Annual Plan 2013-2014

Incorporating the Statement of Intent

THE CANTERBURY HEALTH SYSTEM

working together to make it better

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

Our Mission

TĀ MĀTOU MATAKITE

To promote, enhance and facilitate the health and wellbeing of the people of Canterbury.

Ki te whakapakari, whakamanawa me te tiaki i te hauora mō te oranga pai o ngā tāngata o te rohe o Waitaha.

Our Values

Ā MĀTOU UARA

- Care and respect for others.
  Manaaki me te whakaute i te tangata.
- Integrity in all we do.
  Hāpai i ā mātou mahi katoa i runga i te pono.
- Responsibility for outcomes.
  Te Takohanga i ngā hua.

Our Way of Working

KĀ HUARI MAHI

- Be people and community focused.
  Arotahi atu ki te tangata me te hapori.
- Demonstrate innovation.
  Whakaatu te ihumanea hou.
- Engage with stakeholders.
  Kia tau ki ngā tāngata whai pānga.

our health system

Annual Plan & Statement of Intent

Produced July 2013
Pursuant to Section 149 of the Crown Entities Act 2004

Canterbury District Health Board
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www.cdhb.govt.nz

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Signatory Page

The Canterbury District Health Board (DHB) is one of 20 DHBs, established under the *New Zealand Public Health and Disability Act in 2011.* Each DHB is categorised as a Crown Agent under the *Crown Entities Act 2004* and is responsible to the Minister of Health for a geographically defined population.

This Annual Plan has been prepared to meet the requirements of both governing Acts and the relevant sections of the Public Finance Act. It sets out the DHB's goals and objectives and describes what the DHB intends to achieve in 2013/14 in terms of improving the health of its population and delivering on the expectations of the Ministry of Health.

The Plan also contains service and financial forecast information for the current and two subsequent years: 2013/14, 2014/15 and 2015/16.

Sections of this Annual Plan are extracted to form a stand-alone Statement of Intent document, which is presented to Parliament. As a public accountability document, the Statement of Intent is used at the end of every year to compare the DHB's planned performance with actual performance. The audited results are then presented in the DHB's Annual Report.

The Canterbury DHB has made a strong commitment to a 'whole of system' approach to planning and service delivery and has established clinically led local and regional alliances as a vehicle for implementing system change and improving health outcomes. This includes the large-scale Canterbury Clinical Network (CCN) District Alliance and the South Island Alliance.

In line with this approach, the actions and activities outlined in this Annual Plan present a picture of the joint commitment between the Canterbury DHB and its local primary and community healthcare alliance partners to improving the health of the Canterbury community and delivering the expectations of Government.

The key actions the DHB will deliver as part of its commitment to the regional alliance are also highlighted throughout this Plan. The full South Island Regional Health Services Plan (of which the Canterbury DHB is a signatory) can be found on the South Island Alliance Programme Office website: www.sialliance.health.nz.

The full work plans of the various workstreams of the Canterbury Clinical Network District Alliance can be found on the CCN website: www.ccnweb.org.nz. A summary of the 2013/14 deliverables plan is attached to this document.

The Canterbury DHB also has Māori Health and Public Health Action Plans for 2013/14, both of which are companion documents to this Annual Plan. These documents set out further actions and activity to improve population health and reduce inequalities. Both of these documents are available on the Canterbury DHB website: www.cdhb.govt.nz.

In signing this Annual Plan, we are satisfied that it represents the intentions and commitments of the Canterbury DHB and the wider Canterbury health system for the period 1 July 2013 to 30 June 2014.

Together, we will continue to demonstrate real gains and improvements in the health of the Canterbury population.

Bruce Matheson

Chairman CDHB

Peter Ballantyne

Deputy Chairman CDHB

David Meates

Chief Executive CDHB

Hon Tony Ryall

Minister of Health

Hon Bill English

Minister of Finance

Date: September 2013

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Foreword from the Chair & Chief Executive

Transforming our health system

In spite of our reduced capacity and the extraordinary circumstances we are operating in, we have risen to the challenge and continued to implement innovative solutions that improve the way health services are delivered in Canterbury.

We have continued our commitment to our vision: redesigning patient pathways, integrating services that have historically been fragmented and refocusing investment on services that keep people safe and well in their own homes and communities.

Our system is better connected: More than 600 clinically designed patient pathways now provide links across primary and secondary care to streamline referrals and improve outcomes for patients.

People are receiving more care in the community: Thanks to our Acute Demand Management Service, more than 25,000 acutely unwell people have been supported in the community rather than in our hospitals in the past year.

Our population is making healthier choices: In 2012/13 we immunised 92% of all eight-month-olds in Canterbury (7% above the national target) and 93% of hospitalised smokers have been provided with advice and support to quit (up from 90% the same time last year).

Older people are better supported: Our CREST service supported close to 2,000 older people after discharge from hospital or on direct GP referral. In addition, more than 1,500 people over 65 attended a falls prevention programme, and another 1,500 received a Medications Management Review.

People are waiting less: Average waits for skin lesion removal have dropped from 196 days in 2007 to just 53 days and Canterbury achieved the national health target for shorter wait times in Emergency Departments.

We can, and should, be very proud of what the Canterbury health system has achieved.

However, looking at the work plan for the coming year, we worry that we might have made this look too easy. There is a sense of expectation that we have coped with the worst, that we have 'recovered' and that things are back to normal. Our health system, like our community, is fragile. Things are still far from normal.

The reality of life in Canterbury

The earthquakes have displaced people from their homes, communities and usual support networks. Our population has experienced prolonged levels of stress and anxiety. Poor living arrangements and environments are exacerbating chronic illness and taking a toll on the health of our population. Demand trends are beginning to change, and there are worrying signs in terms of the mental health and wellbeing of young people in Christchurch.

Our health system is operating at full capacity. Resources are stretched, and every day we juggle reduced physical capacity with required repairs, patient need and staff safety. We need to be careful not to expect too much of ourselves. In our most recent staff wellbeing survey, 60% of our employees reported being fatigued by earthquake and insurance stresses and the daily disruptions in their working environment. We still have a long way to go.

Rebuilding our infrastructure

The recently announced redevelopment of Burwood and Christchurch Hospitals is a welcome recognition of the needs of our population, our role as a regional provider and the significant damage sustained by our facilities. This will be the largest health-related building project in New Zealand's history and will allow us to begin rebuilding part of the health capacity required in Canterbury. However, it is important to realise that this does not address all of our facilities issues.

Our health system will continue to have significant capacity challenges for a number of years. The Burwood Hospital redevelopment will not be completed until 2015, and Christchurch Hospital will not be completed until 2018. In the meantime, we have to continue to maintain service delivery and operate safely with fewer hospital beds and severely damaged infrastructure.

This will be long haul. Over 9,000 rooms, wards and theatres across our hospitals are in need of repair, all of our rural hospitals have been damaged, and one has been closed. Our already reduced capacity will be further restricted as we shift and relocate services to make the required repairs. The repair programme and disrupted environment will also put additional pressure on our severely fatigued workforce.

Looking forward

This Annual Plan demonstrates that Canterbury is committed to the delivery of national and regional programmes. It also reflects our commitment to our key role in supporting the West Coast DHB with the development of transalpine services, joint appointments and shared resources. In addition, it presents the work plans of the clinically led alliances under the Canterbury Clinical Network where the DHB works alongside primary and community providers to improve the way the health system works and achieve better outcomes for our population.

We remain focused on improving our performance, meeting national targets, living within our means and, most importantly, ensuring the ongoing delivery of effective and integrated health services for the people of Canterbury. We have plans to enhance our acute demand and long-term conditions programmes and will continue to develop shared information systems and increase access to diagnostics to improve clinical decision-making at the point of intervention.

We will complete the transformation of our older persons' and mental health services and focus on vulnerable population groups – particularly Māori, children and young people. Keeping a close eye on access, waiting times and demand trends, we will collaborate with education, social services and justice to wrap care around those with more complex conditions and lives, who need more support and intervention.

While we make these commitments, we are conscious of the fragility of our system and the pressure we are under. Now, more than ever, we have to make sure that we are not just focusing on delivering more services, but more of the *right services* – delivered in the *right place* at the *right time*.

We need to consolidate our progress and take stock of the wellbeing of Canterbury's health workforce and our wider community. The adrenalin and community spirit that propelled us through the first two years is beginning to wane, and new approaches are needed to maintain momentum.

The biggest lesson we have learnt in the past two years has been the importance of a shared vision, of engagement across the health system and with our community and of empowering people to do the right thing. We will continue to keep everyone informed about our decisions as we move through the coming year.

This has been an incredible journey so far, and we thank everyone across our health system for their contribution over the past two years. We are right to be proud of how well we have coped, and together we can make it through another year.

Bruce Matheson
Chairman Canterbury DHB

David Meates
Chief Executive Canterbury DHB

September 2013

Introducing the Canterbury DHB

The Canterbury DHB is the second largest DHB in the country by both geographical area and population size - serving 510,000 people (12% of the New Zealand population) and covering 26,881 square kilometres and six Territorial Local Authorities. The DHB is also the single largest employer in the South Island, employing over 9,000 people.

1.1 What we do

The Canterbury DHB receives funding from Government with which to purchase and provide health and disability services for the Canterbury population.

Based on the size and demographic mix of our population (age, ethnicity and deprivation), Canterbury received 11.06% of the total population health funding allocated in 2013/14 - over $1.4 billon.

In accordance with legislation, we use this funding to:

Plan the strategic direction of the Canterbury health system, in partnership with clinical leaders, consumers and our alliance partners and in consultation with other DHBs, service providers and our community;

Integrate the activities of health providers across Canterbury to build one health system centred around the patient;

Fund the majority of the health services provided in Canterbury, and through our partnerships and relationships with service providers, ensure services are responsive and coordinated;

Provide hospital and specialist services for the population of Canterbury, and also for people referred from other DHBs where more specialised or higher-level services are not available; and

Promote, protect and improve our population's health and wellbeing through health promotion, education and evidence-based public health initiatives.

1.2 Our vision

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

At its core, our vision is dependent on achieving a truly integrated, 'whole of system' approach where everyone in the health system works together to do the right thing for the patient and the right thing for the system.

Health professionals from across Canterbury are collaboratively redesigning the way we deliver health services, putting the patient at the centre of everything we do, reducing the time people waste waiting and improving outcomes for our population.

This transformation is driven by empowered clinical leaders and cross-sector alliances that support joint planning across the whole health system, including the large-scale Canterbury Clinical Network District Alliance.

1.3 Our operating structure

Governing the DHB

The Board is responsible to the Minister of Health for the overall performance of the DHB. The Board's core responsibility is to set strategic direction and policy that is consistent with Government objectives, improves health outcomes and ensures sustainable service provision. The Board also ensures compliance with legal and accountability requirements and maintains relationships with the Minister of Health, Parliament and the Canterbury community.[1]

While responsibility for overall performance rests with the Board, operational and management matters have been delegated to the Chief Executive, who is supported by an Executive Management Team.[2]

Planning and funding health services

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

In line with Canterbury's vision, we do not do this in isolation. We work in partnership with clinical leaders, health professionals, service providers and consumers to understand our population, identify gaps in service delivery and prioritise investment.

We hold and monitor alliance contracts and service agreements with the organisations and individuals who provide the health services required to meet the needs of our population. This includes an internal service agreement with our Hospital and Specialist Services Division and over 1,000 service contracts and alliance agreements with external providers – including the three Primary Health Organisations (PHOs) in Canterbury.

Providing health and disability services

As an 'owner' of hospital and specialist services, the DHB directly provides a significant share of the health services delivered in Canterbury. This is no small responsibility; in 2012/13 there were 109,570 people discharged from our hospitals, 87,241 attendances at our Emergency Departments, 5,778 babies delivered and 618,162 outpatient appointments.

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[1] *Refer to Appendix 3 for the legislative objectives of a DHB.*

[2] *Refer to Appendix 4 for the DHB's organisational structure.*

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

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

Promoting community health and wellbeing

Good health is determined by many factors and social determinants that sit outside the direct control, but not the influence, of the health system. Our partnerships with other agencies – including local councils, the Canterbury Earthquake Recovery Authority (CERA), Police and Justice, Housing NZ and the Ministries of Education and Social Development – are vital to create social and physical environments that prevent and reduce the risk of ill health.

Canterbury DHB's Community and Public Health Division provides public and population health services and works in cross-sector partnerships to support initiatives that focus on keeping people well.

This work includes improving nutrition and physical activity levels and reducing tobacco smoking and alcohol consumption though service contracts and collaborative ventures such as 'Healthy Christchurch' – with a special focus on younger population groups and Māori and Pacific communities.

Community and Public Health also provide health protection services and lead collaboration on safeguarding water quality, bio-security (protection from disease-carrying insects and other pests), the control of communicable diseases and planning to ensure preparedness for a natural or biological emergency.

1.4 Our regional role

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

These specialist services include: eating disorder services; brain injury rehabilitation; child and youth inpatient mental health services; forensic services; neonatal services; paediatric neurology; gynaecological oncology; specialist diabetes and respiratory services; cardiothoracic services; haematology/oncology; plastics; gastroenterology; neurosurgery; and ophthalmology services.

There are also some specialist services we provide on a national or semi-national basis: laboratory services; endocrinology; paediatric oncology; and spinal services.

[3] *Refer to Appendix 5 for an overview of the services provided.*

Canterbury provides a significant load of regional and national services, and our ability to maintain service delivery is critical to the functioning and sustainability of the whole New Zealand health system.

Canterbury delivers nearly half of all the surgical services provided in the South Island and provides over $100m worth of more complex services to the populations of other DHBs around New Zealand.

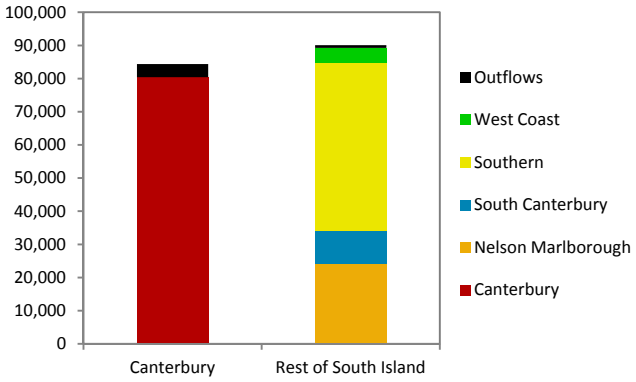
Each year, close to 4,000 people travel to Canterbury for specialist services that their DHBs do not deliver.

In particular, Canterbury provides many services for the population of the West Coast DHB. To formalise this collaborative relationship, we have developed shared service and clinical partnership arrangements. This 'transalpine' approach to service provision has allowed us to better plan the assistance and services we provide to the West Coast DHB and ensure the West Coast population can access the services they need as close to where they live as possible.[4]

The Chief Executive of the Canterbury DHB is also Chief Executive of the West Coast DHB. A number of joint clinical leadership and management positions also support both DHBs at an executive level.

FIGURE 1: NUMBER OF YEARLY HOSPITAL DISCHARGES BY DHB

CDHB inpatient service delivery compared to the rest of the South Island.



[4] *For more information about our transalpine partnership with the West Coast DHB, refer to section 4.3.*

Identifying our Challenges

Analysing the demographics and health profile of our population helps us to predict the demand for services and influences the choices we make when prioritising and allocating resources across our health system. This information also helps us to understand the factors affecting our performance.

1.5 Population profile

Canterbury remains the second largest DHB in New Zealand by population. While there was an initial drop in our population after the earthquakes, projections show that the Canterbury population will be back to pre-quake numbers (510,000 people) by June 2013.[5]

Our population is expected to grow by another 12.4% over the next 13 years, and by 2026 over 568,000 people will be living in Canterbury.[6]

Canterbury's Māori (7.2%) and Pacific (2.0%) populations are younger and have higher fertility rates, but it is our Asian population (6.8%) that is our fastest growing demographic. Projections suggest by 2026 10.8% of Canterbury's total population will be Asian.

Ethnicity is a strong indicator of need for health services, and we consider the unique health needs of each of these population groups in our planning for the future.

However, Canterbury's ageing population is the factor that presents the biggest challenges to our current and future health system.

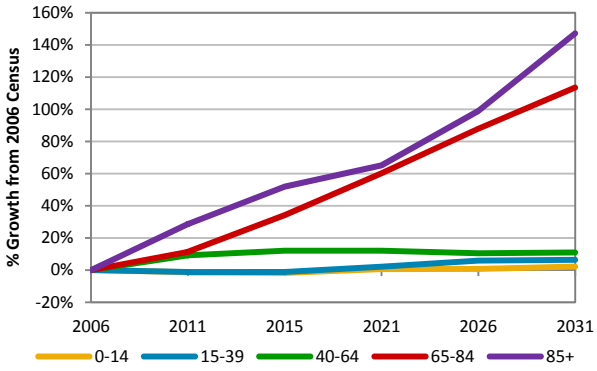
Canterbury has the largest total population aged over 75 and will do so for at least the next 15 years. By 2026 one in every five people in Canterbury will be over 65, and the number of people aged over 85 will have doubled.

As we age, we develop more complicated health needs and multiple health conditions, and therefore consume more health resources. Many long-term conditions become more common with age, including heart disease, stroke, cancer, respiratory disease and dementia.

The ageing of our population will put significant pressure on our workforce, finances and physical capacity. Improving the health of older people is a priority for the Canterbury DHB in 2013/14.

FIGURE 2: CDHB POPULATION GROWTH RATE BY AGE

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



1.6 Health Profile

Health behaviours and risk factors

The negative health outcomes associated with unhealthy lifestyle choices, such as hazardous drinking and tobacco smoking, also place considerable pressure on our health system.

Tobacco smoking, for example, is the major risk factor for several of the leading causes of death - including cardiovascular disease, cancer, diabetes and respiratory disease - and is a substantial contributor to socio-economically based inequalities in health.

The 2011/12 New Zealand Health Survey found that:

- Canterbury has lower obesity levels (24%) than the rest of the country (29%), but a quarter of our adult population are still classified as obese.
- On average, our population is less likely to drink in a hazardous manner (10%) than other New Zealanders (15% nationally), but this still amounts to one in every 10 adults.
- 16% of our population currently smoke - lower than the national average of 18%. However, smoking rates amongst Māori are significantly higher than non-Māori. Nationally, Māori women are nearly two and a half times more likely to smoke.

Social and economic factors, such as education, housing and income, are also widely accepted as contributing greatly to a person's health. In Canterbury, many of the most deprived suburbs were the hardest hit by the earthquakes - displacing people from their usual support networks and reducing housing options and the standard of people's living conditions.

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

The international research literature on disaster recovery indicates that an increase in risk behaviours is typical in response to stressful events. People who were more vulnerable prior to a major disaster have a

[5] *The impact of migration for Christchurch's rebuild is difficult to predict at this stage and has not been included in assumptions.*

[6] *Unless referenced, data is based on Statistics NZ projections and Ministry of Health mortality and demographic data.*

significantly increased risk of poor health afterwards.[7] Patterns of behaviour identified after Hurricane Katrina demonstrate a 45% increase in rates of cigarette use in the three years following the disaster.[8]

Supporting people to make healthy lifestyle choices and reduce risk behaviours is therefore imperative, and disease prevention is a priority for 2013/14.

Health status and service utilisation

Although our population has a higher life expectancy, the leading causes of death in Canterbury are similar to the rest of the country. Cardiovascular diseases, including heart disease and stroke, are the leading cause of death (38%), followed by cancers (28%) and respiratory diseases (9%) such as Chronic Obstructive Pulmonary Disease.

Diabetes is the eighth highest cause of death, but is also an underlying factor for many cardiovascular diseases. It therefore contributes significantly to avoidable mortality and is a disease priority for the DHB, along with cardiovascular disease, cancer and respiratory disease.

Mental health and behavioural disorders are the sixth most common cause of death. In addition, the stress of the earthquakes and ongoing recovery issues will have a significant psychological impact on our population. Hurricane Katrina patterns indicated a substantial increase in experiences of depression, with 31% of displaced people having a mood or anxiety disorder.[9]

The mental health impact of a disaster is generally delayed, but we are beginning to see an increase in demand for mental health services, especially for young people. Mental health will be a priority in 2013/14.

In terms of demand for secondary care services, there are many conditions for which earlier identification and treatment can prevent hospital admission. Reducing these 'avoidable' admissions provides opportunities to improve our population's health and reduce demand.

Canterbury's leading causes of avoidable hospitalisation are gastroenteritis/dehydration; angina and chest pain; upper respiratory and ear, nose and throat infections; cellulitis; and asthma. Although lower than the national rate, falls are also a major cause of avoidable admission. In 2012/13, 2,871 people aged over 75 were admitted to our hospitals as a result of a fall.

With the anticipated increase in demand, improving the management of acute illness and long-term conditions are priorities for the DHB.

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

[8] *Jiao Z, Kakoulides SV, Moscona J, Whittier J, Srivastav S, Delafontaine P, Irimpen A, 2011. Effect of Hurricane Katrina on incidence of AMI in New Orleans three years after the storm. American Journal of Cardiology 109: 502-505.*

[9] *Wang PS, Gruber MJ, Powers RE, Schoenbaum M, Speier AH, Wells KB, Kessler RC, 2007. Mental health service use among hurricane Katrina survivors in the eight months after the disaster. Psychiatry Services 58: 1403-11*

1.7 Operating environment

The Canterbury earthquakes have significantly altered our operating environment. Capacity across our health system has been reduced – not just physically, but also in terms of time wasted as we work around damaged infrastructure and reduced workforce capacity. This affects not just the DHB, but almost every health and social services provider in Canterbury.

13,000 aftershocks after the first major earthquake in September 2010, things are far from over.

Our population remains unsettled. Many people are still living in temporary accommodation and moving about the city while they wait for repairs, rebuild or look for permanent accommodation. Significant resources are going into maintaining contact with vulnerable population groups, and normal recall systems are not as effective in this transient environment.

There is still uncertainty about the influx of people as the rebuild brings workers into the city. Planning is underway, but there are many questions around how long these people will stay, whether they will bring their families and what their health needs will be.

Prolonged levels of stress, anxiety and poor living arrangements are exacerbating chronic illness and increasing demand for services. We can estimate future demand based on known factors, but there is a high level of risk in terms of unpredictable demand from a vulnerable population.

Facilities Pressures

Canterbury has received approval for the Business Case for redevelopment of Christchurch and Burwood Hospitals. However, it will be 2018 before the redevelopments are complete. Despite converting office space, we are still operating with fewer beds than before, and significant structural repairs are needed across our facilities to maintain service delivery. This is no small undertaking; over 9,000 rooms are damaged.

There will be at least another year of disruption as we shift and relocate services to make the required repairs. This will continue to restrict our capacity, increase inter-hospital patient transfer, fragment services and clinical teams and put additional pressure on our workforce.

This is not just a DHB issue. Community organisations continue to work from temporary and makeshift facilities as they undertake repairs and rebuilds, disrupting service provision, stretching capacity and increasing costs.

There are also challenges in maintaining viable health services (such as general practice and pharmacies) where the population has dropped near the 'red zone', while demand now exceeds capacity in other areas.

Workforce Pressures

The prolonged stress of the past two years is also taking its toll on our workforce. When surveyed, 63% of our staff felt they or their families were 'seriously' impacted

by the earthquakes; 48% had 'moderate' to 'severe' damage to their home; and 37% have had to move.

Recent staff survey results indicate that while people want to be here, they are exhausted. More than 20% feel their disrupted working environment is having a negative impact on their wellbeing, and over 60% are still dealing with EQC and insurance issues.

We are acutely aware that this is not just about our own workforce. While the DHB employs over 9,000 people, we indirectly rely on almost the same number of people in public, private and charitable organisations to deliver services to our population. Workforce pressures are affecting our whole health system.

Fiscal Pressures

The future funding path for health is flatter. While the final interplay between repairs, insurance recovery and reinsurance rates remains unclear, we are committed to operating within our funding allocations with reduced reliance on earthquake funding support from the Ministry of Health.

With limited funding available, we must ensure that scarce financial capital is not wasted on repairing buildings that have no future. The cost of the repairs has reinforced the need to make decisions on the future of our facilities. While the new buildings are not likely to be complete until 2018, short-term fixes will be made in the context of the longer-term solution.

1.7 Critical Success Factors

In considering our challenges, the following six factors are those where failure could threaten the achievement of the strategies and goals outlined in this plan.

Connecting the system

The earthquakes identified a number of gaps and flaws in our infrastructure, particularly the risk associated with disconnected patient information systems.

It is critical that we connect our system electronically as well as organisationally to enable us to identify and target populations with the highest need, align care pathways, support the provision of care closer to home and rapidly respond to changes in demand.

Management of acute demand

Acute (urgent or unplanned) admissions are the most significant source of pressure on hospital resources. Canterbury has already reduced the growth rate of acute medical admissions to well below national rates – avoiding over 14,000 acute admissions into our hospitals in 2012/13. With loss of bed capacity after the earthquake, we would be in real trouble had we not already made reductions in acute demand.

Left unchecked, acute demand can quickly 'crowd out' elective (non-urgent) services - increasing waitlists and adversely affecting service quality. It is critical that we continue get ahead of escalating disease prevalence and support people to stay well.

Management of long-term conditions

The prevalence of long-term conditions (such as heart disease, diabetes and respiratory disease) continues to grow. This is a worldwide pattern associated with an ageing population and lifestyle changes.

It is critical that we improve people's understanding of their condition and capacity for self-management, and that we intervene earlier to increase treatment options and reduce the need for complex intervention, hospital admission or early entry in aged residential care. A substantial portion of acute admissions are due to exacerbation of a long-term condition.

Without improving the way these conditions are managed, we simply will not have the infrastructure or workforce to meet future demand.

Releasing workforce capacity

Our ability to meet immediate and future demand relies heavily on having the right people, with the right skills, working in the right place.

To make better use of our limited resources, it is critical that we continue to engage our workforce in the development of integrated models of care and break down the barriers that prevent health professionals from working to the full extent of their scope.

We also need to support staff wellbeing. Without a motivated, engaged workforce committed to the future of our health system, we cannot achieve genuine and lasting transformation.

Reducing the cost of service delivery

If an increasing share of our funding is directed into meeting cost growth, our ability to invest in new technology and initiatives that allow us to respond to increasing demand will be severely restricted.

It is vital that we contain the cost of delivering services through improved efficiency and by focusing on mechanisms that have proven successful: 'lean thinking', improved procurement arrangements and engagement of health professionals in prioritisation and service improvement to introducing technical efficiencies that reduce duplication and waste.

Making the most of rebuild opportunities

With damaged health facilities all across Canterbury, the opportunity exists to make a step-change in our approach to infrastructure and to ensure facilities support, rather than hinder, future models of care.

The DHB now has approval for major redevelopment of our Burwood and Christchurch Hospital sites. We are also supporting primary and community facility rebuilds that enable the provision of services closer to home – including the development of Community Hubs and Integrated Family Health Centres. This is an opportunity that will not come again, and it is critical that we step up and align our health facilities to our models of care.

Setting our Strategic Direction

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

2.1 Strategic context

Populations are ageing, long-term conditions are becoming more prevalent and the needs of vulnerable populations are escalating. As people's conditions become more complex, the care required is more costly in terms of time, resources and dollars.

To ensure the sustainability of our health system, we need to shift our population's health needs away from the complex end of the continuum of care and support more people to stay well.

At the highest level, DHBs are guided by the *New Zealand Health Strategy*, *Disability Strategy,* and *Māori Health Strategy (He Korowai Oranga)* and by the requirements of the *New Zealand Public Health and Disability Act.*

However, in 2010 the National Health Board released *Trends in Service Design and New Models of Care*. This document provided a summary of international trends and responses to the pressures and challenges facing the health sector, to help guide DHB service planning.[10]

International direction emphasises that an aligned, whole-of-system approach is required to ensure service sustainability, quality and safety while making the best use of limited resources. This entails four major shifts in service delivery:

1. Early intervention, targeted prevention and self-management and a shift to more home-based care;
2. A more connected system and integrated services, with more services provided in community settings;
3. Regional collaboration clusters and clinical networks, with more regional service provision; and
4. Managed specialisation, with a shift to consolidate the number of tertiary centres/hubs.

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

The focus is shifting towards supporting people to better manage their own health and to stay well, with the support of clinical networks and multidisciplinary teams.

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

2.2 National direction

These international shifts are consistent with the longer-term changes being driven across the New Zealand health system to meet the Government's commitment to providing *'better, sooner, more convenient health services'*.

Alongside national strategies and commitments, the Minister of Health's 'Letter of Expectations' and the National Health Board's planning guidelines signal annual priorities for the health sector.

DHBs are expected to meet Government commitments to: increase access to services and reduce waiting times; improved quality, patient safety and performance; and provide better value for money**.**

In summary, the Minister's 2013/14 priorities are: [11]

- Better public services – in particular, supporting vulnerable children and young people;
- Care closer to home;
- Improving the health of older people;
- Regional and national collaboration; and
- DHBs living within their means.

