye Health and Rural Health (Kaikoura): ▪ Phase One: Cardiovascular Health, Diabetes, Cancers, Women's Health; ▪ Phase Two: Musculoskeletal Health, Neurological, Older Person's Health; ▪ Phase Three: Consultancy Services, High Specialisation Services, Acute Services; and ▪ Phase Four: Mental Health, Rural Health. Once models are complete a Health Services Plan will be produced, informing the development of: ▪ Service (re)development within HSS and external provider services; ▪ A Strategic Workforce Development Plan; and ▪ A Facilities Masterplan for the DHB.
Outputs	▪ Consumer Groups are established to ensure patient/consumer participation to enhance the planning of future health services. ▪ A Combined Data Set is developed to assist in understanding future demand for services, the development of models of care and ultimately the Strategic Health Services Plan. ▪ Models of Care are developed for selected focus areas. ▪ A DHB-wide Strategic Health Services Plan is developed.

Aim	Continue the implementation of streams of the Improving the Patient Journey Programme: ▪ **Medical Patient Programme** - Reduce inpatient delays, prevent admissions and increase the ability of the service to cope with growing demand and an aging population; ▪ **Surgical Patient Programme** - Improve access to theatre by reducing process delays and making improvements in utilisation of critical resources (staff and beds); ▪ **Radiology Programme** - Reduce patient delays to diagnostic results: and ▪ **After Hours Model of Care Programme** - Review how patient care is provided after-hours - establishing an integrated night service (2230-0800 hours).
Sponsor	Executive Director of Nursing Chief Medical Officer
Actions	**Medical Patient Programme** ▪ Establish a Medical Progressive Care Unit to accommodate patients that currently occupy the Intensive Care Unit or have higher nursing input on wards and speed up the flow of patients from the ED by placing these patients in a more appropriate setting. ▪ Develop a chronic care pathway for respiratory and cardiology patients, focused on assessing the most appropriate care setting for patients and identifying opportunities to improve care. ▪ Enhance management reporting tools and provide improved information to clinical leaders to enable service improvements.

	Surgical Patient Programme ▪ Further improve access to acute theatres – ideally patients wait no longer than 24 hours. ▪ Analyse the elective surgery 'value stream' from GP request to discharge back into community care. Improve the link between critical resources, such as radiology, beds and theatre. ▪ Review peri-operative processes to identify improvements in patient flows and utilisation of critical resources. Assess the implementation of peri-operative management tools to support improved processes. ▪ Identify opportunities to further utilise DHB theatre capacity, within funding allocations. ▪ Implement further reductions in bed-days for surgical patients through improved access to theatre and diagnostics. **Radiology Programme** ▪ Analyse patient demand, and identify priorities for accessing critical radiology resources. ▪ Assess radiology demand versus capacity and identify and implement process improvements to reduce patient delays. ▪ Implement improved resource management tools and additional MRI and CT scanners. **After Hours Model of Care Programme** ▪ Review the impact of the establishment of the Night Team Coordinator role. ▪ Re-audit the workload on the night shift comparing data with the 2006 audit and hold a stake holder workshop to identify issues/perspectives of the night shift processes and interactions. ▪ Establish a working group to use audit and workshop data to define the tasks and skill mix required of a night team.
Outputs	**Medical Patient Programme** ▪ Medical Progressive Care Unit is established. ▪ A joint care plan for chronically ill respiratory patients is commenced, in conjunction with community care providers. ▪ Key performance reports are instituted across the medical stream of the HSS Medical and Surgical division, helping reduce variation in patient processes. **Surgical Patient Programme** ▪ A holistic model/tool is developed to better understand surgical patient flow and constraints. ▪ Improved and standardised peri-operative processes are implemented. **Radiology Programme** ▪ A reduction in delays for patient diagnostic results to be received. **After Hours Model of Care Programme** ▪ A night team defined by required competencies and workload is established. ▪ Opportunities to improve the working lives of staff at night are identified. ▪ Improved quality of patient care with improved risk assessment, co-ordination and prioritisation of work to match patient needs.
Measure	▪ Further reductions in the wait times for patients in the ED. ▪ Resourced bed-days remain static whilst absorbing growth in patient demand. ▪ Increased percentage of acute surgical patients getting to theatre within 24 hours. ▪ Acute surgical bed-days are reduced. ▪ Patient access to radiology within appropriateness guidelines is achieved. ▪ Time taken to report diagnostics is reduced. ▪ Correct after hours resource levels are identified. ▪ RMO run and night nurse evaluation of provision of patient care demonstrates staff satisfaction.

6.1.3 Work Together

We strongly believe that by looking outside of our organisation, establishing partnerships with other agencies and with other sectors, as well as with our community and consumers, the DHB can work to influence the determinates of health, improve the environment in which we live and enhance the continuum of care needed to achieve improved health outcomes.

We remain committed to working collaboratively with our own workforce and to encouraging work across professional and organisational boundaries to optimise the use of combined health resources and to challenge traditional roles to improve health outcomes for patients and consumers.

We will also work closely with the primary sector to address the challenges of increasing demand. In 2006/07 we undertook an Acute Demand and After Hour Cover Review and over the next year we will work in collaboration with primary, community and HSS services to implement the recommendations of that Review.

Aim	Enhance partnerships between our clinical workforce and management - considering the changing mix of skills required for future service provision and changing models of care.
Sponsor	Executive Director of Nursing Chief Medical Officer
Actions	Encourage and support clinical staff working across sectors to enable rapid access to expert advice for the primary and community sector and to support the provision of services in the right place. Consider models to promote the following: ▪ Clinical teams focused more on the patient – more ambulatory focus on service delivery that may require specialist oversight but the patient remains in the community; ▪ Hospital specialists working on more than one site – clinics located in the community; ▪ Specialist nurses more aligned to primary than secondary – from 'out-reach to in-reach'; ▪ GPs with a speciality focus such as plastics or minor procedures clinics; and ▪ Development of specialist Allied Health roles – such as chronic care roles. Continue to challenge the roles of health care workers and the models of services delivery for the benefit of patients, consumers and service users. Direct the focus onto competency rather than who has traditionally performed the tasks: ▪ Nurse and Allied Health led services – treat and discharge in ED, front door physiotherapists and nurse led admissions. ▪ Extending the Registered Nurse and Allied Health roles – pharmacists integrated as part of the patient care team, continued support for the nurse practitioner and the development of advanced and specialist nursing and Allied Health roles. ▪ Develop the roles of Medical Officers and speciality focused GPs. ▪ Continue to develop and implement professional development and recognition programmes.
Outputs	▪ Alternative models of care are identified for specific patient groups. ▪ An 'Expert Patient' Model is developed. ▪ The 'Night Team' is supported and extended to cover afternoon and weekend shifts.

Aim	Optimise access to primary, community, hospital and specialist health services in Canterbury.
Sponsor	GM, Planning and Funding
Actions	Implement the recommendations of the Review of Acute Demand and After Hours Cover in the primary care sector, in collaboration with PHOs on the following work streams: ▪ Work to provide Rapid Access to Expert Advice for general practice; ▪ Support a Telephone Advise Service for general practice; ▪ Develop and implement packages of care, Acute Community Nursing, Community Observation Services and Service Co-ordination Services to support the new direction; ▪ Develop and implement Rapid Diagnostic and Rapid Response services; ▪ Develop a Public Information and Education Programme to support the new direction; ▪ Improve the links with Aged Residential Care; and ▪ In consultation with stakeholders, implement the recommendations of the After Hours Direction Paper for the Canterbury region.
Outputs	▪ After Hours Direction Paper implemented. ▪ Rapid Diagnostic Services in place. ▪ Supportive packages of care, Acute Community Nursing, Community Observation Services and Service Coordination Services in place.

	▪ Public Information and Education programme in place. ▪ Rapid Access to Expert Advise Service for General Practice in place.

6.1.4 Develop our Health Workforce

Workforce development is central to the DHB's ability to provide effective quality services and meet the challenges of improving our community's health. We aim to make Canterbury a preferred district for health workers in NZ by supporting flexibility and innovation and providing leadership and skill development opportunities. In developing our DSP in 2005 we highlighted four key workforce goals:

- Encourage a flexible approach to reflect the changing needs of our community;
- Develop a workforce providing the 'right skills' for the best health outcome to ensure long-term capability and capacity for service provision;
- Ensure Canterbury's health sector is a 'good place to work'; and
- Create a safe and health-promoting environment to support and retain staff.

In aiming to achieve these goals there are a number of specific challenges around workforce; primarily that in order to sustain and deliver services long-term we need to take a coordinated approach to workforce. We must consider not just our own staff but the workforce of the health sector as a whole, this involves:

- Building a co-ordinated approach to workforce development at a local, regional and national level;
- Consideration of and response to our wider community workforce needs; and
- Implementation and sustainability of priority initiatives that provide an organisational work environment which fosters innovation and career development.

At the same time we must develop our own workforce and provide a safe and health promoting environment for our staff through safe handling programmes, membership of the ACC Partnership Programme and continued reduction in our injury costs.

As we near the conclusion of our 2006/07 DAP year, our key achievements to date include:

- Introduction of leadership and management development pilot activity specifically the Middle Management, Orientation to Management and Change Management Programmes;
- Progression of workforce information capacity and structure;
- DHB representation across local, regional and national workforce development initiatives;
- Secondary level attainment in the ACC Partnership Programme Audit;
- Successful delivery of the 12th Annual DHB Health and Safety Conference; and
- A continued decrease in our Lost Time Injury Frequency Rate (LTIFR).

The workforce we nurture must meet the capability and capacity needs of our community and our workforce development activities over the coming year will provide a framework to support management development, skills mapping, workforce redesign and participation in national workforce initiatives as we continue to support the national Future Workforce 2005/10 Strategy[20].

Aim	Future Workforce - Encourage a flexible approach to reflect the changing needs of our community.
Sponsor	Group Manager, Human Resources
Actions	Identify the likely impacts of future models of care on the health workforce to enable strategic workforce planning and development. ▪ Support and sustain a Workforce Steering Group to govern strategic workforce activity, in alignment with Health Services Planning and the CEO's Workforce Development Group; ▪ Participate in, and support, identified Yr 2 Future Workforce Projects, including Health Careers Branding and the Health Careers Framework; ▪ Support and contribute, as appropriate, to the six national Workforce Strategy Group initiatives; ▪ Support and contribute to the 2007/08 Employment Relations (ER) and Industrial Relations (IR) priorities and projects, at a local, regional and national level, including negotiations,

[20] *The Future Workforce Strategy is available on the Ministry's website www.moh.govt.nz.*

	contingency planning and risk mitigation activity; and ▪ Develop a DHB Workforce and Capability Strategy and seek executive level consideration.
Outputs	▪ Increased coordination and strategic alignment of local priority workforce development activity. ▪ Participation in national Future Workforce Strategy and Strategy Group Yr 2 activities. ▪ Specialist participation, advice and coordination of local, regional and national ER/IR activities. ▪ Development of a local Workforce and Capability Strategy.

Aim	Capable Health Workforce - Develop a workforce providing the 'right skills' for the best health outcomes to ensure long-term capacity for service provision.
Sponsor	Group Manager, Human Resources
Actions	Continue to work with education providers to develop programmes for a changing health environment and encourage enrolment, particularly amongst under represented groups: ▪ Respond to opportunities and consider options for referring/engaging with local education providers in the alignment of curricula with our health sector workforce needs. Improve workforce information and data collection to assist with workforce development and capacity planning and as appropriate: ▪ Continue to support and participate in the HR Management System (HRMS) project and provide key support and liaison with the designated Project Change Manager; ▪ Support Health Workforce Information Programme (HWIP) by sourcing and providing workforce data, for the purposes of workforce forecasting, modelling and planning; and ▪ Support and participate in HWIP data quality improvement activity.
Outputs	▪ Assistance and support provided as required to education providers, enabling the development of programme curricula that reflects the needs of our health workforce. ▪ Participation, advice and input from a Human Resources and workforce perspective to the HRMS project, contributing to a tailored system to meet our organisational needs. ▪ Support to HRMS Change Manager to ensure workforce, culture and people considerations are identified and effectively managed. ▪ Provision of required DHB data, as appropriate, to DHBNZ in support of HWIP.

Aim	Good Place to Work - Ensure Canterbury's health sector is a 'good place to work'.
Sponsor	Group Manager, Human Resources
Actions	Provide leadership and career opportunities for our workforce and support career development: ▪ Facilitate and reinforce the CEO's Workforce Development Initiatives, in particular Project 4: Leadership and Management Development Programme (under the Business Development Unit); ▪ Progress the Quality Health NZ Accreditation and Certification Human Resources Standard; ▪ Scope and prepare for consideration an organisational coaching and mentoring programme; ▪ Develop and deliver "Stage 2" identified activity from the Performance Review Project; and ▪ Identify priority improvement opportunities from the Succession Planning Discovery Report, scope and present for consideration.
Outputs	▪ Facilitate from a workforce perspective the CEO's Workforce Development initiative, supporting achievement of programme objectives to reinforce the culture we expect to develop. ▪ Coaching and mentoring programme proposal developed and introduced for consideration. ▪ Stage 2 deliverables from the Performance Review Project such as tools, templates and guidelines tailored to professional groups developed and implemented. ▪ Succession Planning Scope prepared and introduced for consideration. ▪ Accreditation/certification status maintained through delivery of Human Resources Tactical Plan milestones.

Aim	Safe and Healthy Workforce - Create a safe and health-promoting environment to support and retain staff.
Sponsor	Group Manager, Human Resources
Actions	Continue the ongoing progression of Health and Safety management practices and culture: ▪ Develop and maintain a consistent Health and Safety management system and programme; ▪ Maintain membership of the ACC Partnership Programme; ▪ Maintain the Managing Health and Safety sections of the Quality Health NZ Safe Environment and Practice Accreditation and Certification Standards; ▪ Develop and implement a consistent Safe Handling Programme across the DHB that meets relevant competencies and guidelines; ▪ Progress the Occupational Health Programme to monitor staff health in relation to identified hazards they face at work; ▪ Develop and implement an annual healthy workplace and employee wellbeing programme; and ▪ Participate and support national initiatives arising from DHB Health and Safety forums.
Outputs	▪ Annual Health and Safety Tactical Plan developed and implementation commenced and accreditation/certification maintained through delivery of Plan milestones. ▪ Participation, advice and input from a DHB perspective in scheduled national Health and Safety activities. ▪ ACC Partnership Programme audit completed and secondary level status maintained/enhanced. ▪ One hazard management system for the DHB implemented. ▪ Staff Health and Wellbeing Day hosted as part of the employee wellbeing programme, with identified aspects of the programme delivered in partnership with ACC injury prevention. ▪ Staff influenza campaign delivered. ▪ Enhanced occupation health pre-placement screening piloted in identified areas. ▪ Safe patient handling self-learning package and competencies for nurses proposals developed and presented to DHB Directors of Nursing for approval. ▪ Safe patient handling patient risk assessment tool proposal developed.

6.1.5 Be a Leader in Health

In order to enable change we need to provide leadership to our community and develop a stable infrastructure to support the improvements we plan to make. We will continue supporting expertise in health, encouraging innovation and promoting quality health care service delivery.

With challenges around the growing cost of new technology and the expectations of both patients and staff that the DHB will provide access to new treatments it is important that any new technology, drugs or treatments introduced are evidence based, clinically sustainable and cost effective. The DHB has supported the development of a Clinical Review Committee and Health Technology Assessment Committee to review the introduction of new technology and treatments. This support for clinical oversight and review of evidence will continue.

To assist in affecting changes in practice the DHB has begun the development of a Clinical Portal to provide integrated and timely information at the point of care. Clinically relevant information is currently stored in multiple systems which are not integrated. Our clinical staff move from patient to patient and need mobile, wireless access to patient data and information. Our approach to these two problems is to provide an integrated view of the available information through static and mobile wireless terminals. The Clinical Information System (CIS) is a portal which brings into one view the clinical information we already hold on patients and facilitates the entry of new data in an organised way.

Currently this system is being piloted in our HSS Ear, Nose and Throat services and once the pilot is complete and evaluated this will form the basis of a roll-out across HSS. This will be a focus for 2007/08 with future challenges being integrating the systems across the wider health sector.

Aim	Develop innovative models of care and delivery to meet community needs.
Sponsor	Chief Medical Officer
Actions	Continue the development of the CIS as a platform for improved clinical systems, improve access to clinical patient information, provide point of care patient services and work on the provision of electronic patient records. Focusing the roll-out on integrating the following elements into the Portal: ▪ Clinical Documents – discharge summaries, clinical letters and theatre records; ▪ Investigation Results – blood tests and imaging reports; and ▪ Patient Management System Data – admission records and outpatient appointments. Facilitate the bringing together of total sets of laboratory results both hospital and community based and facilitate the integration of the CIS across the wider health sector.
Outputs	Clinical documents, investigation results and patient management data integrated into the CIS.

Aim	Encourage innovation, development and research.
Sponsor	Chief Medical Officer
Actions	▪ Support continuation and development of the Canterbury DHB Innovation Awards. ▪ Support Canterbury DHB projects as entrants in the National Innovation Awards. ▪ Develop a coordinated process to support and manage research projects conducted within the DHB's HSS divisions.
Outputs	▪ Successful coordination of the DHB Innovation Awards. ▪ DHB Projects are supported to progress to National Innovation Awards. ▪ A framework is developed for coordinating research projects within DHB.

6.2 Our Health Gain Priorities

The Strategic Health Gain and Disease Priorities identified in our DSP are a mix of population, service and disease based approaches and they represent the areas where we believe there is potential to make improvements in the health status of our population and in the delivery or effectiveness of services.

The approach to making progress in all of these priority areas will be consistent, in particular:

- Working collaboratively with the primary and community sectors, with our community and with external organisations to ensure an integrated and patient centred approach to care and the development of robust chronic disease continuums;
- Promoting messages related to lifestyle choices, physical activity, nutrition, reducing obesity and smoking cessation; and
- Working with providers and community agencies to reduce inequalities in health status through increased access and uptake of services.

A number of our chosen Strategic Priorities are also a focus nationally and as such the DHB will be taking a 'Common Purpose' approach and is committed to implementing at a local level appropriate strategies and policy developed nationally. We will also be taking all opportunities to work regionally to improve the management of chronic conditions and reduce the burden of long-term illness.

CANTERBURY DHB - HEALTH GAIN PRIORITIES

Child and Youth Health	Older People's Health	Māori Health	Primary Health	Disease Prevention and Management

6.2.1 Child and Youth Health

Child and Youth Health is a key Health Gain Priority for both the government and the Canterbury DHB. Keeping our young populations healthy provides them better opportunities for becoming healthy adults. We aim to improve outcomes for children and youth in Canterbury, particularly those with high needs, those at risk and those in environmentally disadvantaged situations. With an increasing percentage of our younger population being Maori and Pacific (groups with statistically lower health status) it is particularly important that we target inequalities to achieve overall improvements in the health status of these younger population groups.

Our Child Health and Disability Action Plan, *Mahere o te Hauora Tamariki me te Hauatanga,* is now in its third year of implementation. The focus continues to be on initiatives that meet the Plan's ten priorities for improving children's health: access to services, child health information, hearing, immunisation, injury prevention, mental health, nutrition and physical activity, oral health, parenting and smokefree environments.

In the past year particular success coming out of activity around the Action Plan has included:

- Successful implementation of the Fruit in Schools programme with ten schools from low soci-economic areas in Christchurch now taking part and promoting healthy eating, physical education, sun protections and smokefree environments;
- Completion of the Meningococcal B Vaccination Programme, with more than 86% of our eligible population receiving dose one of the vaccine and providing an opportunity to roll out the National Immunisation Register (NIR). The NIR will help us to measure the effectiveness of our immunisation strategies as we work towards raising our coverage to 95%; and
- Launch of the 'Smile for Life' oral health initiative aimed at combating the epidemic of tooth decay in our region. A mail drop to over 230,000 houses distributed an education pamphlet on the importance of a good diet and fluoride for healthy teeth.

Much of this work has involved working closely with external organisations with joint priorities such as the Ministry of Education, Sport and Recreation NZ (SPARC), the National Health Foundation, the Cancer Society, PHOs, Maori health providers and local government. This beneficial collaborative work will continue in 2007/08.

The DHB produced a Youth Health Position Paper in late 2006, outlining actions and initiatives that we will invest in to improve the health of young people in Canterbury. This direction was signed off by the Board in April 2007 and will involve extensive collaboration to achieve our goals and aims:

- To provide a safer, more supportive environment for young people – improving school based health services and access to primary care services;
- To show a measurable improvement in young people's mental health – strengthening links with non-government agencies providing youth respite and community support services to improve accessibility and responsiveness. We will also focus on improved management of suicide prevention and services for young people with drug and alcohol problems; and
- To show measurable improvement in young people's physical health – improving oral health, a reduction in sexually transmitted infections and unintentional pregnancies, lower rates of obesity and an emphasis on increased physical activity. Reducing smoking, alcohol consumption and illicit drug use is also a focus, as is improved management of young people's chronic or complex medical conditions.

In addition to this work we have also signed two MoUs to formalise collaboration around youth health. We will work with the Collaborative for Research and Training in Youth Health and Development to create a centre to enhance the health and development of young people through research and education. We will also work with the University of Auckland and Paediatric Society of NZ to take part in the NZ Child and Youth Epidemiology Study, a three year project to provide high quality child and youth health information to the sector.

Increasingly, Christchurch is becoming a major paediatric centre with additional demand placed on our tertiary services to provide care for much of the South Island. Our challenge is to balance these needs against those of our local population. In the year ahead we will continue our collaborative focus and improve links with primary health care providers to encourage a team approach to the management of child and youth health.

Aim	Improve the interface with providers, stakeholders and external organisations to inform decision-making and shared direction and to collaborate to ensure child services are provided in an effective, equitable and timely manner.
Sponsor	GM, Planning and Funding GM, Women's and Children's (HSS)
Actions	Complete a DHB-wide Immunisation Plan linking primary care, immunisation coordination, outreach service and NIR coordination providers to improve immunisation rates in Canterbury: ▪ Integrate the NIR into ongoing work; ▪ Focus on outreach work to ensure 'hard to reach' children are immunised; ▪ Work with PHOs as part of the PHO Performance Management Programme on meeting targets for childhood immunisations; and ▪ Establish a DHB-wide governance group for immunisation. Work collaboratively particularly around the priorities identified in our Child Health and Disability Action Plan focusing on the reduction of avoidable hospital admissions and on establishing the groundwork for good health, healthy eating and low risk living patterns. ▪ Implement the Ministry's 'Ready for School' programme in Canterbury. ▪ Work with PHOs to implement health promotion services targeted at children. ▪ Work with the Ministry on planning to achieve the first phase of the Newborn Hearing Screening Programme implementation. ▪ Support the HSS Women's and Children's division's commitment to the BFHI, the division's Breastfeeding Policy, and continuation of Smoke-free Pregnancy Services. Continue to work with providers and stakeholders to invest in cultural training and ensure programme are culturally appropriate to improve access and uptake by Maori as a high-risk group. ▪ Place emphasis on the provision of Tamariki Ora well child checks in Canterbury.
Outputs	▪ A DHB-wide Immunisation Plan is developed focused on removal fragmentation of immunisation services and improving immunisation rates. Regular NIR newsletters are circulated and regular practice based audits are implemented. ▪ Tamariki Ora providers deliver according to WellChild Frameworks. ▪ BFHI accreditation is maintained.
Measure	▪ An increase in the percentages of children fully immunised (POP 08).