DHBs are also expected to deliver against the six national health targets:

- Shorter stays in emergency departments;
- Improved access to elective surgery;
- Shorter waits for cancer treatment;
- Increased immunisation;
- Better help for smokers to quit; and
- More heart and diabetes checks. [12]

Canterbury is committed to making continued progress on national priorities and health targets. Activity planned over the coming year to deliver on the Minister's expectations is outlined in the Service Performance section of this document. The DHB will also contribute to delivery of the Budget 2013 initiatives announced by the Minister, and will work with the Ministry of Health over the coming year to implement these initiatives and develop appropriate performance indicators to monitor progress.

[11] *Refer to Appendix 6 for the Letter of Expectations 2013/14.*

[12] *Refer to Appendix 7 for a summary of the Canterbury DHB's commitments towards the six national health targets.*

2.3 Regional direction

In delivering the goal of *'better, sooner, more convenient health services',* the Government has clear expectations of increased regional collaboration and alignment.

Significant progress is expected in implementing Regional Health Service Plans and delivering on regional workforce, information services and capital objectives in the coming year.

Canterbury is part of the South Island region along with Nelson Marlborough, West Coast, South Canterbury and Southern DHBs. Together, the South Island DHBs provide services for 1,050,571 people, representing 23% of the total New Zealand population.

While each DHB is individually responsible for the provision of services to its own population, working regionally enables us to better address our shared challenges and support improved patient care and more efficient use of resources.

Together, the South Island DHBs have established the South Island Alliance: a partnership between the five DHBs that is committed to a '*best for patients, best for system*' framework and strong clinical engagement.

Closely aligned to national direction, the regional vision is a clinically and fiscally sustainable South Island health system focused on keeping people well, where services are provided as close as possible to people's homes.

Regional activity is implemented through service level alliances and clusters based around priority service areas. The workstreams are clinically led, with multidisciplinary representation from community and primary care as well as hospital and specialist services.

Our success relies on improving patient flow and the coordination of health services across the South Island by aligning patient pathways, introducing more flexible workforce models and improving patient information systems to better connect the services and clinical teams involved in a patient's care

We have made good progress in 2012/13 by: establishing a single South Island cancer patient database; launching regional HealthPathways; and introducing the eReferrals Management System. We have also extended the shared Health Connect South clinical portal to three DHBs, with plans to include all South Island DHBs in 2013/14.

We have implemented the 'Walking in Another's Shoes' training programme across the South Island to improve the care of dementia patients and rolled out a community-based early intervention programme for young people with anorexia nervosa.

The South Island Alliance has also collectively delivered 37,616 elective surgical discharges - 2,130 more than the previous year - and delivered close to $15m of savings through regional procurement and supply chain initiatives.

Building on these successes, the South Island Regional Health Services Plan for 2013/14 articulates the agreed direction and prioritised activity for the coming year. The plan has been approved by the Chief Executives and Boards of all five South Island DHBs.

Seven service areas have been prioritised: Cancer, Child Health, Health of Older People, Mental Health, Support Services, Information Services and Quality and Safety. Regional activity will also focus on: cardiac, elective, neurosurgery, ophthalmology, and stroke services. Regional asset planning and workforce planning, through the South Island Regional Training Hub, will contribute to delivery in all service areas.

The Canterbury DHB is contributing to the achievement of the Regional Plan through membership of all activity streams and clinical leadership of the Mental Health, Health of Older People and Support Services streams.

We will also contribute by leading the delivery of regional activity including: the continued rollout of South Island HealthPathways, Heath Connect South, the eReferrals Management Solution, InterRAI assessment tool and the development of regional care protocols.

The longer-term outcomes we are seeking and the impact we are hoping to make on the health of our collective populations are articulated in the following section of this document.

The 2013/14 South Island Regional Health Services Plan is available from www.sialliance.health.nz.

2.4 Local direction

The focus on '*best for patients, best for system*' is not new in Canterbury. Since 2007, health professionals, providers, consumers and other stakeholders have been coming together to find solutions to the challenges we face. We knew if we didn't actively transform the way we delivered services, by 2020 Canterbury would need 2,000 more aged residential care beds, 20% more GPs and another hospital the size of Christchurch Hospital.

We began reorienting our health system around the needs of the patient. In committing to this direction, we recognised it was not just about hospitals, but about a whole-of-system response where providers work collaboratively to wrap care around the patient and improve outcomes for the population.

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

With a foundation of strong clinical leadership and a whole-of-system alliance, we have been working to achieve this vision with a commitment to:

- The development of services that support people to stay well and take increased responsibility for their own health and wellbeing;
- The development of primary care and community services to support people in community settings and provide a point of ongoing continuity (which for most will be general practice); and

- The freeing-up of hospital-based specialist resources to be responsive to episodic events, deliver complex care and support, and provide specialist advice to primary care.

When the earthquakes hit Canterbury, we were able to use our established partnerships and alliances to launch a structured response, ramping up existing programmes and rolling out new ones, to keep people safe and well and reduce demand on our stretched hospital capacity.

- Our Acute Demand Management Service has expanded to ease pressure on our hospitals. In 2012/13, 25,000 acute episodes of care were managed in the community rather than in hospital.
- HealthPathways have been expanded, and over 600 pathways now exist between primary and secondary care to streamline assessment, management and referrals and better connect health professionals across our system.
- After the earthquake, a Residential Options Group and a Community Support Access Pathway were established to provide a single point of entry to community mental health services. Providers now collectively receive, review and determine the response to referrals, and waiting times have dropped from up to 15 weeks to under 10 days.
- The CREST service began in April 2011 and provides a range of home-based rehabilitation services to support people to leave hospital sooner or avoid admission altogether. In 2012/13, CREST had supported close to 2,000 older people.
- In late 2011, we launched a Medications Management Service, where pharmacists support patients on multiple medications to better manage their medicines and reduce medication-related adverse events. In 2012/13, the service provided medication reviews to 1,694 people.
- In February 2012, led by the Clinical Board, we introduced an integrated approach to reduce harm and hospitalisation from falls. Community falls champions deliver tailored falls prevention to frail elderly, and trained volunteers provide 'Stay on Your Feet' or Tai Chi for older people who are more mobile. By the end of 2012/13, the service had received 1,613 referrals.
- In July 2012, we established a new ambulance pathway for patients with Chronic Obstructive Pulmonary Disease (COPD), a major cause of preventable hospital admission. Over 40% of winter COPD callouts are now being treated in the community rather than in ED.

This integrated response helped the Canterbury health system to cope with the significant loss of capacity after the February earthquake. It also demonstrated in a relatively short period of time how effective a collective, whole-of-system response could be.

The health outcomes we are now seeing as a result of these programmes are striking.

Fewer people are being acutely admitted to hospital, and our hospital readmission rates are tracking down.

In spite of the constrained circumstances, more elective surgery has been delivered in Canterbury than ever before, with 17,066 electives being delivered in 2012/13 compared to 16,494 in 2011/12 and 14,974 in 2010/11.

This success has helped maintain the motivation for change in stressful and difficult circumstances, although there are still major challenges ahead. While these are the same challenges that other DHBs face, the difference is the scale on which the Canterbury health system operates (with the second largest population and geographic area of all 20 DHBs) and the fragility of our infrastructure and population in the wake of the earthquakes.

These are not short-term pressures to which there is a 'quick fix' solution. Whole-of-system transformation remains the solution to coping with increasing demand, an ageing population, international workforce shortages and rising costs. It is also the key to rebuilding the Canterbury health system better than it was before.

With capacity severely restricted, we will invest in services that help us get ahead of the demand curve and make the best of our most scarce resources: our people and our time. We expect to contract private capacity to deliver elective surgical services over the short term while we manage repairs to our facilities and complete the redevelopment of our Christchurch and Burwood Hospital sites. It is also likely that the way in which some community services are delivered will have to be adjusted to allow for providers' capacity constraints.

In spite of our operating challenges, we also have ahead of us a unique opportunity to better connect our system, integrate services and, as we rebuild facilities, better align them to future service models. These are opportunities that cannot be lost.

We are fortunate that Canterbury has a collective vision and strong whole-of-system clinical alliances and partnerships. Collaborative partnerships kept our health system together through one of the most unforgettable events in our country's history. With a strong focus on implementation and an emphasis on addressing our key priorities and constraints, we are confident we can meet our challenges and take the next leap forward in the transformation of our health system.

Improving Health Outcomes for our Population

What are we trying to achieve?

DHBs are responsible for delivering against the health sector goal: "*All New Zealanders lead longer, healthier and more independent lives*" and for meeting Government commitments to deliver '*better, sooner, more convenient health services*'.

This section presents an overview of how we will demonstrate whether we are succeeding in meeting those commitments and improving the health and wellbeing of our population. There is no single measure that can demonstrate the impact of the work we do, so we use a mix of population health and service access indicators as proxies to demonstrate improvements in the health status of our population.

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

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

  A reduction in smoking rates.

  A reduction in obesity rates.

- *Outcome 2: People stay well in their own homes and communities.*

  A reduction in the rate of acute medical admission.

  A reduction in premature ischemic heart disease rates.

- *Outcome 3: People with complex illness have improved health outcomes.*

  A reduction in the rate of acute readmissions.

  A reduction in premature cancer mortality rates.

- *Outcome 4: People experience optimal functional independence and quality of life.*

  An increase in the proportion of people over 65 supported in their own homes.

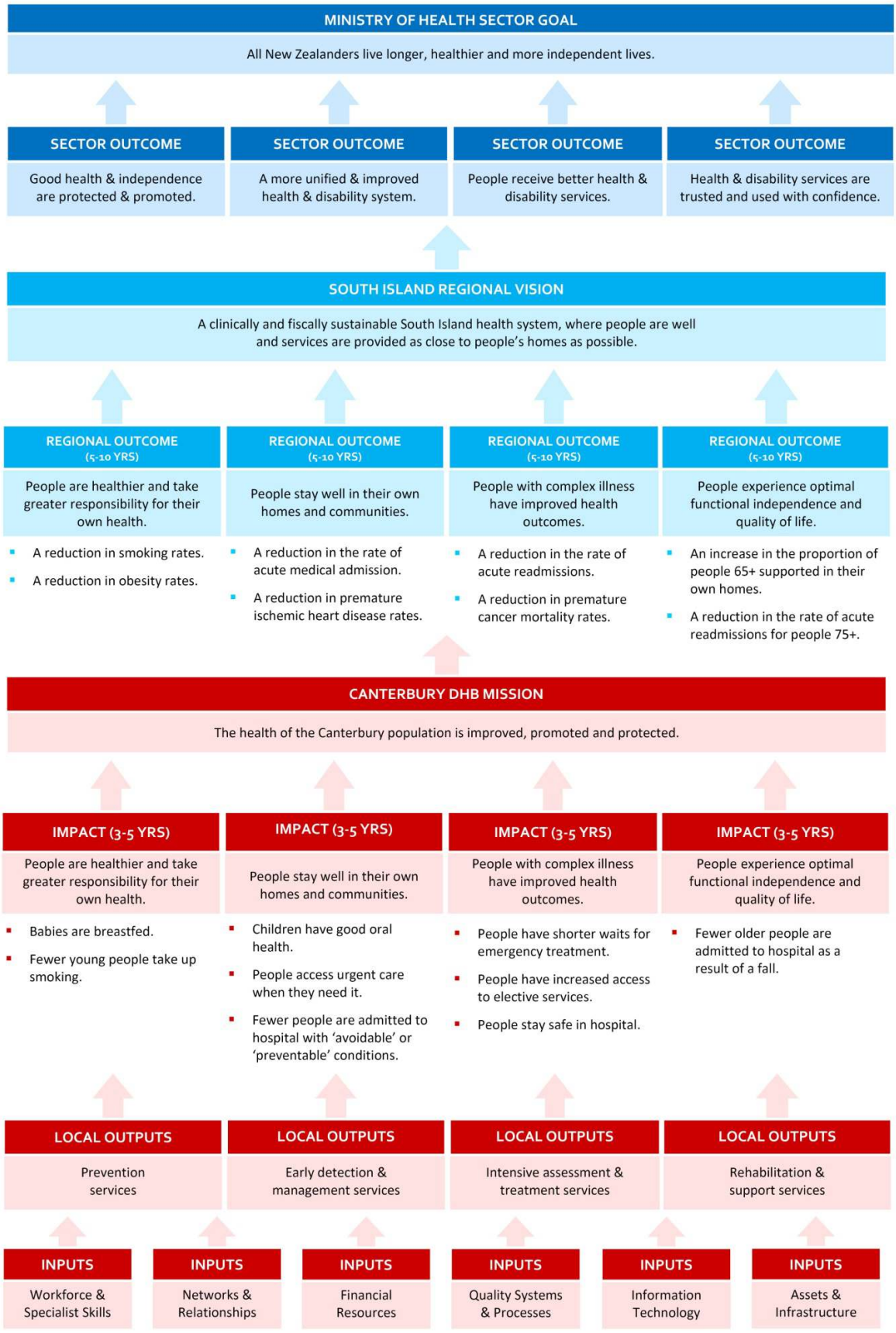
  A reduction in the rate of acute readmissions for people over 75.

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

The following intervention logic diagram visually demonstrates the value chain: how the services that an individual DHB chooses to fund or provide (outputs) have an impact on the health of their population and result in the achievement of desired longer-term outcomes and the delivery of the expectations and priorities of Government.[13]

[13] *The DHB has a Māori Health Action Plan which is a companion document to the Annual Plan and sets out key performance measures to support improvements in Māori health and reduce inequalities. The 2013/14 Māori Health Action Plan is available on the DHB's website.*

FIGURE 3: INTERVENTION LOGIC DIAGRAM



OUTCOME GOAL 1

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

Expectation

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

Why is this outcome a priority?

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

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

OUTCOME MEASURES LONG TERM (5-10 YEARS)

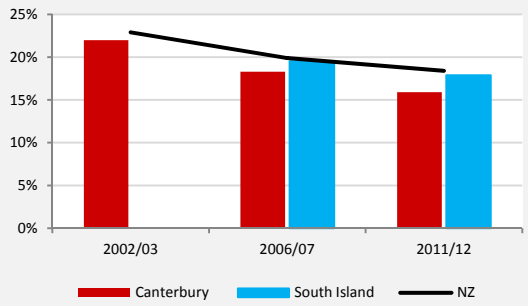
We will know we are succeeding when there is:

A reduction in smoking rates.

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

Data sourced from national NZ Health Survey.[14]

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

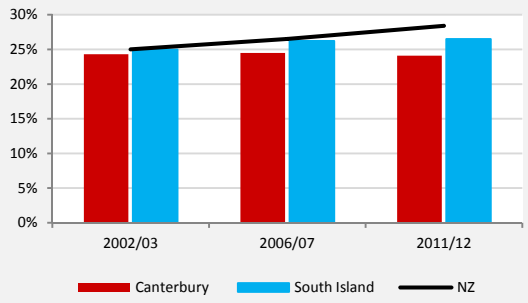


A reduction in obesity rates.

- *There has been a rise in obesity rates in NZ in recent decades, and the 2011/12 NZ Health Survey found that one in ten children (10%) and three in ten adults (28%) are obese. This has significant implications for rates of cardiovascular disease, diabetes, respiratory disease and some cancers, as well as poor psychosocial outcomes and reduced life expectancy.*
- *Supporting our population to maintain healthier body weights through improved nutrition and increased physical activity levels is fundamental to improving their health and wellbeing and to preventing and better managing long-term conditions and disability at all ages.*

Data sourced from national NZ Health Survey.[14]

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



[14] *The NZ Health Survey was completed by the Ministry of Health in 2003/04, 2006/07 and 2011/12. 'Obese' is defined as having a Body Mass Index (BMI) of >30.0, or >32.0 for Māori or Pacific people.*

IMPACT MEASURES MEDIUM TERM (3-5 YRS)

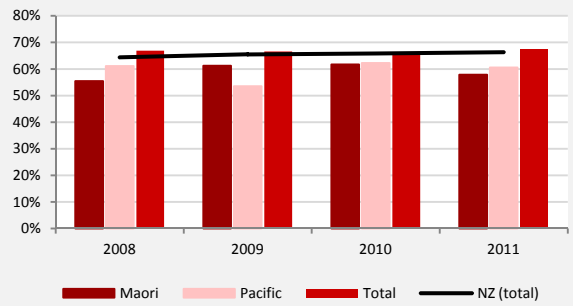
Over the next three years we seek to make a positive impact on the health and wellbeing of the Canterbury population and contribute to achieving the longer-term outcomes we seek. The effectiveness of the services the DHB funds and provides, and the contribution we make, will be evaluated using the following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

More babies are breastfed.

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

Data sourced from Plunket via the Ministry of Health.[15]

The percentage of babies fully/exclusively breastfed at 6 weeks.	Actual 2011	Target 2013	Target 2014	Target 2015
	67%	69%	71%	>71%

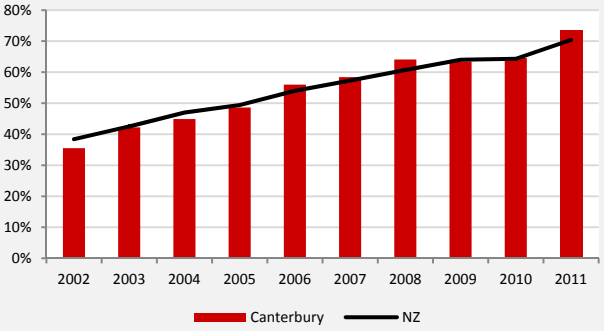


Fewer young people take up tobacco smoking.

- *Most smokers begin smoking by 18 years of age, and the highest prevalence of smoking is amongst younger people. Reducing smoking prevalence is therefore largely dependent on preventing young people from taking up smoking.*
- *A reduction in the uptake of smoking is seen as a proxy measure of successful health promotion and engagement and a change in the social and environmental factors that influence risk behaviours and support healthier lifestyles.*

Data sourced from national Year 10 ASH Survey.[16]

The percentage of 'never smokers' among Year 10 students.	Actual 2011	Target 2013	Target 2014	Target 2015
	74%	75%	76%	77%



[15] *The 2011 result is only for the second half of the 2011 year (i.e. July to December) due to MoH data availability.*

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

OUTCOME GOAL 2

2.6 People stay well in their own homes and communities

Expectation

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

Why is this outcome a priority?

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

Supporting general practice are a range of other health professionals including midwives, community nurses, social workers, personal health providers and pharmacists. These providers have prevention and early intervention perspectives that link people with other health and social services and support them to stay well.

When people are supported to stay well in the community, they need fewer hospital-level or long-stay interventions. This is not only a better health outcome for our population, but it reduces the rate of acute hospital admissions and frees up health resources. Studies show countries with strong primary and community care systems have lower rates of death from heart disease, cancer and stroke, and achieve better health outcomes for lower cost than countries with systems that focus on specialist level care.

OUTCOME MEASURES LONG TERM (5-10 YEARS)

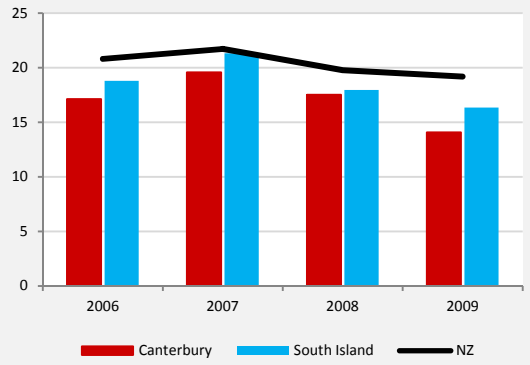
We will know we are succeeding when there is:

A reduction in premature ischemic heart disease mortality rates.

- *Cardiovascular Diseases (CVD) such as heart disease and stroke are the leading cause of death in Canterbury.*
- *Premature mortality due to CVD is largely preventable with lifestyle change, early intervention and effective treatment. By detecting people at risk and improving the ongoing management of their condition, the more harmful impacts and complications of CVD can be reduced.*
- *CVD is significantly more prevalent amongst Māori and Pacific groups, so improved CVD outcomes are an opportunity to reduce inequalities and target improvements in the health of our more vulnerable populations.*
- *The rate of premature death due to ischemic heart disease can be used as a proxy measure of improved conditions management and access to effective treatment.*

Data sourced from MoH mortality collection.

Outcome Measure: The rate of death due to ischemic heart disease in people aged under 65 (per 100,000)

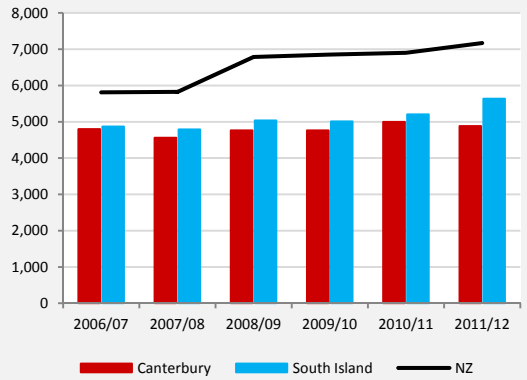


A reduction in acute medical admissions.

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

Data sourced from National Minimum Data Set.

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



IMPACT MEASURES MEDIUM TERM (3-5 YRS)

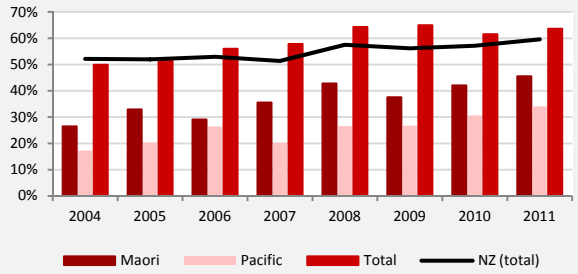
Over the next three years we seek to make a positive impact on the health and wellbeing of the Canterbury population and contribute to achieving the longer-term outcomes we seek. The effectiveness of the services the DHB funds and provides, and the contribution we make, will be evaluated using the following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

Children have good oral health.

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

Data sourced from Ministry of Health.

The percentage of children caries-free at age 5 (no holes or fillings).	Actual 2011	Target 2013	Target 2014	Target 2015
	64%	65%	67%	≥67%

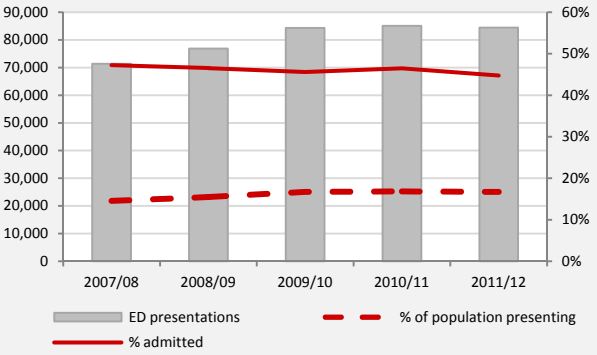


People access care urgent care when they need it.

- *Supporting people to seek early intervention and providing alternative urgent care pathways will ensure people are able to access the right treatment and support when they need it, which is not necessarily in hospital Emergency Departments.*
- *Early and appropriate intervention will not only improve health outcomes for our population, but will also reduce unnecessary pressure on our hospitals.*
- *A reduction in the proportion of the population presenting to the Emergency Department (ED) can be seen as a proxy measure of the availability and uptake of alternative community options to more appropriately manage and support people.*

Data sourced from individual DHBs.[17]

The percentage of the population presenting at ED.	Actual 11/12	Target 13/14	Target 14/15	Target 15/16
	16.7%	≤18%	≤18%	≤18%

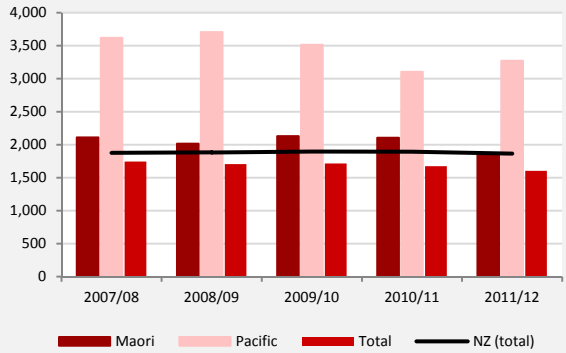


Fewer people are admitted to hospital with conditions considered 'avoidable' or 'preventable'.

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

Data sourced from the Ministry of Health.[18]

The rate of avoidable hospital admissions per 100,000 population (<75).	Actual 11/12	Target 13/14	Target 14/15	Target 15/16
	1,603	<1,883	<1,883	<1,883



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

[18] *This measure is based on the national indicator SI1 and covers hospitalisations for 26 identified conditions including asthma, diabetes, angina, vaccine-preventable diseases, dental conditions and gastroenteritis. It is defined as the standardised rate per 100,000 for Canterbury, and the target is set to maintain performance at below 95% of the national rate.*

OUTCOME GOAL 3

2.7 People with complex illness have improved health outcomes.

Expectation

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

Why is this outcome a priority?

For those people who do need a higher level of intervention, timely access to high quality complex care and treatment is crucial in supporting people to recover or slowing the progression of illness, improving health outcomes by restoring functionality and improving the quality of life. Shorter waiting lists and wait times are also indicative of a well functioning system that matches capacity with demand by managing the flow of patients through services and reducing demand by moving the point of intervention earlier in the path of illness.

As providers of hospital and specialist services, DHBs are operating under increasing demand and workforce pressures. At the same time Government is concerned that patients wait too long for diagnostic tests, cancer treatment and elective surgery. It is commonly assumed that long waiting times indicate insufficient resource or excessive demand. However, this is not always the case. If there are long waits but the number of people waiting is stable, it may reflect that a more innovation approach is needed to re-engineer processes and rethink they way we are delivering the service.

This goal reflects the importance of ensuring that hospital and specialist services are sustainable and that the South Island has the capacity to provide for the complex needs of its population now and into the future. It also reflects the importance of the quality of treatment. Adverse events, unnecessary waits or ineffective treatment can cause harm, resulting in longer hospital stays, readmissions and unnecessary complications that negative impact of the health of our population.

OUTCOME MEASURES LONG TERM (5-10 YEARS)

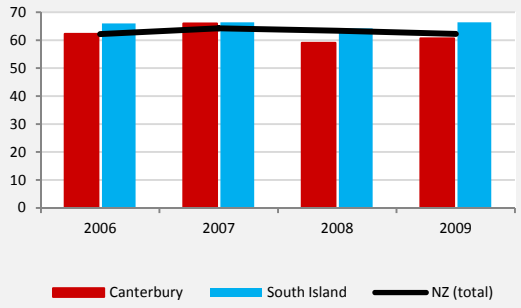
We will know we are succeeding when there is:

A reduction in premature cancer mortality rates.

- *Cancer is the second leading cause of death in Canterbury.*
- *Timely and effective diagnosis and treatment are crucial to improving survival rates for complex illnesses such as cancer. Early detection increases the options for treatment, and early treatment increases the chances of survival.*
- *The rate of premature death due to cancer can be used as a proxy measure of improved specialist care and access to treatment for people with complex illness.*

Data sourced from MoH mortality collection.

Outcome Measure: The rate of deaths due to cancer in people aged under 65 (per 100,000)



A reduction in acute readmissions to hospital.

- *An unplanned acute hospital readmission may (though not always) occur as a result of the care provided to the patient.*
- *Acute readmissions can be prevented through improved patient safety and quality processes and improved patient flow and service integration - ensuring that people receive more effective treatment, experience fewer adverse events and are better supported on discharge from hospital.*
- *Acute readmissions are therefore a proxy measure of the effectiveness of service provision and the quality of care.*
- *They also serve as a counter-measure to balance improvements in productivity and reductions in the length of stay and provide an indication of the integration between services to appropriately support people on discharge.*

Data sourced from Ministry of Health.

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

Note: A new national definition is currently under development and we intend to use to measure and monitor performance once the data and definitions have been confirmed.

IMPACT MEASURES MEDIUM TERM (3-5 YRS)

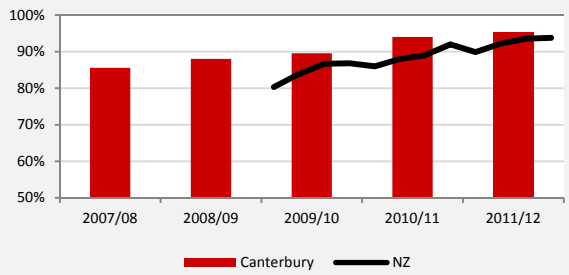
Over the next three years we seek to make a positive impact on the health and wellbeing of the Canterbury population and contribute to achieving the longer-term outcomes we seek. The effectiveness of the services the DHB funds and provides, and the contribution we make, will be evaluated using the following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

People have shorter waits for treatment.

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

Data sourced from individual DHBs.[19]

The percentage of patients presenting in ED who are admitted, discharged or transferred within six hours.	Actual 11/12	Target 13/14	Target 14/15	Target 15/16
	95%	95%	95%	95%

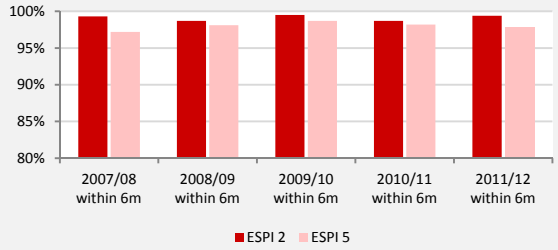


People have increased access to elective services.

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

Data sourced from Ministry of Health.[20]

	Actual 11/12	Target 13/14	Target 14/15	Target 15/16
The time people wait from referral to First Specialist Assessment (ESPI 2).	99% < 6m	100% < 5m	100% < 4m	100% < 4m
The time people wait from commitment to treat until treatment (ESPI 5).	98% < 6m	100% < 5m	100% < 4m	100% < 4m

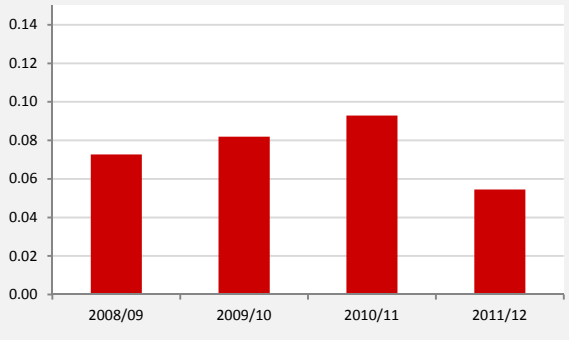


People stay safe in hospital.

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

Data sourced from individual DHBs.[21]

The rate of SAC level 1 and 2 falls in Canterbury Hospitals.	Actual 11/12	Target 13/14	Target 14/15	Target 15/16
	0.05	0.05	0.05	0.04



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

[20] *The Elective Services Patient Flow Indicators (ESPIs) have been established nationally to track system performance and DHBs receive summary reports from the Ministry of Health on a monthly basis. National average performance data is not made available. Historical data is against a six month target, while Canterbury's target reduces to 5 months from January 2014 and 4 months from January 2015.*

OUTCOME GOAL 4

2.8 People experience optimal functional independence and quality of life.

Expectation

As well as providing early intervention and treatment, health services play an important role in supporting people to regain their functionality after illness and to remain healthy and independent. There are also a number of services or interventions that focus on patient care such as pain management or palliative services to improve the quality of life.

Why is this outcome a priority?

With an ageing population, the South Island will require a strong base of primary care and community support, including home-based support, respite and residential care. These services support people to recover and rehabilitate in the community, giving them a greater chance of returning to a state of good health or slowing the progression of disease.

Even where returning to full health is not possible, access to responsive, needs-based services helps people to maximise function with the least restriction and dependence. This is not only a better health outcome for our population, but it reduces the rate of acute hospital admissions and frees up health resources.

OUTCOME MEASURES LONG TERM (5-10 YEARS)

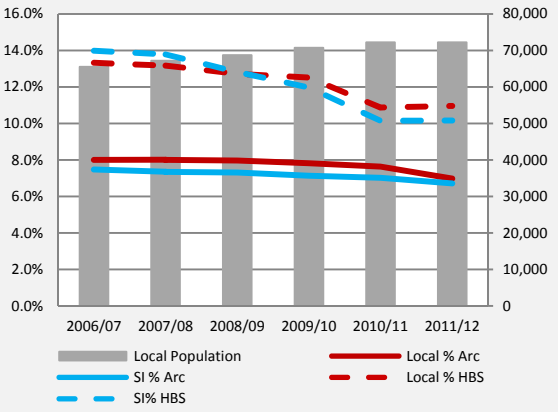
We will know we are succeeding when there is:

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

- *While living in Aged Residential Care (ARC) is appropriate for a small proportion of our population, evaluation of older people's services have shown a higher level of satisfaction and better long-term outcomes where people remain in their own homes and positively connected to their communities.*
- *Living in ARC facilities can be associated with a more rapid functional decline than 'ageing in place'. It is also a more expensive option, and resources could be better spent providing appropriate levels of home and community-based support service to people to stay well in their own homes.*
- *An increase in the proportion of people supported in their own home can be used as a proxy measure of how well the systems is managing age-related long-term conditions and responding to the needs of our older population.*

Data sourced from Client Claims Payments provided by SIAPO.

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



A reduction in the rate of acute readmissions to hospital (people aged 75+).

- *When older people are discharged from hospital, it is important that appropriate supports are in place to help them recover their health, functioning and independence.*
- *Readmission is often for a different condition from that which caused the original admission. This has been classed as 'post discharge syndrome', where non-specific effects associated with being in hospital for a prolonged period or a lack support in the community combine to cause other problems.*
- *Supported discharge and restorative health services enable older people to return to better health or slow the progression of disease, reducing the risk of readmission.*
- *Readmission rates for people aged 75+ can therefore act as a proxy measure of improved restorative care and community-based support for older people.*

Data sourced from Ministry of Health.

Outcome Measure: The rate of acute readmissions to hospital for people aged 75+ (within 28 days of discharge).

Note: A new national definition is currently under development and we intend to use to measure and monitor performance once the data and definitions have been confirmed.

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

IMPACT MEASURES MEDIUM TERM (3-5 YRS)

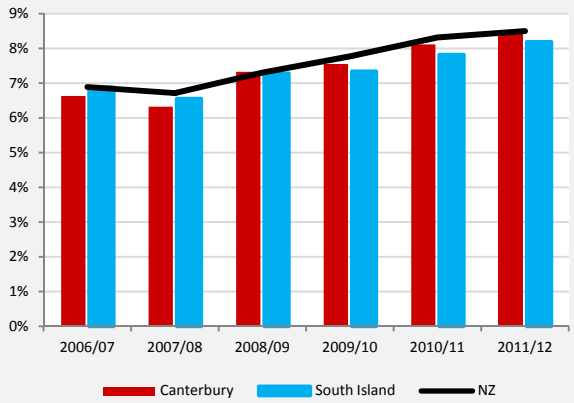
Over the next three years we seek to make a positive impact on the health and wellbeing of the Canterbury population and contribute to achieving the longer-term outcomes we seek. The effectiveness of the services the DHB funds and provides, and the contribution we make, will be evaluated using the following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

Fewer older people are admitted to hospital as a result of a fall.

- *Around 22,000 New Zealanders (75+) are hospitalised annually as a result of injury due to falls. Compared to people who do not fall, those who do experience prolonged hospital stay, loss of confidence and independence and an increased risk of institutional care.*
- *With an ageing population, a focus on reducing falls will help people to stay well and independent and will reduce the relative demand on acute and aged residential care services.*
- *The solutions to reducing falls address various health issues and associated risk factors including: medications use, lack of physical activity, poor nutrition, osteoporosis, impaired vision and environmental hazards.*
- *A reduction in falls can therefore be seen as a proxy measure for improved health service provision for older people.*

Data sourced from National Minimum Data Set.

The percentage of the population (75+) admitted to hospital as a result of a fall.	Actual 11/12	Target 13/14	Target 14/15	Target 15/16
	8.4%	7.9%	7.6%	7.3%



Service Performance Priorities 2013-2014

INTEGRATING THE CANTERBURY HEALTH SYSTEM

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

Our priorities

Over the two years following the earthquake, our focus was by necessity on individual tasks and stabilising services. While our health system is still fragile and operating at reduced capacity, we are moving forward into a new phase.

Knowing the challenges that lie ahead, Canterbury is seizing the moment to rebuild better than ever before. We have established a number of key priorities to drive transformation and integration.

These priorities, reflected through the following section, are enablers that will connect clinical teams across our system, reduce duplication and waste of time and resources, and help to support the level of change needed to improve service delivery and health outcomes in our challenging environment. We have also aligned our priorities with the expectations of the Minister of Health, including delivery of the national health targets and health services closer to home.

Where do we want to be?

To fully implement our vision, we work collaboratively with our alliance partners to improve the interface and connectivity between community and hospital-based care. Our approach to developing a strong Canterbury alliance has been to bring health professionals from general practice, hospital specialties and the community together under the banner of the Canterbury Clinical Network District Alliance. Together, we work to identify and address challenges and design new models of care that improve outcomes for our population and make the best use of our health system's resources.

In a constrained environment with limited capacity, our focus on managing patient flow and reducing demand becomes critical. We are committed to working in an alliance model that supports joint planning and investment in getting ahead of the demand curve to support people to stay well.

This approach requires the introduction of alternative models of care for acute illness, including urgent care options that support people in their own homes and communities rather than in hospital emergency departments.

It also requires recognition of general practice as the point of continuity in the health system and a shift of some traditionally hospital-based services into community settings to minimise waits for treatment and reduce unnecessary hospital visits.

To support this direction, a number of major IT projects are underway to better connect our system. The Electronic Shared Care Record View (eSCRV) provides a portal for viewing a core set of patient information at the point of care to support more informed treatment, whilst the Collaborative Care Management System (CCMS) provides access to shared care plans for people with complex long-term conditions. The Electronic Request Management System (ERMS) enables GPs to refer patients to anywhere in the health system directly from their desktops – streamlining the previously manual referral process. Health Connect South, which is closely intertwined with eSCRV, allows clinicians in the West Coast, South Canterbury and Canterbury DHBs to see exactly the same information for a shared patient.

We have also increased general practice's access to diagnostics and specialist advice to enable faster, more effective care for patients without the need for a hospital referral. New radiology, laboratory and pharmacy models are focused on reducing waste and duplication to free up specialists in these areas to play a bigger role in patient care as part of multidisciplinary teams – improving service quality and clinical outcomes.

Integrated Family Health Centres (IFHCs) and Community Health Hubs will also continue to be developed across Canterbury in the coming year. These will help to replace damaged community health infrastructure in a way that supports greater integration between services and will provide a base for the provision of health care closer to people's homes.

This complete picture will shift intervention to earlier in the continuum of care and support our more vulnerable populations as we rebuild the capacity we lost in the earthquakes. At the same time, it will harness our unique opportunity to build a truly integrated Canterbury health system.

3.1 Connecting the system

To deliver truly seamless care for our population, the whole Canterbury health system must be engaged in the vision, connected through system-wide pathways and shared information systems, and supported by infrastructure that complements and enables responsive service delivery models.

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTION**	**EVIDENCE**
Engage the whole of the health system in the vision and future direction. *To support our transformation and better match system capacity to population demand.*	Continue to ensure system-wide clinical and community participation in all activity under the CCN District Alliance. Support joint planning and service development through the CCN workstreams and service level alliances to continue the transformation of our health system. Broaden the range of partners within the District Alliance. Continue to engage health professionals in the challenges and successes to support continued momentum. Continue to support training and leadership forums that empower people to rethink the way they work. Invest in the development of a Rural Health Strategy to create a clear vision and tailored rural health solutions for all rural areas across Canterbury.	Rural Health Strategy development commences Q1. More signatories to the district alliance agreement – base 8. Health professionals attend Xcelr8 training – base 64 per annum.
Support the closer alignment of clinical information systems and technology. *To provide shared access to information that enables timely clinical decision-making at the point of care and supports the integration of services.*	Maintain the range of clinical pathways across the Canterbury health system to support the delivery of the right care and support, in the right place, at the right time. Support the expansion of HealthInfo (the publicly available companion site to HealthPathways) to provide people with the information they need to better manage their health. Support the expansion of HealthPathways beyond Canterbury to improve the management of referrals and care across regions.	HealthPathways available across the Canterbury system - base 519. All South Island DHB have adopted HealthPathways Q2.
	Continue to roll out eSCRV as a portal to provide health professionals with secure access to a patient's key health information in any health setting. Identify further services and health providers who could contribute valuable information to eSCRV and engage with them to enhance the system.	95% of general practices have eSCRV - View and Extract Q4. 95% of community pharmacies contributing dispensing data to eSCRV Q4.
	Further enhance the capability of the Collaborative Care Management Solution (CCMS) to better coordinate care for individuals with long-term conditions/complex health needs. Engage primary, secondary and pharmacy providers in using the Collaborative Care Programme (CCP) for managing more complex and high-needs patients. Improve the management of medications for CCP patients through use of the Medications Management Service (MMS).	More patients enrolled with the CCP – base 1,186. Ability to create acute care plans in CCMS enabled Q4. CCMS installed at a further 10 health providers Q4.
	Support increased use of ERMS by GPs to streamline referrals and provide capability and capacity to match need in a way that is responsive to the health needs of the population. Enhance the referral management capability of ERMS beyond Community Referred Radiology. Support the rollout of ERMS across the South Island in order to improve the management of referrals across regions.	≥75% of all Canterbury GPs have access to ERMS Q4. ≥75% of all GP referrals to Christchurch Hospital are e-Referrals through ERMS Q4. Four of five South Island DHBs have adopted ERMS Q4.
	Continue the Health Connect South (HCS) upgrade programme in Canterbury to ensure ongoing support for clinical systems. Expand the use of e-Discharges, e-Referrals, and Éclair lab results reporting (electronic lab test sign-off) across all hospital departments to improve efficiency and allocation of resources.	e-Discharges upgraded to national standards Q2. All hospital departments/clinics will be e-Referrals capable Q3.

	Complete the rollout of e-Referrals capability across our hospitals (enabling full ERMS/e-Referrals integration).	
	Provide access to 'on-demand' integrated datasets through the Lightfoot Signals from Noise (SFN) application to better understand and respond to emerging demand. Identify and introduce related datasets that will enable whole-system views and evaluation of current demand strategies.	Identify other datasets to be integrated into SFN Q2.
	Support the SI to achieve a single Patient Administration System (PAS) by preparing for implementation in Canterbury in 2014. Support a SI approach to clinical information management by leading the rollout of the Health Connect South Platform (already in CDHB, WCDHB and SCDHB) to NMDHB & SDHB. Support migration of all DHB PCs to G2012 – COE. Implement the national e-Pharmacy Programme and national e-Medicines Reconciliation (eMR) programme. Implement the national Medication Safety Programme.[22] Emphasise the need for National Health Index (NHI) and ethnicity recording to improve the quality of data systems.	e-Pharmacy available Q1. 25% of PCs migrated to G2012 Q3. Medchart in inpatient wards Q4. All South Island DHBS using Health Connect South Q4. NHI duplications ≤6%. Ethnicities 'Not stated' ≤2%.
Develop a seamless radiology service in Canterbury. *To improve access to diagnostics, support appropriate intervention, reduce waiting times for treatment and improve health outcomes for our population.*	Develop a seamless Radiology Service for Canterbury that provides radiology images and reports to clinicians in both public and private practice. Continue to provide GPs with direct access to a full suite of diagnostics through Community Referred Radiology (CRR). Provide access to both radiology images and reports for referrers through Health Connect South and eSCRV.	GPs' direct access to Ultrasounds, X-ray and CT scans maintained. 100% of images/reports available through HCS/eSCRV Q1. eSCRV access is extended to private specialists Q4.
	Routinely provide radiology activity reports and feedback on referrals patterns to individual clinicians and departments. Develop initiatives to improve the quality of radiology referrals. Provide GP education and updates to HealthPathways on referral guidelines and best practice.	75% of radiology referrers receive monthly activity reports Q3. Programme of six-monthly education sessions on radiology referrals in place Q2.
	Align radiology referral and triage criteria (including across primary and secondary care where appropriate) to improve equity of access to radiology services. Re-scope demand and align resources accordingly to reduce waiting times for diagnostics.	Alignment of appropriate referral and triage criteria complete Q2. 85% of accepted referrals for CT and 75% of accepted referrals for MRI scans receive their scan within six weeks (42 days).
	Review and enhance the information on radiology services available on the HealthInfo website.	Review of HealthInfo by Q2.
Implement a new model for laboratory services in Canterbury. *To improve access to diagnostics, reduce waiting times for treatment and improve health outcomes for our population.*	Support the Laboratory Service Level Alliance (SLA). Review current sample collection sites and implement a plan that improves access, including in rural areas. Support Acute Demand Management Services through provision of laboratory tests within target timeframes.	Collections plan presented to the Laboratory SLA Q1. 95% of ADMS tests provided in 90 minutes Q4.
	Systematically review all tests on the test list to ensure standardisation between laboratory providers. Support laboratory staff to inform the health system of emerging issues and improve clinical outcomes.	High priority tests reviewed Q1. Advice and education provided to referrers via HealthPathways.
	Establish a joint Standards and Audit Committee, with representatives from both laboratory providers, to improve the quality of service provision and clinical outcomes.	Standards Audits commence Q2. Test results jointly accessible to staff from both labs Q4.

[22] *Implementation and timeframes for delivery of this national programme are dependent on sign-off and approval nationally.*

	Make lab test results available to clinicians via HCS/eSCRV. Review and agree the capacity required for emergency situations and implement a plan to meet that capacity.	
Implement new models for community pharmacy services in Canterbury. *To support pharmacists to provide patient-centred service that improves health outcomes for our population.*	Support the implementation of the national Community Pharmacy Services Agreement.	20 Demonstration Pharmacy Sites signed up Q1. All pharmacy sites able to view patient health records in eSCRV Q2. CCMS in place in Demonstration Sites Q4.
	Establish Demonstration Pharmacy Sites to develop and test new models of pharmacy care focused on fostering patient-centred clinical relationships with general practice and secondary care. Support initiatives that free up pharmacist time to carry out more patient-focused work. Enable Demonstration Sites to view patient health records in eSCRV as part of the integrated clinical team.	
	Complete implementation of the Medication Management Service (MMS) to reduce the risk of harm from medications – particularly for older people on multiple medications. Enhance MMS mobile services in rural areas. Review the provision of the MMS and alignment with the new Pharmacy LTC Programme to improve the management of patients with complex health needs.	2,000 people referred to MMS Q4.
Support the closer alignment of facilities and physical infrastructure to the model of care. *To further integrate the health system, improve access to services closer to home and increase capacity by making better use of available resources.*	Support the development and implementation of Integrated Family Health Centres (IFHCs) and networks in Christchurch in the coming year. Establish IFHC projects in targeted areas of Christchurch city where the earthquake as created areas of high demand for primary care services and limited capacity to respond. Establish new models (youth hubs/services) that are responsive to the needs of young people.	2 IFHC business case projects established in targeted areas of Christchurch Q4. 12 IFHC/network business cases complete Q4. 8 IFHC/network business cases accepted by business owners and underway Q4.
	Support the development and implementation of an integrated model of care for newly developed IFHCs. Support the implementation of care coordination functions and management plans in newly developed IFHCs.	IFHC practice groups supported to implement care coordination and CCMS as a part of their integrated models of care.
	Support the Rural Health Workstream and rural general practices to develop rural IFHCs. Enable information transfer between Kaikoura Hospital, Medical Centre and Te Tai o Marokura with a common Patient Management System.	Ashburton IFHC build begins Q4. Akaroa IFHC build begins Q4. Kaikoura IFHC build begins Q4.
	Support the development of Community Health Hubs to provide a range of outpatient and community specialist activity alongside extended primary care.	Rangiora Community Health Hub concept plan agreed Q1. Rangiora Hub build begins Q4.

3.3 Managing acute demand

Continued growth in acute (urgent or unplanned) hospital admissions is one of the most significant challenges for DHBs to manage and places intense pressure on our constrained hospital resources.

Canterbury's whole-of-system approach to managing acute demand has enabled us to successfully maintain the lowest age-standardised rate of acute medical admissions of any large DHB in the country (and the second lowest rate of overnight admissions).

This work is being driven through the Acute Demand Service Level Alliance, whose members are clinicians, health professionals and managers from across the acute care journey who are able to provide collective thinking and experience to reduce the pressures of acute demand. Their focus has been on ensuring appropriate urgent care services are available to meet people's needs at any given time, so that only people who need hospital services present at our hospital emergency department (ED) and are admitted, and so that people leaving our hospitals are appropriately supported on discharge.

Early intervention and acute demand services support the management and care of acutely unwell people in the community and help to reduce crises and the deterioration of people's conditions. In 2012/13, Canterbury's Acute Demand Management Services (ADMS) managed 25,374 episodes of urgent care in the community rather than in hospital.

Health Target

95% of people presenting at ED are admitted, discharged or transferred within 6 hours.

Many acute admissions result from exacerbations of long-term conditions, so acute demand services have close links with programmes that optimise the management of long-term conditions.

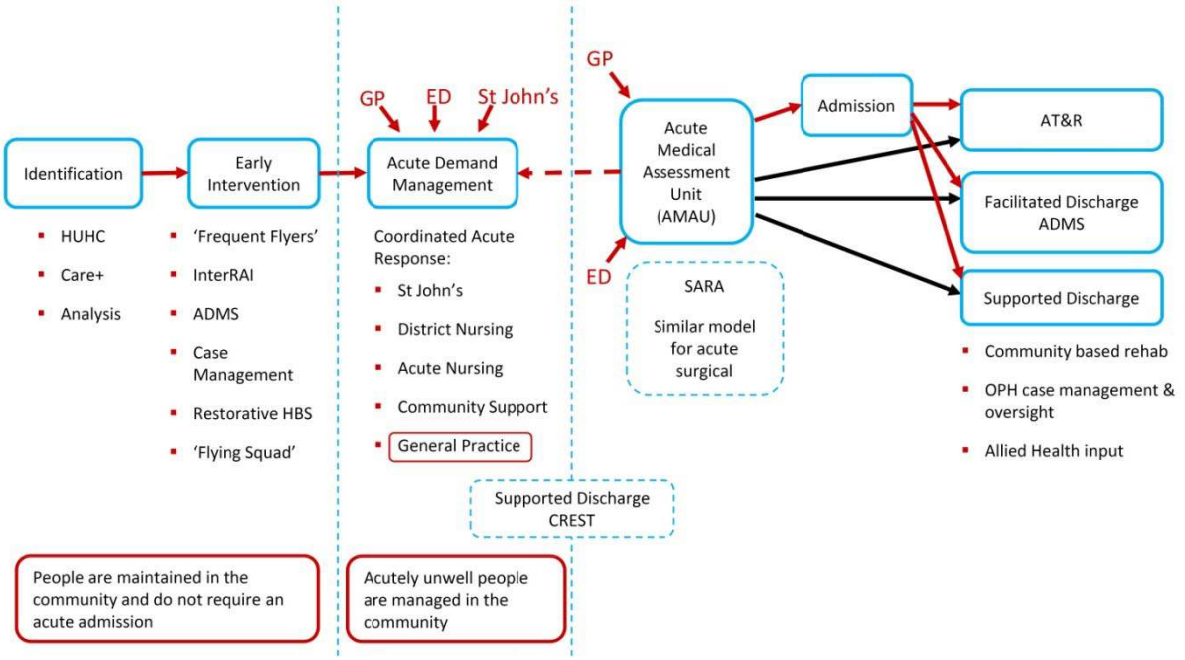
However, a whole-of-system approach is about more than just supporting people to stay well and responding to their acute care needs in community settings.

It also involves making the very best use of our ED resources, supported by best practice within our ED, so that clinical teams ensure people are treated quickly and only those who need hospital services are admitted.

The final step is making sure that appropriate services are in place to provide people with the support they need to return to their own homes - reducing both the time spent in hospital and the likelihood of readmission.

This whole-of-system approach involves general practice, ambulance services, secondary care and community support services – all working together to provide people with the right care in the right setting.

FIGURE 4: CANTERBURY'S IMPROVED ACUTE CARE MODEL



OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTION**	**EVIDENCE**
Continue to develop and refine community-based acute demand services. *To ensure the most appropriate urgent care options are available to meet patient need at any given time, and only people who need hospital services present at ED.*	Under the governance of the Acute Demand Service Level Alliance: Encourage GP practices to take up the under-six-year-old payments and provide zero fees for children under six during working hours. Implement agreed protocol for the provision of zero fees to under-sixes after hours across Canterbury. Support general practices to provide a free afterhours nurse phone advice and triage service. Continue to invest in acute demand services that provide primary care with options to support people with a high level of need to access appropriate urgent care in the community rather than in hospitals. Encourage St John Ambulance crews to use the Ambulance Referral Pathway and ADMS to safely manage patients in the community (with a key focus on COPD patients during winter months). Enable proactive management of vulnerable patients in the community through investment in community observation and increased access to urgent diagnostics. Promote calling general practice as first point of (phone) contact 24/7. Review acute demand (and supported discharge) services to ensure they are targeted at patients with the greatest capacity to benefit and support people with the highest level of need.	100% of the population under six have access to free afterhours care Q4. 22,000 urgent care packages provided in the community Q4. 400 patients utilise the Ambulance Referral Pathway Q4. Avoidable hospital admissions (0-74) maintained at <95% of the national average (<1,883 per 100,000). Rate of acute medical admissions maintained at <5,000 per 100,000. Proportion of the population presenting to ED maintained at ≤18%.
Deliver shorter stays in emergency departments. *To deliver ED services to patients in a timely manner that respects patients' needs and values their time.*	Implement the DHB Recovery Plan to support best use of bed capacity and maintain patient flow over the winter period and during invasive repairs. Implement the E-Quality Framework to support and manage ED performance. Develop and implement new and expanded AMAU arrangements to improve the flow of patients and eliminate waste/steps in the acute patient journey. Increase the visibility of key contributors to ED overcrowding (length of stay, wait times to be seen by inpatient doctors, frequent attendees and load on each ED section) in order to develop targeted responses.	On-screen queues fully available, to support increased visibility and breech analysis Q1. 95% of people presenting at ED are admitted, discharged or transferred within 6 hours.
Improve facilitated discharge services. *To provide people with the support they need to return to their own homes, reducing the time spent in hospital and the likelihood of readmission.*	Complete the implementation of the Restorative District Nursing and Community Support Services model to better support people on discharge and reduce the likelihood of readmission. Apply acute demand resources to support transition to the community from ED and timely discharge for patients where appropriate. Expand CREST services (and ADMS) to maximum capacity to support earlier discharge from hospital and reduce the likelihood of admission or readmission. Ensure older people (65+) discharged after fall events are referred to the Falls Prevention Programme to reduce the risk of further falls. Introduce a 'risk of readmission algorithm' into general practice to identify and support vulnerable people and those at risk of admission.	2,200 people supported by CREST services upon discharge or by direct GP referral Q4. 1,200 people (65+) access community-based falls prevention services Q4. Acute surgical inpatient average length of stay maintained at ≤4.28 days. Readmission rates for people (75+) at or below the national average.

3.4 Managing long-term conditions

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

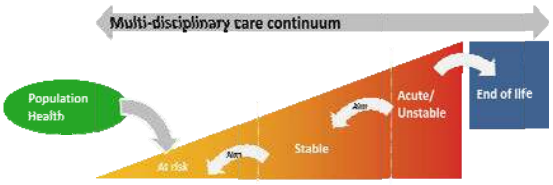
Good management of long-term conditions requires systematic processes for identifying and regularly monitoring patients and for supporting people to self-manage their conditions.

How will we improve health outcomes?

Our approach is to support good practice at every point on the care continuum by aligning funding and models of care across the whole health system to facilitate early intervention and appropriate treatment. This will reduce the impact long-term conditions have on people's lives and keep down acute and avoidable admissions to hospital.

Over the coming year, we will continue to develop integrated pathways and multidisciplinary partnerships to improve care for people with long-term conditions - with a focus on respiratory disease management, the further development of our integrated package of care for diabetes and the provision of CVD risk assessments. However, we will also look to the newly formed Long-term Conditions (LTC) Development Group under the CCN to develop an integrated approach to LTC management across all conditions.

This work will continue to be supported by patient pathways that span the care continuum from wellness to end of life. Clinically led service groups design and review these pathways to eliminate barriers and gaps in order to improve patient care. Information and tools to support patients to self-manage their conditions will also continue to be enhanced.

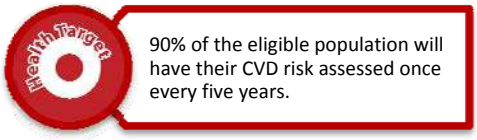


Respiratory disease

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

Canterbury's clinically led Integrated Respiratory Service has brought together health professionals from across the system to design and implement models of care and service delivery that better manage respiratory disease.

This collaborative approach has enabled earlier diagnosis and treatment through services previously only available in hospital that are now delivered in the community. Over 2,000 people were seen in the community for spirometry, sleep assessment or pulmonary rehabilitation in 2011/12.



Cardiovascular disease (CVD)

CVD includes coronary heart disease, stroke and other diseases of the heart and circulatory system, and is a leading cause of death and hospitalisation. Older people, Māori and Pacific people have higher rates of CVD, which will increase as our population ages. Sub-groups of our Asian population also have higher rates of CVD; as an increasing proportion of our population, we will need to closely monitor and respond to the needs of these groups and engage them in health service.