	▪ Increase in the rates of babies exclusively/fully breastfeed. ▪ Reduced Ambulatory Sensitive Admissions for children 0-4years (POP 09).

Aim	Collaborate across sectors to ensure youth services are provided in an effective and equitable manner and meet the annual objectives as identified in the DHB's Youth Health Position Paper.
Sponsor	GM, Planning and Funding GM, Community and Public Health
Actions	Implement the actions outlined in our Youth Health Position Paper aiming to improve access and responsiveness, reduce risk behaviour and improve long-term care and disease management for younger people. ▪ Working with PHOs, develop and implement a specific health promotion programme for oral health targeted at high needs adolescents 'Adolescent Oral Health Promotion Project'. ▪ Work with PHOs to implement health promotion services targeted at youth, particularly around smoking, sexual health and obesity through their Health Promotion Plans. ▪ Establish screening and monitoring of Sexually Transmitted Infections (STIs). ▪ Support the implementation of the national HEHA Strategy in terms of Health Promoting Schools, increased activity levels and improved nutrition. ▪ Provide primary health nurse focused training programme for Public Health Nurses. ▪ Improve the links between providers of mental health services.
Outputs	▪ Recommendations of the Youth Health Position Paper are implemented. ▪ A Health Promoter Workplan is completed for adolescent oral health promotion services. ▪ PHOs are funded to provide free sexual health services to people under 21. ▪ STI network developed and an out-reach programme established ▪ Public Health Nurses are support to complete appropriate training including: the Collaborative Trust HEADDS programme, the NZQA Family Planning course and the National Heart Foundation Stage 2, Smoking Cessation course. ▪ Mental Health NGOs and the HSS division better understand the role of each others services and develop a format to enable networking.
Measure	▪ Reduced Ambulatory Sensitive Admissions for children 0-4 years (POP 09).

Aim	Work to provide ongoing sustainability, child and youth health services in Canterbury, improving national consistency and providing leadership.
Sponsor	GM, Planning and Funding
Actions	▪ Review the funding and overall spend for child and youth service in Canterbury looking particularly at Maori and Pacific services and evaluating our ability to address inequalities in health status, and set common priorities. ▪ Develop closer links with other South Island DHB funders to share knowledge and information and to ensure regional and national consistency in service access and delivery. ▪ Encourage greater provider accountability through improved understanding of guidelines and service development needs. Introduce longer agreement terms for provider contracts with integration of agreements where possible to improve long-term planning and streamline the contracting processes.
Outputs	▪ Regular comparative analysis of agreements is undertaken by region and reported accordingly allowing for national benchmarking. ▪ An effective process is implemented to ensure quarterly monitoring returns are reviewed and updated so that any under-delivery or service need is quickly identified and effectively resolved.

Oral Health

One major undertaking in child and youth health this year is the implementation of the Ministry's Oral Health Reform. This reform includes a move away from the traditional school dental clinics to modern community oral health services with increased emphasis on prevention. The new model involves close collaboration with providers, PHOs and private dentists and will create a community focused service to address inequalities faced by Maori, Pacific, rural and low income groups.

The new model will also address workforce issues being faced by school and community dental services addressing professional and personal isolation issues and promoting more interactive and educative service roles.

Aim	Improve child and adolescent dental health services in Canterbury, promote good oral health practice and ensure long-term sustainability of dental services.
Sponsor	GM, Planning and Funding GM, Organisational Support and Development
Actions	With approval from the Ministry - Implement the recommendations of the DHB's Business Case for Investment in Child and Adolescent Oral Health Services, approved by the Board, February 2007. ▪ Reorientate oral health services to align with the DHB's identified health gain priorities: Child and Youth Health, Maori Health and Disease Prevention and Management: ▪ Increase the hours of oral health service to include school holidays and extended working days; ▪ Maximise the benefits to the community by locating mobile examination and treatment clinics to target at risk and high need population groups; ▪ Measure and report access to all services by Maori and non-Maori and set targets to reduce inequalities in oral health status. Improve integration and configuration of services and apply a health promotion/disease prevention approach to service delivery. ▪ Implement the Adolescent Oral Health Promotion Project working with PHOs to encourage youth to make the most of the free oral health services available to them. ▪ Ensure oral health messages are promoted along with other healthy lifestyle messages particularly as part of the HEHA Strategy; ▪ Promote awareness of the role and value of fluoridation in oral health; and ▪ Implement the pre-school early identification and presentation service. Enhance clinical and management partnerships considering the changing mix of skills required for future service provision and the new model of care for community oral health services: ▪ Foster collaboration and cooperation between dentist, dental therapists and dental assistants; ▪ Utilise support for shared service provision or employment such as the development of dental teams in rural communities; and ▪ Support the development of joint initiatives with dentists in specific services areas such as non-attending adolescents. Encourage a flexible approach to reflect the changing needs of our community and support the development of an oral health workforce providing the 'right skills' for the best health outcomes and ensuring long-term capacity for service provision. ▪ Nurture relationships with education providers to support recruitment and training; and ▪ Continue with the refresher course for dental therapists returning to work and respond to changes in working conditions to retain experienced staff. Increase the level of community action amongst the health sector and intersectorial partners to improve the knowledge and skills base to implement a population health approach. ▪ Increase parent/whanau participation in the oral health care of children and adolescence; and ▪ Consult with stakeholders to ensue the project addresses main issues and concerns.
Outputs	Implement Stage 1 of the Investment in Child and Adolescent Oral Health Services Business Case: ▪ A DHB Project Steering Group is established to oversee the project and a Facilities Project Manager is appointed and responsible to the construction of facilities (fixed and mobile) and liaison with site owners; ▪ A plan is developed to manage service delivery models during transition with a set of key messages for staff so that they can champion and communicate the service vision during the transition process and keep all staff and schools informed; ▪ A system is developed to support monitoring, reviewing and updating the service plan and making evidence based changes; ▪ A process is developed to track and monitor the uptake of service to ensure high risk children continue to receive regular oral health care; and ▪ Construction of the first community facilities is completed by the end of the 2008 calendar year with purchase of mobile units to support each clinic.

Measure	▪ Regular monitoring and reporting of population health indicators for oral health. ▪ Demonstrated increase in adolescent oral health utilisation (POP 11). ▪ A reduction in the incidence of dental disease amongst children and adolescences and a decrease in the inequalities between population groups (POP 04 and POP 05).

6.2.2 Health of Older People

Canterbury is faced with the challenges of an ageing population with estimates that by 2021 nearly 20% of our population will be over 65. People in older age groups, particularly those over 75 and in the last year of their life, consume significant health resources and we must plan ahead to meet our populations future needs. Again this Strategic Priority chosen by the DHB is also one signalled by government and identified by the Minister of Health as a Priority for 2007/08.

In 2002 the Ministry's national Health of Older People (HOP) Strategy was released and subsequent to this (February 2006) the DHB developed a comprehensive health strategy for older people, *Healthy Aging, Integrated Support*. This Strategy provides us with the platform to implement the national HOP Strategy at a local level and the focus and aims of our Strategy are in line with the direction of national work. Our HSS Older Person's Health Service have developed a 'Directions 2006-2010' document, providing specific direction for the HSS in implementing the changes outlined in the DHB's *Healthy Aging Integrated Support* Strategy.

Implementation of the local Strategy has already resulted in the following achievements:

- Further development of home care packages as alternatives to residential care and transitioning of rest home beds to hospital level to meet changes in demand;
- A review of community day support options, with increases in capacity for general and dementia stand-alone day activity centres;
- Development of a map of service location, type and demographics, which will help to improve planning for additional older person's services;
- Development of a database which identifies entry, exit and length of stay trends in residential care and that will assist with future capacity planning;
- A joint initiative with the Nurse Maude Association and Healthcare NZ to improve access to complex wound care for subsidised residents in aged residential care. This two year project is a first in NZ will also focus on mentoring registered nurses and promote improved wound management (less pressure ulcers and other complex wounds) and therefore fewer admissions to secondary care;
- Completion of the two year trial of the geriatric assessment tool, International Resident Assessment Instrument (InterRAI) (Minimum Data Set Home Care Version) with approval for wider use of the tool within our HSS Older People's Health Service. This tool aims to improve coordinated clinical assessment by avoiding duplication and using one integrated plan for each patient. The information captured will also provide insight into the health needs of our ageing population;
- Introduction of a HEHA Nutrition Initiative resulting in additional funding from the Ministry to continue the work. Working with Partnership Health PHO, several nutrition pamphlets and a recipe book were developed for specifically for older people and made free to those living independently and at risk of poor nutrition. Over 1000 initial copies were distributed and a reprint of the recipe book has been undertaken;
- Utilisation of Blueprint funding for re-establishing a Psychiatric Service for the Elderly Memory Assessment Clinic;
- Continuation of the 'Stay on Your Feet' fall prevention programme. Funding has enabled the employment of a Programme Coordinator and further roll-out of the programme;
- Completion of an HSS Community Stroke Service pilot, resulting in improved outcomes for older people and their families; and
- Completion of a pilot to explore the needs of older Maori with particular focus on those admitted to inpatient units which contributed to the development of *Te Huanui,* our Maori Health Plan for Older People and the employment of a dedicated Maori Health Worker.

Our priority for 2007/08 is the continued implementation of both our local Strategy and the national HOP Strategy. We will focus on continuing to support older people in the community and away from institutional care through flexible packages of care and the development of new care coordination and case management models. We anticipate completion of the review of the Needs Assessment

Service Coordination Service (NASC) model in early 2007 and implementation of the outcome of this review in 2007/08.

We will continue to increase community based services, with the introduction of Community Support Worker roles and an increase in stand alone day support facilities. We will also collaborate with primary and community providers to develop integrated continuums of care for older people and will continue the focus on a smooth transition between services and a restorative/rehabilitation approach.

We will continue to work on positive relationships with providers, particularly around capacity and capability issues, quality improvement, workforce development and fair employment practices. Improved management of elective services and increasing access to orthopaedic and cataract surgery will also benefit older people (see Section 7.1.5) and we are also positive about the direction and input being received from the Elder Care Canterbury reference group established in 2006. This group will be a key consultation group for the continued implementation of our Strategy.

Aim	Ensure effective primary and population health services reaching those most in need.
Sponsor	GM, Planning and Funding GM, Older Person's Health (HSS) GM, Community and Public Health
Actions	▪ Work with primary and community providers to target illness prevention, early intervention and effective treatment and interface on shared priorities and goals. Focus on increased screening by nurse led clinics, falls prevention, influenza vaccinations, oral health for older people and continuation of nutrition initiatives for older people – particularly those most at risk. ▪ Ensure primary care is accessible and effective focusing particularly around access to services, enrolments in PHOs and assisting PHOs to reach those most in need by promoting Care Plus to those over 65. Consider the use of the InteRAI assessment tool in primary and community settings and further develop the Medicines Use Review with an older person's focus. ▪ Work with Housing New Zealand and the CCC sharing goals for addressing the determinants of health for older people and the working with the CCC on a strategy of older people around neighbourhood groups and community services.
Outputs	▪ The joint CCC and DHB Winter Warmth initiative is continued. ▪ Increased numbers are enrolled in the 'Stay on Your Feet' falls prevention programme.
Measure	▪ Influenza Immunisation Rates for over 65s in Canterbury remain high. ▪ PHO enrolments of those over 65 remain high with improvement in the number of older Maori enrolled and those 65+ accessing Care Plus services. ▪ Reduced Ambulatory Sensitive Admissions for older people (POP 09).

Aim	Address barriers to accessing services and improve service coordination.
Sponsor	GM, Planning and Funding GM, Older Person's Health (HSS)
Actions	▪ Continue the roll-out of the InterRAI assessment tool to improve identification of service requirements and implement the outcomes of the review on the NASC model, working particularly with those most at risk. ▪ Implement an improved model of care for specialist community based services – the CARE Team Model[21]. Focus on the rehabilitative component of the CARE model and support national workforce initiatives for home based care and specialist support for GP and primary services. ▪ Enhance discharge planning via improved inter-disciplinary team models in in-patient settings. ▪ Scope the provision of a seven day a week allied health community and in-patient service. ▪ Use the Map of Canterbury Services (developed in the past year) to focus on allocation vs utilisation, evaluate bed availability for respite and the use of booking systems and evaluate the impact of increased day support and activity based services.
Outputs	▪ Older Person's Health Assessors and other disciplines have been trained to use the InterRAI Home Care Assessment tool. ▪ Implementation of a Community Support Worker Role to promote intermediate care models. ▪ The HSS Community Stroke Service pilot is implemented as part of the wider community

[21] *The CARE Team Model – Coordinates, Assesses and Rehabilitates the Elderly.*

	services configuration providing stroke patients with access to the full continuum of care (acute, rehabilitation and community service provision). ▪ Scope is completed for the seven day a week service for allied health provision.
Measure	▪ InteRAI and NASC results show improvement in service identification vs service delivery.

Aim	Improve the responsiveness of health and disability services for older people and the coordination between community services.
Sponsor	GM, Planning and Funding GM, Older Person's Health (HSS) GM, Community and Public Health
Actions	▪ Improve the Patient Journey for older people promoting best practice guidelines and awareness of older people's culture with a particular focus on outpatient services. ▪ Improve and develop the cultural awareness within Older Person's Health Services with regular hui and fono and participation of Maori in older person's health services.
Outputs	▪ There is Maori representation on the Elder Care Reference Group. ▪ The Older Person's Health Service Maori Health Action Plan *Te Huanui* is implemented to enhance responsiveness of HSS services.

Aim	Work to ensure that Home Support Services are effective and efficient and that there is a collaborative approach to service provision through improved coordination of services.
Sponsor	GM, Planning and Funding GM, Older Person's Health (HSS)
Actions	▪ Continue to work with providers to develop strategies to assist in the retention and recruitment of carers to ensure a workforce that is flexible and available to provide the services required. ▪ Implement the recommendations of the review of the roll of District Nursing Services in Canterbury working with individual providers to enhance the services provided and implement regular key stakeholder forums to support collaborative service improvement. ▪ Scope the development of a Home Based Support Services Restorative Model of Care, looking at moving away from tasks focused on illness to a wellness prospective.
Outputs	▪ Develop an HSS workforce plan to address the ageing and part-time workforce issues and collate robust data on the current status of our workforce - link into the work being done nationally around workforce recruitment. ▪ Implement Key Stakeholder Forums on District Nursing. ▪ Establish a working party to scope a Restorative Service Model and complete a Request For Proposal (RPF) process to establish provider/s to commence a pilot project.

6.2.3 Maori Health - He Korowai Oranga

Although progress has been made, Maori Health remains an identified priority both locally and nationally. In line with national trends, Canterbury's Maori population has on average a poorer health status than other groups in the region. Maori are twice as likely to develop diabetes, have a shorter life expectancy and are over-represented in measures such as, injuries and heart disease.

A number of strategies are in place to address these disparities in health status and we continue to work closely in partnership with the Maori community and Maori health providers to make continued improvements in Maori health provision with the aim of reducing present inequalities.

We have a regular meeting schedule with Ngai Tahu, as Manawhenua of the district, through Manawhenua ki Waitaha and a representative of Ngai Tahu has been invited to sit as an observer at the Board table. We also meet with Te Runanga o Nga Maata Waka representatives and engage in both formal and informal interactions with Maori providers, agencies and community organisations. The outcomes of these meetings feed directly into our planning processes to ensure Maori participation in planning the long-term direction for Maori health in Canterbury.

We are also pleased to have welcomed a new Kaumatua to the DHB who actively participates in the Te Kahui Taumata group, along with our Taua and Executive Director of Maori and Pacific Health, providing expert advice directly to our CEO.

Over the past year progress has been made in implementing projects that support our Maori Health Plan, *Whakamahere Hauora Maori ki Waitaha*. The Plan, developed in 2002 and currently being revised, recognises our Treaty of Waitangi obligations within the framework of the NZPHD Act and is consistent with the directions outlined in the national Maori Health Plan, *He Korowai Oranga*.

A number of achievements have been made in implementing the direction set out in our Maori Health Plan over the past year:

- Extension of the Christchurch Hospital Maori Health Team working in key services to achieve better health outcomes for Maori patients, particularly services that require cultural protocols (Paediatrics, Oncology, Sexual Health, the Emergency Department and the Mortuary).
- Provision of a cultural programme to Burwood Hospital staff, assisting them to understand how Maori views and values can impact on their clinical practice. It is anticipated that a specific cultural training programme for DHB contract managers and for Board members (currently under development) will be implemented in the 2007/08 year;
- Collaboration with Partnership Health PHO in developing a smoking cessation service targeting Maori women and their families to improve the health of this at risk population;
- Collaboration with local Maori groups to implement a smoke-free marae campaign with several local marae now having designated smoking areas and one becoming smoke-free; and
- Development by Te Korowai Hinengaro Oranga ki Waitaha (a joint Canterbury mental health provider network), of two programmes:
  - An orientation programme to coordinate and integrate Maori mental health services by providing a comprehensive introduction to the Maori mental health provider community in Canterbury and fostering collaboration between the different providers; and
  - A training programme offering governance training to the provider network covering topics from self analysis and strategic planning to financial management. This programme is funded through the DHB, by the Ministry's Maori Provider Development Scheme (MPDS) and will assist providers to provide input into strategic planning.

We continue to work on capacity and capability issues through Te Herenga Hauora o te Waka a Maui (the South Island Maori Managers Network), where a number of projects have been developed to support Maori service provision in Canterbury. These include:

- The development of a Maori Health Workforce Development Plan, *Te Waipounamu*, now in the final stages of consultation;
- The development of a South Island regional Maori workforce recruitment project to enhance the Maori health workforce in our region;
- The development of a Maori health training and education opportunities directory, currently being distributed to Maori health providers; and
- A review of the MPDS, the results of which are being discussed with the Ministry with recommendation expected to be released for implementation in 2007/08.

We have also set expenditure targets for all Maori health services and service-related initiatives in 2006/07 and have established a monitoring programme that we will implement in the coming year. The focus for 2007/08 centres on the implementation of our revised Maori Health Plan and around progression of collaborative projects and initiatives put in place over the past year.

The revised Maori Health Plan was taken to the Board for approval and it has been decided that the Plan will been taken out for further consultation and key stakeholders within the Maori community have been asked to participate in a final review of the Plan. Three consultation hui were held in early 2007 to finalise the Plan which will be re-presented for final approval to the Board.

Aim	Implement the revised Canterbury DHB Maori Health Plan (once approved).
Sponsor	Executive Director Maori and Pacific Health GM, Planning and Funding
Actions	▪ Maintain relative investment in Maori health, implement expenditure targets for all Maori health services and service-related initiatives and a monitoring framework that meets internal and external accountabilities for the community and the DHB. ▪ Review Maori health policy and quality frameworks, within the DHB and its community providers and support Maori providers' participation in quality improvement programmes. ▪ Continue support for Maori provider capacity and capability through the MPDS. Reinforce key

	messages: Quality, Sustainability, Collaboration and Cooperation and evaluate the impact of that scheme. ▪ Progress the Ethnicity Data Collection Project to ensure that all DHB sites collect ethnicity data and introduce processes and systems to analyse that data to determine and formalise access levels and access issues for Maori. ▪ Implement the Maori Mental Health National Strategic Framework, *Te Puawaitanga*, and other mental health frameworks, as well as continued implementation of Mental Health Blueprint and the Mental Health Workforce Development Plan, *Tuutahitia te Wero* . ▪ Continue collaboration around national and local strategies that promote health in areas of priority for Maori such as healthy nutrition and increased physical activity (HEHA and HEAL). ▪ Scope and implement innovative service delivery initiatives in Maori health provision.
Outputs	▪ The revised Maori Health Plan is endorsed. ▪ A Monitoring Framework is implemented. ▪ Maori Health Policy and Quality Framework are reviewed. ▪ The MPDS is reviewed and innovative service delivery initiatives for Maori are implemented.
Measure	▪ Demonstrated improvement in the DHB's inpatient Ethnicity Data Collection. ▪ Demonstrated improvements in the pathways of care focused on improving outcomes and reducing inequalities for Maori (HKO 03). ▪ Actual expenditure on Maori Health is reported (HKO 04).

Aim	Ensuring a coordinated, population based, community approach to reducing disparities and fostering Maori community participation at all levels throughout the DHB.
Sponsor	Executive Director Maori and Pacific Health GM Community and Public Health
Actions	▪ Ensure Maori input into key DHB strategies, PHO process and other integration initiatives particularly in key areas for Maori such as Child Health, Diabetes, and Cardiovascular Disease and focus on pathways of care that will lead to better outcomes for Maori. ▪ Continue to enact, in consultation with Maori, appropriate processes to engage with the Maori community and Maori providers. Formalise the relationship that exists with Ngai Tahu and Manawhenua ki Waitaha through the development of a formal relationship agreement. ▪ Continue regular Maori community consultation hui and participate in intersectoral Maori networking forums and initiatives that positively affect Whanau Ora. ▪ Identify and support Maori-led community development in priority areas. ▪ Continue current involvement in the activities of groups such as: Christchurch Social Policy Integration Network, the Housing Network and Strengthening Families and foster relationships with Te Puni Kokiri and the Ministries of Education and Social Development to address environmental disparities that effect health status. ▪ Improve Maori health status by promoting smokefree lifestyles, as articulated in Auahi Kore initiatives and the Aukati Kai Paipa programme.
Outputs	▪ A formal relationship agreement is in place between the DHB and local iwi. ▪ At least two key milestones from the Mari Health Plan have been achieved in 2007/08.
Measure	▪ An increase in the number of PHOs with Maori Health Plans agreed to by the DHB (HKO 01).

Aim	Further develop the Maori health and disability workforce and work to improve the cultural responsiveness of Canterbury health services.
Sponsor	Executive Director Maori and Pacific Health Group Manager, Human Resources
Actions	▪ Complete the DHB's Maori Workforce Development Plan. The main aim is Whanau Ora with the key focus being the implementation of He Korowai Oranga. ▪ Implement cultural development training for staff, establishing a cultural training programme for contract managers and ensure Board members are also offered training. ▪ Support a trainer position in the DHB's Maori Health Team to develop workforce initiatives, provide cultural training and to develop Tikanga practice guidelines for service delivery. ▪ Collate Maori health workforce data to identify baseline and project areas and develop a

	workplan to implement a strategic directional plan for Maori health workforce needs. ▪ Continue to work with HSS to promote Maori health knowledge and training for non-Maori staff. ▪ Continue to work with the education sector to promote Maori health careers and to support the Te Waiparanu Recruitment Specialist Project to promote health careers to Maori students.
Outputs	▪ Implementation of the DHB's Maori Health Workforce Plan is underway. ▪ A workplan of cultural training programme is development. ▪ Board members received Maori cultural training assisting them to understand how Maori views and values can impact on their governance role. ▪ Tikanga Best Practice Guidelines for staff are distributed.
Measure	▪ Demonstrative improvement in the DHB's recording and monitoring of staff ethnicity (HKO 02). ▪ All Board members receive cultural training (HKO 01)

6.2.4 Primary Health

Primary care is often the first point of contact with the health sector and reducing barriers to access helps people to stay well and avoid hospital admission. Statistics show us that costs may be a significant barrier for some people; hospitalisation rates for people on lower incomes are higher than the Canterbury average.