Like respiratory disease and diabetes, addressing CVD is reliant on systematic identification and management of people who have or are at risk of CVD. Increasing the number of CVD risk assessments delivered in primary care is a national priority. We are working closely with our primary care partners to prioritise CVD risk assessments for those with the greatest need as we work towards achieving the national health target.

Diabetes

Diabetes is estimated to cause around 1,200 deaths per year in New Zealand. This is likely to be an under-representation, as diabetes is also an underlying factor for many circulatory diseases. Diabetes can also lead to blindness, amputation, heart disease and kidney failure. Its impact in terms of both illness and cost to the health sector is significant. Māori and Pacific people are particularly affected, with diabetes rates about three times higher than other New Zealanders.

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

Maori and Pacific populations are disproportionately affected by Respiratory Diabetes and CVD. Specific emphasis will be placed on understanding access and mortality rates and working with Maori and Pacific providers to better target initiatives and improve uptake of programmes.

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTION**	**EVIDENCE**
Align care across the whole health system to facilitate integrated and appropriate management of long-term conditions. *To support early intervention, the improved coordination of services and a reduction in acute admission.*	Through the newly formed LTC Development Group develop an integrated, patient-centred approach to LTC management. Begin proactive risk stratification of people at risk of readmission. Begin proactive risk stratification of people at risk of admission. Review current condition-specific clinical pathways for alignment with agreed LTC approach. Identify generic tools for LTC management and self-management. Align and integrate rehabilitation programmes and nurse specialist resources to increase capacity and capability across the system.	Risk of readmission stratification underway Q1. Risk of admission stratification underway Q4. Review of condition-specific patient pathways Q1-Q4.
	Continue to support Clinical Care Coordinators to work with patients (with LTC and complex health needs) to develop and maintain care plans using the Collaborative Care Management Solution (CCMS). Support primary, secondary and allied health providers to develop or refine care plans for complex patients using CCMS. Review the provision of the Medication Management Service (MMS) and alignment with the new Pharmacy LTC Programme to improve the management of patients with complex health needs.	More patients enrolled on CCMS– base 1,186. Ability to create acute care plans in CCMS enabled Q4. 2,000 people referred to the MMS Q4.

Respiratory Disease

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTION**	**EVIDENCE**
Improve the identification of people at risk of respiratory disease. *To support early intervention, prevent hospital admissions and ensure people are managed under a structured program.*	Align existing work with the LTC Development Group to further consolidate and refine the identification of people with COPD. Continue to maintain direct access to diagnostics in the community. Collaborate and engage with Māori and Pacific health providers to improve access to diagnostics and respiratory services. Maintain the Hip and Knee pathway to support case finding for Obstructive Sleep Apnoea and COPD in primary care. Establish the Continuous Positive Airway Pressure (CPAP) model of care that supports annual patient review in the community.	Respiratory diagnostic test rates reported by ethnicity Q2. CPAP model in place Q4. ≥800 people access community-based sleep assessments Q4. ≥1,000 people access community-based spirometry testing Q4.
Ensure people receive the right care and support at the right time and in the right setting. *To support people to stay well, modify lifestyles, better manage their condition and reduce the progression or impact of their illness.*	Link into programmes that encompass warmer homes and smoking cessation to further support people at risk of respiratory disease. Enhance respiratory services for patients in rural communities to improve access to services and support seamless patient care. Progress the delivery of an integrated, multidisciplinary approach to the management of acute and sub-acute COPD patients. Establish a model of community-based care for cystic fibrosis and bronchiectasis patients with acute pulmonary exacerbation. Maintain direct access to support from community respiratory nurses for general practice managing COPD patients. Continue to support education and enhancement of skills in managing respiratory disease and long-term conditions. Enhance hospital-based activity for complex respiratory diseases, including lung cancer, tuberculosis and respiratory failure.	Increase in the number of respiratory patients with CCMS care plans – base new. Reduction in COPD admission rates – base from 2011/12.[23] Reduction in COPD readmission rates – base from 2011/12.
	Raise awareness of pulmonary rehabilitation programmes amongst general practice to increase referrals into the programmes and improve people's management of their condition. Explore alignment of rehabilitation programmes.	≥150 people access pulmonary rehabilitation.

[23] *The target reduction for COPD patients is over a two-year period from the 2011/12 year base.*

Cardiovascular Disease

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTION**	**EVIDENCE**
Improve the identification of people at risk of cardiovascular disease. *To improve earlier access to appropriate intervention and improve health outcomes.*	Engage with the LTC Development Group to consolidate and refine the identification of the population at risk. Support PHOs to work with general practice to increase the number of eligible people being provided with CVD risk assessments.[24] Support general practice to engage patients in joint interpretation of their CVD risk and development of a management/care plan, including use of the CCMS. Support PHO liaison teams to visit general practice and improve the capture of CVD risk assessments and structured discussions. Meet quarterly with the three PHOs to review and monitor performance against the CVD target and share successful initiatives and resources to improve results. Develop an online health target dashboard to raise the focus of Canterbury's performance against the full set of targets. Establish a CVD Action Group to explore the opportunities to raise CVD risk awareness including community and workplace events.[25] Collaborate and engage with Māori and Pacific health providers to improve CVD risk assessment rates amongst high-needs groups.	Process to record and report CVD structured discussions embedded Q1. Online DHB health target dashboard up and running Q1. CVD Action Group in place Q1. Delivery of CVD risk assessments at community and workplace events explored Q2. Quarterly progress towards 90% of the eligible population having had a CVD risk assessment within the last 5 years – base 20%.[26] Quarterly increase in Māori CVD risk assessment rates – base 19%.
Ensure people receive the right care in the right setting. *To support people to stay well, better manage their condition and reduce the progression of illness or likelihood of a subsequent event.*	Encourage increased referrals to programmes that help improve overall health and wellbeing and reduce CVD risk factors, including: Green Prescription (Be Active), Appetite For Life, Senior Chef and Warmer Homes programmes. Support collective delivery of the ABC Smoking Cessation Programme to reduce the major risk factor for CVD. Support general practice to make steady progress towards 90% of enrolled smokers being provided with advice and help to quit. Promote CVD risk awareness and management in DHB community newsletters across Canterbury.	CVD focus in DHB community newsletter Q1. Quarterly increased in percentage of enrolled smokers provided with advice and help to quit - base 25%. 95% of hospitalised smokers are provided with advice and support to quit Q4. ≥2,000 people access Green Prescriptions for additional physical activity support Q4.
	Maintain the primary/secondary cardiology patient pathway to support an integrated approach to CVD management. Maintain direct GP access to exercise tolerance testing to support CVD risk assessment and improved CVD management. Support the primary care education programme to provide general practice teams with training on the management of cardiology patients in the community.	Current CVD patient pathways in place Q1-Q4. CVD education session developed and delivered to general practice Q2.
	Support increased referral of people to cardiac rehabilitation and programmes that improve overall health after an acute event. Link with the LTC Development Group to explore the alignment of rehabilitation programmes for people with other LTC.	30% of people having an acute event are referred to cardiac rehabilitation.

[24] The DHB is investing $205,000 to support the delivery of more heart and diabetes checks through the funding of dashboards, advanced forms, practice liaison and general practice education sessions. Funding is allocated to the PHOs in line with their population share.

[25] Components of CVD risk assessments captured at community events will need to be transferred to general practice teams for interpretation and to ensure appropriate ongoing care. A process for achieving this will be a key deliverable in exploring these events.

[26] Canterbury's largest PHO has been participating in the CVD risk assessment programme for two and a half years rather than five, and is behind the rest of the country.

Diabetes

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTION**	**EVIDENCE**
Improve the identification and management of people with diabetes. *To improve earlier access to appropriate intervention and improve health outcomes.*	Support the Integrated Diabetes Service development group, operational group and consumer group to ensure an integrated local approach for people with diabetes. Continue to implement the Diabetes Care Improvement Package with identified minimum standard of care (aligned to NZ Primary Care Handbook).[27] Align with the LTC Development Group to support general practice to identify their population with diabetes. Support continued work between the Integrated Diabetes Development Group (IDSDG) and PHO clinical governance to develop and agree outcome indicators for the population identified with diabetes. Collaborate and engage with Māori and Pacific health providers to improve diabetes management amongst high-needs groups. Regularly monitor HbA1c for general practice populations identified with diabetes. Regularly monitor people admitted to hospital with a primary diagnosis of diabetes and advanced kidney disease.	All patients with diabetes coded in general practice systems Q1. Risk stratification processes to identify high-needs/high-risk populations conducted Q3. HbA1c results evaluated Q3. Increased proportion of the enrolled population identified with diabetes have acceptable glycaemic control (HbA1c <64mmol/mol). Increased proportion of the enrolled population with diabetes and microalbuminuria are prescribed an ACE1 or an ARB.[28]
Ensure people receive the right care in the right setting. *To support people to stay well, better manage their condition and reduce the progression of illness or likelihood of an acute event.*	Regularly review diabetes information on HealthPathways and HealthInfo to ensure it is current. Monitor the number of visits to both sites to evaluate use of the pathways and consumer-related information. Encourage increased referrals to programmes that help improve overall health and wellbeing and reduce diabetes risk factors, including: Green Prescription (Be Active), Appetite For Life and Senior Chef programmes.	Diabetes pathways in place Q1-Q4. Diabetes focus in DHB community newsletter Q3. ≥2,000 people access Green Prescriptions for additional physical activity support Q4.
	Continue to support the implementation and design of clinical/patient education tools and models for improving and supporting self-management of diabetes. Continue to support community-based programmes to manage newly diagnosed Type 2 patients. Continue to support community-based programmes to manage those starting insulin. Support increased access to community-based retinal screening for people with diabetes. Support increased access to podiatry services for diabetes high-risk foot patients.	Conversation maps made available to primary care Q1. Diabetes services access rates reported by ethnicity Q2. More people newly diagnosed with type 2 diabetes access support in the community – base 429. More people with Type 2 diabetes starting insulin access support in the community – base 213. More people with diabetes access retinal screening in the community – base 5,529.
	Continue to support diabetes nurse specialists to deliver education and provide support and specialist advice directly to general practice teams to identify, record and care for people with diabetes. Engage practice nurses in training for diabetes care and management to improve the quality of care. Engage optometrists in training with lead ophthalmologist to develop expertise in retinal screening.	Increased number of practice nurses complete diabetes care training – base 105. Number of optometrists having completed training – base new.

[27] *The DHB is investing $740,000 to incentivise the provision of the Diabetes Care Improvement Package. Funding shares are allocated to general practice in accordance with the identified population with diabetes being managed by a general practice.*

[28] *The Ministry is currently working on a means of data capture for this measure nationally baselines are to be established.*

REDUCING THE TIME PEOPLE SPEND WAITING

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

Patients' time is a valuable, non-renewable resource. The government has ambitious objectives to shorten waiting times for diagnostics, surgery and cancer care, which DHBs are expected to meet.

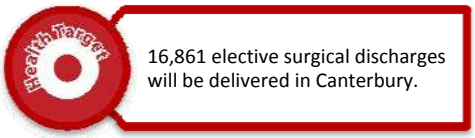
As the major provider of hospital and specialist services in Canterbury and across the South Island, it is crucial that we maintain our ability to deliver hospital and specialist services in order to ensure that the whole New Zealand health system can meet demand. It is also crucial that we maintain timely access to services in order to minimise the progression of illness, help people to stay well, support their functional independence and improve the quality of their lives.

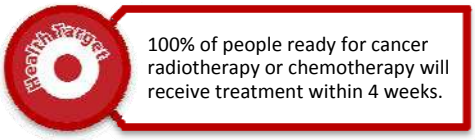
How will we improve health outcomes?

With the loss of hospital beds after the earthquakes and an invasive and disruptive repair schedule ahead of us, maintaining capacity to deliver services and reduce waiting times is going to be a significant challenge.

To respond to our capacity constraints, we have adopted a whole-of-system production planning approach and will significantly increase outsourcing to the private sector while repairs to our facilities are completed. We expect to need private capacity in areas such as Ophthalmology, Orthopaedics, Cardiac Surgery, General Surgery and Urology.

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





patients and patient flow across our hospitals. These are a key part of our 'lean' production planning processes.

Regionally, we will work through the South Island Alliance to improve elective surgical planning. Supporting both local and regional patient care pathways and protocols will also improve equity of access and reduce waiting times.

We will also work locally through the CCN District Alliance to reduce the demand on hospital services, both by supporting people to stay well and by treating and managing more people in the community when they are unwell.

To support this, we will provide timely direct access to diagnostics and specialist advice. This will reduce the need for a hospital appointment – not only saving people's time, but also minimising the harm and complications that can arise from a delay in intervention.

3.5 Elective services

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTION**	**EVIDENCE**
Continually improve access to diagnostic services. *To reduce waiting times and improve patient outcomes through timely diagnosis.*	Continue to maintain direct GP access to a full suite of diagnostics to improve referral quality and help reduce waiting times for treatment. Provide patients with access to diagnostic services in accordance with assigned priority or national referral criteria as appropriate. Ensure internal data collection systems are in place to facilitate accurate reporting of diagnostic waiting times. Monitor diagnostic waiting times for CT, MRI and diagnostic colonoscopy to identify issues and barriers to access. Participate in national/regional clinical networks focused on the development of diagnostic service improvement programmes.	85% of accepted referrals for CT scans receive their scan within six weeks Q4. 75% of accepted referrals for MRI scans receive their scan within six weeks Q4. 50% of people receive urgent colonoscopy within two weeks Q4. 50% of people receive non-urgent colonoscopy within six weeks Q4. 50% of people receive surveillance colonoscopy no later than 12 weeks Q4.

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTION**	**EVIDENCE**
Increase production capability for the delivery of elective surgery. *To meet national expectations and ensure continued access to services for the Canterbury and South Island populations.*	Engage services in developing whole-of-DHB production plans providing a clear plan for delivery (including private capacity). Undertake weekly production plan monitoring and capacity review. Monitor Elective Surgery Patient flow Indicators (ESPIs) and intervention rates to ensure compliance with national targets. Develop more sophisticated measures of patient flow to support 'lean' process improvement. Establish agreements with private providers for outsourcing of elective surgery and for out-placing of DHB staff in private facilities to increase capacity and reduce waiting times. Support surgical teams to monitor theatre benchmarks to improve start times, patient turnaround and theatre utilisation. Review and refine acute theatre models to reduce the impact of acute demand variation on the delivery of elective surgery. Redirect appropriate IDF inflows to increase the capacity available to Canterbury residents in Canterbury facilities. Utilise other DHBs' facilities and staff resources to deliver care to Canterbury residents where possible and appropriate. Engage clinical services teams in planning earthquake repair work to minimise disruption to service delivery.	≥16,861 elective surgical discharges delivered Q4. Elective theatre utilisation maintained at ≥85%. Intervention rates maintained (per 10,000): ▪ Major joints: 21 ▪ Cataracts: 27 No patient waits more than 5 months for FSA or treatment from January 2014.
Continually improve service capacity and patient flow. *To improve service quality, make the most effective use of available resources, reduce waiting times and support increased flexibility in times of higher need (i.e. winter).*	Revise and monitor surgical patient flow plans to reduce wait times for first specialist assessments (FSAs) and treatment. Increase use of national Clinical Priority Access Criteria tools and support treatment of patients in order of assigned priority. Continue to support delivery of elective procedures in acute settings where it is clinically appropriate and more beneficial for patients. Maintain direct access to elective procedures for GPs with ongoing GP-2-GP referral, procedure training and specialist oversight where required.[29] Prioritise repair projects from the Transitional Recovery Plan that will release and create bed capacity. Invest in GP Liaison roles at key points across the system to improve demand management and the triage of referrals. Increase uptake of the Electronic Request Management System (ERMS) to streamline and improve the quality of referrals. Invest in acute demand management and supported discharge services to better manage acutely unwell people in the community.	75% of GP referrals are sent electronically via ERMS Q4. 22,000 acute care packages provided in the community Q4. An increased percentage of elective and arranged surgeries are day of surgery admissions – base 79%. Elective surgical inpatient average length of stay maintained at <3.21 days.
Align strategic activity across the South Island. *To make effective use of resources and ensure equity of access for our populations.*	Participate in the Regional Electives Workstream and support delivery of the regional elective services work plan. Redesign regional pathways to support the management of sub-specialty service delivery. Agree a regional production plan to identify available regional capacity and forecast 'hot spots'.	Regional pathway for Bariatric surgery agreed Q2. Regional elective options for services with access issues developed Q4.

[29] *Current procedures include: skin lesion excisions, Mirena insertions, Pipelle biopsy and musculoskeletal injections.*

3.6 Cardiac services

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTION**	**EVIDENCE**
Increase production capability for the delivery of cardiac surgery. *To meet national expectations and ensure continued access to cardiac services for the Canterbury and South Island populations.*	Monitor ESPIs and intervention rates to ensure equity of access and continued compliance with wait times. Maintain capacity to deliver cardiac surgery at 6.5 per 10,000, even if numbers of patients needing this type of surgery are below the rate. Monitor waiting lists to ensure patients are treated within nationally agreed urgency timeframes. Establish flexible agreements with private providers for the outsourcing of cardiac surgery as needed. Engage cardiac services teams in planning earthquake repair work to minimise disruption to service delivery.	≥320 cardiac surgery discharges delivered Q4. No patient waits more than 5 months for FSA or treatment from January 2014. Intervention rates (per 10,000): ▪ Coronary angiography: 33.9 ▪ Percutaneous revascularisation: 11.9
Continually improve cardiac service capacity. *To improve service quality, reduce waiting times and support increased flexibility in times of higher need (i.e. winter).*	Implement opportunities from the Vector Consulting Report to improve patient flow within the Cardiology Department. Review staffing levels and skills mix to ensure capacity to deliver volumes and meet waiting time targets. Support treatment of patients in order of assigned priority with use of national Clinical Priority Access Criteria tools. Invest in GP Liaison roles in the cardiac department to facilitate better access to specialist advice and support. Increase uptake of ERMS to streamline the referral process. Provide direct GP access to Echocardiography and Exercise ECGs to improve referral quality and patient flow. Review and expand cardiac information on HealthPathways to support primary care management of cardiac conditions. Increase the number of cardiac patients supported by the Chronic Care Programme (CCP) to improve management of their conditions and reduce acute admissions.	Flexible outsourced angiography volumes in place Q3. 75% of GP referrals sent electronically via ERMS Q4. 85% of people receive their elective coronary angiograms within 3 months (90 days). Wait list for cardiac surgery maintained at 5-7.5% of annual throughput and no more than 10%.
Align strategic activity across the South Island. *To make effective use of resources and workforce and ensure equity of access for our population.*	Support the South Island Cardiac Workstream to develop and implement a regional Cardiac Services Plan. Implement regionally agreed protocols and pathways for patients with Acute Coronary Syndrome (ACS) to ensure prompt risk stratification and appropriate patient transfer. Participate in the rollout of the national cardiac register (ANZACS QI) to enable monitoring of intervention rates. Identify opportunities for increased cardiology nursing training via the Regional Training Hub.	Regional ACS pathway in place Q2. ANZACS QI Register in place Q4.[30] 70% of high-risk ACS patients accepted for coronary angiography have it ≤3 days of admission Q4. 95% of patients presenting with ACS who undergo coronary angiography recorded on ANZACS QI Q4.

[30] *Implementation of the ANZACS QI Register is dependent on national contracts being agreed – timeframes are anticipated. Data will be provided for the ACS measure via the South Island Alliance until the ANZACS Register is up and running.*

3.7 Cancer services

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTION**	**EVIDENCE**
Improve access to diagnostic services. *To reduce waiting times and improve patient outcomes through timely diagnosis.*	Implement the Endoscopy Quality Improvement Programme. Identify opportunities and initiatives to further reduce the waiting times for colonoscopy to within national waiting time targets. Use national referral criteria for direct access outpatient colonoscopy. Review acceptance thresholds and the use of clinical pathways to ensure (where appropriate) people are referred for CT Colonography. Review workflow and leave planning and ensure sessions are backfilled when operators are on leave. Expand the service delivery model to increase access to colonoscopy in the community through out-placed clinics, use of Mobile Surgical Services Bus and additional weekend clinics.	50% of patients receive urgent colonoscopy within two weeks. 50% of patients receive non-urgent colonoscopy within six weeks. 50% of patients receive surveillance colonoscopy no later than 12 weeks beyond planned date.
Sustain performance against the radiotherapy and chemotherapy wait time targets. *To continue to meet national expectations and ensure timely access to cancer treatment for the Canterbury and South Island populations.*	Implement 'lean thinking' processes to remove bottlenecks, improve patient flow and reduce waiting times. Make flexible arrangements with St George's Cancer Centre and the Southern Blood and Cancer Service to ensure Canterbury has the capacity to maintain four-week wait times. Monitor waiting lists to proactively identify capacity issues and provide the South Island DHBs with regular performance data. Support Cancer Nurse Coordinators to attend national and regional training and mentoring forums to build capability and supports. Support more interactive recruitment strategies for key oncology roles including: branding, facebook, alumni. Review the Southern Cancer Network (SCN) modelling and Regional Linear Accelerator Investment Plan, and the National Radiation Oncology Plan (once published), to ensure Canterbury has appropriate radiation treatment capacity to meet future demand.	100% of patients ready for treatment wait less than 4 weeks for radiotherapy or chemotherapy.
Progress implementation of the national Faster Cancer Treatment indicators. *To continue to meet national expectations and ensure timely access to cancer treatment for the Canterbury and South Island populations.*	Work with SCN to implement the agreed model for identifying people with a high suspicion of cancer (HSC) to enable the system-wide tracking of patients from referral to treatment across all specialities. Introduce a high suspicion of cancer triage code to enable the tracking of referrals across all data points. Increase uptake of the ERMS to support and streamline referral and triage processes. Make use of the MOSAIQ Oncology Information System to streamline the workflow from first diagnosis/staging to treatment/follow-up. Support the implementation of the South Island Clinical Cancer System as the regional clinical data repository.	Baselines established for Faster Cancer Treatment indicators by Q3. Faster Cancer Treatment reporting captures data across all data points Q4.
Improve the functionality and coverage of multidisciplinary meetings (MDMs). *To improve patient outcomes through best practice treatment and quality clinical decision-making.*	Support the new MDM coordination roles to improve the structure of MDMs, including membership, coverage and use of technology. Standardise information and electronic processes to better support MDMs, including electronic referrals, agendas, forms and data. Review the clinical decision-making and governance processes around MDMs and support professional development and training to help implement the new MDM Model. Expand use of videoconferencing to extend coverage of MDMs across the South Island and nationally.	Video participation from West Coast Q1. All tumour streams utilise MDMs Q2. Increased number of cases discussed at MDMs Q4.
Align strategic activity across the South Island and nationally. *To make effective use of resources and ensure equity of access.*	Support SCN to implement agreed regional initiatives from the National Cancer Programme Work Plan including implementing: ▪ The national tumour standards of service provision; ▪ The national Medical Oncology Models of Care Plan; and ▪ The Prostate Cancer Quality Improvement Plan.	Tumour stream standards consultation response provided Q1. Begin implementing Bowel and Gynaecology tumour standards Q3/4.

SUPPORTING OUR VULNERABLE POPULATIONS

3.8 Disease prevention

International literature on disaster recovery indicates an increase in risk behaviours such as tobacco smoking, alcohol consumption, poor nutrition and reduced physical activity is typical in response to stressful events, and those vulnerable prior to the disaster have an increased risk of poor health. These changes are not immediate and may develop and progress for several years after the event.

The earthquakes have had a considerable impact on Canterbury residents, with many people shifting from their homes and becoming disconnected from their usual community and support networks.

As we rebuild our communities, it is crucial that we continue to provide population and community-based prevention, education and support services that promote wellbeing and healthy lifestyles. Without a deliberate focus, unhealthy lifestyle behaviours may become ingrained for the longer-term.

Common preventable environmental factors and lifestyle choices – such as smoking, lack of physical activity, poor nutrition, excessive alcohol intake and poor housing, heating and air quality – are major causes of long-term conditions. Addressing these risk factors will help to mitigate the increasing incidence and impact of long-term conditions in our community and consequently reduce avoidable hospitalisation and improve the quality of people's lives.

How will we improve health outcomes?

Our disease prevention plans and health promotion programmes are particularly focused on reducing risk factors and supporting positive change amongst identified high-risk groups, who are more likely to be negatively affected by the events of the past few years. With reduced capacity across Canterbury, there will be additional emphasis on inter-sectoral work – working together to develop sustainable, long-term projects that address our communities' needs.

Health Target

95% of hospitalised smokers, and 90% of smokers seen in general practice, will receive quit advice and support.

We are also focused on achieving the national health targets and have embedded the 'Ask, Brief advice, Cessation support' (ABC) programme across our health system, with training available in a range of settings. Strong clinical leadership is key to success, and in the coming year we will look to encourage and facilitate the inclusion of pharmacists and Lead Maternity Carers (LMCs) in the ABC programme.

Canterbury has a detailed Public Health Action Plan for 2013/14 that sits alongside this Annual Plan. The Public Health Action Plan can be found at www.cdhb.govt,nz.

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTION**	**EVIDENCE**
Ensure health and wellbeing are considerations in earthquake recovery. *To positively influence the determinants of health and improve lifelong health and wellbeing.*	Lead the inter-sectoral work of Healthy Christchurch. Work alongside the Mental Health Foundation to lead the 'All Right?' social marketing wellbeing campaign. Update issues papers for the City Health and Wellbeing Profile to inform cross-sector recovery work. Promote the use of Health and Social Impact Assessments. Engage with CERA and CCC rebuild and recovery planning, including participation in the Community Wellbeing Planners Group, Wellbeing Survey Working Group, and Wellbeing Index Project. Partner with ECAN to ensure health and drinking water quality are key considerations in the Canterbury Water Management Strategy.	'All Right?' campaign evaluation initial results available Q1. A regular programme of Healthy Christchurch hui and lunchtime seminars is developed, with 2 hui and 8 seminars held Q4. 1-2 medium-scale Health Impact Assessments completed Q4.
Contribute to programmes and initiatives that improve housing quality. *To positively influence health and reduce risk factors that lead to hospitalisation.*	Work alongside Community Energy Action encouraging referral of vulnerable people to the 'Warm Families' programme. Contribute to the work of the CERA-initiated Sustainable Homes Working Party to further enable sustainable home improvements. Continue to contribute to other cross-sector initiatives to resolve housing issues, particularly for unwell and at-risk families, and support Māori and Pacific health organisations to identify housing issues and where to locate help.	Increased referrals to Warm Families - base 192. CDHB contribution is evident in relevant group/project outputs.
Implement programmes that reduce the harm	Contribute to the work of Smokefree Canterbury to ensure an integrated approach towards Smokefree Aotearoa by 2025 by:	≥90% of tobacco retailers identified from controlled

caused by tobacco smoking. *To reduce the major risk factor of long-term conditions and inequalities in health outcomes, particularly for Māori and Pacific people, who have disproportionately higher smoking rates.*	Maintaining and promoting smokefree environments to support cessation attempts and reduce exposure to second-hand smoke. Undertaking controlled purchase operations to ensure tobacco retailers comply with existing and new smokefree legislation. Supporting social service organisations and workplaces to establish policies and deliver interventions to address smoking issues.	purchase operations are compliant with legislation. Increase in the percentage of year 10 students who have 'never smoked' – base 74%.
	Raise the profile of clinical smokefree leaders in primary, secondary and maternity settings, including Directors of Nursing (DONs) and Midwifery, to engage clinical colleagues in achieving ABC targets. Continue to support monthly ward champion meetings across the hospital to monitor and improve performance.	ABC messages and success promoted in DHB publications Q1-Q4. 95% of hospitalised smokers are provided with advice and support to quit Q4.
	Enhance and integrate ABC documentation, data collection and supporting resources (including IT tools) in primary, secondary and maternity settings to ensure ABC is part of routine clinical practice. Work with LMCs to and smoking cessation providers to support the provision of interventions to pregnant women who smoke. Build on gains made in the delivery of ABC in primary care with: quarterly PHO-level performance review; regular practice-level coaching to improve coding and enable targeting of practices where performance is low; and positive inquiry and education by practice liaison teams to improve performance and systems. Consolidate gains made in the delivery of ABC in hospital settings with: close performance monitoring by DONs and charge nurses; direct coding department feedback to wards; online performance dashboards; ward audits and analysis of care pathways where no intervention is being recorded, followed up with positive inquiry to improve performance and systems.	90% of enrolled smokers seen in general practice are provided with advice and help to quit Q4. Progress is made towards providing 90% of women who identify as smokers at the time of confirmation of pregnancy with advice and support to quit Q4.
	Continue to provide ongoing staff ABC training in primary/secondary settings, including training on the delivery of ABC, documentation, ABC process guidelines and promotion of e-learning. Continue to provide 'train the trainer' training to community agencies and groups to increase the capacity for delivery of ABC. Continue to train pharmacists to provide brief advice, NRT and referrals to cessation support. Identify and implement opportunities to provide training and resources to support LMCs to deliver ABC to pregnant women.	4 ABC training sessions are delivered in primary care. 2 'train the trainer' sessions delivered in the community. 60% of community pharmacies are delivering ABC Q4.
	Ensure cessation support is provided in primary, secondary and maternity settings for current smokers motivated to quit by: Strengthening referral pathways between primary and secondary care and community cessation programmes. Working with PHOs to ensure that existing cessation programmes and support are delivered using current best practice. Providing targeted community-based cessation support to Māori and whānau through the Aukati Kaipaipa cessation programme. Providing targeted community-based cessation support to pregnant women who smoke through Smokechange, Aukati Kaipaipa and Pacific Quit Coaches.	≥200 people enrol with the Aukati Kaipaipa smoking cessation programme Q4. Increased number of women referred to Smokechange Q4. ≥7,000 Canterbury residents seek cessation support from Quitline Q4.
Implement programmes that reduce the harm caused by alcohol. *To reduce a major risk factor of harm and long-term conditions.*	Develop new communication tools to engage and inform patients and professionals around alcohol misuse and improve the overall response of the health sector in addressing alcohol-related harm. Deliver host responsibility training to improve the skills of Duty Managers in reducing alcohol-related harm. Monitor On-, Off- and Club-Licensed premises assessed to be of high or medium risk of creating alcohol-related harm. Assist Police with alcohol controlled purchase operations to reduce the supply of liquor to minors.	Quarterly work programme and electronic bulletin. ≥ 6 monitoring visits per year for high- or extreme-risk premises and ≥3 per year for medium-risk premises Q4. 30 host training sessions delivered Q4.

3.9 Older people's health services

Canterbury's population is ageing, which reflects the health system's success in achieving longer life spans for our population. However, older people experience more illness and disability than other population groups, and the majority of health spending for an individual generally occurs in the last two years of life. The ageing of our population can therefore reflect an increase in the risk of illness and hence health expenditure, including for aged residential care (ARC) services. We estimate that approximately half our health resources are used to provide care for people aged over 65.

There is scope for reducing demand on hospital and ARC by integrating services across primary, community, secondary and residential care settings. Providing wrap-around support and investing in targeted community services for older people will help them to stay healthy and well in their own homes for as long as possible.

A number of wrap-around strategies and support services for older people were prioritised to help address capacity pressures across our system after the earthquakes. This included the implementation of supported discharge and restorative care models, which help support people in their own homes and communities. We are now seeing improved outcomes from these programmes in terms of reduced acute admissions and readmissions for people aged over 65.

This work has been largely driven through the Aged Care Workstream of the CCN District Alliance, and as we move into 2013/14, we will continue to place a strong emphasis on flexible, responsive, needs-based care that supports older people to retain their independence for longer. In doing so, we will review and consolidate the rollout of existing programmes to ensure that we are working effectively and reaching all population groups across all locations.

Alongside consolidation and review of current programmes, we will invest in a limited number of new initiatives in the coming year. Our focus will be on initiatives that complement current programmes and further support the delivery of the right care and support, at the right time.

There are a number of national priorities around dementia, fracture and stroke services that we will deliver. We will also implement sector standards and benchmark our service performance against measures of quality and patient outcomes to identify opportunities for improvement.

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTION OR DELIVERABLE**	**EVIDENCE OF SUCCESS**
Ensure older people receive timely and comprehensive clinical assessment of need. *To support the development of effective packages of care and promote seamless transitions between services and providers.*	Continue to support Community Support Services (CSS) providers and the DHB's Older Persons' Health Specialist Services (OPHSS) to assess clients using InterRAI. Continue to support the provision of read-only access to InterRAI for general practice and ARC providers.	≥95% of long-term CSS clients have an InterRAI assessment and a care plan in place Q4. ≥95% of people entering ARC have had an InterRAI assessment Q4.
	Support ARC providers to implement clinical assessments using the InterRAI Long-Term Care Facility (LTCF) module. Provide OPHSS Gerontology Nurse Specialists with the tools to help support and train ARC providers using InterRAI. Engage nationally to bring forward funding to support implementation of the InterRAI LTCF module to 2013/14.	InterRAI training plan for the LTCF module is in place Q1. Training has commenced Q2. 100% of ARC facilities are using or training nurses to use the InterRAI LTCF assessment tool Q4.
Consolidate and refine wrap-around services for older people. *To provide a more responsive service that better meets the needs of older people and supports them to stay well by reducing harm and hospitalisation or early entry into ARC.*	Complete the review of the Community Rehabilitation Enablement and Support Team (CREST) to identify opportunities to refine the rapid response and supported discharge model and to review the impact of the service. Expand CREST to full capacity and into rural areas. Build on clinical relationships between CREST, general practice and OPHSS to support increased GP referrals and the provision of specialist advice to general practice. Establish utilisation baselines by ethnicity and identify opportunities to improve access and utilisation of services.	CREST review completed Q1. 2,200 people access CREST Q4. 500 direct referrals from GPs Q4. 20% reduction in acute admissions for people supported by CREST. 10% reduction in readmissions for people supported by CREST.[31]

[31] *The 10% target reduction for CREST patients is over a two-year period from the beginning of the programme in April 2011. The impact of the service will be considered as part of the CREST review to be completed in Q1 2013/14.*

	Complete implementation of the Medication Management Service (MMS) to reduce the risk of harm from medications. Enhance MMS mobile services in rural areas. Review the provision of MMS in alignment with the new Pharmacy LTC Programme.	2,000 people referred to MMS Q4.
	Complete the rollout of the restorative home support services model across all community support services. Further develop service processes to better define interaction with general practice and alignment of service. Improve equipment availability to support people at home. Develop service protocols for providers to ensure a culturally appropriate approach when working restoratively. Develop and implement case-mix (needs-based) models for short-term (under 65) and district nursing clients.	ENABLE service accreditation for CREST and Falls Champions Q3. Review of readmission rates for people (65+ and 75+) completed quarterly Q1-Q4.
	Continue to implement clinically led falls prevention strategies that improve the integration of falls prevention activity and enhance access in rural areas. Enhance primary care team involvement in preventing falls. Support the Active Canterbury Network to monitor and improve the effectiveness of community physical activity and health-focused programmes. Support the 'Zero harm from falls' focus in our hospitals by monitoring the effectiveness of falls prevention strategies. Promote 'Zero harm from falls' in ARC settings and provide an ARC-based Vitamin D supplementation programme.	1,200 people (65+) access community-based falls prevention programmes Q4. 75% of ARC residents receiving Vitamin D Q4. 10% reduction in the proportion of the population aged 75+ presenting at ED as a result of a fall. 10% reduction in the proportion of the population aged 75+ admitted to hospital as a result of a fall.[32]
Invest in the development and expansion of targeted specialised services. *To support people to maintain independence and to remain in their own homes.*	Support the Aged Care Alliance to champion use of the jointly developed Cognitive Impairment Pathway to improve care for people with dementia across the whole system. Engage primary, community and secondary care clinical leads in a review of the Cognitive Impairment Pathway for consistency with the national framework. Develop a system pathway to identify isolated older adults with depression earlier and provide appropriate support. Expand 'Walking in Another's Shoes' (WIAS) dementia training to Community Support Services (CSS) carers.	Isolation/Depression pathway established Q3. Cognitive Impairment pathway reviewed Q4. Increased number of CCS carers completing the WIAS programme – base 21.
	Develop an integrated Fracture Liaison Service.[33] Engage clinical leads and multidisciplinary stakeholders in aligning preventative care to prevent future fractures. Establish a Fracture Pathway that covers identification, investigation and intervention.	Stakeholder engagement Q2. Pathway agreed Q3. Fracture Liaison Service in place Q4.
	Engage clinical leads in the integration of Stroke Services and referral pathways to support a single Canterbury stroke service that meets NZ Stroke Guidelines. Support a standardised referral process for people requiring support and further rehabilitation after an acute event. Continue to participate in the regional Stroke Alliance Workstream to implement the NZ Clinical Guidelines for Stroke Management. Continue to participate in national clinical stroke networks to improve outcomes for people after stroke.	Plan for integration agreed Q1. Current pathways reviewed against integrated model Q2. Regional thrombolysis pathway implemented Q2. 6% of potentially eligible stroke patients are thrombolysed Q4.[34] 80% of stroke patients admitted to an organised stroke service Q4.

[32] *The 10% target reduction for both falls measures is over a two-year period from the beginning of the programme in February 2012.*

[33] *Supported by the Minimum Data Set for hip fracture developed by the Australia NZ Hip Fracture Registry Working Group.*

[34] *Collection of this data is dependent on training and data systems currently being implemented and agreed regionally.*

Engage providers in quality improvement work and capacity management. *To ensure older people receive consistent and high quality health services.*	Continue to support the CSS Service Level Alliance to undertake joint planning and quality improvement. Ensure all CSS providers meet Sector Standards, as part of the revised community support model. Use national core quality measures for CSS (to be produced by the MoH) to review and improve service performance. Participate in a HCSS costing exercise conducted through the national Health of Older People (HOP) Steering Group.	All contracted CSS hold a certificate of conformance with NZS 8158:2012. Pressure injury and CSS core quality measure baselines established Q2.[35] CSS quality measures and admission baselines reviewed Q4. Elder Abuse implementation Plan developed Q4. 6 ARC nurses complete postgraduate nursing leadership programme Q4. Review of readmission rates for people (65+ and 75+) completed quarterly Q1-Q4.
	Establish a baseline for 'inappropriate' hospital admissions and identify opportunities to reduce these. Benchmark the DHB's readmission rates for the population aged 65+ and 75+ against those in individual programmes and against other DHBs to evaluate performance.	
	Review and build on existing Elder Abuse Policies to ensure they meet the national Elder Abuse Guidelines. Provide advice and training to OPHS specialists, ARC providers and HCCS providers to ensure incorporation of the Guidelines into DHB programmes and practice.	
	Continue to maintain key specialist roles to support the provision of specialist advice to colleagues in primary care and aged residential care in order to improve outcomes for older people including: OPHSS geriatricians and gerontology nurse specialist roles, and the CREST Service. [36]	
	Implement the ARC Residential Recovery and Improvement Plan, monitor ARC utilisation and engage ARC providers in capacity management and quality improvement. Continue to provide specialist support to ARC provider through the OPHSS gerontology nurse specialist roles. Provide access to advice and training to ARC providers to reduce the incidence and severity of pressure injuries. Establish a postgraduate nursing programme to promote leadership development in the ARC sector.	
Align strategic activity across the South Island and nationally. *To make effective use of resources and workforce.*	Support the regional Health of Older People Alliance Workstream in the implementation of the SI Advance Care Planning (ACP) initiative. Support regional DHBs to establish whole-of-system falls prevention strategies and coordinate evidence-based falls prevention in alignment with HQSC requirements. Continue to participate in the national HOP Steering Group to develop and roll out the Home and Community Support Services Standards and Specifications.	ACP documentation and pathways plan developed Q2. Regional Falls Targets established Q2.

[35] *This timeline is dependent on the MoH and HIQ establishing these measures.*

[36] *Specialist advice and support is provided to primary care and aged residential care providers through psychiatric services for the elderly and a number of dedicated OPHSS roles including: OPHSS geriatricians (4 FTE) and gerontology nurse specialist roles (3 FTE) and the CREST Service (7 RN Liaison and 6 RN Case Managers).*

3.10 Child, youth and maternal health services

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

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

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

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

Prime Minister's Youth Mental Health Services

Many common mental health problems, such as depression, anxiety and substance abuse, emerge when people are young and can have life-long consequences.

In April 2012, the Prime Minister announced a package of initiatives focused on 12- to 19-year-olds with, or at risk of, mild to moderate mental health issues.

This package is designed to help prevent mental health issues developing, and improve access to appropriate services and treatment if they do develop. It aims to reach young people in key settings: their families, communities, schools, health services and online.

As part of this approach, the DHB will support a collaborative, cross-agency youth initiative to help bridge the gap between primary brief intervention and specialist services so that young people can be expertly assessed and provided with the most appropriate level of intervention and support.

The initiative is based around two experienced community-based organisations (Odyssey House and Stepping Stone Trust) who are working together as a mobile team, with a strong connection to Specialist Mental Health Child, Adolescent and Family (CAF) Services. A Kaupapa Māori organisation (Pura Pura Whetu) is soon to become a third partner to provide expertise around cultural and clinical issues.

This work, while focused on young people, will largely be driven through the Mental Health Alliance Workstream.

Immunisation Services

Immunisation is an important component in keeping vulnerable children well and out of hospital, particularly over winter. It is also a national health target.

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

Child and Youth Services

We will prioritise children and young people with the highest need and focus on strengthening the relationships between their families and their general practice teams to support them to stay well. We will also foster a collaborative approach to reconnecting families with their general practice as their key point of contact and responding quickly to their immediate needs.

This work will be largely driven through our Child & Youth Health Workstream under the CCN District Alliance. Progress in improving outcomes will also be monitored by this Workstream, whose members will help resolve barriers to success.

Linkages will be made with the Mental Health Workstream to ensure alignment between activity under the national Child Health Action Plan and the implementation of the national Mental Health Service Development Plan '*Rising to the Challenge*' and regional review of maternal/perinatal mental health services in line with the national guidelines '*Healthy Beginnings*.

Maternity Services

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

Canterbury's multidisciplinary Maternity Development Group has produced a *Maternity Journey Action Plan* based on opportunities identified at a participatory workshop with over 120 consumers and health providers from across the system. This plan is available on the CDHB website: www.cdhb.govt.nz.

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

Delivering the Prime Minister's Youth Mental Health Project

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTION**	**EVIDENCE**
Support an integrated and responsive service approach for young people with mild to moderate mental health issues. *To improve service responsiveness and better support young people and their families to maintain more stable lives.*	Extend the coverage of School-Based Health Services (SBHS) to Decile 3 secondary schools and support SBHS nurses to provide HEEADSSS assessments to Year 9 students enrolled in the service. Review delivery of SBHS against service expectations and monitor performance through quarterly performance reports. Support expansion of HEEADSSS assessment training to primary care to increase HEEADSSS assessment capability, including promotion of training sessions to general practice. Work with primary care to improve coordination of referrals resulting from HEEADSSS assessments. Expand the Community Youth Mental Health Collaborative mobile service to provide additional support to SBHS and primary care.	100% of Decile 1-3 schools, teen parent units and alternative education facilities have SBHS in place Q1. 100% of Year 9 students in SBHS receive HEEADSSS assessments Q4.
	Adopt a stepped care model to enhance primary mental health services for young people (and their families) in line with national service expectations. Implement and evaluate the chosen model as one of the mechanisms to improve integration between services. Increase specialist consult/liaison to improve communication and responsiveness between primary and secondary care. Support the Collaborative Youth Mental Health Initiative to further bridge the gap between primary and specialist services.	Stepped care model defined Q1. Specialist consult/liaison service in place Q1. Stepped care model implementation underway Q2.
	In collaboration with primary and community service providers, complete a stock-take and gap analysis of all DHB-funded primary and community services for young people. Identify key actions to address issues and capture opportunities. Establish new models (youth hubs/services) that are responsive to the needs of young people. Provide direction for the emerging Community Hubs and IFHCs models to support multiagency workspace and service delivery.	Results of stock-take and actions to be taken documented Q2. Progress in resolving gaps and issues shared with sector Q4. Youth hub model evaluated Q4.
	Continue to implement the Choice and Partnership Approach to improve access and achieve phased waiting time targets by 2015. Monitor demand and waiting times for referrals to CAF and Youth AOD services to ensure system responsiveness. Develop a CAF earthquake mobile response team to support young people in schools and community settings. Work collectively with the NGOs and through the Collaborative Youth Mental Health Initiative to reduce waiting times.	75% of youth (aged 0-19) referred for non-urgent mental health or addiction services seen ≤3 weeks Q4. 85% of youth (aged 0-19) referred for non-urgent mental health or addiction services seen ≤8 weeks Q4.
	Review follow-up care for young people discharged from CAMHS and youth AOD in line with the stepped care model. Develop a consistent process that ensures follow-up plans can be activated by primary care within three weeks of discharge. Refine data systems to monitor the provision and use of follow-up plans, and track outcomes for young people on discharge. Consider the role of the Collaborative Youth Mental Health Initiative in providing discharge support for young people.	Discharge practices reviewed Q1. Baseline established for youth being discharged with follow-up care plans Q4.

Delivering Better Public Services: Immunisation

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTION**	**EVIDENCE**
Increase immunisation coverage. *To reduce vaccine-preventable diseases and support people to stay well.*	Support the cross-sector Immunisation Service Level Alliance and the Immunisation Provider Group to: Support and maintain systems for seamless communication and handover between maternity, general practice and WCTO services and support the multiple enrolments of newborns. Explore linkages with CYF, MSD, Justice and other social service agencies to raise awareness of the importance of immunisation and to improve the timely delivery of vaccinations.	95% of all newborn babies are enrolled on the National Immunisation Register (NIR) at birth Q4. 100% of newborns are enrolled with a GP provider by 6 weeks of age Q4.
	Implement the DHB Immunisation Promotional Plan 'Immunise for Life' and support Immunisation Week. Maintain a systems resource 'Immunisation Toolkit' to support general practice to discuss and deliver immunisations. Streamline access to immunisation awareness information.	Immunisation Toolkit in place Q1. Narrative report on interagency activities to promote Immunisation Week Q4.
	Refine NIR reporting to provide direct advice to general practice, support timely immunisation and locate unvaccinated children. Expand reporting to include practice-level coverage reports to identify and address gaps in service delivery. Support the Missed Event Coordinator to locate missing children and support Canterbury's missed event plan. Focus Outreach Services on locating and vaccinating hard-to-reach children and reducing inequalities for tamariki Māori. Continue to support close links between the Child Health Division and NIR Team to identify the immunisation status of children presenting at hospital and provide overdue immunisations.	85% of all six-week-olds are fully immunised Q4. 90% of all eight-month-olds are fully vaccinated Q4. 95% of all two-year-olds are fully immunised Q4. Quarterly performance reports circulated to PHOs, to review progress against targets.
	Link 11-year-old and HPV immunisation events. Support active pre-call programmes for HPV to increase uptake.	60% of girls born in 2000 receive HPV dose 3 Q4.
	Invest in free seasonal flu vaccinations for those under 18, as well as older people (65+) and pregnant women. Provide free pertussis vaccinations for pregnant women.	40% of people aged <18 and 75% of people aged 65+ have a seasonal flu vaccination Q4.

Delivering Better Public Services: The Child Action Plan

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTION**	**EVIDENCE**
Prepare to implement the national Child Health Action Plan. *To improve the DHB's response to the needs of vulnerable and at-risk children.*	Use established governance arrangements and engagement processes under the CCN Child and Youth Health Workstream to lead and monitor implementation of the Children's Action Plan. Complete a stock-take and gap analysis of all DHB-funded services for vulnerable pregnant women, children and parents. Use findings of the stock-take to inform future service planning.	Governance lead confirmed Q1. Results of services stock-take presented to Child and Youth Workstream Q2. Actions confirmed Q4.
	Strengthen identification, risk assessment and responses for vulnerable and at-risk children and their families across DHB services through the Violence Intervention Programme (VIP). Provide training for health professionals on the impacts of family violence and in the identification of abuse, neglect and harm. Identify opportunities through 6 monthly monitoring of the MoU with CYF and Police to improve the coordination of responses to child abuse and neglect. Introduce an enhanced child protection alert system.	Shaken Baby Prevention Policy implemented Q1. Regional MoU with CYF, Police and DHBs agreed Q1. Child Protection Alert System in place Q3. Combined audit score of child and partner abuse components of the VIP ≥170/200.

	Continue to work with Young Parent Units to support vulnerable mothers and children and increased participation in quality Early Childhood Education (ECE) via Health Promoting Schools teams. Identify opportunities to raise awareness of the importance of quality ECE and strengthen connections between health and education providers working with high-needs families. Contribute to MoE initiatives that help engage vulnerable children in quality ECE – including shared information and pathways.	Engagement with the Ministry of Education (MoE) via the Child and Youth Health Workstream Q1. Identify common objectives Q2. Share progress in realising opportunities via the Child and Youth Health Workstream Q4.

Maternal and Child Health Services

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTION**	**EVIDENCE**
Implement a collaborative and integrated approach to the delivery of maternity services. *To enhance the maternity journey, reduce fragmentation and improve outcomes for both mothers and babies.*	Work with the NZ College of Midwives to increase the number of women who register with a Lead Maternity Carer (LMC) by week 12 of their pregnancy. Support the 'Find a Midwife' web-system to enable women to identify a LMC who best meets their needs. Work with primary care to ensure pregnant woman are enrolled with a PHO and registered with a GP. Fund LMC referrals to general practice for women in need of additional support for medical, mental health or social concerns. Work with LMCs to support the provision and recording of smoking cessation interventions for pregnant women who smoke.	Increased number of visitors to 'Find a Midwife' site – base new. Progress towards 90% of women who identify as smokers at confirmation of pregnancy being offered ABC Q4.
	Enhance pregnancy/parenting courses to better meet the needs of a wider range of women – particularly Māori and Pacific women and younger mothers.[37]	≥30% of new mothers access DHB-funded pregnancy and parenting education courses Q4.
	Promote supportive environments and expand the variety and locations of breastfeeding courses to better engage with more women and improve integration of services. Invest in supplementary services - including Mum-4-Mum peer support and lactation services - that are accessible and appropriate for high-needs and at-risk women. Establish a breastfeeding referral pathway to help providers refer women to the most appropriate level of support. Collaborate and engage with Māori and Pacific health providers to improve Māori and Pacific breastfeeding rates.	50 volunteer mothers engage in Mum-4-Mum training Q4. 580 mothers referred to lactation support in the community Q4. ≥75% of mothers have established breastfeeding on hospital discharge Q4. 69% of babies fully or exclusively breastfed at 6 weeks and 28% at 6 months Q4.
Implement a collaborative and integrated approach to the delivery of child and youth services. *To support continuity of care, early intervention and better health outcomes for children and young people.*	Work with PHOs to ensure children under six have access to free afterhours primary care.	100% of children <6 have access to free afterhours care Q4.
	Ensure universal access to the core WellChild/Tamariki Ora (WCTO) services and equitable access to additional WCTO contacts. Monitor access and referral patterns for B4 School Checks to identify opportunities to improve delivery and coverage. Work with PHO mobile engagement teams to improve uptake of B4SC amongst Māori, Pacific and Quintile 5 children. Monitor access to referred services following WCTO/B4SC and implement actions to expedite service delivery.	90% of eligible children receive a B4SC Q4. Children referred following a B4SC are seen before their fifth birthday Q4. Fewer children (aged 0-4) admitted to hospital with avoidable conditions – <6,656 per 100,000.
	Maintain delivery of Gateway Assessments and monitor access and referral patterns to further develop the service.	100% of children referred by CYF receive Gateway Assessments.

[37] *The Ministry of Health is currently reviewing content and service specifications for pregnancy and parenting education; the DHB will align service delivery with national requirements once this review is complete.*

	Continue to work with WCTO providers and general practice teams to identify children most at risk of tooth decay and support their families to maintain good oral health and access preventative care. Develop a whole-of-DHB Oral Health Promotion Plan. Identify further barriers to timely recall by DHB Community Dental Services and implement strategies to support caries-free teeth. Continue to investigate and implement alternative oral health service models for adolescents to engage more young people, particularly those in low decile schools or who have left school. Utilise HealthPathways and ERMS to increase coordination between the DHB's Dental Service and community dentists.	68% of children (0-4) are enrolled with DHB-funded oral health services. 90% of children are examined according to planned recall. 65% of 5-years-olds will be caries-free. DMFT rate for Year 8 children (11-12 years) will be 0.82. 85% of adolescents (<18) access DHB-funded oral health services.
Support quality improvement across all services. *To ensure families receive consistent and high quality health services.*	Consolidate the Maternity Quality and Safety Programme (MQSP) as business as usual by June 2015: Implement recommendations from first MQSP Report. Consolidate the MQSP approach across Canterbury and West Coast DHBs to align direction. Enhance maternity governance structures within and between DHBs to engage LMCs, primary care and consumers in the development and implementation of the programme. Review data collection and data quality to identify gaps and opportunities to improve service delivery. Establish a mechanism for review of NZ Maternity Clinical Indicators and a process for identifying opportunities to improve clinical care and reduce unnecessary variation in practice.	Combined maternity governance structure in place Q1. Review of data completed Q2. Second MQSP Annual Report completed Q4. Process for disseminating Maternity Clinical Indicators embedded Q4.
	Improve the quality of B4SC data collection and reporting. Incorporate the WCTO Quality Improvement Framework to reduce unnecessary variation in delivery of WCTO/B4SC services.[38]	Findings of B4SC quality improvement letters incorporated Q4.
	Develop and enhance child health 'navigator links' on HealthInfo and HealthPathways and agree Youth HealthPathways content. Develop alternative formats and models for delivery of information to young people that are more youth-friendly and engaging (e.g. texting/online questionnaire/gaming framework). Review format and language used through youth consultation and engagement processes.	Youth-friendly and accessible format and language used in information provided.
Align strategic activity across the South Island. *To make the most effective use of resources and workforce and ensure equity of access.*	Support the development of a Regional Rheumatic Fever Prevention Plan and align DHB activity with the agreed regional approach to maintain low South Island rheumatic fever rates (≤0.5 per 100,000). Review pathways for LMC and DHB referrers to maternal/perinatal mental health services in line with the national guidelines '*Healthy Beginnings'*, to reduce waiting times. Lead the development of a South Island Maternal Depression Pathway. Strengthen workforce development/liaison between South Island Mother and Baby Services.	Regional Rheumatic Fever Plan agreed Q1. Baselines for LMC/DHB referral - treatment established Q1. SI Maternal Depression Pathway established Q4.

[38] *The WCTO Quality Framework is currently under development with the Ministry of Health.*

3.11 Mental health services

It is estimated that at any one time, 20% of the population have a mental illness or addiction and 3% are severely affected by mental illness. With the ongoing stresses on our population as a result of the earthquakes, an increased emphasis on mental health and wellbeing is even more critical, and our health system is working to improve access to mental health services at all levels.

Addressing the impact of the earthquakes is a key component of our planning, and our response spans public, primary, community and secondary health services and settings. This includes dedicated earthquake-related services, but most health services in Canterbury are dealing with increased need for mental health and wellbeing services as a result of the earthquake, particular child and youth services.

Our response is based on a recovery approach and a commitment to integrated services, which is evident in the willingness of all parties to work closely together to wrap care around the individual.

We will continue to develop community-based options that provide services closer to home, supported by expanded consult liaison across a range of services within our hospital and specialist division.

This will provide the benefit of timely specialist advice without the need for a specialist appointment or disruption of the primary/community care relationship. It will also help build capability across our system, with primary and community organisations better supported to provide services to people with more complex needs.

Cross-sector partnerships, pathways and alliance behaviours have delivered significant success over the past two years, including reduced waiting times, freed-up resources redirected into service provision, strengthened relationships between service providers and improved referral management.

In the coming year, we will continue to build on our success and focus on delivering the Prime Minister's Youth Mental Health Project, in particular expanding primary mental health service options and forensic services for young people. (Refer to Section 3.10.)

We will work collaboratively with the Ministries of Health, Education and Social Services to wrap support services around young people.

We will also review our direction against the priorities identified in the Ministry of Health's Mental Health Service Development Plan '*Rising to the Challenge*' to ensure we are meeting national expectations.

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTION**	**EVIDENCE**
Use DHB resources effectively across the whole mental health continum.	Undertake a gap analysis between the national Mental Health and Addiction Service Delivery Plan and Canterbury's current service provision. Identify how resources will be reprioritised (where necessary) to deliver the actions expected.	Gap analysis completed as per MOH template and considered by Mental Health Leadership Workstream Q1. Action Plan operational Q2.
Implement the Prime Minister's Youth Mental Health Project. *To improve service responsiveness and better support young people and their families to maintain more stable lives.*	Support the Child and Youth Health Workstream to establish new models (youth hubs/services) that are responsive to the needs of young people.	Youth Hub Model defined Q1.
	Adopt a stepped care model to respond to the mental health needs of youth in line with national service expectations. Implement and evaluate the chosen model as one of the mechanisms to bridge the gap between services. Increase specialist consult/liaison to improve communication and responsiveness between primary and secondary care and better meet the needs of young people and their families. Support the Collaborative Youth Mental Health Initiative to also bridge the gap between primary and specialist services.	Stepped care model defined Q1. Specialist consult/liaison service in place Q1. Stepped care model implementation underway Q2.
Enhance the responsiveness of primary and community mental health services. *To improve the continuity of care and build on gains in resilience and recovery.*	Continue the implementation/development of the stepped care model for mental health across the wider service continuum Enhance the Single Point of Entry service with a phone roster, ensuring a psychiatrist is available for GPs seeking advice. Clarify criteria for entry to services and delineate the community-based options for care if the consumer is not eligible for specialist mental health services. Expand the range of services available closer to home through continued investment in primary care.	Enhanced Single Point of Entry service established Q1. Direct telephone access to psychiatrist operational Q1. Agreed pathways developed and made available Q4. ≥4,000 people receive BIC in primary care (includes EQ BIC) Q4.