Since 2002 major changes have been made to the way primary health care is funded and delivered in NZ. As part of the Ministry's national Primary Care Strategy, PHOs have been created to help deliver primary care services to communities. PHOs are seen as the key vehicles in achieving improvements in primary health outcomes and reductions in inequalities.

Canterbury has five PHOs that encompass the region and we have developed a close working relationship with those PHOs[22]. Together we have achieved a number of successes in implementing the Primary Care Strategy over the past year:

- PHO enrolments cover 98% of the Canterbury population, with all PHOs providing Care Plus;
- The implementation of several 'Services to Improve Access' programmes including: longer GP consultations, school health clinics, community nursing services;
- Collaboration on health promotion programmes including smoking cessation, youth oral health, physical activity and nutrition programmes. Successful implementation of the Meningococcal B vaccination campaign was a significant collaborative effort between the DHB and PHOs along with the development of a nutritional cookbook for older people. Health promotion funding has also enable initiatives such as the funding of a Pacific Worker in Ashburton (by the Rural Community PHO) focused on chronic conditions;
- Streamlining of primary care service funding to ensure limited funding is targeted at key health priority areas. This includes our commitment to fund all primary care through PHOs;
- Continued development of audit process for PHOs to enhance better ways of working. All PHOs in Canterbury are now enrolled in the PHO Performance Management Programme enabling the DHB to monitor their performance in line with key indicators;
- A review of Acute Demand and After Hours Cover in Canterbury in collaboration with PHOs and GPs, resulting in the development of the Canterbury DHB After Hours Discussion Paper; and
- The DHB has also made available additional resources to increase Pacific community nursing services in Canterbury. District Nursing Organisations and PHOs will be able to utilise the expertise of this nursing position to help reduce inequalities faced by Pacific People particularly around chronic conditions management;
- The development of the Canterbury DHB Primary Mental Health Positioning Paper and continued implementation of Mental Health Demonstration Models within primary care.

A priority not only for us but also for government; we will continue to support the ongoing implementation of the Primary Care Strategy and will aim to enhance the our population's health by improving access to primary care and public health programmes designed to meet local needs and to reduce inequalities in access and in health status.

We support the priorities of the joint DHB/Ministry Implementation Work Programme signed off in mid 2006 and will emphasis the following priorities in 2007/08:[23]

[22] *The Canterbury Community, Rural Canterbury, Hurunui Kaikoura, Partnership Health and Christchurch PHOs.*

- PHOs and DHBs working more closely together;
- PHOs involved in DHB planning, particularly primary/secondary interface and shared targets;
- Development and consolidation of primary health capacity and expertise;
- Rapid development of population health and a focus on chronic conditions; and
- Improved governance and the involvement of communities in PHO governance.

The DHB's representatives regularly attend PHO Board meetings to provide support and direction in PHO development and strategy. The DHB will continue to support any necessary changes to the PHO agreement and will utilise the Ministry Toolkits to support change regarding PHO governance. Attendance at these PHO Board meetings has shown that the Maori and Pacific representatives within PHOs in Canterbury have key input into PHO decision making and setting direction. To further assist these PHO Board members the DHB is considering facilitating meetings between these PHO representatives and the DHB's Executive Director of Maori and Pacific Health.

In addition to the work being done to implement the Primary Care Strategy we have been working to improve access to all primary care services including pharmacy and laboratory services, oral health services, community mental health services and home support services. In 2006/07 we:

- Completed the Review of Community Laboratory Services resulting in retention of the multi-provider structure, adoption of a risk-sharing model of funding, splitting of the pre-analytical and analytical service components and development of a Laboratory Reference (Stakeholders) Group; and
- Continued the evaluation of the role of Pharmacy within the primary care environment. This has been driven by the pilot of the Pharmacy Based Medicine Management Service (Medicines Use Review) where positive evaluation has resulted in a DHB wide implementation of the service.

This work will continue in 2007/08 with emphasis on the effective management of demand, the collaborative development of disease management tools such as disease registers and on integrated care continuums for chronic disease and the management of long-term illness.

Aim	Streamline primary care services and work with the sector to reduce the number of avoidable admissions to hospital.
Sponsor	GM, Planning and Funding
Actions	Continue to work with PHOs to implement the Primary Care Strategy; focusing on reducing inequalities and providing support for GPs to allow them to manage the care of their enrolled populations by: ▪ Continuing to reduce economic barriers and inequalities to access in primary care by implementing reduced subsidies for 25-44 year olds and supporting any change in government policy regarding free health care for under six year olds; ▪ Continue to implementation of a variety of new PHO services including mental health workers, child health liaison workers and chronic care programmes; ▪ Complete the DHB and Canterbury PHO After Hours Cover Discussion Paper and implement the recommendations of this paper to ensure our population has 24-hour access to services; ▪ Complete a DHB-wide Immunisation Plan linking primary care, immunisation coordination, outreach service and NIR coordination providers to reduce fragmentation of immunisation services and improve immunisation rates in Canterbury. Work with PHOs as part of the PHO Performance Management Programme on meeting targets for childhood immunisations. ▪ Work with the PHOs to determine their role in the areas of pharmacy, laboratory and personal health services.
Outputs	▪ Agreement is reached with PHOs to reduce co-payments for the 25-44 year age group. ▪ New PHO services are implemented with a particular focus on high need groups. ▪ The recommendations of the After Hours Cover Discussion Paper are implemented. ▪ A DHB-wide Immunisation Plan is developed regular NIR newsletters are circulated and regular practice based audits are implemented.
Measure	▪ An increase in the percentages of children fully immunised (POP 08). ▪ Reduced Ambulatory Sensitive Admissions (POP 09).

[23] *Information on the programme can be found at www.moh.govt.nz/primaryhealthcare.*

	▪ An increase in the rate of GP consultations per high need person (SER 01) ▪ An increase in the number enrolled in PHO Care Plus services (SER 02).

Aim	Ensure equitable access to Laboratory and Pharmacy Services in Canterbury.
Sponsor	GM, Planning and Funding
Actions	**Laboratory Services** ▪ Continue to implement the recommendations of the Review of Community Laboratory Services; ▪ Continue to contract in a way that ensures consumer choice and access to multiple collection facilities; ▪ Promote access to phlebotomy services for high needs populations; and ▪ Work with the Laboratory Reference Group to ensure the community is informed of pathology-related issues and initiatives within Canterbury. **Pharmacy Services** ▪ Implement Medicine Use Review Services across Canterbury with the aim of improving the management and safe use of pharmaceuticals in the community; ▪ Implement the dispensing of Clozapine by Community Pharmacy; and ▪ Continue to work with Pharmacies to investigate their role within the primary care sector and PHO environment.
Outputs	**Laboratory Services** ▪ A review of phlebotomy services and collection facilities is undertaken. ▪ A Strategy regarding the sharing of Laboratory results is developed. **Pharmacy Services** ▪ Medicines Use Review services are implemented. ▪ Dispensing of Clozapine is devolved to Community Pharmacy. ▪ Working with the Pharmacy Reference Group a 'New Services' pilot is implemented.
Measure	An increase in the number of government subsidised community pharmaceutical items dispensed by pharmacies and an increase in the number of tests carried out by community laboratories – submitted with valid NHI numbers (SER 03).

6.2.5 Disease Prevention and Management

Disease Prevention and Management is a key Health Gain Priority for the DHB and is closely aligned with the Minister of Health's priority *Chronic Disease Management*. Our four Disease Priorities, Cancer, Cardiovascular, Diabetes and Respiratory Disease, are all strongly influenced by lifestyle choices and risk behaviours.

Smoking contributes to a number of preventable illnesses resulting in a large burden of disease and is currently the single major cause of preventable death in NZ. However inactivity, poor nutrition and rapidly rising obesity rates are beginning to rival tobacco as the leading cause of preventable disease. All give rise to the disease priorities we have identified along with poor psychosocial outcomes and reduced life expectancy.

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. A complex range of environmental influences affect the lifestyle choices of our community and hence, we believe, a comprehensive multi-sector approach is needed to promote change and influence improvement in the health of our community.

In 2005/06 the Healthy Eating, Active Living (HEAL) Action Plan was developed which provides a platform for the DHB's newly appointed HEHA Development Manager to implement the national HEHA Strategy at a local level. The implementation of HEHA and HEAL have already contributed to a number of collaborative successes within the Canterbury District:

- Development of workshops on nutrition and physical activity for Pacific people working with schools and language nests and providing workshops in community halls. These workshops, run by Tagata Atumotu, Matua Pasifika and Pacific Trust Canterbury, are proving very popular with the Pacific community and a programme focused on reducing the number of young Pacific smokers is also planned;

- Implementation of Health Promoting Schools initiative which is the framework for health promotion in schools, delivered by our Community and Public Health division and focused on priority schools in the region (based on deprivation, ethnicity and other indicators of need);
- Introduction of our Health Promotion in Schools Grant. This Grant enables schools to develop initiatives around smokefree, nutrition, physical activity and mental health and well-being and we provide not only funding but also professional development assistance. We anticipate the uptake of this Grant will promote shared goals and emphasis consistent good health messages;
- Development of Appetite for Life, a six-week programme for women who are motivated to make lifestyle changes. The programme addresses physical activity issues, key nutrition issues and social and environmental influences on food choices and is designed to be delivered in a primary health care setting by a trained facilitator;
- Support for Community Action to Improve Nutrition Capacity (CATINC). This is a joint project involving funding between the DHB and PHOs with Partnership Health PHO as the lead agency. The project is focusing on workforce development (particularly in primary care) and building nutrition capacity in priority communities;
- Continued support of the Canterbury Active Communities (CAC) Project. A project which focuses on developing tools and systems for providers to encourage people to be more active, more often. This project received funding from SPARC along with a number of key stakeholders and was supported in its application by CIPANG (Canterbury Intersectoral Physical Activity and Nutrition Group). The DHB provides a governance role in the development of this project as well as funding for the evaluation tools; and
- We have also been able to collaborate on and support a number of community based initiatives to promote health and wellbeing including: research by the Canterbury West Coast Sports Trust and Partnership Health PHO into inactivity by young women 15-18, the Cancer Society's SunSmart School Programme and the Health Foundation's School Food Awards Programme.

As we move into 2007/08 the DHB is committed to its role as a leader in the implementation of the national HEHA Strategy and will ensure that there are good lines of communication between key stakeholders and providers and an appropriate governance structure in place to support this work.

The DHB will seek to build on existing services, strengthen foundations and ensure a collaborative and intersectoral approach to the implementation of the HEHA Strategy at a local level. The DHB is currently completing a Ministry Approved Plan (MAP) for implementation of the Strategy which will ensure that the DHB is committed to the implementation of the HEHA Strategy and its outcomes.

The DHB is emphasising collaborative involvement in developing the MAP and has already engaged with a range of stakeholders, providers and local community including Maori and Pacific providers to seek their input into the local direction for implementing the national HEHA Strategy.

The DHB will also continue its commitment to supporting smokefree environments and supporting smoking cessation programmes. Our focus on smoking cessation is highlighted through this document and our activity will support the achievement of health sector targets: to increase the prevalence of 'never smokers' amongst 14 and 15 years olds and the proportion of smokefree homes with one or more smokers and one or more children. This focus will also assist the DHB in addressing a major risk factor associated with our four Disease Priorities.

Also of particular note in 2006/07 was the beginning of the development of a framework for the management of chronic conditions. This framework will look at the continuum of care from 'wellness' at one end to 'unwellness' at the other and work to place the patient at the centre of the health continuum. The expected outcomes are early detection and intervention, continuity and coordination of care and improved information exchange and workforce alignment. The work will heavily influence the activity in each of our four Disease Priority areas in coming years.

Aim	Continued implement the HEHA Strategy and HEAL Action Plan - assisting our community to make healthy choices through supportive environments and a commitment to common goals for improved health and wellbeing.
Sponsor	GM, Planning and Funding GM, Community and Public Health
Actions	Work collaboratively with providers, sectors and agencies (including PHOs, TLAs, NGOs, education sector, local/regional government and Maori and Pacific providers) to promote a population-based approach to HEHA across the continuum of care with a particular focus on education, prevention, and early intervention. ▪ Foster and build policies and initiatives that meet HEHA's goals by working in partnership with

	other sectors. Assist this process by developing environments that support healthy choices. Focus particularly on supporting intersectoral agencies to *Walk the Talk*, encouraging Active Transport and creating a Healthy Hospital environment including Baby Friendly Hospitals. ▪ Foster initiatives that promote health in a range of key settings and communities. Work with the education sector to improve access to healthy food in schools and Early Childhood Centres through accessing the Ministry's Nutrition Fund, particularly those lower decile schools with the highest levels of need. Encourage work on the Under Fives Healthy Heart initiative with the National Heart Foundation and Sport Canterbury's Active Movement to promote healthy eating and physical activity in early childhood centres and Maori education centres. Work with individuals, families/whanau to promote healthy weight, healthy eating and active living. ▪ Foster systems and services to achieve and maintain healthy weight, healthy eating and active living for children and youth and their families. Focus on both population strategies to prevent the rise in obesity but also on services to met the needs of those children who are already overweight and obese. Support the HSS Paediatric Department's Healthy Families Project and the PHO/Sport Canterbury Green Prescription Active Families Model and the BFHI - promoting breast feeding in our hospitals. ▪ Foster systems and services to achieve and maintain healthy weight, healthy eating and active living for adults. Focus on cardiovascular disease, cancer and type II diabetes, and older adults at risk of malnutrition. Support initiatives which promote these messages such as Stay on Your Feet, Well Elderly and Baby Friendly community projects. Build foundations to ensure the success of the HEHA Strategy focusing on capacity and workforce development, monitoring, evaluation and communication. ▪ Communicate clear, consistent and effective messages that promote healthy weight, healthy eating and active living. Assist this by distributing health information relating to wellbeing issues through intersectoral partners. ▪ Build a skilled and knowledgeable workforce to support the promotion of healthy weight, healthy eating and active living in the Canterbury region. Support training for staff and providers particularly those working with at risk or high needs groups and support community based education programmes aimed at increasing knowledge of nutrition and physical activity. ▪ Monitor and evaluate initiatives developed through HEHA.
Outputs	▪ An effective intersectoral approach to the implementation of the national HEHA Strategy is coordinated locally. ▪ Completion of a MAP to assist in the implementation of the HEHA Strategy.
Measure	▪ Evidence of partnership and joint projects with intersectoral agencies. ▪ An increase in the number of adults (15+ in the Canterbury region) consuming at least three servings of vegetables and at least two servings of fruit per day. ▪ An increase in the proportion of infants exclusively and fully breastfed. ▪ An increase in the physical activity levels of the population in the Canterbury region.

Aim	Implement a framework for managing chronic conditions to enable better outcomes for people with chronic illness – supporting inter-sector collaboration that leads to effective development of integrated continuums of care.
Sponsor	GM, Planning and Funding
Actions	Implement a strategic framework that will enable a move from a diagnosis-centred acute episodic treatment model of care, to a person-centred, managed care model that can be applied across the community-primary-specialist continuum of care for people with chronic conditions. This framework will be used to reconfigure services for people with chronic conditions to services that: ***Are person-centred rather than provider/location-centred*** ▪ Services are built around the needs of service users, their family/whanau, carers and supports. ▪ Services will be delivered as close to the users' own environment and supports as possible. ▪ The model of service delivery and physical environment will allow or encourage staff to deliver care in a culturally sensitive and patient focused manner. Flexibility is inherent to allow for as much future-proofing as possible. ***Encompass the sector-wide continuum of care*** ▪ Service plans will be developed that span the continuum of care and promote collaboration and integration of service delivery that transcends current primary, secondary, tertiary boundaries. ▪ Service plans will support teamwork and collaboration between specialist, community and rural

	services and will cover the continuum of care including health promotion, primary prevention, early intervention and treatment - that is, the plans will not be facility based. ***Are consistent*** ▪ Service plans will be aligned to national and district policies and strategies. ▪ Service plans will use the Primary and Community Framework as developed by the DHB. ***Are evidence-based*** ▪ Service plans will be developed consistently with best practice/evidence-based approaches. ▪ Service plans will ensure quality, comprehensive health care services with a population health focus that aim to improve outcomes by understanding and responding to community needs. ***Are appropriately prioritised*** ▪ Service plans will recognise the need to optimise the use of finite resources within a context of increasing demand. ▪ Service plans will be evaluated and decisions made about which services will be delivered at what level within a clinical service area and how they may be delivered. The decision will be made using the DHB's established decision-making principles: Effectiveness, Cost, Equity, Maori Health and Acceptability (Section 2.5).
Outputs	Service plans, consistent with the framework for managing chronic conditions, are implemented for the following priority conditions: ▪ Respiratory Disease; ▪ Cardiovascular Disease; ▪ Diabetes; and ▪ Depression.
Measure	▪ Evidence of a person-centred integrated continuum of care for people with chronic conditions. ▪ Improved baseline data regarding patients, and health provider performance. ▪ Improved sharing of information between health professionals regarding patient management. ▪ Improved knowledge and self management skills for patients and their families /carers. ▪ Increased population screening for chronic conditions. ▪ Decreased ambulatory sensitive admissions (POP 09). ▪ Decreased ED presentations.

6.3 Our Disease Priorities

CANTERBURY DHB - HEALTH GAIN PRIORITIES			
Cancer	Cardiovascular Disease	Diabetes	Respiratory Disease

6.3.1 Cancer

When all forms of Cancer are grouped together it is the second largest cause of death and a major cause of hospitalisation in Canterbury. Our rates of cancer will rise over the coming year as our region's population ages, however due to improved treatment and early diagnosis the risk of dying from cancer has not increased. This change presents other challenges for us in terms of the increasing costs of cancer treatment, home based support services, palliative care and long-term chronic treatment related conditions faced by survivors of cancer.

We have begun work, with other South Island DHBs, on implementing the Ministry's national Cancer Control Strategy and Action Plan at a regional level[24]. This Strategy is the first phase in the development and implementation of a comprehensive and coordinated approach to reducing the burden of cancer through prevention, screening and early detection, diagnosis and treatment, support and rehabilitation, palliative care, data collection and research. A number of initiatives are already underway as part of the implementation of this national Strategy:

- Establishment of a South Island Regional Cancer Network whose steering group, made up of experts in the delivery of cancer services, will help advise on regional initiatives to meet the national Strategy's objectives;
- The launch of the Late Effects Assessment Programme (LEAP) and clinic for children and adolescents with cancer. More than 80% of young people with cancer survive and as they transition into adulthood many have chronic treatment related conditions needing long-term care. The clinic has been established to help monitor and support children and adolescents who have completed active cancer therapy;
- Funding for the Oncology Service's Radiation Therapist New Graduate Integration Programme designed to enhance the practical skills of graduates enabling them to integrate more easily without putting additional pressure on the clinical oncology team. This six month pilot enabled the Service to employ two additional graduates.

As highlighted in Section 6.2.5 (*Disease Prevention/Management*) we work very closely with community providers to promote health initiatives that reduce cancer rates, such as improving nutrition, promoting smoke-free lifestyles and increasing physical activity. In the past this has also included health education initiatives such as the launch of the Cancer Society's Colossal Colon to help educate the public on the importance of a healthy lifestyle in preventing bowel cancer.

Our primarily focus over the coming year will be working towards the goals and objectives of the national Cancer Control Strategy and meeting the priorities outlined in the Action Plan. We will be looking to maximise shared learning and provide the opportunity for consistency across regions. Treatment availability and cost are continuing challenges and together with community providers and agencies we will also be looking at ways to improve patient flow from diagnosis through treatment to cure or palliative care.

Aim	Work with other South Island DHBs to identify options for improved collaboration in delivering cancer treatment services and to progress the NZ Cancer Control Strategy and Action Plan.
Sponsor	GM, Planning and Funding GM, Medical and Surgical Division (HSS)
Actions	▪ Promote a population-based approach to improving screening and awareness of risk activity and disease prevention activity across the DHB's four Disease Priorities particularly: primary intervention, QUIT programmes, smokefree policy and support for HEHA and HEAL projects. ▪ Assist our community to make healthy choices through supportive physical, social, economic and policy environments and commitment to improved health and wellbeing. Working with TLAs, Maori and Pacific community groups and community agencies on the development of policy, distribution of health information, and social initiatives to reduce risk behaviours.

[24] *The NZ Cancer Control Strategy and Action Plan is available on the Ministry's website www.moh.govt.nz.*

	▪ Streamline primary health care services and work with the sector to reduce the number of avoidable admission to hospital and to promote population health and risk reduction. ▪ Further develop the Maori health and disability workforce to work to improve the cultural responsiveness of our cancer and palliative care services. ▪ Support the South Island Regional Cancer Control Network work to develop a regional approach to Cancer Control and reduction in inequalities in access and health status. ▪ Continue to support the development of service standards and multi-disciplinary teams to ensure effective diagnosis and treatment of cancer – through treatment advisory groups and tumour boards. ▪ Work through the Improving the Patient Journey Programme to reduce patient delays to diagnostic results and to achieve national targets for radiation treatment waiting times. ▪ Support innovation, development and research to encourage change in practice, increased screening and improved service delivery. ▪ Support the Late Effects Assessment Programme (LEAP) targeting paediatric patients who are assessed as being no longer at risk of disease relapse. ▪ Continue to work with providers to ensure opportunities are maximised to reduce inequalities for Maori and Pacific people.
Outputs	▪ Continued development of a regional approach to Cancer Control led by SISSAL with recommendations for future alignment of DHB and regional cancer services. ▪ Produce a DHB Implementation Plan to demonstrate local implementation of the national Cancer Control Strategy. ▪ Analyse patient demand and identify priorities for accessing critical radiology resources and identify and enactment process improvements to reduce patient delays. ▪ Evaluation of the effectiveness of the LEAP programme with recommendation for future direction. ▪ Providers are encouraged to submit applications to the Ministry for Rural Oncology and Maori and Pacific Screening Services. ▪ Support is provided to Maori provider currently providing a Ministry funded screening programme and work with the provider to reduce any gaps that may become apparent through the implementation of this programme.
Measure	▪ A reduction in delays for patient diagnostic results is achieved. ▪ Radiation Treatment Targets are met (POP 10).

Aim	Work with palliative care providers to ensure equity of access for rural and urban service users.
Sponsor	GM, Planning and Funding
Actions	▪ Establish a community Palliative Medicine Specialist position in Canterbury. Investigate opportunities for residential care facility consultations for palliative care; home/community based consultations; and community registrar supervision in palliative medicine. ▪ Continue the SupportCare funding programme. Review the role and function of Needs Assessment Service Coordination (NASC) role in SupportCare Services. ▪ Develop a multi-disciplinary focused Palliative Care Service including hospice services, care coordinators, social workers, allied health and bereavement services. ▪ Continue to work with providers to ensure opportunities are maximised to reduce inequalities for Maori and Pacific people. The DHB's recently agreed Palliative Care agreement will see additional resources available for the Canterbury community and this will be enhanced by initiatives such as a recent provider initiative employing a Maori support worker to enhance Maori access to information around Palliative Care Services.
Outputs	▪ Employment of a Community Palliative Medicine Specialist. ▪ Review of SupportCare NASC undertaken and recommendations of the Review implemented. ▪ A new Palliative Care Agreement is implemented to support a multi-disciplinary focused Palliative Care Service. ▪ Support is provided to providers to address inequalities in access for Maori and Pacific people.

6.3.2 Cardiovascular Disease

Cardiovascular Disease (CVD) includes coronary heart disease, other disease of the heart and circulation and stroke. It is the main cause of death in Canterbury and the incidence of CVD is likely to increase as our population ages, is usually linked with diabetes and is strongly influenced by lifestyle choice. Maori and Pacific have higher rates of CVD than other ethnicities.

Over the past year we have worked collaboratively to make gains in CVD and have entered into an agreement with the National Health Foundation, Partnership Health PHO and Pegasus Health to undertaken a home based Heart Guide Aotearoa Programme to support rehabilitation following heart attacks. The training programme was introduced in 2006/07 and it is anticipated that the programme will commence in 2007/08.

Other recent successes will provide a good foundation for change and improvement over 2007/08:

- A health promoter is working with early childhood centres to encourage nutritionally health and physically active environments for children to establish a foundation for healthy lifestyles. Thirty-five centres have achieved the Heart Foundation's Healthy Heart Award; and
- A primary care based CVD risk assessment project was completed in Rangiora concluding that while practice had high levels of recording information on age, smoking, cholesterol and blood pressure their current practice for screening for CVD risk factors varied greatly. The assessment also highlighted the need for additional information technology support for general practice.

A plan for minimising the effects of CVD on our population was approved by our Board in 2004. This Plan, *Canterbury Heart Health Strategy*, highlighted the importance of population-based strategies for reducing the impact and incidence of CVD and the importance of improving rehabilitation and community treatment after acute heart events. Implementation of the recommendations of this Plan will continue to direct our focus over the next year.

Challenges include curbing and stabilising childhood obesity rates through community, school and early childhood centre programmes. We also intend to increase the numbers of partnerships, collaborations and alliances across the health sector in order to develop future initiatives to reduce the risk of heart disease and to ensure long-term capacity and capability in manage demand.

Aim	Implement the actions associated with the *Canterbury Heart Health Strategy*, covering the continuum from health promotion, disease prevention, treatment, rehabilitation and palliative care.
Sponsor	GM, Planning and Funding GM, Community and Public Health GM, Medical and Surgical (HSS)
Actions	▪ Continue the DHB's collaborative health promotion approach to reducing the incidence and impact of CVD including supporting initiatives of community agencies and organisations and working with key stakeholders to promote messages related to physical activity, nutrition, weight reduction and smoking cessation. ▪ Implement the national HEHA strategy and local HEAL Action Plan. ▪ Support strategies to target heart health in Maori and Pacific communities to reduce health inequalities particularly through primary and community sector activity. Work to ensure services are culturally appropriate and work with Maori and Pacific communities to support prevention, early detection, and service uptake. ▪ Continue to work with primary care and hospital services to ensure and integrated approach to patient care and support the development of chronic disease management continuums. ▪ Continue to review specific interventions to meet indicator targets for cardiac surgery and angioplasty and (through the Improving the Patient Journey Programme) develop a chronic care pathway for cardiology patients, focused on assessing the most appropriate care setting for patients and identifying opportunities to improve care. ▪ Continue to support the Heart Guide Aotearoa Programme to support rehabilitation.
Outputs	▪ A HEHA co-ordinator is in place to ensure implementation of the national HEHA Strategy. ▪ The chronic care pathway is developed. ▪ The Health Guide Aotearoa Programme commences.
Measure	▪ An increase in the number of people who have suffered Acute Coronary Syndrome who attend a cardiac rehabilitation outpatient programme (POP 02). ▪ An increase in the number of people who have suffered a stroke event, who have been admitted to organised stroke services (POP 03).

6.3.3 Diabetes

Diabetes is estimated to cause around 1,200 deaths per year in NZ and managing diabetic complications (such as heart disease, blindness and kidney failure) is a significant burden for the country's health system. Type II diabetes, most frequently diagnosed in adults, is now more common in Canterbury's children and youth. While Type I diabetes continues to be priority for us, it is this increase in Type II diabetes, linked to poor nutrition and smoking, that is of greatest concern.

We work closely with community and primary care providers to progress a coordinated community approach to diabetes, to ensure equitable access to services and to promote timely intervention. Annual diabetes checks are undertaken by GPs and this service has been boosted by an increase in funding in 2006/07 to support PHOs to contribute to the overall direction of diabetes work in Canterbury.

One of our largest PHOs has developed a diabetes direction paper which outlines their objectives with regard to diabetes: to reduce the incidence of diabetes through prevention and health promotion strategies; to ensure effective screening and early diagnosis to reduce the impact of diabetes: to improve the quality of life for those with diabetes and their family/whanau through support and self-management; to ensure effective multidisciplinary treatment to enhance the quality of life and lastly; to improve the integration of diabetes services through planning, innovation and workforce development. These objectives strongly support the direction the DHB has chosen for diabetes, as set our in our DSP.

Success in 2006/07 centred on population-based interventions to promote healthy eating and increase physical activity and on implementation of initiatives to support our objectives and direction around increasing diabetes screening and improving self-management; these have included:

- A revised impaired blood glucose programme for those newly diagnosed with impaired blood glucose and the development of a community podiatry programme;
- The use of CarePlus to improve access to primary care services and PHO Maori Health and Health Promotion Plans which support the DHB's diabetes direction;
- Collaboration with the Christchurch Methodist Mission on the Healthy Lifestyle project helping food bank users to gain knowledge and skills to improve their own health. The Mission also improved the nutritional content of food parcels and the food and beverages offered to the public;
- Support for an opportunistic diabetes check programme by the Rural Canterbury PHO for the freezing workers in Ashburton where there is a high proportion of Maori and Pacific staff.
- Implementation of a Healthy Eating Policy for the DHB covering vending content of vending machines on DHB sites and the menus of DHB cafeterias.
- Completion of a purpose-built Diabetes and Home Dialysis Training Centre bringing together for the first time under one roof the DHB's Diabetes Services, Diabetes Life Education and Diabetes Christchurch (the local branch of Diabetes NZ). The building offers space for new treatment and assessment rooms, meeting rooms, diabetes administration and research and a Home Dialysis Training Centre.

The work that falls out of this direction happens in collaboration with the Local Diabetes Team whose membership includes a representative group of health professionals, community providers and consumer representatives with a vested interest in improve diabetes services.

This collaboration and shared direction will be important in making changes in diabetes service models and in improving diabetes health outcomes. The funding applied to diabetes prevention and services in 2007/08 is intended to impact on service outcomes, outputs and quality in a number of ways. We will continue to review diabetes services in Canterbury evaluating progress and achievements and focus on gains in this area. It is important to us to ensure accurate and robust monitoring of diabetes screening to enable a full picture of the current situation in Canterbury and to allow us to track and evaluate the success of interventions and initiatives.

In 2007 we expect to see more people diagnosed with diabetes as a result of a focus on opportunistic screening programmes, targeted to our Maori and Pacific communities. This work follows on from a local audit of diabetes case detection showing an increase in overall screening rates but a relatively small increase in screening of Maori and Pacific patients. A lifestyle programme will also be launched that aims to support people with diabetes with their ongoing management of diabetes and we anticipate an increase in overall numbers of people having annual diabetes checks.

The opportunistic screening and lifestyle programmes and the introduction of a community podiatry programme will see increased investment in diabetes in 2007/08.

Aim	Coordination of Diabetes services within the community to improve access and intervention.
Sponsor	GM, Planning and Funding GM, Community and Public Health
Actions	Continue to work in collaboration with PHOs, local agencies and organisations to raise diabetes awareness and to progress shared goals and direction. ▪ Support the implementation of both HEHA and HEAL to improve lifestyles and reduce risk behaviours. ▪ Support PHOs to provide health promotion in physical activity, nutrition and smoking cessation and to increase diabetes awareness amongst their enrolled populations. ▪ Continue to support initiatives and programmes that encourage prevention, early intervention and ongoing uptake of services by Maori and Pacific groups at high-risk of diabetes. ▪ Support an increase in the number of people with diabetes receiving annual checks and the number of diabetics managing their diabetes with adequate glycaemic control. ▪ Scope and develop an opportunistic screening programme in the community to increase diagnosis of diabetes in the Canterbury community. Target the programme at Maori and Pacific groups and low incomes families where the risk of diabetes is higher. ▪ Progress a coordinated approach to access to retinal screening and increase the rates of screening in Canterbury. ▪ Work to ensure all annual review data is collected for regional/national databases and improve the process for collecting and reviewing this information. ▪ Develop a diabetes lifestyle programme for people newly diagnosed with diabetes to provide self-management skills. ▪ Work with community podiatry services on providing access to foot care assessments and treatments for those with uncomplicated high risk feet and on providing education on foot care. ▪ Undertake a self-evaluation of the planning and funding of diabetes services in Canterbury to assess effectiveness of services over time and value for money and improve the setting of targets for achievement in out-years.
Outputs	▪ An improved process for collecting diabetes screening and management data is established. ▪ A working party is established (involving PHOs and other key stakeholders) to agree on the direction of the opportunistic diabetes screening programme. Alongside the development of the screening programme, information technology query building is developed to help identify at-risk populations. ▪ A working party is established to determine the scope of the diabetes lifestyle programme and undertake an RFP process to determine provider(s) for this programme. ▪ Community podiatry clinics are established. ▪ A self-evaluation of diabetes services in Canterbury is complete.
Measure	▪ An increase in the numbers on the diabetes register who received their annual check (POP 01). ▪ An increase in the numbers on the diabetes register that have had retinal screening in the last two years (POP 01). ▪ An increase in the numbers on the diabetes register that have good diabetes control (an HBA1c of equal to or less than 8%) (POP 01).

Value for Money

A part of the Ministry's priorities for 2007/08, DHBs are required to focus on Diabetes as a means of determining the extent to which Value for Money is being obtained through the pursuit of efficiency, productivity and innovation. To meet this expectation and to confirm its commitment to continuous improvement the Canterbury DHB will undertake a self-evaluation of the planning and funding of diabetes services based on the Diabetes Scorecard developed by PriceWaterHouseCoopers.

This evaluation will assist us to gauge our progress over time in providing diabetes related service and indicate how effective those services are in reducing the burden of diabetes. This evaluation will also assist the DHB in the setting of targets for out-years by determining the effectiveness and value of services and the best use of diabetes funding. Refer to Appendix 5 for the Diabetes Scorecard.

6.3.4 Respiratory Disease

Chronic respiratory diseases, particularly asthma and smoking related diseases such as Chronic Obstructive Pulmonary Disease (COPD) and emphysema, represent a significant public health problem. Nationally, asthma hospitalisations are higher for Maori than non-Maori despite asthma prevalence being similar in Maori and non-Maori children. Improved asthma self-management has been shown to significantly reduce hospital admissions.

Having identified Respiratory Disease as one of our four disease priorities we have, as an initial step, conducted a review of work currently being undertaken to meet the community's needs under this priority and identified some positive work being done in the region:

- Collaboration with Maori health teams and Hauora Matauraka and primary care providers on promoting smokefree environments and smoking cessation.
- Working with the CCC and other TLAs in Canterbury on a Health Housing Project looking for collaborative solutions to help improve air quality and create warm, dry homes for the elderly, the very young and low income groups. A research project is also underway to monitor 100 homes where there is a child diagnosed with asthma; and
- Provision of specific services to improve the management of respiratory disease such as: outreach services, diagnostic testing, pulmonary rehabilitation classes, a sleep laboratory and the South Islands only bronchoscopy services.

In the coming year we will work to formalise a direction to help manage respiratory disease in Canterbury and further develop collaborative relationships to reduce risk factors, improve screening and early intervention levels and self management of respiratory diseases and to promote rehabilitation and continuums of care for chronic conditions.

Work being done on the development of a framework for the management of chronic conditions and the development of service models as part of our Health Services Planning project will lead the direction for respiratory disease action over the coming year.

Aim	Work collaboratively to address risk activity that impacts on respiratory disease, to provide appropriate and timely treatment and work to improve the quality of life for those with chronic respiratory disease.
Sponsor	GM, Community and Public Health GM, Planning and Funding
Actions	▪ Support the development of a framework for the management of chronic conditions and the development of a Health Services Plan to ensure that respiratory disease continuums of care are considered and developed. ▪ Through the Improving the Patient Journey Programme, develop a chronic care pathway for respiratory patients, focused on assessing the most appropriate care setting for patients and identifying opportunities to improve care. ▪ Continue to work on reducing exposure to second-hand smoke and the uptake of smoking by strengthening smoke-free promotion and support smoking cessation programmes. ▪ Continue to work collaboratively with external agencies and organisations to reduce admissions with influenza and asthma – contribute to joint projects such as the Warm Homes Project to ensure adequate home heating for older people to keep them healthy in their own homes. ▪ Work collaboratively on influenza immunisation planning and awareness. ▪ Support Maori and Pacific initiatives to reduce asthma admissions in children. ▪ Improve the self management of respiratory disease through enhanced provision of education and support to patients, families/whanau and caregivers.
Outputs	▪ Service plans, consistent with the framework for managing chronic conditions are developed for respiratory disease as an identified priority condition under the Health Service Planning Programme. ▪ A joint care plan for chronically ill respiratory patients is commenced through the Improving the Patient Journey Programme. ▪ HSS sites remain smokefree and smoking cessation support is offered through HSS divisions. ▪ Canterbury retains a high level of update of influenza vaccinations.
Measure	Risk Reduction – Smoking rates in Canterbury decrease across population and age groups.

7 ADVANCING OTHER GOVERNMENT PRIORITIES

As a DHB we have a number of non-negotiable obligations and responsibilities under key national health strategies, the NZPHD Act, the Treaty of Waitangi, Crown Funding Agreement and as part of the Minister of Health's yearly and ongoing expectations and priorities. The following section addresses the specific expectations that fall outside our DSP priorities but never-the-less reflect ongoing work in our region.

7.1.1 The NZ Disability Strategy

The Canterbury DHB has a current Disability Strategy Action Plan 2004/2007 (*Action Plan for Disability*). This Plan sets out objectives and priorities for implementing the NZ Disability Strategy at a local level. In the past year we have worked to implement the principles of the Strategy including:

- Completing a survey of our HSS divisions which outlined the key areas of progress under the NZ Disability Strategy;
- Participating in the scoping of a project to address issues pertaining to assessment and referral of children with disabilities; and
- Conducting a survey of consumers of our services to better understand how the services can meet the needs of patients and consumers.
- Building new facilities (Christchurch Women's Hospital, the Diabetes Centre and redevelopment of Burwood Hospital) has also offered us an opportunity to upgrade service delivery in terms of the needs of people with disabilities through implementation of the DHB Accessibility Plan.

The DHB's HSS Rehabilitation Services are located at Burwood Hospital and include: the Burwood spinal unit, musculoskeletal services, brain injury rehabilitation services, pain management services and orthopaedic rehabilitation. The Burwood Spinal Unit is one of only two such units in the country and treats 60% of NZ's spinal injury patients. The Spinal Unit is also involved in leading international research to help spinal patients rehabilitate and adjust.

A key success for our Rehabilitation Service over the past year has been the implementation of a Circuit Training Programme. The aim of this programme is to reduce physiotherapy outpatient waiting times and improve the efficiency of delivery without increasing therapist case loads. The programmes aims also includes increasing participant satisfaction, improving reporting and auditing and improving therapist satisfaction and morale - therefore assisting with effecting staff recruitment and retention. This change in the model of service delivery will mean the same resources can be allocated differently and allow a more flexible service that best meets the patients needs. We will aim to continue to improve service delivery over the coming year.

In developing our Disability Action Plan, we recognised that we cannot address every barrier over night but can take a step by step approach to practical and attitudinal changes that will benefit everyone. We see the NZ Disability Strategy as a 'whole of government strategy' of which we form only a part and during the coming year we will continue to work to achieve our objectives in the areas we are able to influence:

Aim	Progress the objectives of the NZ Disability Strategy though implementation of the DHB's Disability Action Plan – address, maintain or promote physical and non-physical accessibility issues.
Sponsor	GM, Older Person's Health and Rehabilitation (HSS)
Actions	Ensure that the health concerns and needs of people with disabilities are known at a service and planning level: ▪ Collect through patient admission data information on a patient's disability, including type of disability, severity, particular needs and any other information the patient deems relevant; ▪ Continue to survey patients, as part of the monthly consumer satisfaction surveys to assist in determining what consumers of health services want in order to improve their experience; and ▪ Ensure the DSAC workplan is informed on progress against the Disability Strategy Action Plan. Work to reduce inequalities of access to health services for people with disabilities: ▪ Implement actions from the DHB's Maori Disability Strategy Development Project to help meet disability needs of Maori with disabilities; ▪ Continue to ensure all site redevelopment conforms to current standards of accessibility through adherence to the DHB's Accessibility Plan;

	▪ Continue to provide 24-hour interpreter services, including those for Deaf people, in all major hospitals and comply with the requirements of the NZ Sign language Bill when enacted into law and as funding allows. Enhance HSS Specialist Rehabilitation Services: ▪ Develop Strategic Business Plans that support rehabilitation in the patient journey for Spinal Services, Brain Injury Services and Pain Management Services. ▪ Work with the DHB's Business Support and Site Redevelopment Divisions to progress the redevelopment of Burwood Hospital to improve delivery of rehabilitation services on this site. ▪ Identify areas of challenge with regard to workforce and develop sustainable workforce plans to meet ongoing staffing requirements in those areas. Work collaboratively with other organisations and agencies in Canterbury to eliminate barriers that people with disability face in their daily lives and ensure equitable access to our services: ▪ Continue to work through Healthy Christchurch and other similar joint ventures to highlight health and disability issues for our population. ▪ Maintain links to assist people with disabilities to return to the community including liaison with ACC, Lifelinks, domiciliary care and equipment access.
Outputs	▪ Strategic Business Plans are developed for the DHB's Specialist Rehabilitation Services. ▪ A review of Stage II of the Burwood Redevelopment is undertaken and a framework is developed for the Business Case for Stage III. ▪ Workforce Plans are developed for HSS Rehabilitation Services to support service demands going forward.

7.1.2 The NZ Mental Health Strategy

Completion of the DHB's Mental Health and Addictions Strategy in 2004 provided a local framework for managing access to, and delivery of, a 'System of Care' model based on advancing recovery for people with serious mental illness. This marked a shift away from tertiary and secondary services towards community-based care with increased collaboration between providers, service users and their families/whanau.

Our local Mental Health and Addictions Strategy is consistent and complimentary to existing work at national and regional levels. Over the last two years $4.4M additional funding has been invested in the mental health sector. The majority of this additional funding has gone to the NGO sector and has greatly expanded the range of community-based services available to those in our population with serious mental illness. The additional funding has provided a platform from which the sector can address issues such as how to improve access and ensure services are responsive to the needs of service users.

The DHB is aware that these issues must, for the main part, be addressed within existing resources therefore necessitating that services be reconfigured. Decisions about any reconfiguration of services will be made according to local priorities and national direction, primarily the national Mental Health Strategy, *Te Tahuhu Improving Mental Health,* and associated Implementation Plan, *Te Kokiri* and our own Mental Health and Addictions Strategy.

Over the past year we have furthered the implementation of our local Strategy undertaking projects that improve access and responsiveness within our mental health services and focusing on national initiatives to improve patient care:

- Bottlenecks have been pin-pointed within our Specialist (HSS) Mental Health Services in both adult and child and youth services and work has begun to streamline the patient journey through a single point of entry to improve access, reduce duplication, provide for a better use of resources and increase the range of treatment options;
- Our HSS Child, Adolescent and Family Services are also adopting a single point of entry model as part of wider changes to the units overall structure;
- Investment has been made in Peer Support Services which has led to the development of a Canterbury Warmline (telephone support service) and a Strengths Based Peer Support Service;
- An additional six Community Support Worker FTEs have been funded, two of which are dedicated to rural areas in a unique demonstration service;
- An additional Family Peer Support Worker has been funded in the Alcohol and Other Drug sector;
- Three clinical FTEs were funded to deliver GP Liaison services in the primary care sector.

- The District Nursing Medication Service (a 2005/06 demonstration service) has been expanded;
- Additional funding has been received from the Ministry for methadone services funding a clinical FTE to support GP Liaison and a project worker;
- Additional one-off funding was provided by the Ministry for a Canterbury mental health website, mental health workforce development and education and support for specialist staff;
- The Consult Liaison Function delivered through our HSS Mental Health Services to support NGO providers and the primary care sector has been expanded;
- A joint initiative was undertaken with the CCC to identify service gaps and partnership opportunities between specialist mental health services and tenants of CCC Social Housing;
- A Child and Adolescent Mental Health Services Placement Project was established as a demonstration project between the Werry Centre and the DHB to support recruitment into the child and adolescent mental health sector;
- A Kaupapa Maori scoping project was completed to identify the level of need and potential models for service delivery in Canterbury;
- A NGO Mental Health Workforce Development Plan is currently being completed to identify workforce priorities, develop a training calendar and scope an NGO supervision brokerage service; and
- A key stakeholder forum on the development of a Home Based Treatment Approach was undertaken, which provides important background work for a project to explore, develop and improve our mental health system's acute response. This will be a HSS led initiative in partnership with NGOs and primary care and will be jointly sponsored by the Planning and Funding and HSS divisions.

Blueprint Funding

The 'Blueprint for Mental Health Services in NZ' is a government planning framework that identifies the services necessary for an effective mental health system and determines the types and levels of service that DHBs are expected to provide. The proportion of funding that DHBs receive for mental health and addiction services is tagged or 'ringfenced' specifically for those services, to ensure access for the 3% of the DHB's resident population (those considered most in need). The Canterbury DHB is currently resourced at 76% of Blueprint, and access levels reflect this.

Child and youth mental health access rates in Canterbury are slightly under Ministry expectations. This is partly because additional resources (7 FTE in 2005/06) invested in both Pacific and Maori child and youth community support worker services are strongly linked into primary care and therefore not captured in HSS reporting against population access targets. Access rates are expected to increase, for both Child and Youth and Adult Mental Health Services, through the implementation of a Single Point of Entry (using the UK Choice and Partnership Approach) and the increase in Consult Liaison Services as described below.

In 2007/08 the additional Blueprint Funding that we will receive is $680,000 and we intend to invest this funding in the following new services:

- Community Support Workers (MHCR09.2) - funding for six additional FTEs to address the growth in demand for these services;
- Alcohol and Other Drug Services (MHCS01B) – funding for an additional 0.5 FTE Consultant Psychiatrist in Alcohol and Other Drug Services; and
- Mental Health Workforce Development (MHWD01) – funding of $40,000 to support the implementation of the NGO Mental Health Workforce Development Plan and Training Calendar.

As in 2006/07 some providers of mental health services raise financial pressure as an issue citing pay equity demands as a flow on effect of the nurses' salary agreement, difficulties with recruitment and retention in a highly competitive environment and infrastructure/technology issues. In order to respond to these issues we will continue to examine the range and mix of mental health services to better understand effectiveness, efficiency and how responsive services are to the needs of service users and their families. We are continuing to address funding equity issues within the Canterbury mental health sector, utilising FFT to do this. Although this has caused some frustration for providers that have been relatively well funded in recent years, it has provided the sector with a more equitable funding base.