	Maintain ready access to programmes to support people suffering anxiety and trauma as a result of the earthquake. Implement the cross-government Child & Youth Health Action Plan to address emerging issues for children and young people as a result of the earthquakes (in conjunction with the Ministries of Health, Social Development and Education). Finalise the Peer Service Development Plan, including strategies for how peer support will be blended across the whole system.	≥2,000 people access EQ-related mental health services Q4.[39] At least two actions from the Child & Youth Health Action Plan in implementation Q2. At least two actions from the Peer Development Plan in implementation Q4.
Improve the responsiveness of specialist services to the needs of young people and their families. *To improve service responsiveness and better support young people and their families to maintain more stable lives.*	Continue to implement the Choice and Partnership Approach to improve access and achieve waiting time targets by 2015. Monitor demand and waiting times for referrals to CAF and Youth AOD services to ensure system responsiveness. Develop a CAF earthquake mobile response team to support young people in schools and community settings. Work collectively with the NGOs and through the Collaborative Youth Mental Health Initiative to reduce waiting times.	75% of youth (aged 0-19) referred for non-urgent mental health or addiction services seen ≤3 weeks Q4. 85% of youth (aged 0-19) referred for non-urgent mental health or addiction services seen ≤8 weeks Q4.
	Review follow-up care for young people discharged from CAMHS and youth AOD in line with the stepped care model. Develop a consistent process that ensures follow-up plans can be activated by primary care within three weeks of discharge. Refine data systems to monitor the provision and use of follow-up plans, and track outcomes for young people on discharge. Consider the role of the Collaborative Youth Mental Health Initiative in providing discharge support for young people.	Discharge practices reviewed Q1. Baseline established for youth being discharged with follow-up care plans Q4.
Continue the implementation of the Adult Mental Health Services Direction of Change. *To improve service responsiveness and better support people and their families to maintain more stable lives.*	Enhance the Single Point of Entry service with a phone roster, ensuring a psychiatrist is available for GPs seeking advice. Enhance models and processes to support mental health services users across the continuum. Develop a Crisis Resolution Service to enhance community care. Develop a psychiatric consult service with MHSS nursing support in Christchurch Hospital. Establish four integrated Multidisciplinary Locality Teams that work across inpatient and outpatient settings, operate from a shared treatment plan and provide extended service hours. Facilitate collaboration/connection with the community, including general practice teams through the Locality Teams. Develop extended treatment strategies for consumers with high and complex mental health needs. Develop and implement an evaluation framework for the Adult Mental Health Services Direction of Change.	Direct telephone access to psychiatrist operational Q1. Consult/Liaison Service operational Q1. Locality Teams established Q4. ≥95% of all long-term clients have current relapse prevention plans in place (included as part of the shared treatment plan) Q4. 75% of people (20-64) referred for non-urgent mental health services seen in three weeks Q4. 90% of people (20-64) referred for non-urgent mental health services seen in eight weeks Q4.
Continue the implementation of the Canterbury Alcohol and Other Drug (AOD) Project. *To improve service responsiveness and better support people and their families to maintain more stable lives.*	Support the Alcohol Harm Reduction Coordinator to implement public health alcohol-related harm interventions. Provide AOD brief intervention training to target workforce groups, including: general practice, mental health, Corrections. Increase centralisation of referrals by expanding the Central Coordination Service. Implement the AOD Withdrawal Management/Respite Pathway. Provide training to increase responsiveness of the AOD sector. Expand the range of intervention and support service options to enable people to remain in their own homes and communities, including access to community support workers (CSW) and housing facilitation coordinators. Continue implementation of the Co-Existing Problems Action	Central Coordination Service expanded Q1. Access to CSW and increase in housing facilitation services Q1. Six introductory CEP sessions and six advanced sessions run Q2. AOD brief intervention training provided to 4 target groups Q4. 75% of people (20-64) referred for non-urgent AOD services are seen in three weeks Q4. 90% of people (20-64) referred for non-urgent AOD services are

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

	Plan to increase sector capability to respond to people with both mental health and AOD issues. Provide Co-Existing Problems (CEP) training across the system.	seen in eight weeks Q4.
Implement national policy and action plans. *To improve the coordination between public health services and the continuum of care for vulnerable population groups.*	Continue to support a local suicide prevention plan. Review local suicide prevention approaches against the goals in the national Suicide Prevention Action Plan *(yet to be released).*	Review existing model Q2. Alignment of goals evident Q4.
	Prepare to implement the actions from the national Child Health Action Plan and keep informed of demonstration site progress. Continue to support delivery of Gateway Assessments. Work with the Child and Youth Health Workstream to complete a stock-take and gap analysis of all DHB-funded primary and community health services for young people. Consider alignment of activity under the national Mental Health Service Development Plan, regional maternal/perinatal mental health services review and national Child Health Action Plan.	100% of children referred by CYF receiving Gateway Assessments. Results of youth services stock-take Q2 and actions to be taken confirmed Q4.
	Support the national Drivers of Crime initiative by: Continuing to support School-Based Health Services (SBHS) to deliver HEEADSSS Assessments. Continuing to work with Corrections and courts to increase access to AOD additional assessment and treatment.	100% of Year 9 students in SBHS receive HEEADSSS assessments Q4.
	Support the national Welfare Reforms by: Increasing the number of mental health and addiction clients enrolled in the Knowing the People (KPP) planning project. Support those people enrolled in KPP into full or part time employment.	Increased number of people enrolled in KPP – base 244. Increased number of people in KPP in full or part time employment – base 17.
Participate in the South Island Regional Mental Health Alliance. *To make the most effective use of joint resources.*	Participate in the South Island Regional Mental Health Alliance and support the 2013/14 work plan. Lead the development of a regional Youth Forensic Framework. Support pathway development between MoH Disability Support Services and DHBs to support improved service provision for people with intellectual disability and mental health issues.	Disability Support Services/DHB pathway developed Q4.

3.12 Māori and Pacific health services

The Canterbury population generally has better access to health services and better health status than the average New Zealander. This is true for all ethnicities living in Canterbury and a number of improvements have been made in Māori and Pacific health over the past several years. Nonetheless, inequalities still exist. We will not achieve our vision while Māori and Pacific health outcomes lag behind the general population. Reducing inequalities pervades everything we do, but in 2013/14 we are placing specific emphasis on child and youth population groups.

Canterbury's Māori and Pacific populations, while each having their own unique health issues, have some similar major characteristics. Both have higher rates of diabetes, respiratory disease and cardiovascular disease and are over-represented in terms of risk factors, particularly smoking.

Two in every five Māori are daily smokers (41%) and three in every ten Pacific people (29%) compared on 19% of the total population. Smoking is linked to almost every long-term condition and reducing smoking rates is key to improving health outcomes.

However, there are a number of other environmental and lifestyle factors that also influence health outcomes including – poor housing, heating and air quality, lack of physical activity, poor nutrition and excessive alcohol intake. Addressing any of these risk factors will improve health outcomes and the quality of people's lives.

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

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

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

We have already made some positive gains for Māori and Pacific people, with substantial reductions in rates of avoidable hospital admissions for both these populations over the last several years. With a collective approach from across the health system, we are determined to make further progress.

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

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

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

The DHB has also been working closely with the Māori Health Reference Group Te Kāhui o Papaki Ka Tai on development of a collective outcomes framework. This framework is based around a set of impacts where collectively we can make a difference in the health of our Māori population. The framework will inform local work plans and will be refined and enhanced over the next several years. Dashboard reporting against the framework will begin in the 2013/14 year, and a similar framework will be developed for our Pacific population.

Services to improve outcomes for vulnerable and at-risk children - including immunisations, WellChild/Tamariki Ora and B4 School Checks and oral health services - have been prioritised. Improving cervical screening rates for Māori and Pacific women has also been identified as a key priority in 2013/14.

In line with the activity and initiatives planned for the coming year, the DHB has refreshed its Māori Health Action Plan, as a snapshot of the activity and action happening across our health system to improve health outcomes for Māori. This plan is available on the CDHB website: www.cdhb.govt.nz. The DHB publicly monitors performance against the plan as a means of increasing the focus on Māori health.

Delivering Whānau Ora

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTION**	**EVIDENCE**
Work together to support the implementation of the national Te Puni Kokiri-led Whānau Ora initiative. *To ensure health and social services empower whānau and provide wrap-around services tailored to their needs.*	Enhance the capacity and capability of provider collectives through the CDHB-funded Māori Development Organisation: He Oranga Pounamu. Continue to support the agreed Māori appointment process across the system (led by He Oranga Pounamu) to enhance the capability of advisory boards and working groups.	He Oranga Pounamu service agreement in place Q1. Appointment process being used by Advisory Boards Q1.
	Identify opportunities for the introduction of Integrated Contracts across government agencies to support the implementation of the Whānau Ora models. Provide advice around outcomes-based monitoring and evaluation frameworks that have proven successful in alliance workstreams. Work with the Ministry to support GP providers who are part of Whānau Ora collectives to use their practice management systems to report on whānau outcomes.	Meeting with government funders to share direction Q1. Feedback and written responses provided to Ministry of Health in a timely manner.
	Support the Whānau Ora collectives to move into Phase 2 of the national programme and develop Whānau Ora models, including advice and expertise in the following areas: ▪ Service planning and the provision of information and trend data for analysis; ▪ Analysis of Census 2013 returns, identifying significant population changes that might influence demand; ▪ Development of organisational infrastructure; and ▪ Support for research and professional development within Whānau Ora collectives.	Māori and Pacific Health Profiles complete and distributed Q1. 2013 Māori and Pacific Census data analysis distributed to Whānau Ora collectives Q2. Māori and Pacific Health Scholarships funding supported through He Oranga Pounamu Q4.
	Participate in the Whānau Ora Regional Leadership Group. Work with other government agencies at a local and regional level to actively support the implementation of Whānau Ora and improve cross-sector collaboration. Seek opportunities for the DHB to become more informed and updated on the national MoH contribution to Whānau Ora and help to share that information across the sector: ▪ Formalise relationships between the Whānau Ora Collectives, DHB and Māori and Pacific Provider Forum; ▪ Engage with Whānau Ora Collectives should there be any high-level Māori and Pacific planning that will result in changes to services or direction; ▪ Share regular updates on progress received as part of the Whānau Ora Regional Leadership Group; and ▪ Support continued engagement with the Māori and Pacific Health Provider Forum to enhance relationships with providers outside of the Whānau Ora Collective.	Relationship between CDHB and Whānau Ora Collectives formalised Q2. Consistent process for regional distribution of information agreed through Te Herenga Hauora and South Island Māori and Pacific GMs Network Q2.

BETTER PUBLIC HEALTH SERVICES

3.14 Living within our means

With current and projected constraints on government funds, we must maximise value from our limited resources, prioritise capital more closely and fund new programmes from internal sources.

Prior to the earthquakes, Canterbury was on track to break even. Strong procurement controls, improved patient flow, clinically led decision-making, joined-up patient pathways and service integration were removing waste and duplication from our system. It is critical that we continue to make the best use of limited health dollars for our community.

Future funding increases will be modest. If our funding has to be directed into meeting cost growth, it will severely restrict our ability to invest in technology and services to better meet the needs of our population. It will also put continued healthcare service delivery at risk both locally and regionally. We must therefore focus heavily on reducing and removing waste from our health system and living within our funding allocations.

Canterbury is aiming to reduce its reliance on earthquake funding support from the Ministry of Health.

We will achieve this by using mechanisms that have proven successful in the past, including: 'lean thinking' initiatives, quality and safety improvements, smarter production planning, tighter expenditure and purchasing arrangements, shared information systems and joint staff appointments that improve the use of limited resources.

We will continue to engage health professionals in prioritisation and service improvement. By shifting decision-making into the hands of the health professionals providing services, we have been able to introduce technical efficiencies that have eliminated duplication and waste across our system.

We will also ensure that scarce financial capital is not wasted on repairing buildings that have no future. Any short-term fixes will be made in the context of long-term solutions.

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTION**	**EVIDENCE**
Connect the System to support technical and clinical efficiencies to reduce waste and duplication and improve care and responsiveness.	Continue to ensure system-wide clinical and community participation in all activity under the CCN District Alliance. Review the clinical pathways across our health system to support the delivery of the right care, in the right place, at the right time. Further roll out eSCRV to provide a core set of patient information at the point of care to support more informed treatment. Expand the use of e-Discharges, e-Referrals (ERMS) and Éclair lab results reporting to improve efficiency and allocation of resources. Support the rollout of ERMS across the South Island in order to improve the management of referrals across regions.	HealthPathways available across the Canterbury system – base 519. 95% of general practice and community pharmacy have eSCRV by Q4. ≥75% of all GP referrals to Christchurch Hospital are e-Referrals (through ERMS) by Q4.
Realign service models and expenditure to get ahead of the disease curve and reduce acute demand for health services.	Maintain GP access to diagnostics and specialist nursing support to reduce unnecessary hospital and specialist referrals. Invest in acute demand services to provide people with access to appropriate urgent care in the community rather than in hospital. Expand CREST services to support earlier discharge from hospital and reduce the likelihood of readmission. Continue to implement clinical led falls prevention strategies and enhance primary care involvement in preventing harm from falls. Continue to implementation/development of the stepped care model for mental health across the wider health continuum to support mental health patients to stay well, including shared care arrangement and relapse prevention planning.	22,000 urgent care packages provided. 2,200 people access CREST. 1,200 people access fall prevention programmes. 95% off all long-term mental health clients have current relapse prevention plans in place. Rate of acute medical admissions maintained at <5,000 per 100,000.
	Invest in long-term conditions programmes that support people in their own homes and communities rather than in hospital settings. Further enhance the Collaborative Care Management Programme to improve care for people with complex health needs. Begin proactive risk profiling and stratification of our population to better target limited resources and improve health outcomes. Align and integrate rehabilitation programmes and nurse specialist resources to increase capacity and capability across the system.	Risk profiling and stratification underway Q1. Ability to create acute care plans in CCMS enabled Q4. More patients enrolled with the CCP – base 1,186.

Release and expand workforce capacity to make better use of limited resources.	Expand the scope of practice for key and critical roles and support the development of new roles through the Regional Training Hub. Support joint clinical appointments between the Canterbury and West Coast DHBs to support an improved service in both districts. Support models of care and training programmes that allow staff to work to the greatest extent of their scope and continue to support enrolment in the NETP and NESP Programmes. Support Maori and Pacific workforce training and scholarships to encourage more Maori and Pacific people to enter health fields. Increase the level of engagement across our workforce to increase productivity and foster positive behaviours.	10 people complete Level 3 NZQA allied health assistant qualifications. 13 nurses complete practicum or thesis for Nursing Practitioner Training. 10 Maori Health Scholarships awarded. 1% increase in staff engagement levels by Q4.
Maintain a focus on efficient and effective use of resources to reduce the cost of service delivery.	Improve clinical quality and patient flow in our hospitals to reduce duplication and unnecessary delays. Implement the Transitional Recovery Plan to maintain patient flow during invasive facilities repairs and over the winter period. Implement new, expanded AMAU arrangements to improve patient flow, the use of resources and transfers between facilities. Review and refine acute theatre models to reduce the impact of acute demand variation of the delivery of elective surgery. Implement medications and infection control initiatives to support safer and shorter patient stays.	Elective theatre utilisation maintained at ≥85%. Hospital outputs delivered to within 5% of plan. Elective surgical inpatient length of stay maintained at ≤3.21 days.
	Redirect appropriate IDF inflows to increase the capacity available to Canterbury residents in Canterbury facilities. Support the Canterbury Health Innovation Hub to facilitate the flow of ideas and joint ventures with commercial potential and identify and pursue opportunities to engage with commercial service providers to maximise benefits for the sector. Work with CERA and the Ministry of Health to find solutions to the added cost associated with health care for rebuild workers. Actively participate in the Regional Alliance to achieve regional savings and reduce duplication and lead the Procurement and Supply Chain Workstream. Identify further opportunities from national Health Benefits Limited initiatives and ensure these are applied locally to achieve mutual benefits and cost savings across the sector.	SI Procurement Plan implemented Q1. Patient Transfer Service agreement signed Q1. SI Procurement and Supply Chain workstreams deliver savings of $7.5m by Q4.[40]
Make the most of rebuild opportunities.	Use the Built Infrastructure Decision-making Framework to direct capital funding into the maintenance and repair of highest priority facilities and those with a long-term role.	

[40] *Using agreed national methodology.*

Supporting our Transformation

Organisational strengths – expanding our capability and capacity

Organisational strength is what an organisation needs in terms of culture, leadership, people, processes, technology, physical infrastructure and relationships to efficiently deliver the outputs and change required to achieve its goals.

4.1 Our culture

Planning, funding and delivering health services is a highly complex business and in Canterbury is further complicated by the challenges of delivering quality health services to a vulnerable and dislocated population – when our resources and infrastructure are stretched. To meet the needs of our population and fully achieve our vision, we need to be able to do things differently and to do that we need an engaged, motivated workforce - committed to doing the best for their patients and for the health system. We recognise that our health system's culture is an important element in our future success.

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

Our weekly CEO messages and daily staff updates keep staff and health professionals from across the system engaged in developments in Canterbury. Face-2-Face rounds, community meetings and 6-monthly 'HealthFirst' community publications also provide our community with updates as well as a chance to provide feedback and input into the direction.

To respond to the evolving needs of our population and pressures we face, we all need to work together flexibly and responsively. Our approach is to view the Canterbury health system as one system with one health budget. Our decision-making and prioritisation framework recognises that our relationships with the organisations we fund are more than contractual. While some decisions remain the role of the DHB, others are devolved to the health professionals, alliance workstreams and providers delivering the services - ensuring rapid decision-making and clinical leadership.

Creating a shared vision

In 2007 we began our journey to engage the whole Canterbury health system in the 2020 challenge by encouraging people to 'make it better' for the patient or service user. Over 2,000 people participated in our six-week Vision 2020 showcase and took the message with them out to the wider health workforce.

Supporting people to stay well, providing care closer to people's home and accelerating the integration of services was the key focus. This has not only increased our health system's capacity but improved the continuity of care for patients and helps to attract and retain staff by promoting leadership and engagement.

Over the last six years we have invested in leadership and engagement programmes that promote 'lean thinking' approaches to service and system design. 'Xcelr8', 'Improving the Patient Journey' and the 'Canterbury Initiative' were all aimed at empowering health professionals to improve the effectiveness and efficiency of our health system. Having since introduced 'Particip8' and 'Collabor8' to sit alongside 'Xcelr8', all three programmes are now open to anyone in the Canterbury health system, not just DHB employees. In the coming year, we anticipate another 300+ people will participate in these unique engagement programmes.

Viewing clinical leadership as intrinsic to our success, we engage health professionals from across Canterbury in all stages of service design and in the development of alternative models of care and integrated patient pathways between primary and secondary services. This approach has fostered strong cross-system partnerships and alliances that have increased capacity, improved the continuity of care and reduced duplication and delays. Over 600 clinically designed HealthPathways are now in place across the Canterbury health system.

We further engage and encourage our health workforce through our Quality Improvement and Innovation Awards, which recognise excellence in quality improvement. Already we have recognised 162 projects from across both hospital and community services. Many have gone on to experience success in national and international awards programmes.

By investing in a patient-centred culture of participation, innovation, clinical leadership and continuous quality improvement, we have built up considerable momentum and support for transformation. We will continue to engage the Canterbury health workforce and inspire then to 'make it better' for our population.

4.2 Our governance

Our strategic vision is underpinned by a clear decision-making and accountability framework that empowers our governors and leaders to provide direction and monitor performance.

We are fortunate to have Board members who contribute a wide range of expertise to their governance role. Governance capability is supported by a mix of experts, professionals and consumers on the Board's advisory committees. Several of Canterbury's Board and advisory members are also members for the West Coast

DHB, supporting an understanding of transalpine priorities and a more regionalised approach.

Our Board and Chief Executive ensure their strategic and operational decisions are fully informed with support at all levels of the decision-making process, including the following formal governance and advisory mechanisms.

Clinical leadership

Clinical input into decision-making is embedded in the DHB's shared clinical/management model, which is in place across all service divisions. This model is replicated across the whole of Canterbury's health system, with a framework of primary/secondary clinical leadership helping to drive transformation through the Canterbury Clinical Network District Alliance.

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

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

Māori participation in decision-making

The DHB works in partnership with Māori communities throughout Canterbury in a spirit of cooperation that encompasses the principles of the Treaty of Waitangi:

- *Partnership* - Working together with iwi, hapū, 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; and
- *Protection* - Commitment to the goal that Māori enjoy at least the same level of health as non-Māori and the safeguarding of Māori cultural concepts, values and practices.

The DHB has a formal Memorandum of Understanding with Manawhenua Ki Waitaha (representing the seven Ngāi Tahu Rūnanga) and engages informally at many levels with Māori providers and community groups to enhance participation in decision-making.

Te Kāhui o Papaki Ka Tai is our Māori Health Reference Group whose members include primary and community providers, public health and the DHB. The Reference Group provides advice and support to primary care, the DHB and the Canterbury Clinical Network and is focused on harnessing collective activity to improve outcomes for Māori.

Canterbury also has a Māori and Pacific Provider Leadership Forum to improve collective planning and delivery of services and provide advice and insight to support improved decision-making.

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

Consumer and community input

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

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

Clear prioritisation and decision-making principles

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

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

The DHB has an established prioritisation framework and set of prioritisation principles - based on best practice and consistent with our strategic direction.

Prioritisation principles

- *Effectiveness:* Services should produce the outcomes desired: a reduction in pain, greater independence and improved quality of life.
- *Equity:* Services should reduce inequalities in the health and independence of our population.
- *Value for money:* Our population should receive the greatest possible value from public spending.
- *Whānau ora:* Services should have a positive impact on the holistic health and wellbeing of the person and their family/whānau.
- *Acceptability:* Services should be consistent with community values. Consideration will be given to whether there has been service user or community involvement in the development of the service.
- *Ability to implement:* Implementation is carefully considered, including the impact on the whole system, workforce considerations and any risk and change management requirements.

These principles assist us in making the final decisions on whether to develop or implement new services. They are also applied when we review existing investments and support the reallocation of funding, on the basis of evidence, to services that are more effective in improving health outcomes and reducing inequalities.

4.3 Our partnerships and alliances

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

The DHB is committed to sharing resources, information and knowledge to boost capability and capacity across the health sector. We are also committed to working with external agencies and organisations outside the health sector to positively influence the social determinants that affect the health of our population.

Canterbury Clinical Network District Alliance

The Canterbury Clinical Network (CCN) is a collective alliance of healthcare leaders, professionals and providers from across the Canterbury health system. With the explicit inclusion of the DHB as a key partner, the CCN partners work to improve the delivery of health care in Canterbury and realise opportunities to transform and integrate our health system.[41]

The overarching purpose of the CCN is to provide people with access to the right care, in the right place at the right time – that is, quality care closer to people's own homes in a way that allows them to play an active role in managing their health. This includes the establishment of Integrated Family Health Centres and Community Hubs, the development of integrated patient pathways and the strengthening of clinical leadership as a fundamental driver of improved patient care.

Under the CCN, we have established a significant array of local service level alliances (SLAs) and workstreams to improve the quality of care, reduce the time people spend waiting and support the delivery of services closer to home. A number of the key goals for the coming year will be achieved through CCN workstreams and SLAs, and the CNN Work Plan for 2013/14 is reflected in this document and attached as Appendix 8.

Healthy Christchurch

Healthy Christchurch is a DHB-led inter-sectoral collaborative partnership based on the WHO Healthy Cities model. The key idea is that all sectors and groups have a role to play in creating a healthy city, whether their specific focus is recreation, employment, youth, environmental enhancement, transport, housing or any other aspect of city life.

This inter-sectoral initiative fosters collaboration between organisations who have signed the Healthy Christchurch Charter. There are currently over 200 Charter signatories, ranging from government agencies and business networks to voluntary sector groups and residents' associations.

Much of Healthy Christchurch's focus until 2015 will be on the recovery of Christchurch. This will involve support and advice to policy and planning processes, community resilience initiatives, and a sustainable and accessible information portal for recovery practice and strategies - all of which contribute to the overall vision of a healthier Canterbury.[42]

Health in All Policies partnerships

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

The DHB provides leadership for the Canterbury HiAP partnership with the Christchurch City Council, Environment Canterbury (the Regional Council) and the Canterbury Earthquake Recovery Authority (CERA). This partnership uses health impact assessment and relevant methodologies to assess policies and initiatives for their potential impact on health outcomes - bringing in a health focus early in the policy-making cycle.

This partnership is working well, ensuring coherent planning for communities. The DHB is committed to an ongoing partnership role as the Canterbury recovery gathers momentum.

Canterbury - West Coast transalpine partnership

The Canterbury and West Coast DHBs now share senior clinical and management expertise including: a joint Chief Executive, Executive Directors, Clinical Directors and Senior Medical Officers, as well as joint planning and funding, finance, human resources, information support and corporate services teams.

Formalising our collaboration with shared services, joint positions and clinical partnerships has allowed us to actively plan the assistance and services we provide to the West Coast and to build the most appropriate workforce and infrastructure in both locations.

Initial priorities have been to improve the use of video and telemedicine technologies and to develop protocols for the transfer of patients between the two DHBs.

Clinical networks, referral guidelines and videoconferencing now support clinical teams to provide 'transalpine' services for paediatrics and oncology.

A joint Specialist Recruitment Centre provides expert advice and resourcing for both DHBs and supports training and secondment opportunities.

[41] *For further information refer to www.ccnweb.org.nz.*

[42] *For further information: www.healthychristchurch.org.nz.*

The West Coast has also gone 'live' with Health Connect South, bridging the two DHBs with a single, shared clinical record and enabling a much closer clinical partnership. This software enables clinical records to be read by clinicians involved in the delivery of a patient's care regardless of whether that care occurs on the West Coast or in Canterbury.

In the coming year, the focus will be on transalpine medical and surgical services, services for older people and mental health services.[43]

Regional collaboration

The five South Island DHBs have adopted a modified alliance framework to support accelerated regional planning and service delivery. This regional alliance better supports collective decision-making and enables the South Island DHBs to provide clear long-term signals around regional service planning and capital investment.

The DHB Chief Executives form the Alliance Leadership Team and take responsibility for coordination of regional service planning under the Alliance Governance Board (the DHB Chairs). Regional activity is then implemented through service level alliances and workstreams.

Canterbury is well represented across the regional workstreams, and our commitment to regional activity has been reflected throughout this document. The full regional work plan can be found in the South Island Regional Health Services Plan www.sialliance.health.nz.

National collaboration

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

We are committed to implementing a number of national programmes to improve health outcomes, including the Minister of Health's national health targets, the Prime Minister's Youth Mental Health Project, the Child Health Action Plan and the national rollout of the InterRAI assessment tool for which Canterbury is taking a lead in the South Island.

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

4.4 Our people

Our ability to meet future demand for health services relies on having the right people, with the right skills, working in the right place in our health system.

Demand for services is increasing and, like the community we support, our workforce is ageing. All DHBs face growing global shortages in some professional areas, widening gaps in capability as a result of technology changes and generational differences, and increasing diversity in the workforce. On top of this, Canterbury has the added challenges of attracting staff in the aftermath of the earthquakes and supporting our workforce through a period of extraordinary stress and disruption.

We need to make the best use of the health workforce we have available and cultivate a workplace environment that attracts and retains that workforce. This requires the development of integrated service delivery models and new roles that will ultimately have an impact on all health professional groups.

Similar challenges exist at a regional, national and global level. Any workforce transformation will need to be backed by policy change that supports skill shifts across professional groups and the expansion of current scopes of practice in order to enable the New Zealand health system to meet future demand.

In considering our challenges, it is worth noting that traditional sources of workforce supply are changing. Quality education is available in South East Asia, with growing enrolments in tertiary education. As traditional sources of talent shift, we will have to adjust our methods for attracting and developing our workforce.

Embedding our culture and supporting our workforce

As the biggest single employer in the South Island (employing over 9,000 staff), the Canterbury DHB is committed to being a good employer, and we are aware of our legal and ethical obligations in this regard. We continue to promote equity, fairness, a safe and healthy workplace, and a clear set of organisational values, including an integrated code of conduct and a commitment to continuous quality improvement and patient safety. The DHB is also committed to national change management framework.

However, in Canterbury's current context, it is not sufficient just to be a good employer. We are aware that a patient-centred culture of innovation, integration and clinical leadership is critical to attracting and retaining appropriately skilled health professionals. We have spent the past several years transforming the way we work and engaging our workforce in determining the direction of health services in Canterbury.

In 2010 (prior to the earthquakes), the DHB undertook an engagement survey of all our staff which demonstrated positive levels of engagement. International research suggests highly engaged people put forth considerably more effort and are much less likely to leave. Our 2010 results showed 68% of our workforce was 'engaged', with only 4% disengaged.

Unfortunately, the post-earthquake stress that is increasingly evident across our community is also affecting our workforce. As well as dealing with personal insurance issues, land re-zoning, house repairs and family relocation, our staff must cope with workplace repairs and disruption - all while addressing

[43] *For further detail refer to the West Coast Annual Plan, available at www.westcoastdhb.org.nz.*

the increasingly complex health issues experienced by the people in their care. A staff wellbeing survey (undertaken at the end of 2012) indicated that while people want to be here, they are stressed and fatigued. Over 60% of respondents are still dealing with EQC and insurance issues, and 20% identified their disrupted work environment as having a negative impact on their wellbeing.

CANTERBURY DHB WORKFORCE 2012		
Female Headcount	*Male Headcount*	*DHB Total Headcount*
7,459	1,728	9,187
82% part time		14% of NZ total
Average Age	*Largest Ethnic Group*	*Avg. Length of Service*
45.9 years	NZ European 58%	8.68 years
Largest Workforce	*Youngest Workforce*	*Oldest Workforce*
Nursing 4,405	Technical and Scientific	Care and Support
48% of DHB workforce	Avg. Age 43.6 years	Avg. Age 50.9 years

In the coming year, we will continue to foster positive behaviours that support our transformation and improve employee engagement. We will continue to invest in 'Xcelr8', 'Particip8', 'Collabor8', our Quality Improvement and Innovation Awards, Clinical Board 'Walk Rounds', Friday Grand Rounds and Mid-Winter Dialogues. We will also keep building resilience in our workforce through employee wellbeing programmes, workplace support and counselling.

A second staff engagement survey will be undertaken in 2013 to measure engagement levels and determine key areas for improvement. Our goal is to achieve a 1% overall increase in engagement.

Expanding our workforce capacity

From a recruitment perspective, Canterbury is able to attract health professionals to most positions due to our size and reputation. However, there are a few notable exceptions where workforce shortages affect capacity. These include cardiac physiologists, specialist mental health nurses, radiation therapists and rural community nurse specialists. In response, we have strengthened our interactive and targeted recruitment strategies, including branding, profiling, Facebook and a new Canterbury Alumni and Employee Referral Programme to keep people connected to Canterbury.

We also tap into available talent through national and regional initiatives, links with the education sector, support for internships and increased clinical placements in our hospitals.

Canterbury employs over 120 new graduate nurses each year through the national Nursing Entry to Practice (NETP) programme and a further 25 nurses into our specialty stream, New Entry to Specialist Practice (NESP). In the coming year, we will identify opportunities to extend NETP beyond primary and secondary settings into aged residential care. We will also support the new role of Allied Health Educator (implemented through NESP) to support and engage social work and occupational therapy students.

Six years ago, a collaborative partnership between CDHB and the Christchurch Polytechnic Institute of Technology (CPIT) developed an alternative model for clinical placement for students undertaking the Bachelor of Nursing Programme. This Dedicated Education Unit (DEU) approach is based on the original model developed at Flinders University, South Australia. We began with five DEUs, and we now have 26 in clinical practice areas across the DHB. This has enabled CPIT to increase their intake of Bachelor of Nursing students by approximately 30%. Our positive relationship with CPIT allows us to jointly plan these increases and increase employment across the Canterbury and West Coast health systems as the number of graduates grows.

We support the development of an appropriately skilled Māori health workforce by taking the South Island lead for Kia Ora Hauora, a national initiative aimed at increasing the number of Māori working in health fields. By March 2013, 496 Māori had already registered in the South Island for support in studying towards health careers. In Canterbury, we also support local scholarships to encourage Māori and Pacific students into health careers. A further ten scholarships will be awarded in the 2013/14.

We are also supporting the development of our rural clinical workforce both in Canterbury and on the West Coast, with recent investment in Rural Learning Centres in Ashburton and Greymouth. The aim is to encourage people to work in rural locations by reducing isolation factors through collaboration, peer support and mentoring.

We continue to expand capacity by better connecting our health system through telemedicine, outreach clinics, electronic patient information sharing and electronic referral systems. Videoconferencing and telemedicine smooth the transfer of patients between services and support the provision of specialist services, advice and supervision without a significant increase in workforce numbers. Alongside transalpine specialist appointments, this technology is helping to increase workforce capacity across Canterbury and West Coast.

For example, through Rural Focused Urban Specialist (RuFUS) roles, designated clinicians in urban areas provide clinical leadership to rural centres. This supports direct patient care, sharing of available resources and skills, professional development and coordination of service provision for rural patients. Supported by the use of technology, Canterbury Clinical Nurse Specialists in paediatrics and gynae-oncology are supporting generalist nurses on the West Coast to care for patients, while Respiratory Clinical Nurse Specialists on the West Coast provide case management with support from Christchurch medical specialists.

Over the next year in conjunction with our primary care partners, we will build an integrated approach to workforce planning that will be informed by the transformation occurring across our health system and, in partnership with CERA, the changes happening across Canterbury. This will include improved reporting, analysis and predictive modelling to help understand our current and future needs.

Enhancing our workforce capability

Developing our existing staff is a key strategy for enhancing the capability of the Canterbury health system. We have strengthened our core development training calendar, which can be accessed by health professionals working anywhere in the Canterbury (and West Coast) health system. We have embedded formal performance appraisals into operational management, along with support for career plans. In 2013/14, succession planning initiatives such as talent identification will be introduced to increase talent mobility and reduce talent gaps across the organisation. Moodle technology learning/management systems and training portals will be established, and 70% of DHB employees will be using the online performance system by the end of the year.

Training and education programmes continue to support health professionals to work to the greatest extent of their scope. The Professional Development Recognition Programme (PDRP) and the Regional Allied Health Assistant Training Programme are helping to expand the scope of existing roles and establish new ones. Clinical pharmacists now join wards rounds, community pharmacists are working more collaboratively with general practice teams, and physiotherapists are completing specialised assessments. New advanced gerontology nurse specialist and haematology roles also reflect a more connected and capable workforce. In the coming year, a credentialing process will be developed using the PDRP framework for expanded nursing practice. We will support at least 10 people to complete Level 3 NZQA allied health assistant qualifications, and 13 nurses to complete their practicum or thesis for the Nursing Practitioner Training Programme.

Investment in primary care education enables GPs, practice nurses and pharmacists to attend peer-led, evidence-based education sessions. Aligned to the transformational across Canterbury, these sessions promote the use of clinical best practice and integrated pathways and increase the capability of our system.

The South Island Tertiary Alliance has developed its first leadership and management development curriculum for all health employees in the South Island.[44] Actively supported by Health Workforce New Zealand (HWNZ), this will support career enhancement and maximise people's potential.

We have also stepped up our participation in the HWNZ-sponsored Regional Training Hubs to support critical role identification and expand workforce capability through sharing of training resources and areas of good practice. The South Island Regional Training Hub takes the lead for the region in directing postgraduate clinical training, placements and education; career planning for HWNZ-funded trainees; new role development; and administration of activities such as bonding schemes. Canterbury is particularly interested in the hub's nursing workstream, which is looking at initiatives to address the ageing nursing workforce. We will support the 2013/14 work plan for the Regional Training Hub, which can be found in the South Island Health Services Plan at www.sialliance.health.nz.

4.5 Quality and patient safety

Our patient-focused, clinically led culture supports two of our health system's greatest strengths: our commitments to 'zero harm' and continuous quality improvement.

We are committed to progressing the Health Quality & Safety Commission's (HQSC) national priority areas: reducing harm from falls, hospital-acquired infections, surgery and medication, as well as reporting against the HQSC's quality and safety markers.

In November 2012, we also published our first set of Quality Accounts. The Quality Accounts articulate how our patient-focused culture supports our commitment to zero harm and continuous quality improvement. The Accounts contain a snapshot of key activity and goals across the Canterbury health system, with particular emphasis on priority areas for the Clinical Board.

In the coming year, in line with our Quality Strategic Plan, Quality Accounts and the national direction, our Clinical Board will champion quality and safety projects focused around the following areas.

Patient experience

We recognise that consumers have a unique perspective of health services and are able to provide important information about the experience of care they receive. By working in partnership with our consumers and their whānau to improve their experiences, we will be able to improve health, clinical, financial and service outcomes. Working closely with our Consumer Council, facilitating consumer focus groups, gathering consumer stories and identifying effective methods for gathering feedback help us improve the experience for our consumers.

[44] *The South Island Tertiary Alliance partners are CDHB, Canterbury and Otago Universities, the TANZ Polytechnic Network via CPIT. The Alliance is also supported by HWNZ.*

Medication safety

Over the coming year, we will continue to focus on reducing the harm that can occur from medication. We acknowledge that the use of medications always carries the risk of a side effect, allergy or other adverse outcome and are committed to participating in the national medication initiatives being driven through the HQSC. In addition to the HQSC focus areas of medicine reconciliation and electronic medicines management, the information we obtain through our Adverse Drug Event Trigger Tool initiative will help us move towards our goal of zero harm. This initiative provides valuable information about the severity and type of medication events occurring and helps us identify where we need to focus our safety improvement initiatives.

Preventing healthcare-associated infections

Healthcare-associated infection is one of the most common adverse events in health care. Our work to reduce the number of healthcare-associated infections is focused around the three national HQSC Infection Prevention and Control Programmes: hand hygiene, central-line-associated bacteraemia and surgical site infection surveillance.

Hand hygiene is an important measure in the fight against healthcare-acquired infections. The 'five moments' of hand hygiene are the key opportunities for healthcare staff to dramatically reduce the risk of spreading infection. For the July-October 2012 period, our overall compliance rate was 59.5%. Work over the coming year will focus on improving compliance with the 'five moments' across all staff groups.

Another key focus for infection prevention is central-line-associated bacteraemia (CLAB). The use of a central line introduces a potential track for infection, so prevention is a major quality target for critical care. Reducing the number of CLAB infections will lead to safer patients, shorter stays in Intensive Care Units and reduced costs. By the end of June 2012, the Christchurch Hospital Intensive Care Unit had achieved 218 CLAB-free days, and we will be working hard to maintain this over the coming year.

Surgical site infections are the second most common healthcare-associated infection. The HQSC recently launched a programme aimed at reducing the rate of surgical site infections. We are working with Auckland DHB and the HQSC on the national Surgical Site Infection Surveillance Programme, with the development phase set to begin in March 2013.

Preventing harm from falls

We are committed to achieving our goal of zero harm from falls and are focusing on the three key areas: falls prevention in the community, in rest homes and in our hospitals. Reducing the harm from falls is a key component in our strategy for improving the health of older people in Canterbury and reducing acute demand.

We will continue to invest in our community falls champion model that focuses on enhancing primary care team involvement in preventing falls for the frail elderly. This will specifically target older people at risk of admission to hospital.

We will promote the use of vitamin D in aged residential care as another means of falls prevention. We are working collaboratively with rest homes and primary care providers to ensure 75% of residents are receiving Vitamin D supplementation by the end of June 2014.

In our hospital setting, we will continue to pay close attention to the evidence-based essentials of falls prevention and to the specific falls risk for each elderly patient in our care. During 2011/12, there were 947 falls in our hospitals that resulted in harm. Over the next year, we will continue to adopt strategies to further reduce the harm from falls amongst patients in our care.

Surgical safety

We are also committed to ensuring that the Safe Surgery Checklist is used in all of our operating theatres. The use of this checklist will help us to ensure that the right operation is being performed, on the right patient, at the correct site or side of the patient. This checklist also assists with improving outcomes through promoting better communication and teamwork in the operating room. Through regular audits, we will be able to assess the impact of this tool in reaching our goal of zero harm.

Greater collaboration

Increased collaboration between DHBs and across the wider health sector will also help us to identify opportunities to improve quality and patient safety. Canterbury will participate in the HQSC's CLAB Programme. This will enable DHBs to learn from each other in a collaborative environment, share experiences and trial improvements that identify best practices.

Our ongoing leadership role in the Adverse Drug Event Collaborative in partnership with Counties Manukau and Capital and Coast DHBs will help us identify opportunities to improve medication safety.

Canterbury is also participating in some of the Australasian Health Round Table initiatives: Long Stay Patients, Global Trigger Tool Methodology and Standardised Hospital Mortality Ratio. These projects will further improve the quality of the care we provide.

4.6 Research and development

Clinical research

A significant body of clinical research is conducted within the Canterbury DHB, with over 400 current projects listed on our Research Register.

The Canterbury DHB Research Committee, a standing committee reporting to our Clinical Board, provides governance and advice on matters related to clinical research activities within the Canterbury DHB and develops research policy.

The Research Office is a shared facility funded by the University of Otago - Christchurch and the Canterbury

DHB. It provides open access service for anyone involved in health research working within these organisations. While directing research remains the role of the principal investigator, the Research Office offers complementary functions, such as: providing advice on all aspects of the conduct of research in Canterbury; supporting staff who do not work within a research-based environment to conduct research activity; ensuring that clinical groups are adhering to the Clinical Research Policy; and maintaining the Research Register. A major focus of the Research Office is the dissemination of research grant funding information and the provision of advice and assistance to applicants.

Innovation

Canterbury is also one of the four founding DHBs of the national Health Innovation Hub - launched in late 2012. The focus of the Health Innovation Hub is to facilitate the flow of ideas with both commercial potential and a positive impact on health care between DHBs and the health innovation industry.

In tandem with this national system, Canterbury has a strong health innovation environment. The Via Innovations brand, launched in late 2012, has strengths in health IT and health service delivery improvement, and represents the CDHB's contribution to innovation.

Both the national Health Innovation Hub and Via Innovations are supported by the Canterbury Development Corporation, universities and other tertiary providers. Through these regional and national networks, clinicians now have improved opportunities to access innovation support, with the aim of accelerating the rate of innovations focused on improved patient outcomes and health system improvements.

4.7 Information systems

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

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

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

Our integrated information solutions involve working closely with clinicians and stakeholders across Canterbury to ensure that the right clinical information is available to the right people, at the right time and in the right place. We will progress the following major Information Services initiatives in 2013/14.

HealthPathways and HealthInfo

The HealthPathways website provides assessment, management, and referral information developed by health professionals, for health professionals. There are over 600 clinical pathways and GP resource pages available on HealthPathways. HealthInfo is a recently developed 'sister site' to HealthPathways, providing locally approved health information for consumers. During 2013/14, we will focus on reviewing and updating the existing pathways, supporting the adoption of HealthPathways across the rest of the South Island and expanding the content and visibility of HealthInfo.

Health Connect South (HCS)

HCS is a portal that brings all a patient's clinical information into one view, greatly improving clinical decision-making and providing timely information at the point of care. HCS includes e-Discharges, which allow documentation to be sent electronically to GPs, significantly assisting a whole-of-system approach to patient care. Canterbury is taking the lead in the rollout of HCS across the South Island, and a single HCS record now exists across Canterbury, West Coast and South Canterbury DHBs. HCS will be extended to Nelson Marlborough and Southern DHBs during 2013.

Our Electronic Request Management System (ERMS)

The next step in the rollout of HCS is supporting e-Referrals. Previously, all GP referrals were sent by fax to our hospitals and to private providers. ERMS automates this process so that GPs can refer patients using their desktop practice management systems. Almost 75% of Canterbury's GPs now use ERMS, which carries over 9,000 referrals every month. We will assist the West Coast to adopt ERMS in the coming year, and we will lead and support the rollout of ERMS across the whole of the South Island over the next two years.

Our Electronic Shared Care Record View (eSCRV)

The eSCRV is a secure system for sharing core health information (such as allergies, dispensed medications, clinical correspondence and test results) between all health professionals involved in a person's care. eSCRV enables faster, more informed treatment, shorter waiting times and better outcomes for patients. eSCRV is in place across most general practices and community pharmacies. In the coming year, the system will be enhanced by incorporating information live from general practice management systems.

Our Collaborative Care Management System (CCMS)

CCMS integrates clinical information and shared planning to support primary and community providers to better manage individuals with complex needs and long-term conditions. CCMS is being implemented in the first instance to support Canterbury's CREST programme and to introduce systemised planning and collaborative care for people with complex long-term conditions. We aim to enable the creation of acute care plans in the CCMS and make these available across afterhours providers in Christchurch by Q4.

A single patient administration system

Canterbury currently supports three different patient administration systems across our hospital services. In line with the South Island's regional direction, we are preparing to move to a single, South Island-wide patient administration system. This is a significant undertaking and will take several years to complete. Implementation will focus on best practice processes and will enhance data quality locally, regionally and for national collection. A regional business case will be delivered by Quarter 2, and Canterbury will prepare to implement a single regional patient administration system in 2014.

4.8 Repair and redesign of facilities

In the same way that information systems underpin our transformation, health facilities can support or hamper the delivery and quality of the care we provide.

Our facilities suffered extensive damage in the earthquakes. Only the dedication of our maintenance and engineering team has kept our major sites going. Almost all of our 200 buildings need repairs, some have had to be closed and demolished, and many of our staff and services are working in inadequate and temporary locations.

In 2013, Canterbury has received approval from the national Capital Investment Committee for the redevelopment of the Burwood and Christchurch Hospital sites. This will be the largest health-related building project in New Zealand's history and will allow us to begin rebuilding part of the health capacity required in Canterbury. However, it is important to realise that this does not address all of our facilities issues.

Our health system will continue to have significant capacity challenges for a number of years. The Burwood Hospital redevelopment will not be completed until 2015, and Christchurch Hospital will not be completed until 2018. In the meantime, we have to continue to maintain service delivery and operate safely with fewer hospital beds and severely damaged infrastructure.

Outside of the redevelopment of Burwood and Christchurch Hospitals, we have over 9,000 rooms in need of repair, and a number of theatres and wards have been closed. These need to be fixed and replaced, causing continued disruption as we shift and relocate services to repair the damage. This invasive structural repair programme will put additional pressure on our workforce, 20% of whom are already identifying their disrupted work environment as having a negative impact on their wellbeing. Moving services around will further restrict our capacity, increase inter-hospital patient transfers and, despite our best efforts, fragment clinical teams and services.

This is not just a DHB issue. Community organisations continue to work from temporary and makeshift facilities as they undertake repairs and rebuilds, disrupting service provision, stretching capacity and increasing costs. There are also challenges in maintaining viable health services (such as general practice and pharmacies) where the population has dropped near the 'red zone', while demand now exceeds capacity in other areas.

The timing of the rebuild projects is critical. As we begin repairs, we must make careful decisions about short-term capital investments in the context of the longer-term direction, or health dollars will be wasted. This risk is heightened by changes in building codes, which increase the extent and cost of repairs - not all of which is covered by insurance.

In order to avoid costly and wasteful investment, close alignment of redevelopment and repair programmes is essential, and the DHB is working closely with the nationally appointed Hospital Redevelopment Partnership Board to ensure that the most is made of every opportunity.

The DHB is also working closely with primary and community health and social services providers as they look to repair and redevelop their own facilities. We will support the development of Community Hubs and Integrated Family Health Centres (IFHCs) in key locations across Canterbury to further align community health facilities with the future model of care.

The DHB will also carefully consider the future of all of its rural hospitals, many of them significantly damaged by the earthquakes. A Rural Strategy (to be completing in the coming year) will consider the role of facilities, alongside strategies for the future sustainability of health services in rural communities.

Facilities redevelopments being undertaken or considered over the coming year will include:

- Stage one of the Burwood Hospital and Christchurch Hospital redevelopment.
- The rebuild of damaged buildings at Ashburton Hospital, including theatre and ward blocks.
- The development of an IFHC in Kaikoura to be located on the current Kaikoura Hospital site.
- The development of a Community Hub in Rangiora to be located on the current Rangiora Hospital site.
- The development of an IFHC in Akaroa, as earthquake damage has closed the Akaroa Hospital.
- The development of the former Women's Hospital site on Colombo Street. In conjunction with a number of partner organisations, the site is being considered for a Community Hub with extended services, including 24/7 acute primary care.
- The development of the Health Precinct as a major anchor project under the Christchurch City Rebuild. The DHB is working with Christchurch Central Development Unit on this project, and all of our outpatient, teaching and parking facilities are being considered in this master plan.
- A number of private urban IFHCs and rural private IFHC developments are also expected to get underway in the coming year.

4.9 Subsidiary companies

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

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

Canterbury Linen Services Limited (formerly Canterbury Laundry Services Ltd) was incorporated as a company in 1993. The Canterbury DHB owns all shares, as well as the land and buildings used by the laundry service. Plant and equipment, motor vehicles and the rental linen pool are the major fixed assets of the company, which pays a rental to the DHB for the use of the land and buildings. The company provides laundry services to DHB hospitals and a range of external clients.

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

Legal transfer of the employees has taken place, and transfer of the assets is being progressed. The company will be retained as a shell, pending dissolution. SIAPO is funded jointly by the South Island DHBs to provide services such as audit, service development and project management with an annual budget of just over $4m.

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

4.10 Accountability to the Minister

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

The DHB may also wish to enter into cooperative agreements and arrangements to: assist in meeting its objectives; enhance health or disability outcomes for our population; or enhance efficiencies in the health sector. In doing so (in accordance with Section 24(1) of the NZPHD Act 2000), we will ensure that the arrangements we enter into do not jeopardise our ability to deliver the services required under our statutory obligations in respect of accountability and funding agreements.

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

Monitoring our performance

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

In addition, we will comply with reporting requirements and obligations in the Crown Entities Act and Operational Policy Framework and with specific expectations that the Minister communicates to us.

The national Health Board monitors DHB performance on behalf of the Minister of Health. Financial and non-financial performance frameworks are in place as part of wider accountability arrangements, providing assurance to the Minister about DHB performance in terms of legislative requirements and government priorities. This includes ad-hoc information reports, service agreement reporting and regular formal reporting.

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

As a provider of services, we monitor and publicly report against annual performance expectations alongside an agreed set of productivity and quality indicators. We also participate in quality benchmark reporting to compare our performance with other providers, both through the national Health Quality and Safety Commission and the Australian Health Roundtable.

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

4.11 Service configuration

Delivering a flexible and responsive health system

As we move ahead with the transformation of our health system and respond to the after-effects of the

Canterbury earthquakes, it is critical that we are able to reorient and rebalance the limited resources we have available to enable us to do more for our population

Flexibility in our approach enabled us to continue to deliver core health services despite significant disruption and constraint in the wake of the earthquakes. Two and a half years on, Canterbury's recovery is underway, but our population remains stressed and vulnerable, and our health system's capacity is still reduced.

Unfortunately, sometimes traditional policy and service change processes can delay decision-making and take it out of the hands of health professionals and service providers. To enable our recovery, we need to be flexible in the way we fund, contract and deliver health services in order to act responsively and decisively to support the changing needs of our population. We will work with the Ministry where we need to make innovative changes in areas such as pharmacy, laboratories, primary care and aged care services to order to meet the needs of our population and manage capacity constraints.

Service coverage

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

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

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

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

Service change

In line with Canterbury's shared decision-making approach, decisions regarding how a service should be delivered are made collectively and wherever possible in partnership with the people delivering the service. Therefore, while we anticipate that new models of care and delivery will continue to emerge as we respond to the changing needs of our population, we cannot pre-empt the extent or detail of any service change.

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

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

Service shifts or reconfiguration to support the repair of infrastructure or the provision of services with reduced capacity - in line with our Transitional Recovery Plan.

The redesign of service models to improve patient safety, clinical quality and productivity - in line with Vision 2020 and our Quality Strategic Plan.

The redesign of service models to build capacity to responsively meet both immediate needs and future demand and to improve health outcomes - in line with Vision 2020 and the CCN work plan.

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

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

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

Service risks and opportunities

Our greatest service risk going into the next 12 months is simply dealing with the unknown. We are already seeing increased vulnerability and health need in our population, consistent with international research on disaster recovery, while the influx of workers for the rebuild adds a further degree of uncertainty as to the level and type of future demand.

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

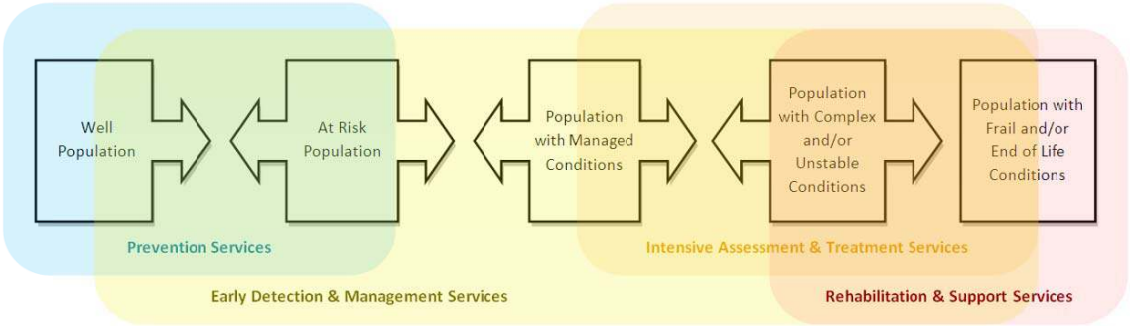
Forecast of Service Performance

Measuring our performance

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

FIGURE 5: SCOPE OF DHB OPERATIONS – OUTPUT CLASSES AGAINST THE CONTINUUM OF CARE

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



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

One of the functions of this document is to demonstrate how we will evaluate the effectiveness of the decisions we make. Over the longer term, we do this by measuring our performance against a set of desired outcomes (outlined in the strategic direction section of this document on page 12).

In the more immediate term, we evaluate our performance by providing a forecast of our planned outputs (what services we will fund and provide in the coming year). We then report actual performance against this forecast in our end-of-year Annual Report.[45]

Choosing measures of performance

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

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

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

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

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

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

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

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

Setting standards

Wherever possible, we have included the past year's baseline data to support evaluation of our performance at the end of the year, and the most recently published national result to give context in terms of what we are trying to achieve. However, measures that relate to new services have no baseline data, and a number of the output measures relate to Canterbury-specific services for which there is no national comparison available.

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

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

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

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

Additional notes

Some data is provided for calendar rather than financial years; other data is provided to the DHB by external parties and can be affected by a lag in invoicing. Rather than footnote every instance, symbols are used to indicate where this is the case:

† indicates data provided by calendar year (2011 result).

Δ indicates data that could be affected by a lag in invoicing and is subject to change; data for such measures in this document was run on or before 22 April 2013.

Where does the money go?

The table below presents a summary of the 2013/14 budgeted financial expectations by output class.

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

REVENUE	TOTAL $'000
Prevention	27,005
Early detection and management	313,701
Intensive assessment & treatment	928,364
Support & rehabilitation	223,634
Grand Total	**1,492,703**

EXPENDITURE	TOTAL $'000
Prevention	27,337
Early detection and management	317,011
Intensive assessment & treatment	947,541
Support & rehabilitation	225,815
Grand Total	**1,517,704**
Surplus/(Deficit)	**(25,001)**

OUTPUT CLASS

6.1 Prevention services

Output class description

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

These services are the domain of many organisations across the region including: the Ministry of Health; Community and Public Health (the DHB's public health unit); primary care; a significant array of private and non-government organisations; and local and regional government. Services are provided with a mix of public and private funding.

Why is this output class significant for the DHB?