We will also continue to pursue the goals of Te Puawaitanga[25] and progress cultural responsiveness of mainstream mental health services and the development of the Kaupapa Maori Mental Health Sector. We contract with an NGO provider to support and lead Kaupapa Maori Mental Health Workforce Development in partnership with our Planning and Funding division. This provider facilitates the Kaupapa Maori Mental Health Provider Forum, supports providers with policy and procedure development, delivers identified training packages, and undertakes specific project work.

Priority Actions from the national Mental Health Strategy Te Tahuhu

In considering the ten challenges of the national Mental Health Strategy and implementation plan (*Te Tahuhu* and *Te Kokiri*) the DHB has undertaken a mapping project leading to the development of a draft local Strategic Framework that is currently with our mental health sector for consultation. This Strategic Framework aligns the ten challenges with the strategic objectives of the DHB as defined in our DSP, SOI and with our local Mental Health and Addictions Plan. It suggests priorities for action for the next three years and feedback from the sector will help to influence our future direction.

Primary Mental Health Care

In 2006/07 two PHOs were contracted to deliver a GP Liaison Service across Canterbury (3 clinical FTEs MHCS06A). The GP Liaison Service supports GPs (rural and urban) in their treatment of people with serious mental illness, who meet the criteria for specialist services but whose needs are able to be met in the primary care sector.

In 2007/08 we are putting another three clinical FTEs into HSS Mental Health Services to build up the consult liaison function, to better support the primary care and NGO sector.

Eating Disorders

The Canterbury DHB is the funder and provider of the regional specialist Eating Disorder Service. The South Island DHBs are currently participating in a regional specialist services project. The purpose of which is to establish criteria for determining which services should be regional and resolve issues related to access to regional services.

Aim	Improve and support flexibility and responsiveness in mental health services.
Sponsor	GM, Planning and Funding GM, Mental Health Services (HSS)
Actions	▪ Complete the Mapping Project for Canterbury's mental health services producing a Strategic Framework which links DHB accountability documents and direction with national policy requirements and local sector initiatives to better inform future funding and planning decisions. ▪ Reprovision Dual Diagnosis (Intellectual Disability and Mental illness) Residential Services to the NGO sector and increase specialist outpatient services in HSS Mental Health Services. ▪ Formalise provider specifics that reflect actual service purchased. ▪ Set target volumes of service users supported within contracts. ▪ Finalise the development of the Mental Health Information Database to bring together contract and activity information for sector analysis and to improve relationships with providers based on strong information flow. ▪ Encourage NGO providers to use the information available to develop provider specifics that reflect actual service purchased for negotiation with the DHB. ▪ Challenge under-delivery of contract and performance targets by NGO and HSS providers. ▪ Implement Single Point of Entry to reduce barriers to access and duplication of triage systems. ▪ Complete a project to review the Mental Health Service's system of acute response and reconfigure inpatient (acute and rehabilitation) resources (if required) to support improved and increased service and treatment options for service users. ▪ HSS Mental Health Services and Planning and Funding divisions work collaboratively with the wider sector to take opportunities to the maximise utilisation and flow through of rehabilitation beds - including reviewing and changing models of service delivery and contract arrangements.
Outputs	▪ A Strategic Framework for mental health services is completed, in consultation with the sector. ▪ Mental Health Information Database is developed. ▪ HSS Mental Health Services exit provision of Dual Diagnosis Residential Services and smooth

[25] *Te Puawaitanga is the Māori Mental Health National Strategic Framework developed by the Ministry in 2002.*

	transition to NGO sector enabled. ▪ Single Point of Entry is introduced within HSS Mental Health Services reducing duplication and improvement responsiveness with consistent information available to referrers. ▪ Our Mental Health Services' system of acute response is reviewed and recommendations are implemented. ▪ Collaborative review of Rehabilitation Services.
Measure	Improved Access to HSS Mental Health Services (POP 06).

Aim	Support cohesiveness and collaboration between mental health providers and stakeholders.
Sponsor	GM, Planning and Funding GM, Mental Health Services (HSS)
Actions	▪ Support the roll-out of Mental Health Information National Collection (MHINC) and Mental Health Standard Measures of Assessment and Recovery (MHSMART) and commit to national Key Performance Indicators. ▪ Encourage responsiveness by NGO and HSS providers to the reporting requirements of South Island DHBs with regard to activity and process regarding regional services. ▪ Encourage innovation through working together. Encourage providers to trial multi-agency intake teams for like services (such as mainstream residential and community support worker services and the national 'Knowing the People Project' engaging and support service users with enduring mental illness. ▪ Collaborate with GPs and PHOs to support mental health service development in the primary care sector.
Outputs	▪ Regular forums for communication and consultation with the mental health sector and internal stakeholders held. ▪ South Island activity reports for regional services completed on a quarterly basis. ▪ Knowing the People Project piloted at the Hereford Centre with the recovery model well embedded in care and service users engaged to improve physical health status through primary care.
Measure	An increase in the number of long-term clients (with enduring mental illness) with up-to-date crisis prevention plans (QUA 02).

7.1.3 Infrastructure - The Health Information Strategy

DHB Chairs and CEOs have established 'Information' as a collective strategic priority for DHBs; taking a collective approach to implementing the government's Health Information Strategy NZ (HIS-NZ). Regional workshops have determined a collective view of the strategic importance of action zones within the Strategy and have provided initial input into 'roadmaps' for each action zones. A regional view is expected to be presented for endorsement by the national CEO group in early 2007 which will assist us in our continued implementation of the HIS-NZ.

Alongside our commitment to the implementation of HIS-NZ we have also established an Information Services Strategic Plan (ISSP) and, through the implementation of both these strategic documents, significant changes have been made to our Information Services infrastructure and some key projects and initiatives have begun:

- Formation of a South Island Secure Health Data Network (action zone 1) providing the network infrastructure for agencies to share information. The network conceived and administered by us, currently connects all South Island DHBs along with other significant healthcare agencies such as Medlab South, Christchurch Radiology Group and Cashmere Medical Imaging;
- Implementation of a local Health Practitioners Index (HPI) (action zone 3) this local index will allow us to link to the national HPI numbers once they are assigned;
- Implementation of Electronic Discharge Summaries (action zone 6) which will allow for the summaries to be sent to GPs electronically and this initiative will significantly improve primary/secondary integration;
- Participation in the pilot of National Non-admitted Patient Collection (NNPAC) (action zone 9) looking at the coding of outpatient visits. We were one of the first DHBs to provide data for stage 1 of this project;

In the coming year we plan to continue the implementation of our ISSP (currently being reviewed) the direction of which re-enforces the objectives outlined in national strategies and involves working closely with stakeholders to implement solutions that satisfy clinical and business requirements. Development of a clinical portal continues along with development of a Single Patient Administration System and we aim to complete a business plan for implementing the system in the coming year.

The next twelve months also brings a couple of key challenges for our information services:

Benefit Realisation - Over the past year we have made significant investment into infrastructure. It is important that the benefits of this investment are realised. Significant effort will be made to ensure that the promised benefits are achieved and to put in place processes to ensure that the benefits are maintained.

HOMER Patient Management System (PMS) - The PMS which is used in our acute hospital settings is approaching 'end of life'. We are expecting that the vendor will soon advise us of an end of support date as the system is designed in archaic computer language for which it is now very difficult to recruit and retain support staff. This is particularly noticeable in the current climate of high turnover and labour shortage. We will be initiating a programme of work to replace this software.

HIS-NZ - We will also be demonstrating our commitment to the HIS-NZ through continued implementation of the action zones within the Strategy moving on to the second stage of NNPAC and concentrating on data quality (action zone 2) in 2007/08.

Aim	Continued implementation of the DHB's ISSP and delivery of a robust infrastructure framework.
Sponsor	GM, Organisational Support and Development
Actions	▪ Further develop infrastructure programme procedures and systems. ▪ Continue the roll-out of the Clinical Information System Portal. ▪ Progress the upgrade of HR Payroll (HRIS) and Rostering systems. ▪ Move significantly towards selecting a new Patient Administration System. ▪ Support national initiatives that are not on Action Zones including the Project for the Integration of Mental Health Data (PRIMHED) Project.
Outputs	▪ The DHB's ISSP is reviewed and updated to meet stakeholder expectations. ▪ System monitoring is expanded to the DHB's new systems. ▪ Clinical Information System Portal is rolled out to Hospitals. ▪ HRIS and Rostering Systems are implemented and supported. ▪ A new Patient Management System is evaluated and a case for the Regional Capex Committee is prepared for Ministry approval. ▪ The Project for the Integration of Mental Health Data is supported.

Aim	Actively participate in HIS-NZ, progress collaborative work to improve the stability and capability of Health Information Systems.
Sponsor	GM, Organisational Support and Development
Actions	▪ Work with South Island DHBs to integrate the South Island Network with the new National Network as the National Network becomes available (Action Zone 1 - National Network). ▪ Actively participate in NHI promotion and work on the continuous improvement of data quality (Action Zone 2 - NHI Promotion). ▪ Integrate local HPI with the National system as the National system becomes available (Action Zone 3 - HPI Implementation). ▪ Progress resolving concerns re privacy around a regional repository of laboratory results (Action Zone 5 - E-Labs). ▪ Continue the rollout of electronic discharge summaries to all Canterbury DHB hospitals (Action Zone 6 - Discharge Summaries). ▪ Work with the Planning and Funding division to identify suitable plans for the implementation of systems that support chronic disease management (Action Zone 7 - Disease Management). ▪ Continue involvement in the development of Health Information Standards for forms server (Action Zone 8 - Electronic Referrals). ▪ Implement compliance changes as required by the Ministry (Action Zone 9 - National

	Outpatient collection).
Outputs	▪ South Island Network is integrated with the new National Network. ▪ The DHB is represented on the NHI National Committee. ▪ The local HPI is integrated with the national system as it becomes available. ▪ Resolution of privacy concerns around community and hospital results available in one system are resolved. ▪ Electronic discharge summaries can be sent by all DHB hospitals. ▪ The DHB has input into the development of a forms server standard. ▪ Required outpatient compliance changes are implemented.

Aim	Drive to improve data quality throughout the organisation
Sponsor	GM, Organisational Support and Development
Actions	Implement a programme to highlight the importance of data quality.
Outputs	▪ All training courses provided by DHB's Information Services Group will include a section that: - Highlights the importance of correctly identifying patients NHI; - Highlights the importance of correctly identifying clinical caregivers (HPI); and - Highlights the importance of quality data not just for clinical purposes but also highlighting that it is key to the planning and funding of services. ▪ All data quality reports from NZHIS will be routed to appropriate management for action. ▪ A Clinical Coding Audit will be carried out by external auditors.
Measure	An improvement in the quality of data provided to National Collections Systems (QUA 03).

7.1.4 Quality and Patient Safety

We have a strong commitment to the provision of high quality health care services and strive to ensure provision of an integrated service that strongly encourages evidence based clinical care and is responsive to consumer needs.

In 2003 we established a DHB-wide Quality and Patient Safety Council to ensure a coordinated approach to considering quality and patient safety. Supported by our Corporate Quality and Risk Team the Council's primary goal is to provide leadership in improving quality and patient safety.

To advance this goal we have developed a Quality Strategic Plan which provides the Council with a framework that promotes leadership as the underlying driver of quality improvement and quality improvement as a continuum.

Developed within the context of the national document *Improving Quality (IQ): A Systems Approach for the NZ Health and Disability Sector*; our Quality Strategic Plan presents five key goal areas. These are: community participation/involvement, initiating organisational change and development, clinical risk management, instituting mechanisms for effective reporting and accountability and knowledge management for clinical services and quality.

The Council monitors progress on the goals set out in the Plan and there have been a number of key successes over the past year:

- The development and promotion of key quality and patient safety policies including the Culture of Patient Safety, No Blame Incident/Accident Reporting and Open Disclosure Policy.
- The beginning of an Incident Management Software selection project to select a standardised incident management software system for our HSS with the view of offering this system to external community providers in the future. A standardised system will assist us to address the ongoing identification and mitigation of serious clinical risk to the quality and delivery of health and disability services. It will also assist and support the national approach to the consistent management of healthcare incidents;
- The continued development of the DHB's Quality and Innovation Awards Programme which has seen a total of 71 projects having been entered in the annual awards and many going on to enjoy national and international success. By encouraging staff and external provider organisations to record their quality improvements and innovations we have also fostered the sharing of

information both internally and externally. Roadshows have also been run to facilitate the sharing and learning gained from the applicants project activities;

- A stocktake of quality activities and reporting within community based services to help the Council gain a better understanding of quality initiatives in the community sector and to provide information for the Quality Strategic Plan;
- The development of quality clinical indicators for our four Disease Priorities. Diabetes and Cardiovascular Disease reports are being developed and work is continuing on indicators for Respiratory Disease and Cancer;
- The launch of an Infection Control Staff Policy Handbook for frontline staff. This Handbook is a first in NZ and is designed to be carried by staff to give them infection control policies at their fingertips. Infection control is fundamental to the way staff work in hospitals, both for their own safety and for the wellbeing of our patients.

Over the coming year our key focus will be on completing the development of the Quality Strategic Plan 2007-2010 and initiatives that will assist us to achieve the goals and objectives contained within that Plan. The area of indicator development and reporting remains a priority.

Aim	Continue to implement the Canterbury DHB's Quality Strategic Plan – reviewing and realigning the Quality Strategic Plan with the DSP for 2006-2010 and the IQ Action Plan for 2007-2010.
Sponsor	Executive Director of Nursing Chief Medical Officer
Actions	▪ The new Quality Strategic Plan and Quality and Patient Safety Council's workplan is implemented with cohesive quality and risk management structures in place across the DHB. ▪ Continue to develop quality and patient safety policies. ▪ Hold the DHB Quality and Innovation Awards annually and continue to review and develop the awards programme. ▪ Progress the work on developing a set of quality indicators and implementing regular reporting to the Board. ▪ Select and implement a new incident management software system for the HSS with a view to offering this system to our community based providers in the future. ▪ Implementation of the Intensive Care Outreach and Follow-up Service at Christchurch Hospital. ▪ Continue to develop and implement the Improving the Patient Journey programme. ▪ Continue to build capacity at all levels to enable consumers to be more effective partners in the care process.
Outputs	▪ An education programme for staff on the key patient safety policies is developed. ▪ A new component to the current Quality and Innovation Awards programme is piloted. ▪ The needs of HSS and community based providers with regards to a new incident management software system are considered. The tender process is overseen and evaluated by the Council and the software option that best suits our requirements is selected. ▪ A review of the serious falls (over the two year period July 2004–June 2006) is conducted. ▪ The DHB works with national Quality and Risk Managers on the development and implementation of a standardised incident dataset to facilitate a consistent approach to the management of incidents nationally. ▪ A senior nursing position (Clinical Nurse Specialist) is established to further extend the intensive care outreach service at Christchurch Hospital. ▪ Key Performance Indicators related to the effectiveness of the Intensive Care Outreach Service are developed along with a regular audit plan. ▪ A Consumer Council is established to provide the DHB with patient/consumer advice about health priorities, to ensure that community stakeholder views are properly considered and to encourage effective community participation in all aspects of health service provision.
Measure	New incident management software system software is implemented across the HSS.

7.1.5 Elective Services, Orthopaedics and Cataracts

Managing demand for elective services is a primary focus for the DHB and a high priority nationally for the Minister of Health. The DHB's Elective Services Steering Committee continues to monitor

compliance against national Elective Services Performance Indicators (ESPIs) which are reported regularly to the Ministry. The key objectives with regard to elective services are to:

- Deliver services within contracted volumes and improve capacity within existing resources;
- Communicate to patients and referrers of the likelihood of service;
- Develop strategies to deliver elective services within current resources and improve milestones;
- Collect information to identify future demand/need; and
- Identify and develop new initiatives.

We are also committed to implementing government initiatives around electives in particular areas with national projects currently underway in both Orthopaedic and Cataract services. Over the past year we have made a number of significant achievements:

Elective Services:

- ESPI compliance was achieved at a DHB level and additional electives funding was secured for the majority of elective services;
- The primary/secondary interface was strengthened with additional GP Liaison resources, and collaboration commenced on a variety of patient flow initiatives;
- There was a renewed focus on referral management and prioritisation practices at clinician level; and delivery of more timely information at service level to inform improved process and matching of promises to capacity;
- Weekly ESPI patient and service level monitoring reports have been implemented to ensure patients are selected based on their assigned priority. This audit process applies to all surgical services.
- The Improving the Patient Journey initiatives delivered improvements in theatre utilisation and resource allocation that reduced the impact of trauma overload on elective volume delivery; and
- The Orthopaedic Continuous Quality Improvement (CQI) initiative delivered increased utilisation of resourced theatres, and reduced reliance on RMOs through Nurse Led activity.

During the process of achieving ESPI compliance it was identified that a more robust system was necessary for sustaining compliance and achieving the principles of clarity, timeliness and fairness. An *Elective Services Sustainable Compliance Plan,* incorporating an *Accountability Framework* was developed and approved. The purpose of the Framework is to provide a transparent and accountable system of electives management, where roles and responsibilities are defined, performance is monitored and measured and improvements achieved and sustained in a structured and supported manner.

An Elective Services Steering Group has also been re-established with clinical and management representation from PHOs, the DHB and the Ministry. This group governs the activities of the Transactional (Compliance) and Transformational Groups. Dedicated Elective Services Manager and Elective Service Analyst roles have also been approved and advertised. During 2007/08 this framework will continue to be devolved throughout the organisation.

Orthopaedic Initiative:

- Initiative volume target and ESPI compliance achieved with the access threshold for orthopaedic surgery lowered to 90 points;
- Increased capacity has been commissioned at Burwood Hospital as part of the Stage II Redevelopment;
- A GP Liaison role has been appointed to coordinate central referral management with PHOs and department policy has been introduced to ensure all referrals follow an agreed pathway;
- A Physiotherapy Scoring Trial has been completed for all hip and knee referrals with confirmation that the tool improves the ability to delineate patient need and ability to benefit;
- A nurse-led model for pre-admission was introduced resulting in reduced reliance on RMOs;
- A patient 'Road Map' has been designed for patient (by patients);
- There has been a 40% increase in resourced theatre utilisation and the Acute Trauma Review has been completed resulting in recommendations to reduce the impact of trauma on elective surgery productivity; and

- An Orthopaedic Primary Hip and Knee Prioritisation Audit was completed where prioritisation outcomes for both public and private referred patients were compared using two different tools (the national tool and a local physio screening tool). The results were then evaluated by a combined DHB/PHO panel which evidenced that the local physio tool provided much improved ability to delineate need and ability to benefit. As a result a decision has been made to implement the physio screening tool for all primary hip and knee patients. Regular ongoing audit will be undertaken including inter-reliability across assessors also being monitored.

Cataract Initiative:

- Volume delivery target exceeded and ESPI compliance achieved with the access threshold for cataract surgery lowered to 25 points;
- Health Services Planning completed for Ophthalmology with the objective of identifying future objectives and challenges for the service;
- Cataract scores can now be applied by GPs, Optometrists and Ophthalmologists;
- Cataract patients are 'pooled' on the treatment lists to improve equity of access across all referral sources and the DHB has ongoing liaison with GPs in primary care regarding referral completeness and access to services;
- Initiative completed to improve the management of Post Operative Follow-up patients with an increase in the number of patients discharged directly to their GP supported by appropriate clinical management guidelines; and
- New equipment has been introduced to streamline the flow of patients through the pre-admission clinic achieving a reduction in wait-time of ten minutes per patient.

In the coming year we will continue our commitment to the priorities for Elective Services:

Aim	Progress and implement frameworks to achieve sustainable Elective Services management.
Sponsor	GM, Medical and Surgical (HSS) GM, Women's and Children's Health (HSS)
Actions	Implement DAP commitments via the Elective Services Accountability Framework - devolve the objectives, policy, procedure and responsibilities through HSS annual performance management programme. Implement a Monitoring and Reporting Framework - support understanding and compliance at all levels. Meet operational needs and enable early response to fluctuations in demand, changes in referral patterns, capacity and resources: ▪ Transaction group will monitor ESPI compliance and take early action to correct any changes required to remain compliant; ▪ Weekly reports available to all services; ▪ Elective Services Manager to be appointed as the key contact for Electives activity; and ▪ Threshold Models to be developed and reporting tools enhanced by the appointment of a dedicated Elective Services Analyst for the DHB. Improve Referral Gateway Management - ensure every service has a single point of entry and that each referral follows an agreed pathway, so that promises made to patients are able to be delivered: ▪ Develop new initiatives to increase access for referrals. Capacity Planning and Threshold Modelling - provide the services with the tools to more closely match their promises to patients with their ability to treat them, within the six month timeframe. Improving Prioritisation Practice - focus on aligning priority and treatment decisions. Provide improved tools and reporting at a clinician level, to inform fair and equitable decision making. Increasing Efficiency and Utilisation of Current Resources - Roll out the successful Elective Orthopaedic Nurse Led Admission and Pre Admission models as standards across the DHB, thereby reducing the reliance on RMOs and Specialists: ▪ Introduce virtual clinics in Gynaecology that enable access to Consultant advice for GPs, to avoid unnecessary referrals; and ▪ Continue monitoring "did not attend" rates to reduce wastage of clinical time. Improve Data Integrity - improvement programme to ensure accuracy of ESPI data: ▪ Undertake Six monthly audits of booking systems; and

	▪ Ensure ongoing training of staff with booking system processes. Shared DHB/PHO approach to Electives Management - work alongside the PHOs to develop centralised systems of referral monitoring and management that will better inform funding decisions and enable GPs to be clinically up skilled in specific areas: ▪ Continue to work with primary sector to develop alternative options in the community; and ▪ Continue to improve primary providers access to diagnostics.
Outputs	▪ ESPI compliance maintained. ▪ Tools established to measure production and demand. ▪ Booking systems audits undertaken and completed. ▪ "Did not attend" rates being measured. ▪ Development of a reporting framework overseen.
Measure	The DHB demonstrates continuous quality improvement and achievement of ESPIs (SER 04).

Aim	Implement systems to improve access to elective surgery across all population groups
Sponsor	GM, Medical and Surgical (HSS)
Actions	Implement the Theatre Module of the Improving the Patient Journey Programme: ▪ Increased number of acute theatre session to minimise impact on elective throughput; ▪ Increase the utilisation of preadmission clinics and identify patients suitable for 23hr pathway; ▪ Addressing staffing models in theatre; ▪ Measuring time of admission to time to theatre; ▪ Introduce 23hr pathway for selected procedures with nurse led discharges; ▪ Continue to increase day surgery percentages and day of surgery admission percentages; ▪ Increase number of anaesthetic technicians in training; and ▪ Continue to monitor recruitment and retention of skilled theatre staff.
Outputs	▪ There is an increase in the number of acute theatres available. ▪ Theatre Scheduled Sessions are allocated in line with contracted volumes. ▪ Preadmission procedures for all specialties are implemented to increase day of surgery admission and day surgery. ▪ Alternative staff rosters and shifts allocated, where applicable, to maximise theatre availability.

Aim	Achieve consistent prioritisation for patients in all services with a focus on the link between assignment of priority and treatment decisions by clinicians.
Sponsor	GM, Medical and Surgical (HSS)
Actions	▪ Work with surgeons to further delineate patient need and ability to benefit. ▪ Increase the elective surgery throughput with increase in funding. ▪ Identify opportunities for developing a local score tool, where there is no national tool. ▪ Working with primary sector to identify areas of unmet demand. ▪ Transformation group will identify new ways of working including community initiatives.
Outputs	▪ The number of elective theatre sessions is increased. ▪ All areas to have a prioritisation tool in place. ▪ Projects are identified which implement new ways of working.

Aim	Progress and implement the national Orthopaedic initiative within the Canterbury DHB.
Sponsor	GM, Older Persons Health and Rehabilitation (HSS)
Actions	Orthopaedic Volume Delivery: ▪ Meet the target intervention rate and develop a plan to sustain this rate; ▪ Ensure additional public sector capacity is maximised; and

	▪ Secure approval to proceed with Stage III Burwood Redevelopment. ESPI Compliance: ▪ Maintain ESPI compliance for Orthopaedics; and ▪ Apply the principles of the DHB's Elective Services Accountability Framework to the Orthopaedic Service. Clinical Prioritisation of Patients: ▪ Register the Physiotherapy Score Tool as the local tool for all hip and knee replacement patients; and ▪ Achieve consistent prioritisation for non-joint patients with a focus on the link between assignment of priority and treatment decision by clinicians. CQI Productivity and Efficiency Initiatives: ▪ Continue the programme to streamline the elective Orthopaedic Patient Journey and ensure an efficient model of care in the new facility.
Outputs	▪ Health Services (Facilities) Planning findings are used to scope public sector capacity requirements and to develop a business case for Stage III Redevelopment at Burwood. ▪ A medium term workforce plan is developed to maximise available electives funding and support new capacity for Orthopaedics in 2008 and beyond. ▪ Roles and responsibilities for maintaining ESPI compliance within Orthopaedics are defined. ▪ Matching priority given to a patient with the order in which patients are treated (at an individual clinician level) becomes an integrated function within the service. ▪ Work continues with surgeons to further delineate patient need and ability to benefit into sub specialty areas, e.g. spine, hand etc. Streamlining Programmes ▪ An Orthopaedic DHB/PHO Focus Group is established to improve the understanding of access levels and to develop alternative patient pathways. ▪ An Orthopaedic Theatre Staffing Model is developed with a focus to reduce FTE requirements. ▪ A Consumer Reference Group is established to provide advice on standard messages for patients across the patient continuum. ▪ Outpatient patient flow and staffing schedule is redesigned to reduce patient wait times in clinic.
Measure	▪ A increase in theatre capacity commissioned at Burwood Hospital. ▪ A Single Referral gateway is maintained and enhanced, in conjunction with PHOs. ▪ The matching of promises to capacity for both outpatient and inpatient treatment improves. ▪ Patient wait times in clinics are further reduced.

Aim	Progress and implement the national Cataract Initiative within the Canterbury DHB.
Sponsor	GM, Medical and Surgical (HSS)
Actions	Cataract Volume Delivery: ▪ Meet the target intervention rate and develop a plan to sustain that rate; and ▪ Progress the Health Services Plan recommendations for Ophthalmology. ESPI Compliance: ▪ Apply the DHB's Elective Services Accountability Framework principles to Ophthalmology. Clinical Prioritisation of Patients: ▪ Evidence consistent prioritisation for patients with a focus on the link between assignment of priority and treatment decisions by clinicians. CQI Productivity and Efficiency Initiatives: ▪ Focus on streamlining the Cataract patient Journey from referral to discharge; and ▪ Improve capacity within current resources by introducing Nurse Led Preadmission support by the Anaesthetic Service.
Outputs	▪ Interim solutions to current capacity issues are facilitated, while concurrently developing longer term plans for increasing public sector capacity. ▪ Roles and responsibilities for maintaining ESPI compliance within Ophthalmology are defined.

	▪ All referring clinicians are provided with regular information showing scoring patterns. ▪ The links between priority and treatment decision are monitored. ▪ Nurse led initiatives are further developed, under the governance of the 'Improving the Patient Journey" Nurse Led Pre Admission Framework.
Measure	▪ Detailed scoping and business case for future facility requirements are completed. ▪ Promises continue to be matched to capacity.

7.1.6 Family Violence

Reducing family violence is one of the thirteen health objectives of the NZ Health Strategy. It is a priority of the Minister of Health and is identified in the DHB's Child Health and Disability Action Plan.

In 1998 the Ministry introduced its national Family Violence Guidelines for Health Sector Providers and national Family Violence Implementation Guidelines in 2002. There are seven principles outlined in the guidelines:

- Health sector providers will develop family violence protocols, procedures and policies to ensure best practice;
- Family violence protocols will be consistent with legislation;
- Health and disability service providers will be appropriately trained to respond to family violence;
- Effective and comprehensive community and hospital based services will be available to family violence victims and abusers;
- The sector will provide a coordinated, culturally effective response to family violence;
- Health and disability services will provide a timely, quality response to family violence; and
- Public heath action on preventing and reducing the prevalence of family violence and abuse will be strengthened.

In response to various government reports, past guidelines and good clinical practice the Canterbury DHB already has a number of processes in place within our HSS, particularly in paediatric services, ED and mental health services. Work in line with the national guidelines has also taken place including a early stock-take of the status of Family Violence Guideline Implementation completed in 2001 and some uptake of the Ministry's 'train the trainer' training for a number of HSS paediatric, women's health, ED and sexual health staff.

However, primarily due to funding limitations, the DHB has taken an evolutionary approach to implementing the Guidelines. Over the coming years we will be establishing a more focused approach this work and the following outlines the beginning of that approach:

Aim	Work to implement the Ministry's Family Violence Guidelines
Sponsor	Chief Medical Officer
Actions	▪ Identify a Sponsor to lead implementation of the national Family Violence Guidelines. ▪ Consolidate the work completed to date and evaluate opportunities to apply this knowledge across the organisation. ▪ Fast track the development of a DHB Policy on implementing the Family Violence Guidelines across the organisation and external provider networks. ▪ Establish interim process requirements within targeted areas: Paediatrics, Child Health, ED, Sexual Health, Women's Health and Older Person's Health. ▪ Identify data and resource requirements to implement the Guidelines (including determining FTE allocations). ▪ Identify public health action already underway and evaluate opportunities to consolidate and support this work in alignment with the principles of the Ministry's Guidelines. ▪ Seek approval for the DHB Policy and begin implementation.
Outputs	▪ Updated stock take report on the current status of Family Violence protocols across the DHB. ▪ Interim Process requirements developed and implemented in targeted areas. ▪ DHB policy on implementing the national Family Violence Guidelines approved with implementation plan and resource requirements identified.

8 MEASURING SUCCESS

DHBs are expected and required to monitor and report on their performance. The Canterbury DHB meets it obligations in this regard through a number of internal and external reporting methods and structures including:

- Internal reporting on a mix of financial and non-financial performance indicators to the CEO, EMT and General Managers, Quality and Patient Safety Council, Clinical Board and our Board and Statutory Committees;
- Public reporting at our Board and Statutory Committee meetings against a mix of financial and non-financial performance indicators – including the performance goals and targets set in our DSP, SOI and DAP and yearly publishing of our Annual Report which includes an audited report against the performance targets set in our SOI document;
- Active monitoring and assessment of the quality of services provided by our HSS division and external providers; via service agreements. Monitoring includes reporting adverse incidents, routine quality audits, consumer surveys, service reviews and issues-based audits; and
- Existing reporting requirements under service contracts with the Ministry and information requirements contained in the Crown Funding Agreement and Operational Policy Framework such as;
  - Monthly financial reporting to the Ministry's DHB Funding and Performance Directorate;
  - Submitting of ad-hoc service or disease specific reports to the Ministry, such as data relating to elective surgical services and waiting times; and
  - Quarterly performance reporting against national accountability indicators of non-financial performance, Indicators of DHB Performance (IDPs) and national Balanced Scorecard Indicators.

8.1 Monitoring and Reporting Our Performance

The Ministry has established a number of accountability indicators to focus DHBs on priority health objectives, monitor activity, compare DHB performance, and to hold DHBs accountable. Progress toward achieving the targets set for these indicators is reported as part of our quarterly performance reports to the Ministry. Attached to this document (Appendix 4) are the Canterbury DHB's IPDs, primary focusing on DHB activity in accountability priority areas.

While the IDPs reflect the accountability that we have for improving the health status of our population there are indicators where our ability to influence the outcome is not through direct funding but through influencing other funders or providers and in some cases influencing our community. This differential is reflected by the use of both quantitative and qualitative IDPs where the actions taken by the DHB to influence the direction of performance in relation to some targets is of as much importance as the match between actual performance and the indicator itself.

For each of the quantitative IDPs used, targets have been set for the 2007/08 year. These targets have been based on expectations expressed by the Ministry, the latest national data and the latest Canterbury DHB specific data.

This year the Minister of Health has also introduced national health indicators or 'core health targets' aligned with national priorities. It is anticipated that the development of these national core health targets will increasingly be used to drive performance improvement in the sector, incorporating shared learning and collaboration. The core health targets follow, accompanied by the local targets we have set.

We have endeavoured throughout this document to demonstrate the links between our activity and outcomes measures or targets against which we can evaluate our progress. In developing a set of indicators for our DSP and for our SOI we have used the base indicators used by the Ministry with the addition of indicators specifically relevant to the Canterbury DHB. In this way we can measure our ongoing performance against the sector as a whole.

<table>
<tr><th>CORE HEALTH TARGETS MINISTRY EXPECTATION LONG-TERM</th><th>DHB TARGET 07/08</th><th>PRIORITY</th></tr>
<tr><td>Improving immunisation coverage</td><td>95% of two year olds are fully immunised with at least 4 to 6 percent point increase on 2005 national immunisation coverage survey baselines.</td><td>85-88% of children are fully immunised at 24 months.[26]</td><td>Child and Youth Health</td></tr>
<tr><td>Improving oral health</td><td>Progress is made towards 85% adolescent oral health utilisation.</td><td>74.2% adolescent oral health utilisation.</td><td>Child and Youth Health</td></tr>
<tr><td>Improving elective services</td><td>Each DHB will maintain compliance in all Elective Services Patient Flow Indicators (ESPIs).

Each DHB will set an agreed increase in the number of elective service discharges, and provide the amount of service agreed.

<table><tr><td>(Excluding OI & CI)</td><td>Base</td><td>Add.</td><td>Total</td></tr><tr><td>E. CWD</td><td>15,822</td><td>1,631</td><td>17,453</td></tr><tr><td>Est E Discharges</td><td>12,823</td><td>1,421</td><td>14,244</td></tr></table></td><td>ESPI 1 >90%
ESPI 2 <2%
ESPI 3 <5%
ESPI 4 Nil
ESPI 5 <5%
ESPI 6 <15%
ESPI 7 <5%
ESPI 8 >90%</td><td>Elective Services</td></tr>
<tr><td>Reducing cancer waiting times</td><td>All patients wait less than eight weeks between first specialist assessment and the start of radiation oncology treatment (excluding category D).</td><td>100% of patients wait less than eight weeks.</td><td>Cancer</td></tr>
<tr><td>Reducing ambulatory sensitive (avoidable) Hospitalisations</td><td>There will be a decline in admissions to hospital that are avoidable or preventable by primary health care across all population groups.

<table><tr><td></td><td>Maori Ethnicity</td><td>Other Ethnicity</td><td>Pacific Ethnicity</td></tr><tr><td>0-4yrs</td><td><= 1</td><td><= 1.312</td><td><= 1</td></tr><tr><td>45-64yrs</td><td>< 1</td><td><= 1</td><td><= 1</td></tr><tr><td>0-74yrs</td><td>< 1</td><td><= 1.071</td><td><= 1</td></tr></table>**0-4yrs**: Remaining at or below national level for Maori & Pacific and reducing to 31.2% above the national average for Other.
45-64yrs: Remaining below national level for Maori, and at or below national level for Pacific and Other.
0-74yrs: Remaining below national level for Maori, remaining at or below national level for Pacific and reducing to 7.1% above the national average for Other.</td><td>Ratio of Observed to Expected (ethnic level) Ratio at 99% CI:</td><td>Primary Care</td></tr>
<tr><td rowspan="3">Improving diabetes services</td><td>There will be an increase in the percentage (%) of people in all population groups: estimated to have diabetes accessing free annual checks</td><td>Maori ≥42%
Pacific ≥81%
Total ≥64%</td><td rowspan="3">Diabetes</td></tr>
<tr><td>There will be an increase in the % of people in all population groups: on the diabetes register who have good diabetes management</td><td>Maori 70%
Pacific 53%
Total 78%</td></tr>
<tr><td>There will be an increase in the % of people in all population groups: on the diabetes register who have had retinal screening in the past two years.</td><td>Maori 54%
Pacific 57%
Total 60%</td></tr>
<tr><td>Improving mental health services</td><td>At least 90% of long-term clients have up to date relapse prevention plans (NMHSS criteria 16.4).</td><td>95% of long-term clients have up to date plans.</td><td>Mental Health</td></tr>
<tr><td>Improve nutrition
Increase activity
Reduce obesity</td><td colspan="2">DHB activity supports achievement of these health sector targets:
- the proportion (%) of infants exclusively and fully breastfed (74% at six weeks, 57% at three months, 27% at six months); and
- the proportion (%) of adults (15+) consuming at least three servings of vegetables/two servings of fruit per day (70% for vegetables, 62% for fruit).</td><td>Disease Prevention and Management</td></tr>
<tr><td>Reduce the harm caused by tobacco</td><td colspan="2">DHB activity supports achievement of health sector targets to increase:
- the prevalence of ‘never smokers’ among year 10 students by at least 2% (absolute increase) over the 2007/08 year; and
- the proportion of homes, which contain one or more smokers and one or more children, that have a Smokefree Policy to over 75% in 2007/08.</td><td>Child and Youth Health
Primary Care</td></tr>
</table>

[26] *Note that this target is based on the results of the Immunisation Coverage Survey and should be considered provisional. This target will be confirmed once NIR data becomes available for this age group.*

9 MANAGING FINANCIAL RESOURCES

9.1 Managing Within Our Operating Budget

The Canterbury DHB will receive a funding increase of approximately $62M for 2007/08. Of this funding increase, $32M is tagged for specific health services or previous years commitments, such as PHO funding, additional elective services funding and Holiday's Act commitments. In addition, non-base revenue and one-off revenue will reduce by $19M. This leaves $11M available for general price increases and acute demand growth.

Costs are assumed to increase at the same rate as baseline funding increases received from the Ministry. This is forecast to be around $22M. This leaves a funding shortfall of $11M to be filled by operational efficiencies for the DHB to breakeven. The 2007/08 forecast is summarised as follows:

	$M (GST excl)
Overall Net Increase in Funding/Revenue (include non-Base)	37
Less	
Increase in Expenditure (external and CDHB Provider service)	(44)
Incremental Interest, Depreciation and Capital Charge	(4)
Estimated 2006/07 Operating Shortfall	(11)
Required Annual Efficiencies/Revenue Enhancement	11
Budget Net Result After Efficiencies	-

In budgeting for a breakeven position, the DHB has assumed that the sector will be able to manage cost increases, especially personnel costs, within the baseline funding increase. In addition, efficiencies will be realised from the improved management of chronic conditions and long-term illness, improved management of acute demand, service changes flowing from the Improve the Patient Journey Programme and realisation of 'gain on sale' from the approved disposal of surplus assets. The risks associated with these assumptions are set out in Section 5.

9.2 Outyears Scenario

The DHB expects funding increases for outyears to be 2% for 2008/09 and 2% for 2009/10. The DHB has also assumed that expenditure will increase at the same rate as the funding from the Ministry. In previous years we have relied on 'gain on sale' from approved surplus assets to address some of the financial operating gaps. As the DHB is unlikely to have any gain on sale in 2008/09 further efficiencies will be required to achieve breakeven.

All assumptions carry risks as identified in Section 5. Whilst the DHB will always seek to re-configure services and change how services are delivered to yield efficiencies, ultimately we may need to reduce services so that we can operate within the funding we receive. A Health Services Planning Project has begun, with a view to completing our Facilities Master Plan. This project will also greatly assist the DHB to better understand where, what and how many services need to be provided in the future, thus providing the information needed by the DHB to assist it to operate within available funding while providing maximum health care to the population of Canterbury.

The outyears' scenario position if the assumptions are achieved will be as follows:

	2007/08 $M	2008/09 $M	2009/10 $M
Overall Net Increase in Funding/Revenue (include non-Base)	37	15	23
Less: Estimated Net Annual Cost Increase	(48)	(24)	(23)
Estimated Operating Shortfall	(11)	(9)	-
Estimated Annual Efficiencies	11	9	-
Budget Net Result after Efficiencies	-	-	-

9.3 Asset Planning and Investment

9.3.1 Business Cases

With the need to operate within available funding, service reconfigurations and facility realignments are likely to take place and service reductions may need to be included to ensure breakeven in the outyears. The Canterbury DHB will also review continued ownership of subsidiary and associate companies as appropriate legal structures. The Minister of Health's approval will be obtained in accordance with government guidelines.

The Canterbury DHB has submitted a business case for the building of a Physical Containment Level 3 Laboratory based on a request from the Ministry. In addition, as part of the Ministry's national Oral Health Strategy, we will be submitting a business case requesting an equity injection of $18.835M and annual operating costs of $4.555M to improve oral health services in Canterbury for children and adolescents. As these business cases have not been approved, their financial impact has not been included in our forecast.

Business cases relating to information technology and other significant capital projects will include Regional Capital Committee, Ministry and National Capital Committee review and endorsement, where appropriate. Business cases that will be presented in 2007/08 include the replacement of the outdated legacy rostering, payroll, and human resources information system.

9.3.2 Capital Expenditure

The estimated capital expenditure budget for 2007/08 is $30M and will be primarily for normal asset replacement and priority new equipment. Detailed requirements of recent Building Act changes are yet to be finalised by TLAs and these may require some buildings to be rebuilt.

As referred to previously, a Health Services Planning project is in progress. This project will guide the development of the DHB's Facilities Master Plan. Accordingly, we now forecast that the building replacement as part of that legislative compliance will take place after 2009/10. Several projects will require internal resourcing and prioritisation as well as regional and national prioritisation. Funding for these significant projects will be discussed with the Ministry when the full implications of legislative requirements are known.

9.4 Debt and Equity

The DHB's estimated total term debt is expected to be $88M as at June 2007. It is assumed that the available cashflow from depreciation funding will be applied to fund capital expenditure, thus deferring the need to increase loans until the major property rebuilding projects in outyears.

The current approved credit facility available through the Crown Health Financing Agency is approximately $130M. In addition, working capital of approximately $50M is financed from a private bank.

We comply with the banking covenants required of our loans. The key covenants together with forecast ratios for 2007/08 based on the forecast financial statements are:

REQUIRED		FORECAST RATIO
Interest cover ratio:	>2.75 times	Approx 9.83times
Debt/Debt plus Equity ratio:	<50%	Approx 24.5%

We are not repaying equity and are instead retaining and investing the funds to meet future building replacement as indicated in Section 9.3.2.

9.5 Efficiencies and Service Reconfigurations

In budgeting for break-even results, the Canterbury DHB is planning to implement and achieve a number of efficiencies and/or service reconfigurations to close the operating gap. These have been outlined earlier in this plan. Examples of the initiatives to be undertaken include:

- Improve chronic conditions and acute demand management and reduce 'avoidable' admissions;

- Improve HSS employee cost control processes, leave management and roster activity and ;
- Continue to implement the Improving the Patient Journey Programme;
- Implement the recommendations of the community laboratory services review;
- Achieve procurement/usage savings on clinical and non-clinical consumables; and
- Improve collaborative arrangements with external providers on elective services delivery.

In addition, gain on sale from the disposal of surplus assets, as approved by the Minister of Health, is an integral part of the efficiency target. Some of our planned initiatives are longer term and are only expected to generate major savings in future years. Early planning is essential to ensure the implications of the reduction in transitional funding in outyears are adequately addressed.

Initiatives will have input from clinicians, where appropriate, to ensure patient safety and related issues are adequately considered and factored in the decision making process.

9.6 Forecast Financial Statements - 2007/08 to 2009/10

The accounting policies adopted are consistent with those in the prior year. A full statement of accounting policies is an appendix to the DHB's 2007/10 SOI.

9.6.1 Forecast Group Statement Financial Performance

	2005/06 Actual $'000	2006/07 Forecast $'000	2007/08 Forecast $'000	2008/09 Forecast $'000	2009/10 Forecast $'000
Operating Revenue					
MoH Revenue	972,575	1,054,030	1,096,676	1,124,093	1,152,195
Patient Related Revenue	31,224	32,846	33,536	34,374	35,234
Other Revenue	19,843	23,963	26,259	18,619	18,988
Total Operating Revenue	1,023,642	1,110,839	1,156,471	1,177,086	1,206,417
Operating Expenditure					
Employee Costs	406,846	430,631	444,945	450,748	461,946
Treatment Related Costs	109,289	106,213	115,187	116,541	119,430
External Providers & IDF	381,660	447,621	462,314	472,871	484,693
Non Treatment Related & Other Costs	55,602	54,840	55,992	56,891	58,314
Total Operating Expenditure	953,397	1,039,305	1,078,437	1,097,052	1,124,383
Result before Interest, Depn & Cap Chrge	70,245	71,534	78,034	80,034	82,034
Interest, Depreciation & Capital Charge					
Interest Expense	(4,936)	(5,032)	(5,932)	(5,932)	(5,932)
Depreciation	(47,372)	(46,905)	(50,405)	(52,405)	(54,405)
Capital Charge Expenditure	(15,076)	(22,097)	(21,697)	(21,697)	(21,697)
Total Interest, Depreciation & Capital Charge	(67,384)	(74,034)	(78,034)	(80,034)	(82,034)
Net Operating Results	2,861	(2,500)	0	0	0

9.6.2 Summary of Revenue and Expenses by Output Class

Funding Arm

	2005/06 $'000	2006/07 $'000	2007/08 $'000	2008/09 $'000	2009/10 $'000
Revenue					
MoH revenue	932,035	1,007,707	1,056,985	1,083,410	1,110,495
Total Revenue	932,035	1,007,707	1,056,985	1,083,410	1,110,495
Expenditure					
Other - Personal Health	661,256	727,366	767,500	786,687	806,354
Other - Mental Health	107,837	109,937	114,566	117,430	120,366
Other - Disability Support	150,475	164,849	169,524	173,762	178,106
Other - Public Health	3,166	977	684	701	719
Other - Maori Health	935	936	960	984	1,009
Other - Governance & Admin	3,332	3,642	3,751	3,845	3,941
Total Expenditure	927,001	1,007,707	1,056,985	1,083,410	1,110,495
Net Surplus/(Deficit)	**5,034**	-	-	-	-

Governance & Funder Admin

	2005/06 $'000	2006/07 $'000	2007/08 $'000	2008/09 $'000	2009/10 $'000
Revenue					
MoH revenue	3,333	3,642	3,751	3,845	3,941
Total Revenue	3,333	3,642	3,751	3,845	3,941
Expenditure					
Personnel	2,225	2,436	2,507	2,570	2,634
Depreciation	16	50	50	50	50
Interest & Capital charge					
Other	1,057	1,156	1,194	1,225	1,257
Total Expenditure	3,298	3,642	3,751	3,845	3,941
Net Surplus/(Deficit)	**35**	-	-	-	-

Provider Arm

	2005/06 $'000	2006/07 $'000	2007/08 $'000	2008/09 $'000	2009/10 $'000
Revenue					
MoH revenue	582,549	602,767	630,611	646,376	662,536
Patient Related Revenue	31,224	32,846	33,536	34,374	35,234
Other	19,843	23,963	26,259	18,619	18,988
Total Revenue	633,616	659,576	690,406	699,369	716,757
Expenditure					
Personnel	404,621	428,195	442,438	448,178	459,312
Depreciation	47,356	46,855	50,355	52,355	54,355
Interest & Capital charge	20,012	27,129	27,629	27,629	27,629
Other	163,835	159,897	169,984	171,207	175,461
Total Expenditure	635,824	662,076	690,406	699,369	716,757
Net Surplus/(Deficit)	**(2,208)**	**(2,500)**	-	-	-

In House Elimination

	2005/06 $'000	2006/07 $'000	2007/08 $'000	2008/09 $'000	2009/10 $'000
Revenue					
MoH revenue	(545,342)	(560,086)	(594,671)	(609,538)	(624,776)
Total Revenue	(545,342)	(560,086)	(594,671)	(609,538)	(624,776)
Expenditure					
Other	(545,342)	(560,086)	(594,671)	(609,538)	(624,776)
Total Expenditure	(545,342)	(560,086)	(594,671)	(609,538)	(624,776)
Net Surplus/(Deficit)	-	-	-	-	-

Consolidated

	2005/06 $'000	2006/07 $'000	2007/08 $'000	2008/09 $'000	2009/10 $'000
Revenue					
MoH revenue	972,575	1,054,030	1,096,676	1,124,093	1,152,195
Patient Related Revenue	31,224	32,846	33,536	34,374	35,234
Other	19,843	23,963	26,259	18,619	18,988
Total Revenue	1,023,642	1,110,839	1,156,471	1,177,086	1,206,417
Expenditure					
Personnel	406,846	430,631	444,945	450,748	461,946
Depreciation	47,372	46,905	50,405	52,405	54,405
Interest & Capital charge	20,012	27,129	27,629	27,629	27,629
Other	546,551	608,674	633,492	646,304	662,437
Total Expenditure	1,020,781	1,113,339	1,156,471	1,177,086	1,206,417
Net Surplus/(Deficit)	**2,861**	**(2,500)**	-	-	-

9.6.3 Forecast Group Statement Financial Position

	30/06/06 Actual $'000	30/06/07 Forecast $'000	30/06/08 Forecast $'000	30/06/09 Forecast $'000	30/06/10 Forecast $'000
Public Equity					
Opening Equity	199,705	287,326	269,972	269,972	269,973
Revaluation	106,760				
Transition to IFRS		(14,854)			
Equity Repayment	(22,000)				
Net Result for the period	2,861	(2,500)	0	0	0
Total Public Equity	287,326	269,972	269,972	269,973	269,973
Current Assets					
Cash & Bank (OD)	12,838	14,577	14,282	12,188	7,093
MoH Debtor	8,525	9,000	9,000	9,000	9,000
Other Debtors & Other Receivables	15,965	16,000	16,000	16,000	16,000
Prepayments	901	800	800	800	800
Stocks	7,196	7,000	7,000	7,000	7,000
Total Current Assets	45,425	47,377	47,082	44,988	39,893
Current Liabilities					
Creditors & Accruals	67,901	64,000	60,000	55,000	50,000
Capital charge payable	3,738	4,500	4,500	4,500	4,500
GST	6,178	5,000	5,000	5,000	5,000
Interest Accrual	377	377	377	377	377
Staff Entitlement	78,136	81,744	76,744	71,744	71,744
Total Current Liabilities	156,330	155,621	146,621	136,621	131,621
Working Capital	(110,905)	(108,244)	(99,539)	(91,633)	(91,728)
Investments	375	14,875	29,375	43,875	58,375
Restricted Assets - Trust Fund	8,110	8,110	8,110	8,110	8,110
Fixed Assets	477,905	460,500	437,295	414,890	400,485
Total Non Current Assets	486,390	483,485	474,780	466,875	466,970
Term Staff Entitlement	(9,509)	(9,509)	(9,509)	(9,509)	(9,509)
Trust Funds Liabilities		(8,110)	(8,110)	(8,110)	(8,110)
Term Loans	(78,650)	(87,650)	(87,650)	(87,650)	(87,650)
Total Non Current Liabilities	(88,159)	(105,269)	(105,269)	(105,269)	(105,269)
Net Assets	287,326	269,972	269,972	269,973	269,973

9.6.4 Forecast Group Statement of Movement in Equity

	30/06/06 Forecast $'000	30/06/07 Forecast $'000	30/06/08 Forecast $'000	30/06/09 Forecast $'000	30/06/10 Forecast $'000
Public Equity					
Opening Equity	199,705	287,326	269,972	269,972	269,973
Add/(Less):					
Equity Injection / (Repayment)	(22,000)	-	-	-	-
Revaluation of Property	106,760				
Transition to IFRS		(14,854)			
Net Result for the period	2,861	(2,500)	0	0	0
Total Public Equity	287,326	269,972	269,972	269,973	269,973

9.6.5 Forecast Group Statement Cashflow

	2005/06 Actual $'000	2006/07 Forecast $'000	2007/08 Forecast $'000	2008/09 Forecast $'000	2009/10 Forecast $'000
Cashflows from Operating Activities					
Cash provided from:					
MOH Receipts	963,919	1,053,555	1,096,676	1,124,093	1,152,195
Other Receipts	44,340	47,028	48,049	49,247	50,476
	1,008,259	1,100,583	1,144,725	1,173,340	1,202,671
Cash applied to:					
Employee Costs	392,601	433,767	449,945	455,748	461,946
Supplies & Expenses	549,811	612,278	637,492	651,304	667,437
Capital Charge Payments	4,928	21,335	21,697	21,697	21,697
Finance Costs	19,955	5,032	5,932	5,932	5,932
Taxes Paid	(3,557)	1,178	-	-	-
	963,738	1,073,590	1,115,066	1,134,681	1,157,012
Net Cashflow from Operating Activities	**44,521**	**26,993**	**29,659**	**38,659**	**45,659**
Cashflows from Investing Activities					
Cash provided from:					
Sale of Assets	6,650	12,500	10,800	-	-
Interest Received	3,102	3,746	3,746	3,746	3,746
	9,752	16,246	14,546	3,746	3,746
Cash applied to:					
Advance to JV/Trust Investments	(231)	14,500	14,500	14,500	14,500
Purchase of Assets	29,775	36,000	30,000	30,000	40,000
	29,544	50,500	44,500	44,500	54,500
Net Cashflow from Investing Activities	**(19,792)**	**(34,254)**	**(29,954)**	**(40,754)**	**(50,754)**
Cashflows from Financing Activities					
Cash provide from:					
Equity Injection					
Loans Raised	-	9,000	-	-	-
	-	9,000	-	-	-
Cash applied to:					
Loan Repayment					
Equity Repayment re FRS-3	22,000	-	-	-	-
	22,000	-	-	-	-
Net Cashflow from Financing Activities	**(22,000)**	**9,000**	**-**	**-**	**-**
Overall Increase/(Decrease) in Cash Held	2,729	1,739	(295)	(2,095)	(5,095)
Add Opening Cash Balance	10,109	12,838	14,577	14,282	12,188
Closing Cash Balance	**12,838**	**14,577**	**14,282**	**12,188**	**7,093**

10 APPENDICES AND REFERENCES

The Canterbury DHB has developed key documents that have been referenced throughout this DAP. These documents can be accessed via the DHB website, www.cdhb.govt.nz, or by contacting the DHB's Planning and Funding Division on (03) 364 4160.

- District Strategic Plan: A Healthier Canterbury: Directions 2006.
- Canterbury DHB Statement of Intent 2006/2009.
- Health Needs Assessment for Canterbury, 2004.
- Canterbury DHB Quality Strategic Plan 2004/2006.
- Rural Health Action Plan: Rural Health in Canterbury DHB 2002.
- Child Health and Disability Action Plan 2004/2007.
- Canterbury DHB Aged Care Strategy: Healthy Ageing, Integrated Support 2005.
- Disability Strategy, Action Plan for Disability 2004/2007.
- Healthy Eating, Active Living Plan 2005/2010.
- Canterbury DHB Information Strategy Strategic Plan 2005.
- Canterbury Heart Health Strategy, September 2004.
- Oral Health Strategy, September 2003.
- Pacific Health Action Plan, March 2002.
- Diabetes Strategy Action Plan (Interim), 2002.
- Mental Health and Addiction Strategy, May 2004.

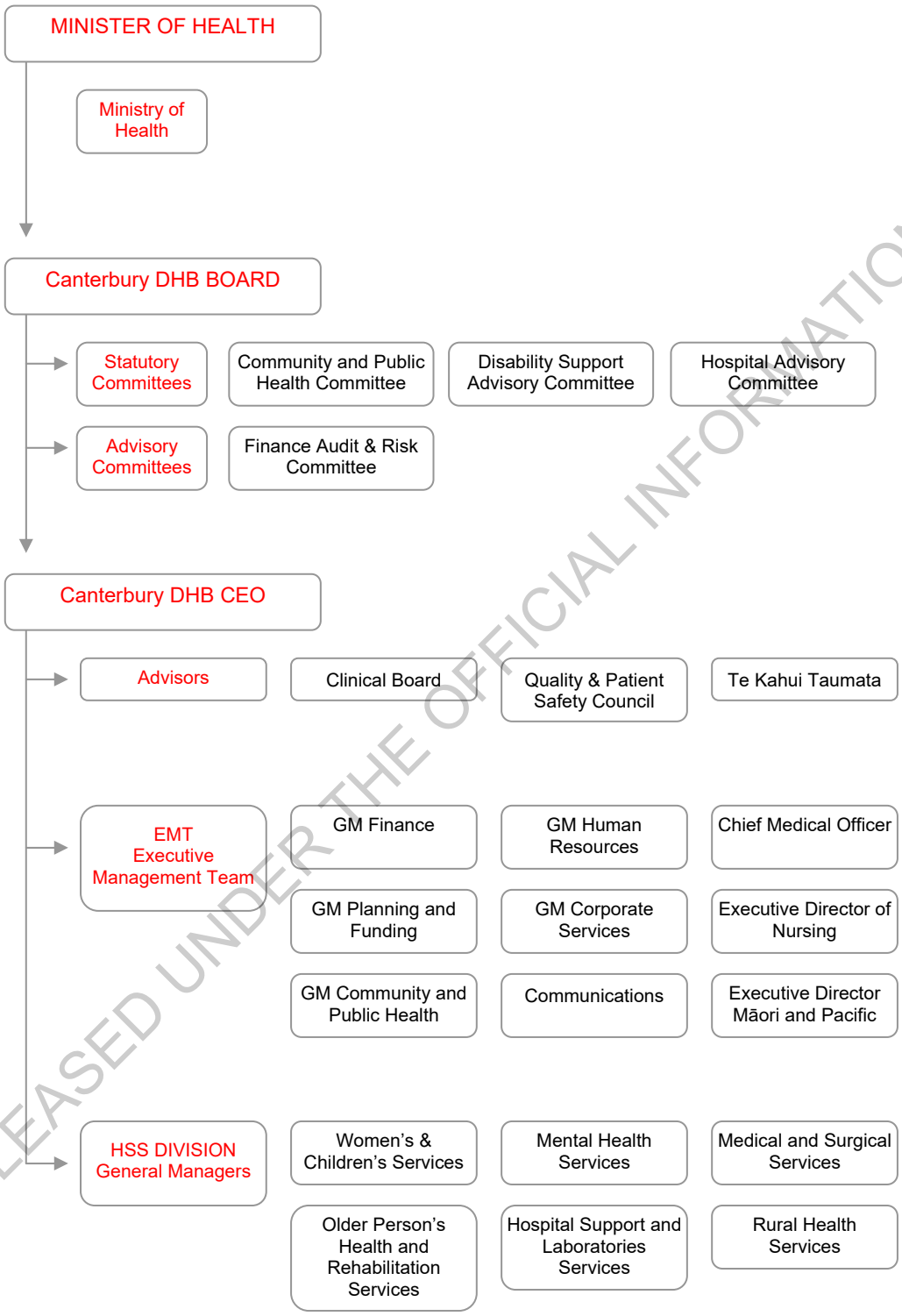
All Ministry documents referenced in this SOI are available on the Ministry's website (www.moh.govt.nz).

Appendices

- Appendix 1. Organisational Chart of the Canterbury DHB.
- Appendix 2. Hospital and Specialist Service Division - Overview of Services.
- Appendix 3. Glossary of Terms.
- Appendix 4. Consolidated List of Indicators of DHB Performance.
- Appendix 5. Diabetes Case Study Value for Money.

Appendix 1.

10.1 Organisational Chart of the Canterbury DHB



Appendix 2.

10.2 Hospital and Specialist Services - Overview of Service Divisions

HOSPITAL SUPPORT AND LABORATORY SERVICES

Covers support services such as: medical illustrations, specialist equipment maintenance, sterile supply and hospital maintenance. It also covers the provision of diagnostic services through Canterbury Health Laboratories (CHL) for patients under the care of the Canterbury DHB and offers a testing service for GPs and private specialists. CHL is 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

Covers medical services: cardiology/lipid disorders, endocrinology/diabetes, respiratory, rheumatology/immunology, infectious diseases, oncology, gastroenterology, clinical haematology, neurology, hyperbaric medicine and sexual health and surgical services: vascular, cardiothoracic, orthopaedics and neurosurgery, urology, plastic and cardiac surgeries and the services of the day surgery unit. Services also cover: emergency investigations, outpatients, anaesthesia, intensive care, radiology, nuclear medicine, clinical pharmacology, pharmacy, medical physics and allied health services. The Christchurch Hospital has the busiest Emergency Department in Australasia treating around 72,000 patients per annum.

MENTAL HEALTH SERVICES

Our Mental Health Service is one of the two largest providers in NZ covering: child and youth, adult specialty, community services and rehabilitation services, forensic (regional), acute psychiatric and alcohol and drug services, long-term care, assessment, treatment and rehabilitation and psychiatric services for adults with intellectual disabilities. A number of community based services and mobile teams also provide mental health services (including alcohol and drug services) throughout Canterbury.

OLDER PERSON'S HEALTH AND REHABILITATION SERVICES

Covers assessment, treatment and rehabilitation services, psychiatric services for the elderly and psychiatric needs assessment, generic geriatric outpatients, specialist osteoporosis clinics, meals on wheels, community therapy services and needs assessment service co-ordination. The Older Person's Health Service also operates a geriatric day hospital. Rehabilitation health services cover the spinal injuries unit, musculoskeletal services, brain injury rehabilitation services, pain management and orthopaedic rehabilitation. The Burwood Spinal Unit is one of only two such units in the country, treats 60% of NZ's spinal injury patients and is involved in leading international research to help patients rehabilitate and adjust.

RURAL HEALTH AND COMMUNITY SERVICES

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. Services include: general medicine and surgery, palliative care, maternity services, assessment treatment and rehabilitation services for the elderly and long-term care for the elderly including specialised dementia care and diagnostic services. Also offered are rural community support services: day care services, district nursing, home support, meals on wheels, clinical nurse specialist in respiratory, cardiac education and stoma therapy. The Rural Health Service also operates Tuarangi Home a facility providing hospital care for the elderly in Ashburton.

WOMEN AND CHILDREN'S HEALTH SERVICES

Covers acute and elective gynaecology services, primary, secondary and tertiary obstetric services, neonatal intensive care services, pregnancy terminations (at Lyndhurst Hospital) and primary maternity services through Lincoln Maternity, Rangiora Hospital and the Burwood Birthing Unit. This service also covers children's health: 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.

Appendix 3.

10.3 Glossary of Terms

GLOSSARY OF TERMS USED IN THIS DOCUMENT		
	Access	Ability of people to reach or use health care services. Barriers to access can be: (1) a persons locality, income or knowledge of services available; or (2) the acceptability or availability of existing services
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.
	Ambulatory Sensitive Admissions	Hospitalisation or death due to causes which could have been avoided by preventive or therapeutic programme
AT&R	Assessment Treatment and Rehabilitation	These are specialist health services for older people provided by teams of health professionals specially trained to treat illness, rehabilitate and maintain the older person's ability and mobility so that they can retain an independent lifestyle.
ALOS	Average Length of Stay	ALOS is the sum of bed days for patients discharged in the period (ie 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.
CCC	Christchurch City Council	Local Council in the Christchurch region.
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.
CNS	Clinical Nurse Specialist	Registered nurses with an advanced degree in a particular area of patient care; e.g., neurosurgery clinical nurse specialist.
	Crown Agent	A Crown Entity that must give effect to government policy when directed by the responsible Minister.
	Crown Entities	A generic term for a diverse range of entities referred to in the Crown Entities Act 2004, namely: statutory entities, Crown entity companies, Crown entity subsidiaries, school boards of trustees, and tertiary education institutions. Crown entities are legally separate from the Crown and operate at arms length from the responsible or shareholding Minister(s); 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.
COSE	Co-ordinator of Services for the Elderly	An Elder Care Canterbury initiative, running in two areas of Christchurch since October 2000. Staff, working alongside GPs, are responsible for co-ordinating packages of care for older people in the community. The most important outcome of the COSE project has been the provision of an overall link between any hospital and any provider service and the GP in Christchurch.
CWD	Case Weighted Discharge	Relative measure of a patient's utilisation of resources
	Credentialling	A process used to assign specific clinical responsibilities to health professionals on the basis of their training, qualifications, experience and current practice, within an organisational context. Credentialling is part of a wider organisational quality and risk management system designed primarily to protect the patient.
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.
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.
	Disparity (or deprivation)	Socio-economic or health inequality or difference relative to the local community or wider society to which an individual, family or group belongs.
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 New Zealand	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.
	Equity Lens	A tool to assess planned service development targets against the needs of those who face health inequalities
EMT	Executive Management Team	Senior Management Team of the Canterbury DHB who report directly to the Chief Executive.
FSA	First Specialist Assessment	(Outpatients only) First time a patient is seen by a doctor for a consultation in that speciality for that reason, this does not include procedures, nurse appointments, diagnostic appointments or pre-admission visits.
	Follow-ups	Further assessments by hospital specialists.
	Fono	Samoan word for 'meeting'.
FTE	Full Time Equivalent	An Employee who works an average minimum of 40 ordinary hours per week on an ongoing basis.
FFT	Future Funding Track	FFT is the annual percentage price increase to DHBs from the Ministry.
HbA1c	Haemoglobin A1c; also known as glycated haemoglobin.	The level of HbA1c reflects the average blood glucose level over the past 3 months.
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.
HealthPAC	Health Payments Agreements and Compliance	Formed from the merger of Health Benefits and the Shared Support Service Group within the Ministry. HealthPAC undertakes a number of activities based on a Service Level Agreement with the Ministry, and also provides information to several health agencies.
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.
HPCA	Health Practitioners Competency Assurance	The purpose of the HPCA Act, which came into force on 18 September 2004, is to protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practice their professions.
HWAC	Health Workforce Advisory Committee	Committee who advises the Minister on how to ensure an adequate and responsive professional health workforce
HEAL	Healthy Eating Active Living 'Action Plan'	This Plan provides us with the platform to implement the national HEHA Strategy at a local level.
HEHA	Healthy Eating Healthy Action 'Strategy'	HEHA is the Ministry's strategic approach to improving nutrition, increasing physical activity and achieving healthy weight for all New Zealanders.

HSS	Hospital and Specialist Services	The Provider-arm of the Canterbury DHB.
	Hui	Maori word for a meeting or gathering of people for a specific reason.
	Improve the Patient Journey Project	Project with the goal of reducing unnecessary waits and delays within the patient continuum of care through innovation, reducing variation, focusing processes on patient orientated processes and collaboration.
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.
	Iwi	Tribe
KPIs	Key Performance Indicators	Key Performance Indicators are quantifiable measurements, agreed to beforehand, that reflect the critical success factors of an organisation.
LEAP	Late Effects Assessment Programme	LEAP is a clinic (and programme) for children and adolescents with cancer established to help monitor and support children and adolescents who have completed active cancer therapy.
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.
LTCCP	Long Term Council Community Plan	Plan that sets out the type of community the people of a region would like to live in, and the things they would like to see for their community. It shows how the Council (for that region) and other organisations will work to build that community.
	Medical Credentialing	Medical credentialing refers to the process of permitting an individual physician to practice in a particular hospital, clinic or other medical practice setting
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.
MeNZB™	Meningococcal B	Meningococcal disease is a bacterial infection. It causes severe illnesses including: meningitis (an infection of membranes that cover the brain) and septicaemia (a serious infection in the blood). There are several different strains of bacteria which cause meningococcal disease including A, B and C.
MVS	Meningococcal B Vaccine Strategy	MeNZB™ vaccine has been developed to protect against the strain of meningococcal B causing the NZ epidemic.
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.
MH-SMART	Mental Health Standard Measures of Assessment and Recovery	The aim of the MH-SMART initiative is to support recovery by promoting and facilitating the development of an outcomes-focused culture in the mental health sector. The principle means of achieving this will be by implementing a suite of standard tools to measure changes in the health status of mental health service users that is responsive to the needs of Maori and other cultures within a recovery framework.
	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.
NNPAC	National Non-admitted Patient Collection	Coding of outpatients – a pilot project under the national Health Information Strategy.
NASC	Needs Assessment & Service Co-ordination	NASC assists older people with long-term disabilities/ health problems (i.e. longer than 6 months) to remain living at home, safely and independently, for as long as possible. Needs Assessors complete an assessment of needs with the older person, and Service Coordinators use this assessment to develop care packages of support services to assist at home.

NZBS	New Zealand Blood Service	Manages the donation, collection, processing, and supply of blood, controlled human substances, and related or incidental matters
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/Maori 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.
NZIFRS	NZ Equivalents to International Financial Reporting Standards	Accounting Standards, which will come into use from 1 July 2007.
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. These are given effect through the Crown Funding Agreements between the Minister and the DHB.
PP	Pacific Peoples	The population of Pacific Island ethnic origin (for example, Tongan, Niuean, Fijian, Samoan, Cook Island Maori, and Tokelauan) incorporating people of Pacific Island ethnic origin born in NZ as well as overseas.
PPDF	Pacific Provider Development Funds	The PPDFs are provided for initiatives to improve the overall health and reduce social inequalities for Pacific people. There are four priority areas: strengthening existing Pacific providers, development of the existing workforce, workforce and leadership scholarships best practice and research. The funds are allocated by the Ministry in consultation with DHBs and the Ministry of Pacific Island Affairs.
PMS	Patient Management System	PMS (secondary-care usage), or Practice Management System (primary-care usage). The system used to keep track of patients. In the case of secondary care the focus is usually on tracking the admissions, discharges or transfers of patients. In the case of primary care, the focus is on maintenance of the register.
PHARMAC	Pharmaceutical Management Agency	Agency which secures, for eligible people in need of pharmaceuticals, the best health outcomes that are reasonably achievable from pharmaceutical treatment and from within the amount of funding provided.
PACS	Picture Archiving and Communications System	A picture archiving and communications system is a versatile system that enables the transfer of digital images and patient information throughout the organisation. In broad terms, PACS is a technology, system and process for handling medical images (X-rays, CT, ultrasound etc) without the need for film. Images are stored on computer as digital information and displayed on computer screens for viewing.
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.
	Quality Assurance	Formal process of implementing quality assessment and quality improvement in programmes to assure people that professional activities have been performed adequately
RMO	Resident Medical Officer	This is another name for a House Officer or Registrar.
	Risk Factor	An aspect of personal behaviour or lifestyle, an environmental exposure, or an inborn or inherited characteristic that is associated with an increased risk of a person developing a disease.

	Secondary Care	Specialist care that is typically provided in a hospital setting
SMO	Senior Medical Officer	This is another name for a Consultant.
SIMHN	South Island Mental Health Network	SIMHN is a forum of mental health representatives appointed by the six DHBs and is assisted in its work by the South Island Shared Services Agency Ltd (SISSAL).
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. The main services provided include contract and provider management, audit, strategy and service development, analysis, and project and change management.
SOI	Statement of Intent	The SOI covers three years and is the DHB's key accountability document to Parliament. It is a statutory obligation under the Public Finance Act. It has a high level focus similar to an executive summary, of the DHB's key financial and non-financial objectives and targets.
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
	Treaty of Waitangi	NZ's founding document. It establishes the relationship between the Crown and Maori as tangata whenua and requires both the Crown and Maori to act reasonably toward each other and with utmost good faith
	Well-child / Tamariki ora Services	Term used to describe all activities that promote health and prevent disease that are undertaken in the primary care setting for children and their families and whanau
	Whanau	Family
WMRS	Workforce Management and Reporting System	The WMRS tool analyses fortnightly, year-to-date and previous year's payroll data against phased budgets and is designed to give management at all levels a means of detecting cost trends at an early stage as well as highlighting areas where more intense planning and monitoring is required.
YTD	Year to Date	The 12 month period immediately prior to the date given.

Appendix 4.

10.4 Consolidated List of Indicators of DHB Performance

Our IDPs for 2007/08 follow and are in addition to a wider set used by the Ministry within its accountability arrangements with DHBs. These arrangements, as a package, ensure there is public accountability for DHB spending.

IDP CODE	MEASURE AND CANTERBURY DHB TARGETS	REPORTING PERIOD	CDHB PRIORITY
HKO-01 Local Iwi/Maori are engaged and participate in DHB decision-making and the development of strategies and plans for Maori health gain	1. Percentage of PHOs with Maori Health Plans (MHP) agreed to by the DHB Target – 100% 2. Percentage of DHB members that having Treaty of Waitangi training Target – 100% 3. Report on achievements against the Memorandum of Understanding (MoU) between a DHB and its local Iwi/Maori relationship partner, and describe other initiatives achieved that are an outcome of engagement between the parties. Provide a copy of the MoU. 4. Report on how (mechanisms/frequency of engagement) local Iwi/Maori 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 MHPs are being implemented by PHOs and monitored by the DHB (include the names of the PHOs with MHPs) OR for newly established PHOs, a report on progress in the development of MHPs (include the names of these PHOs). 6. Describe when Treaty of Waitangi training (including facilitated by the MoH) has, or will, take place for Board members. 7. Identify at least two key milestones from your MHP to be achieved in 2007/08. For reporting in Q2, provide a progress report on the milestones, and for reporting in Q4, provide a report against achievement of those milestones.	Six-monthly in the second and fourth quarter.	Maori Health
HKO-02 Development of Maori health workforce and Maori health providers	Report the number of (i) management (ii) clinical (iii) administrative and (iv) other FTEs held by Maori out of the total numbers of (i) management, (ii) clinical, (iii) administrative and (iv) other FTEs in the DHB respectively. Target - The number of Maori people employed by the CDHB moves closer to the % of Maori people in the Canterbury population. Provide a copy of the DHB Maori Health Workforce Plan (or regional Maori Workforce Plan), or timeframe for completion. Report on achievements based on key deliverables in the DHB (or Regional) Maori Workforce Plan, or if the Plan is being developed, describe at least two key DHB Maori health workforce initiatives that the DHB has achieved.	Six-monthly in the second and fourth quarters	Maori Health
HKO-03 Improving mainstream effectiveness	A report describing the reviews of pathways of care that have been undertaken in the last 12 months that focused on improving Health outcomes and reducing health inequalities for Maori. Report on an example(s) of actions taken to address issues identified in the reviews.	Six monthly, in the second and fourth quarters	Maori Health
HKO-04 DHBs will set targets to increase funding for Maori Health and disability initiatives	Report actual expenditure on Maori Health Providers by GL code. Report actual expenditure for Specific Maori Services provided within mainstream services targeted to improving Maori health by Purchase Unit (PU). Report total actual expenditure for Iwi/Maori-led PHOs. Report actual expenditure for mainstream PHO services targeted at improving Maori health.	Annual reports to the MoH in quarter four (not part of the monthly financial reporting template).	Maori Health
PAC-01 Pacific peoples	Percentage of DHB strategies and plans on which Pacific communities or representatives were consulted. Target - 50%	Six monthly in the second and fourth	Improving the Health of Our Community

are engaged and participate in DHB decision-making and the development of strategies and plans for Pacific health gain	Percentage of DHB working groups and steering groups that included representation from Pacific communities. Target - 50% Report the number of (i) management (ii) clinical (iii) administrative and (iv) other FTEs held by Pacific peoples out of the total numbers of (i) management (ii) clinical (iii) administrative and (iv) other FTEs respectively in the DHB. Target - The number of Pacific people employed by the CDHB moves closer to the % of Pacific people in the population serviced by the DHB. Provide a report describing how Pacific peoples have been involved in the development of strategic planning at different levels (eg, steering group, consultation fono, service delivery by Pacific health service providers, or Pacific DHB staff members).	quarter.	
POP-01 Diabetes – supportive environments.	Report on the number and type of agencies, organisations, and providers that have an influence on the environment, and the type of programmes and initiatives that are planned or underway, together with any evaluations and monitoring of implementation (for improving nutrition, physical activity and reducing obesity).	Annually in the third quarter.	Disease Prevention Management
POP-01 Diabetes follow-up	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 (broken down into Maori, Pacific, and Other ethnic groups) as a % of the expected number of unique individuals to have type I or type II diabetes, as at the end of the reporting period. Target – Maori >42%, Pacific >81%, Other >64%, Total >64%	Annually in the third quarter.	Diabetes
POP-01 Diabetes – Diabetic Retinopathy Screening	The number of people with type I or type II diabetes on the register that have had retinal screening or an ophthalmologist examination in the last two years, and the date of the free annual check is during the reporting period (broken down into Maori, Pacific, and Other ethnic groups) as a % of the total number of people with type I or type II diabetes on the register whose date of their free annual check is during the reporting period. Target – Maori 54%, Pacific 57%, Other 61%, Total 60%	Annually in the third quarter.	Diabetes
POP-01 Diabetes – Diabetes Management	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 (broken down into Maori, Pacific, and Other ethnic groups) as a percentage of the total 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. Target – Maori 70%, Pacific 53%, Other 79%, Total 78%	Annually in the third quarter.	Diabetes
POP-02 Cardiovascular disease - Risk recognition	The number of people in each target group who have had their five-year absolute CVD risk recorded in the last five years as a % of the total number of people in each target group. Target groups: Maori/Pacific & Indian subcontinent men >35 years, women >45 years of age NZ European & other men >45 years of age, women >55 years of age. Target – The DHB is not currently able to measure this indicator through PHO Performance Monitoring.	Annually in the third quarter.	Cardiovascular Disease
POP-02 CVD Risk Management Statins	The number persons where CVD risk is greater than or equal to 15% where statins have been prescribed in the past year (broken down into Maori, Pacific, and Other ethnic groups) as a % of the total number of persons where CVD risk is greater to or equal to 15 %. Target – The DHB is not currently able to measure this indicator through PHO Performance Monitoring.	Annually in the third quarter.	Cardiovascular Disease
POP-02 Cardiovascular Rehabilitation Programme	The number of people who have suffered Acute Coronary Syndrome who attend a cardiac rehabilitation outpatient programme (broken down into Maori, Pacific, and Other ethnic groups) as a % of the total number of people who have suffered Acute Coronary Syndrome who were admitted and discharged from hospital. Target – The DHB's target to establish a baseline and target for this indicator.	Annually in the third quarter.	Cardiovascular Disease
POP-03 Stroke Organised	The number of people who have suffered a stroke event, who have been admitted to organised stroke services and remain there for their entire hospital stay (broken down into Maori, Pacific, and Other ethnic groups) as a % of the total number of people who have suffered a stroke event .	Annually in the third quarter.	Cardiovascular Disease

Stroke Services	Target – The DHB's target to establish a baseline and target for this indicator.		
POP-04 Oral health - Mean DMFT score at year eight	The total number of permanent teeth of Year eight children, Decayed, Missing (due to caries), or Filled at the commencement of dental care, at the last dental examination, before the child leaves the DHB SDS against the total number of children, who have been examined in the Year eight group, in that year. The data must be broken down by: ethnic group, fluoridation status (of school area the child attends) and mean components of DMF index. Target - Maori 2.30-2.82 Pacific 2.30-2.82 Other 1.46 Total 1.6	Annually in quarter three for the period 1 January to 31 December 2007.	Child and Youth Health
POP-05 Oral health - Percentage of children caries free at age five years	The total number of caries free children at the first examination after the child has turned five years, but before their sixth birthday, examined by the DHB SDS against the total number of children who have been examined in the age five group, in the year to which the reporting relates. The data must be broken down by: ethnic group, fluoridation status (of school area the child attends) and mean components of DMF index. Target - Maori 19-39% Pacific 16-36% Other 60% Total 51%	Annually in quarter three for the period 1 January to 31 December 2007.	Child and Youth Health
POP-06 Improving the health status of people with severe mental illness	The average number of people domiciled in the DHB region, seen per year rolling every three months being reported (the period is lagged by three months) against the projected population of the DHB region: The data must be broken down by age and ethnicity for the following groupings: child and youth aged 0-19, adults aged 20-64, people aged 65+. Target - Maori Other Total 0-19 2 2 2 20-64 2.5 2.5 2.5 65+ - (no targets as service historically funded by DSS)	Quarterly for the period to end of previous quarter.	Mental Health
POP-07 Alcohol and other drug service waiting times	DHBs will report their longest waiting time, in days, for each service type for one month prior to the reporting period. 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.	Measured, for one month, every three months. Reports due: Every quarter.	Mental Health
POP-08 Progress towards 95% of two year olds fully immunised	1. DHBs should provide qualitative information about the DHB strategies to progress towards the national immunisation target, including information on improving Maori and Pacific childhood immunisation coverage rates. A) DHB NIR Enrolled Populations 2. Number of newborns born and enrolled during the reporting period as a % of the number of children born during the same period. Target - 95% 3. Number of newborns born during reporting period of each ethnicity as a % of the number of children born and enrolled during reporting period of each ethnicity. Target – Ethnicity not currently reliably identified 4. Number of newborns born and enrolled during reporting period of each level of deprivation as a % of the number of children born during reporting period of each level of deprivation. Target – Deprivation not currently reliably identified 5. Number of children on the NIR less than two years of age with an 'Opt-Off' status as at the report date as a % of the number of children less than two years of age on the NIR as at that date. Target – 2% B) Progress towards the health target of 95% of two year olds fully immunised NIR Immunisation coverage at 6, 12, 18 and 24 months of age - for each of these reporting periods, coverage will be reported for each of the following	The indicator will be measured quarterly and annually.	Child and Youth Health

	birth cohorts: those who turned 6mths, 12mths, 18mths and 24mths of age during report period. 6. Number of children on the NIR up-to-date with immunisation on the day they turned (6, 12, 18, 24 months) during the reporting period as a % of the total number of children on the NIR who turned a specified age during the period. Target – 6&12 months 88-92%, 18&24 months 85-88% 7. Number of children on NIR of each ethnicity up to date with immunisation on the day they turned (6, 12, 18, 24 months) during the reporting period as a % of the number of children on NIR of each ethnicity who turned that age during the period. Target – Ethnicity not currently reliably identified 8. Number of children on NIR at each deprivation level up-to-date with immunisation on the day they turned (6, 12, 18, 24 months) during the reporting period as a % of the number of children on the NIR of each level of deprivation who turned that age during the reporting period. Target – Deprivation not currently reliably identified 9. Number of children on the NIR up-to-date with MMR immunisation on the day they turned 18 months during the reporting period as a % of the number of children on the NIR who turned 18 months during the reporting period. Target – 85-88%		
POP-09 Reduce ambulatory sensitive admissions	The observed number of hospital discharges, considered being ambulatory sensitive, as they result from diseases and conditions sensitive to prophylactic or therapeutic interventions deliverable through primary care and are, therefore, avoidable as a ratio of the expected (ethnic level) number of ambulatory sensitive hospital admission as derived from national intervention levels. Targets must be presented in the following age bands: <5, 45-64, 0-74. Target – Observed to Expected (ethnic level) Ratio Ethnicity 0-4years 45-64years 0-74years Maori ≤1 <1 <1 Pacific ≤1 ≤1 ≤1 Other ≤1.312 ≤1 ≤1.071 Note: Measured at 99% confidence level. **0-4yrs**: Remaining at or below national level for Maori & Pacific and reducing to 31.2% above the national average for Other. **45-64yrs:** Remaining below national level for Maori, and at or below national level for Pacific and Other. **0-74yrs:** Remaining below national level for Maori, remaining at or below national level for Pacific and reducing to 7.1% above the national average for Other.	Six-monthly in the second and fourth quarters. Results based on most complete previous 12 months' data	Primary Care
POP-10 Reduced radiation oncology and chemotherapy treatment waiting times	M1 - Monthly templates that measure the interval between the patient's referral from a medical practitioner to the oncology department, and the beginning of radiation/chemotherapy treatment, are supplied on time and complete from each DHB (or from cancer centre for contributing DHBs as agreed). (Including information by DHB of domicile and ethnicity.) M2 - A report updating on progress towards ensuring all patients receive oncology megavoltage radiation treatment, and chemotherapy treatment, according to nationally agreed standards. This report is to be agreed with all the peripheral DHBs whose populations have used the service during the quarter. In Q4 include information that demonstrates the centre has undertaken a data audit of waiting time data, and is satisfied high quality data is being provided. Target - No patients wait more than 8 weeks for Radiation Therapy.	M 1— Monthly. M 2— Quarterly.	Cancer
POP-11 Oral Health – Utilisation of DHB funded dental services by adolescents	The total number of completions and non-completions under the Combined Dental Agreement for adolescent patients plus additional adolescent examinations with other DHB funded dental services (eg SDS, Maori Health providers and other contracted providers) as a % of the cohort (provided by the MoH). Broken down by ethnic group (Maori, Pacific, Other). Target – 74.2%.	Annually in quarter three for the period 1 January to 31 December 2006.	Child and Youth Health

Risk Reduction – Smoking	The number of enrolled persons aged over 14 years with smoking status on record (by Maori, Pacific, and Other) as a % of the total number of enrolled persons over 14. Target – The DHB is not currently able to measure this indicator through PHO Performance Monitoring.	Annually in the third quarter.	Disease Prevention Management
QUA 02 Improving results for People with enduring severe mental illness	Report the number of adults (20–64 years) with enduring serious mental illness (two years or more in treatment since first contact with any mental health service (in treatment = at least one provider arm contact every three months for two years or more.) Report the number of long-term clients with up to date crisis prevention plans (NMHSS criteria 16.4), and describe how this is assured. Target - 95% of long-term clients have up to date plans. Number (and %) of long-term clients in full-time work (>30 hrs). Number (and %) of long-term clients with no paid work. Number (and %) of long-term clients undertaking education. Target – The DHB currently only records this information for a specific groups of clients participating in the Knowing the People Project.	Annual in 2nd quarter.	Mental Health
QUA-01 Quality Systems	The DHB provider arm demonstrates an organisational wide commitment to quality improvement and effective clinical audit by reporting a list of key quality improvement and clinical audit initiatives and results aligned to the Goals in *Improving Quality (IQ): A Systems Approach for the NZ Health and Disability Sector (2003)*. Using the reporting template provided by the MoH describe improvement initiatives and the effectiveness of those initiatives – in the following categorises: 1. There are more effective service outcomes for Maori by acknowledging the special relationship between Maori and the Crown under the Treaty of Waitangi, and applying the principles of participation, partnership and protection. 2. There is a shared vision towards safe and quality care that is engendered through committed leadership at all levels, which supports constant maintenance and improvement in service quality, and takes into account Maori aspirations and priorities. 3. People are encouraged and supported to participate in the planning, delivery, and assessment of health and disability services and programmes, including active participation of Maori. 4. There is widespread awareness, understanding, and commitment to a quality improvement culture at all levels of the organisation. 5. There is evolutionary redesign of systems of care to support delivery of quality services. 6. Unexpected adverse outcomes are managed in an open and supportive manner that builds trust and confidence in the organisation, and is fair to all participants. 7. There is effective, open communication, co-ordination and integration of service activity recognising the value of teamwork. 8. There is a supportive and motivating environment that provides the workforce with appropriate tools, including cultural competency tools, for continuous learning and ongoing improvement in planning, delivery and assessment of health and disability services. 9. Useful knowledge and information, including Maori satisfaction information and clinical evidence, is readily available and shared to support a quality-conscious culture. 10. Regulatory protections that assure safe care are in place to support people and service providers. 11. There are more effective service outcomes for Pacific people, to address the current situation where Pacific peoples have generally worse health that that of the total population.	Annual in the third quarter.	Quality and Patient Safety
QUA-03 Improving the quality of data provided to National Collections	1. National Health Index (NHI) duplications – The number of NHI duplicates that require merging by NZHIS per DHB per quarter and a % of the total number of NHI records created per DHB per quarter. 2. Non-specific NHI Ethnicity – The total number of NHI records created with ethnicity status of 'Not Stated' or 'Other' per DHB per quarter as a % of the total number of NHI records created per DHB per quarter.	NZHIS will report to DHBs on the outlined measures quarterly	Infrastructure

Systems (NCS)	3. Standard versus specific descriptors in the National Minimum Data Set (NMDS) – The number of versions of text descriptor per code per DHB as a % of the total number of codes per DHB. 4. Error Diagnostic Related Group (DRG) – The number of discharge events with an error DRG as a % of the total number of NMDS events for patient discharges per DHB per quarter. 5. The number of MHINC records able to be successfully loaded into the MHINC per DHB per quarter as a % of the total number of MHINC records submitted to NZHIS per DHB per quarter.		
RIS-01 Service Coverage	A report providing information on progress achieved during the quarter towards resolution of gaps in 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.	Quarterly.	Better Ways of Working
SER-01 Accessible appropriate services	The age-standardised rate of General Practitioner consultations per high need person to the age-standardised rate of General Practitioner consultations per non-high need person. Target – 1.2 to 1	Quarterly.	Primary Care
SER-02 Care Plus Enrolled Population	The number of each PHOs Care Plus enrolled population (broken down into Maori, Pacific peoples, and Other ethnic groups) as a % of each PHOs expected Care Plus enrolled population. Target – 80%	PHOs report Care Plus data quarterly.	Primary Care
SER-03 The proportion of laboratory test and pharmaceutical transactions with a valid National Health Index	Pharmaceuticals: the number of government subsidised community pharmaceutical items dispensed by pharmacies in the DHB district with a valid NHI submitted as a % of the total number of government subsidised community pharmaceutical items dispensed by pharmacies in the DHB district. Target – 95% Laboratory tests: The number of tests carried out by community laboratories in the DHB district with a valid NHI submitted. As a % of the total number of tests carried out by community laboratories in the DHB district. Target – 95%	Quarterly.	Primary Care
SER-04 Continuous Quality Improvement and Improving Elective Services	Standardised Discharge Ratios (SDR) for 11 elective procedures as published on the Ministry website each quarter (excluding hip and knee replacements, and cataracts covered by separate initiatives). Target – SDRs of 0.95 or above for the 11 procedures. A report demonstrating for any SDR that is more than 5% below the national average of one, i.e. a rate of less than 0.95, what analysis the DHB has done to review the appropriateness of its rate OR the reason that the DHB considers the rate to be appropriate for its population, or an action plan as to how it will address its relative under delivery of that procedure.	Six-monthly, based on second and fourth quarter results.	Elective Services
SER-07 Low or reduced cost access to first level primary care services	Report the number of fee increases that are above the annual statement of a reasonable standard GP fee increase that have been referred to a regional fee review committee and the number of practices who comply with the recommendations of the regional fee review committee, and in all cases where practices fail to comply the DHB applies appropriate sanctions. Target - 100%. The number of PHO practices ensure public access to local information on the fees PHO practices are charging patients. Target - 100%. The number of PHO practices that demonstrate that all increased subsidies translate into low or reduced cost access for eligible patients as a % of the number of PHO practices in a DHB region. Target - 100%.	Quarterly.	Primary Care

Appendix 5.

10.5 Diabetes Case Study – Value for Money

***DRAFT* SCORECARD**

CONSUMER/DHB POPULATION

Diabetes Case Detection[27]

	2003	2004	2005	2006
Maori			24%	32%
Pacific			51%	82%
Other			52%	61%
Total	53%	53%	49%	59%

Diabetes Case Management[28]

Maori	58%	60%	66%	70%
Pacific	51%	48%	48%	52%
Other	75%	76%	79%	78%
Total	74%	74%	78%	77%

Diabetes Retinal Screening[29]

Maori	72%	41%	57%	44%
Pacific	30%	37%	74%	47%
Other	45%	48%	73%	56%
Total	45%	48%	72%	55%

FINANCIAL

Diabetes Education, Detection and Management

Primary Care	
Annual Reviews	$480,000
Community Nursing	$89,760
Mobile Nursing	$146,000
Local Diabetes Team Support	$30,600
Secondary Care	
First Specialist Assessments	$228,690
Follow-Up Assessments	$606,034
Education and Management	$563,534
Diabetes Support (high risk type 1)	$18,403
Maori Diabetes Programme	$50,278
Nurse Clinics	$1,044,415

INTERNAL PROCESSES

Total Annual Reviews (2005)	6052
Total HBA1c <=8 (2005)	1378 (78%)

Inpatients admitted with a diabetes code in primary or secondary diagnosis.

	2005/06
Rate of admissions due to short-term diabetes complications per 1000 population (aged 19+).	0.24
Rate of lower extremity amputations due to diabetes complications per 1000 population (aged 19+).	0.23
End Stage Renal Failure due to complications of diabetes.	TBC

LEARNING/INNOVATION

- Support the implementation of HEHA and HEAL to improve lifestyles and reduce risk behaviours.
- Support the development of a DHB Health Service Plan and a framework for the management of chronic conditions
- Support PHOs to provide health promotion in physical activity, nutrition and smoking cessation and to increase diabetes awareness amongst their enrolled populations.
- Scope and develop an opportunistic screening programme in the community to increase diagnosis of diabetes and target the programme at high risk groups.
- Ensure annual review data is collected for regional/national databases and improve the process for collecting/reviewing this information.
- Develop a Diabetes Lifestyle Programme for people newly diagnosed with diabetes to provide self-management skills.
- Work with community podiatry services on providing access to foot care assessments and treatments for those with uncomplicated high risk feet and providing education on foot care.
- Undertake a review of diabetes services in Canterbury to assess effectiveness of services over time and improve the setting of targets for achievement in out-years.

[27] *Case Detection – % of people who have an annual review of the total expected number of diabetics in the population according to the Ministry's Diabetes Model.*

[28] *Case Management – % who have an annual review who have good diabetes management (i.e. an HBA1c < = 8).*

[29] *Retinal Screening – % who have had an annual review and who have had retinal screening in the last two years.*