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

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

OUTPUTS SHORT-TERM PERFORMANCE MEASURES (2013/14)

Health Promotion and Education Services *These services inform people about risks and support them to be healthy. Success begins with awareness and engagement, reinforced by programmes and legislation that support people to maintain wellness and make healthier choices.*	Notes	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
Volunteer mothers trained in Mum-4-Mum peer support	V [46]	44	50	-
Lactation support and specialist advice consults provided in community settings	V	650	≥580	-
% of mothers establishing breastfeeding on hospital discharge	Q [47]	77%	≥75%	-
% of smokers identified in hospital receiving advice and help to quit	C	83%	95%	-
% of smokers identified in primary care receiving advice and help to quit	C	25%	90%	34%
Enrolments in the Aukati Kaipaipa smoking cessation programme	V	207	≥200	-
% of tobacco retailers compliant with current legislation	Q [48]	97%	≥90%	-
% of priority schools supported by the Health Promoting Schools framework	C [49]	78%	≥70%	-
People accessing Green Prescriptions for additional physical activity support	V [50]	1,941	≥2,000	-
'Appetite for Life' courses provided in the community	V [51]	68	>50	-

[46] *Mum-4-Mum training supports social change by allowing the DHB to significantly increase its capacity to deliver key messages through informal contact facilitated by appropriately trained volunteer mothers.*

[47] *The percentage of women breastfeeding is seen as a measure of service quality, demonstrating the effectiveness of consistent, collective health promotion messages delivered during the antenatal, birthing and early postnatal period. This measure definition differs from the one previously published as this measure has been aligned to the Maternity Quality and Safety Programme (and World Health Organisation target) being babies 'exclusively' breastfed on discharge from hospital.*

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

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

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

Population Based Screening Services *These services are mostly funded and provided through the National Screening Unit and help to identify people at risk of illness and pick up conditions earlier. They include breast and cervical cancer screening and antenatal HIV screening. The DHB's role is to encourage uptake, as indicated by high coverage rates.*	Notes	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
% of four-year-olds provided with a B4 School Check (B4SC)	C [52]	76%	90%	79%
% of referred children receiving a Gateway Assessment	C	new	100%	-
% of Year 9 students in deciles 1-3 schools, alternative education facilities and teen parent units provided with a HEADSSS assessment	C [53] †	n/a	100%	-
% of women aged 25-69 having a cervical cancer screen in the last 3 years	C [54]	75%	80%	77%
% of women aged 45-69 having a breast cancer screen in the last 2 years	C [54]	82%	≥70%	71%

Immunisation Services *These services reduce the transmission and impact of vaccine-preventable diseases. The DHB works with primary care and allied health professionals to improve the provision of immunisations both routinely and in response to specific risk. A high coverage rate is indicative of a well-coordinated, successful service.*	Notes	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
% of children fully immunised at eight months of age	C	new	90%	-
% of eight-month-olds 'reached' by immunisation services	Q [55]	new	90%	-
% of Year 8 girls completing HPV vaccinations (i.e. receiving Dose 3)	C [56] †	21%	60%	47%
% of young people (<18) receiving a free influenza ('flu') vaccination	C †	21%	40%	-
% of older people (65+) receive a free influenza ('flu') vaccination	C †	71%	75%	65%
% of the older population (65+), deemed high-needs, receiving a flu vaccination	Q †	69%	75%	64%

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

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

[53] *A HEADSSS assessment covers Home environment, Education/employment; eating and exercise, Activities and peer relationships; Drugs, cigarettes and alcohol; Sexuality; Suicide, depression, mood screen; Safety; and Spirituality. While 173 HEADSSS assessments were delivered in 2011, it is difficult to determine what denominator to use for that year, as school rolls were significantly affected by the February 2011 earthquake. Therefore, no 2011 'actual' is included above.*

[54] *These national screening programmes screen women for signs of breast and cervical cancer to enable early treatment to reduce the rate of associated mortality. Standards are based on national targets.*

[55] *'Reached' is defined as those children fully immunised, as well as those who have declined immunisations or have opted off the NIR. This reflects the quality of immunisation services in 'reaching' the parents of eligible children and providing advice and support to enable parents to make informed choices for their children.*

[56] *The baseline is the percentage of girls born in 1998 receiving Dose 3 by the end of 2011, and the target is for 2013 for girls born in 2000.*

OUTPUT CLASS

6.2 Early detection and management services

Output class description

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

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

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

Why is this output class significant for the DHB?

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

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

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

OUTPUTS SHORT-TERM PERFORMANCE MEASURES (2013/14)

Primary Health Care (GP) Services *These services are offered in local community settings by teams of general practitioners (GPs), registered nurses, nurse practitioners and other primary healthcare professionals, aimed at improving, maintaining or restoring people's health. High levels of enrolment with general practice are indicative of engagement, accessibility and responsiveness of primary care services.*	Notes	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
% of the DHB population enrolled with a Primary Health Organisation	C [57]	96%	≥95%	96%
Maintain current HealthPathways across primary/secondary care	V [58]	519	≥600	-
People provided Brief Intervention Counselling (BIC) in primary care settings	V [59] Δ	5,750	≥4,000	-
Avoidable hospitalisation for children aged 0-4 rate per 100,000	Q [60]	5,021	<6,656	4,628

[57] *The national target for PHO enrolments is 95%, and the aim is to continue to achieve above this level.*

[58] *These clinically designed pathways inform new patient-centred models of care. The HealthPathways website helps general practice navigate the pathways, with information on referrals, specialist advice, diagnostic tools, GP procedure subsidies and patient handouts. The measure includes clinical, resource and referral pathways. With more than 500 HealthPathways established, the focus has shifted to refinement and review of the existing pathways.*

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

[60] *Some admissions to hospital are seen as preventable through appropriate early intervention. These admissions provide an indication of the access and effectiveness of primary care and an improved interface between primary and secondary services. The measure is based on the national DHB performance indicator SI1, which has been redefined as the standardised rate per 100,000.*

Oral Health Services *These services are provided by registered oral health professionals to help people maintain healthy teeth and gums. High enrolment indicates engagement, while timely examination and treatment indicates a well-functioning, efficient service.*	Notes	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
% of children aged under 5 enrolled in DHB-funded oral health services	C †[61]	54%	68%	63%
% of enrolled children (0-12) examined according to planned recall	T †	87%	90%	
% of adolescents (13-17) accessing DHB-funded oral health services	C †	65%	85%	72%

Long-term Conditions Programmes *These services are targeted at people with high health need due to long-term conditions and aim to reduce deterioration, crises and complications. Success is demonstrated through identification of need, regular monitoring and outcomes that demonstrate good conditions management. A focus on early intervention strategies and additional services available in the community will help to reduce the negative impact of long-term conditions and the need for hospital admission.*	Notes	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
% of the eligible population having had a CVD Risk Assessment in the last 5 years	C [62]	20%	90%	49%
People receiving individual self-management support from their general practice team when newly diagnosed with Type 2 diabetes or starting insulin	V Δ	642	≥640	-
Skin lesions (skin growths, including cancer) removed in primary care	V Δ	2,320	≥2,000	-
Spirometry tests are provided in community rather than hospital settings	V [63] Δ	1,179	≥1,000	-

Pharmacy Services *These services include dispensing of medicines and are demand-driven. As long-term conditions become more prevalent, demand for pharmaceuticals will likely increase. The medication management service for those on multiple medications aims to improve service quality and reduce potential negative interactive effects.*	Notes	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
Pharmaceutical items dispensed in the community	V Δ	8.4M	est. <9M	-
People on multiple medications receive initial reviews via the Medication Management Service	V	632	2,000	-

Referred Services *These are services to which a health professional may refer a person to help diagnose a health condition, or as part of treatment. They are provided by personnel such as laboratory technicians, medical radiation technologists and nurses. To improve performance, we will target improved primary care access to diagnostics to aid decision-making and improve clinical referral processes.*	Notes	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
Laboratory tests completed for the Canterbury population	V Δ	2.6M	est. <2.6M	-
GP referred Community Referred Radiology tests completed	V Δ	39,763	est. 30,000	-
% of people receiving their Computed Tomography (CT) scan within 6 weeks	T	new	85%	-
% of people receiving their Magnetic Resonance Imaging (MRI) within 6 weeks	T	new	75%	-

[61] The Ministry's official 2011 oral health enrolment result (54%) uses pre-quake population estimates, which predict an increase in the 0-4 population, when in fact this population has been the most quake-affected. The best post-quake estimate comes from post-quake PHO enrolment, which shows a 4.4% drop in this age group. This would mean an oral health enrolment figure of 59%.

[62] This refers to CVD risk assessments undertaken in primary care in line with the expectations of the PHO Performance Programme and the 'More heart and diabetes checks' health target. Canterbury's largest PHO has been participating in the CVD risk assessment programme for just 2 years, while most have been participating for over 5 years. Consequently, Canterbury starts from a lower base.

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

OUTPUT CLASS

6.3 Intensive assessment and treatment services

Output class description

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

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

Why is this output class significant for the DHB?

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

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

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

OUTPUTS SHORT-TERM PERFORMANCE MEASURES (2013/14)

Specialist Mental Health Services *These are services for those most severely affected by mental illness or addictions. They include assessment, diagnosis, treatment, rehabilitation and crisis response when needed. Utilisation and wait times are monitored to ensure service levels are maintained and to demonstrate responsiveness to need.*	Notes	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
% of young people (0-19) accessing specialist mental health services	C [64] Δ	2.8%	3%	2.9%
% of adults (20-64) accessing to specialist mental health services	C [64] Δ	3.6%	3%	3.5%
% of people referred for non-urgent MH and AOD services seen within 3 weeks	T [65]	69%	75%	73%
% of people referred for non-urgent MH and AOD services seen within 8 weeks	T [65]	85%	90%	89%
% of long-term clients aged 0-19 with current relapse prevention plans	Q [66]	90%	≥95%	87%
% of long-term clients aged 20-64 with current relapse prevention plans	Q [66]	99%	≥95%	94%

[64] *The national expectation is that around 3% of the total population will need to access specialist mental health service. This measure includes specialised services provided by the DHB and NGOs (who submit NHI level reporting). 2011/12 results differ from those previously published as the result of the correction of a calculation error.*

[65] *This measure is national DHB reporting measure PP8, subject to MoH availability. Results are for the year to March 2012.*

[66] *Relapse prevention/resiliency planning helps to minimise the impact of mental illness, improving outcomes for clients. Clients with enduring serious mental illness are expected to have an up-to-date plan identifying early warning signs and what actions to take. This measure is based on the national DHB reporting measure PP7.*

Acute/Urgent Services *These are medical or surgical services for illnesses that have an abrupt onset or progress rapidly. While the need for care is urgent, it does not always require a hospital admission. There are a number of acute and urgent community-based approaches, unique to Canterbury, that have been established to reduce acute demand on hospital services in light of lost capacity post-quake. For more complex acute conditions, hospital-based services include emergency services, short-stay acute assessment, acute medical and surgical services and intensive care services.*	Notes	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
% of children under six with access to free primary care after hours	C	new	100%	-
% of general practices using telephone triage outside business hours	C	83%	95%	-
Acute demand packages of care provided in community settings	V [67]	19,645	22,000	-
Attendances at emergency departments (ED)	V [68]	84,444	≤91,775	-
% of people ready for treatment waiting less than 4 weeks for radiotherapy or chemotherapy	T	100%	100%	-
Standardised acute inpatient average length of hospital stay	Q [69]	new	≤4.28	-

Elective/Arranged Services *These are services for people who do not need immediate hospital treatment and are 'booked' or 'arranged' services. They include elective surgery, but also non-surgical interventions (such as coronary angioplasty) and specialist assessments (either first assessments, follow-ups or preadmission assessments).*	Notes	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
Medical and surgical First Specialist Assessments (FSAs) provided	V	60,533	est. >60,000	-
% of medical and surgical FSAs that are non-contact (virtual)	Q [70]	10.75%	>10%	-
Outpatient attendances	V	611,205	est. >600,000	-
Outpatient 'Did not Attend' rates	Q	4.9%	≤5%	-
Elective surgical discharges (surgeries provided)	V [71]	16,494	16,861	-
% of elective/arranged surgeries provided as day cases.	Q [72]	56%	≥54%	55%
% of people who receive their surgery on the day of admission	Q [72]	82%	≥79%	79%
Standardised elective surgical inpatient average length of hospital stay	Q [69]	new	≤3.21	-

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

[68] *This measure is based on the national ED Health Target definition. As such, it counts Christchurch and Ashburton EDs.*

[69] *This measure is based on the OS3 national DHB performance measure. Average length of stay is balanced against readmissions rates to ensure service quality is appropriate.*

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

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

[72] *When elective surgery is delivered as a day case or on the day of admission, it makes surgery less disruptive for patients, who can spend the night before in their own homes, and frees up hospital beds. Day case and day of surgery admission rates are balanced against readmissions rates to ensure service quality is appropriate. With the removal of the national DHB performance measures OS6 and OS7, these measures are now calculated locally using National Minimum Data Set figures and may differ slightly from the previous numbers provided by the Ministry of Health.*

Maternity Services *These services are provided to women and their families through pre-conception, pregnancy, childbirth and the early months of a baby's life. Services are provided in home, community and hospital settings by a range of health professionals, including lead maternity carers, GPs and obstetricians. Services include: specialist obstetric, lactation, anaesthetic, paediatric and radiology services. We will monitor volumes in this area to determine access and responsiveness of services.*	Notes	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
Maternity deliveries in Canterbury DHB facilities	V	5,736	est. 6,000	-
Baby friendly hospital accreditation of Canterbury DHB facilities	Q [73]	yes	yes	-
% of total deliveries made in Primary Birthing Units	V [74]	11%	13%	-

Assessment, Treatment and Rehabilitation Services (AT&R) *These are services provided to restore functional ability and enable people to live as independently as possible. Services are delivered in specialist inpatient units, outpatient clinics and also in home and work environments. An increase in the rate of people discharged home with support, rather than to residential care or hospital environments (where appropriate) reflects the responsiveness of services.*	Notes	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
Admissions into inpatient AT&R services	V	3,261	est. >3,000	-
% of admissions into AT&R (PMH) made by direct community referral	Q	16%	20%	-
% of AT&R inpatients discharged to their own home rather than ARC	Q[75]Δ	72%	≥80%	-

Quality and Patient Safety Measures *These quality and patient safety measures apply across all services provided in Canterbury DHB hospitals.*	Notes	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
Rate of all patient falls resulting in harm – per 1,000 inpatient bed days	Q	2.40	≤2.17	-
Reporting rates for medication, IV & blood incidents – per 1,000 inpatient bed days and day patients	Q [76]	1.9	≥2.5	-
Rates of Staph aureus healthcare-associated bloodstream infection – per 1,000 inpatient bed days	Q [77]	0.07	≤0.06	-

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

[74] The DHB aims to increase people acceptance and confidence in using primary birthing units whenever it is clinically appropriate, in order to ensure limited secondary services are available for those women who need more complex or specialist intervention.

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

[76] Targets for medication, IV and blood incidents are set to increase the rate of reported incidents, in line with our policy of open disclosure of events. Achievement reflects transparency and willingness of staff to learn from events and prevent them from reoccurring.

[77] Staphylococcus aureus is often found in the nose or on the skin of healthy people, causing them no harm. However, Staph aureus can cause infection, and hospitalised patients are at greater risk because they are unwell and have lowered resistance to infection. It is transmitted via contact with people already carrying the bacteria, or through improperly washed hands, surfaces or equipment; therefore, rates of Staph aureus in hospital can reflect the effectiveness of infection control procedures. The definition for this measure has been aligned to the national Hand Hygiene programme.

OUTPUT CLASS

6.4 Rehabilitation and support services

Output class description

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

Support services also include palliative care services for people who have end-stage conditions. It is important that they and their families are appropriately supported, so that the person is able to live comfortably, have their needs met in a holistic and respectful way and die without undue pain and suffering.

Delivery of these services is likely to include coordination with many other organisations and agencies and may include public, private and part-funding arrangements.

Why is this output class significant for the DHB?

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

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

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

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

OUTPUTS SHORT-TERM PERFORMANCE MEASURES (2013/14)

Needs Assessment and Services Coordination Services *These are services that determine a person's eligibility and need for publicly funded support and the best mix of supports based on the person's strengths, resources and goals. The supports are delivered by an integrated team in the person's own home or community. The delivery of assessments and the use of evidence-based tools indicate quality, equity of access and responsiveness.*	Notes	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
Older people (65+) provided with a clinical assessment of need using InterRAI	V Δ	3,969	est. >3,500	-
% of older people (65+) receiving long-term home and community support services who have had a comprehensive clinical assessment using InterRAI	Q [78] Δ	85%	≥95%	-
% of people entering ARC having had a clinical assessment of need using interRAI	Q [79] Δ	new	≥95%	-

[78] *Comprehensive clinical assessment ensures that service decisions are based on a robust, internationally verified assessment tool so that the level of support provided matches a person's level of need and people receive equitable access to support. This measure is based on the PP18 national DHB performance measure.*

Palliative Care Services *These are services that improve the quality of life of patients and their families facing life-threatening illness, through the prevention and relief of suffering by means of early intervention, assessment, treatment of pain and other supports.*	Notes	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
People supported by hospice or home-based palliative services	V [80] Δ	3,076	est. >2,000	-
ARC facilities trained to provide the Liverpool Care Pathway option to residents	V [81]	27	≥45	-
People in ARC services being supported by the Liverpool Care Pathway	V	154	>150	-

Rehabilitation Services *These services restore or maximise people's health or functional ability following a health-related event. They include mental health community support, physical or occupation therapy, treatment of pain or inflammation and retraining to compensate for specific lost functions. Success is measured through increased referral of the right people to these services.*	Notes	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
% of people referred to an organised stroke service after an acute event	C	75%	80%	-
% of people enrolled in cardiac rehabilitation services after an acute event	C [82]	25%	30%	-
People accessing pulmonary rehabilitation courses	V [83]	170	≥150	-
People 65+ accessing community-based falls prevention programmes	V [84]	737	1,200	-

Home and Community-Based Support Services *These are services designed to support people to continue living in their own homes and to restore functional independence. They may be short or longer-term in nature. An increase in the number of people being supported is indicative of increased capacity in the system, and success is measured against decreased or delayed entry into residential or hospital services.*	Notes	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
People supported by long-term home-based support services	V Δ	8,124	est. 8,000	-
People supported by district nursing services	V Δ	5,833	est. 6,000	-
People accessing CREST services on hospital discharge or GP referral	V [85] Δ	1,154	2,200	-

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

[80] The 2011/12 result differs from the one previously reported in the Annual Report as the result of an error being corrected.

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

[82] This measure counts those enrolled in Phase 2 (outpatient) Cardiac Rehabilitation on discharge.

[83] This measure now includes all people attending pulmonary rehabilitation, whether through DHB-run courses in Ashburton and Christchurch or through community-based courses in other parts of Canterbury.

[84] This measure refers to Canterbury's Integrated Falls Prevention Service which launched in February 2012. The service seeks to support older people to maintain their independence and live safely in their own homes and communities, reducing harm as a result of falls. The 2011/12 result differs from the one previously published due to the correction of a manual counting error.

[85] The CREST service began in April 2011 and provides a range of home-based rehabilitation services to facilitate early discharge from hospital or avoid admission entirely (via GP referral).

Respite and Day Services *These services provide people with a break from a routine or regimented programme so that crisis can be averted or so that a specific health need can be addressed. Services are provided by specialised organisations and are usually short-term or temporary in nature. They may also include support and respite for families, caregivers and others affected. Services are expected to increase over time, as more people are supported to remain in their own homes.*	Notes	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
People supported by day services	V Δ	664	est. >550	-
People accessing mental health planned and crisis respite	C Δ[86]	754	est. >750	-
Occupancy rate of mental health planned and crisis respite beds	C [87] Δ	71%	85%	-
People supported with aged care respite services	V Δ	1,119	est. >1,000	-

Residential Care Services *These services are provided to meet the needs of a person who has been assessed as requiring long-term residential care in a hospital or rest home indefinitely. With an ageing population, a decrease in the number of subsidised bed days for lower-level care is seen as indicative of more people being successfully supported to continue living in their own homes and is balanced against the level of home and community-based support.*	Notes	2011/12 DHB Actual	2013/14 Target	2011/12 National Result
Subsidised ARC rest home beds provided (days)	V Δ	613,514	est. <676,000	-
Subsidised ARC hospital beds provided (days)	V Δ	464,188	est. <507,000	-
Subsidised ARC dementia beds provided (days)	V Δ	212,439	est. >212,000	-
Subsidised ARC psycho-geriatric beds provided (days)	V Δ	65,369	est. >62,000	-
% of ARC residents receiving vitamin D supplements	C [88]	63%	75%	-

[86] *This will include the new mobile respite service, launching 1 May 2013.*

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

[88] *ARC Vitamin D supplementation results are provided quarterly by MoH. The 'actual' provided is for the three months to June 2012.*

Financial Performance 2013-2016

Fiscal sustainability

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

7.1 Meeting our financial challenges

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

Despite these pressures, Canterbury was on track to deliver a break-even financial performance. However, the earthquakes and ongoing aftershocks have (to date) resulted in unplanned net expenditure and costs of over $60m. These earthquake cost impacts are expected to continue to influence and distort our financial results for the next several years. They appear in various types of expenditure: from the securing of external capacity to support our service delivery, through to emergency repairs and maintenance.

As a direct result of the earthquakes, Canterbury's planned financial result in 2012/13 was estimated at a $40m deficit, the major contributors being earthquake-related costs and the revenue impacts of short-term population changes. Through a variety of initiatives and measures, Canterbury DHB was forecasting a net deficit of $35m for 2012/13. This has been reduced to a breakeven position with the addition of planned earthquake funding support from the Ministry of Health.

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

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

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

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

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

7.2 Financial outlook

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

For 2013/14, we are forecasting that Canterbury's base funding will increase by approximately $34m. Whilst this is a significant increase compared to last year ($18m), the 2012/13 year is considered an aberration that was significantly affected by the earthquake-related changes in population trends. The current forecast funding, whilst a return to 'normal' funding increase levels, is approximately $16m lower than expected when compared to the out-year forecasts performed in 2011. We have not seen, nor are we forecasting, a corresponding decline in demand for services.

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

the past several years, and the intent is to continue to build on that success in the coming year.

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

Out-years scenario

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

We have provided out-year results based on these assumptions and variables to provide a clearer sense of our financial results. However, changes in the complex mix of contributory factors will drive results that may differ significantly from those shown here.

Living within our means

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

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

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

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

In particular, the Canterbury DHB is taking a lead in a number of workstreams, including the Procurement and Supply Chain workstream, and will contribute to predicted South Island savings of $7.5m in the next year (using Health Benefits Limited methodology). Workstreams focused on food, laundry, maintenance and engineering and clinical engineering services will be re-engaged (after being put on hold after the earthquakes) and regional work and savings plans identified.

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

Canterbury DHB is also working closely on a number of HBL workstreams to provide assistance to HBL and support to external providers of solutions, particularly in regard to facilities management workstreams such as food, laundry and supply chain services. From a DHB perspective, we continue to look to add value to the sector as a whole wherever HBL would consider it prudent to be involved in these national initiatives.

We are also committed to supporting national entities' initiatives locally to achieve mutual benefits and cost savings across the sector; Table 1 indicates the level of inclusion in the 2013/14 financial projections.

TABLE 1: COMMITMENT TO NATIONAL ENTITIES' INITIATIVES

	Capital	Operating Costs		Operating	Net
	Costs	One-Off	Ongoing	Benefits	Operating
Microsoft G2012	-	-	(1,492,492)	-	(1,492,492)
NZ ePrescription Service (NZePS) / CPSA	(154,830)	(232,246)	-	-	(232,246)
Legacy Patient Administration System (PAS)	(1,593,000)	-	-	-	-
Finance, Procurement and Supply Chain	(1,659,000)	(906,000)	-	(1,240,000)	(2,146,000)
Information Services - National Infrastructure Platform	-	(220,000)	-	-	(220,000)
Information Services - Procurement	-	-	-	143,000	143,000
Human Resources	-	(165,000)	-	-	(165,000)
Procurement	-	-	-	754,000	754,000
Banking and Insurance	-	-	(18,000)	-	(18,000)
DHB Initiatives / All of Government	-	-	-	885,000	885,000
Total Impact for Canterbury DHB	(3,406,830)	(1,523,246)	(1,510,492)	542,000	(2,491,738)
DHB contribution to HBL Core Funding			(660,000)		(660,000)

7.3 Assumptions

We have made the assumption that Canterbury will run a deficit for the 2013/14 financial year as a continued result of covering the cost of the earthquakes. This is entirely consistent with the financial assessments considered under the detailed facilities business case recently approved by Cabinet.

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

We are also aware that there will be increased demand from a vulnerable population that has been under stress for more than two years. However, there is no comparative situation we can use to make assumptions about the level of this demand; while we have made conservative predictions as a precautionary measure, this creates a level of uncertainty for the next several years.

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

- Revenue and expenditure have been budgeted on current Government policy settings and known health service initiatives.
- Population-based funding in 2013/14 will remain at the level indicated in December 2012.
- We will receive fair prices for services provided on behalf of other DHBs and the Crown, including paediatric oncology services.
- The DHB will retain early payment arrangements.
- Costs of compliance with any new national expectations yet to be identified will be cost neutral or fully funded. Any future legislative changes, sector reorganisation or service devolvement (during the term of this Plan) will be cost neutral or fully funded.
- The Ministry of Health will continue to fairly fund Canterbury for expenditure in relation to the recent series of earthquakes.
- There will be fluctuations between actual results and budget depending on both the costs and applicable accounting treatment of repairs to buildings, infrastructure, and equipment not covered by insurance recoveries. Due to the continuing emergent nature of current insurance claims, insurance proceeds as included in these financial forecasts have been limited to recognition of that which is virtually certain only, in line with current NZ accounting standards.
- There will be fluctuations between actual results and budget where repairs are covered by insurance and expenditure but recoveries cannot be recognised within the same financial year.
- We are currently undertaking a revaluation of our land and buildings. As a result of this, there will be further impacts on our land, building and infrastructure values. The quantum of the earthquake impairment, coupled with the regular period valuation, is not yet known; therefore, we have not made any adjustment for this in our forecasts.
- As a result of the recent Cabinet approval, work will continue on the Facilities Redevelopment Plan (for Christchurch Hospital and Older Persons' Health Specialist Services at Burwood Hospital) in conjunction with decisions relating to earthquake repairs. Capital expenditure associated with the redevelopment that will take place during the term of this Plan has therefore been included.
- Borrowings required to fund both our Facilities Redevelopment Plan and our seismic repair programme costs (those which are unfunded by insurance proceeds) will be available from an external source.
- Employee cost increases for expired wage agreements will be settled on fiscally sustainable terms, inclusive of step increases and the impact of accumulated leave revaluation.
- External provider increases will be made within available funding levels.
- Transformation and earthquake recovery strategies and programmes will not be delayed due to sector or legislative changes, and investment to meet increased demand will be prioritised and approved in line with our Board's strategy.
- Revenue and expenditure have been budgeted on current and expected operations with no assumption for costs or disruptions associated with further natural disasters, or with any pandemic.

7.4 Asset planning and investment

Business cases

In 2010, the DHB submitted a business case seeking approval for the redevelopment of Christchurch Hospital and Older Persons' Health Specialist Services. This process culminated in approval of the Business Case redevelopment by Cabinet and the national Capital Investment Committee (CIC) in March 2013.

Timeframes for the fast-tracked design and execution of this redevelopment are particularly critical to avoid the substantial and unnecessary costs of short-term structural upgrades that will not improve the clinical suitability of facilities already unfit for service needs. The timelines for completion of the redevelopment are: Burwood (Older Persons' Health Services) site by 2015 and Christchurch site by 2018.

A business case for the redevelopment of the Kaikoura Hospital site as an Integrated Family Health Centre received Cabinet and CIC approval in April 2013 and the DHB expects to commence construction in mid-2014.

In the coming year we also expect to seek approval for the development of Community Hubs in Rangiora and on the former Christchurch Women's Hospital site and for the development of an IFHC in Akaroa.

Capital expenditure

Canterbury's capital expenditure budget totals $171m for the 2013/14 year, subject to appropriate approvals. In addition to normal clinical and other operational capital requirements, this includes the following significant capital projects:

- Children's Haematology Oncology Centre (deferred from 2011/12 due to earthquake disruption);
- Ashburton rebuild, including Theatres and Wards;
- Strategic IT developments, including our Patient Management System, Medication Management System, Electronic Shared Care Record View and Collaborative Care Management System; and
- Phase 1 of the Facilities Redevelopment Programme, focusing on the Burwood Hospital site.

Capital expenditure associated with immediate projects required as a result of damage to our infrastructure and the infrastructure of providers we fund, has been included within our capital plans, on the basis of the recent approval of our overall Facilities Development Plan. As the overall cost of seismic repairs has been intrinsically linked to the approval of our Facilities Development Plan, the overall impact of lengthy building delays could be a significant increase in capital expenditure.

7.5 Debt and equity

The Canterbury DHB currently has a $129.650m total loan facility with the Ministry of Health (formerly the Crown Health Funding Agency), which is fully drawn down. The DHB's estimated total term debt is expected to be $144.650m as at June 2014. This reflects additional borrowing of $15m, of which $7.5m will be drawn at the end of 2012/13 and the remaining $7.5m during 2013/2014. The DHB is also repaying $1.861m of equity annually as part of the agreed FRS-3 funding.

The Ministry-funded term loans are secured by a negative pledge. Without the Ministry of Health's prior written consent, the DHB cannot:

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

As the timing and quantum of the earthquake insurance proceeds are not yet known, Crown equity for the Facilities Redevelopment Programme has been 'notionally' brought forward, as this is only a notional entry; no corresponding capital charge has been recognised in the operating statements. However, this is only a timing issue, and the total Crown contribution for the Facilities Redevelopment Programme remains as set out in the detailed business case.

7.6 Additional information

Disposal of land

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

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

Due process will be undertaken with regard to any sale of DHB land. Our policy is that we will not dispose of any estate or interest in any land without having first obtained the consent of the responsible Minister and completed required public consultation.

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

Activities for which compensation is sought

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

Acquisition of shares

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

Accounting policies

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

Forecast of Financial Performance

7.7 Group statement of comprehensive income

	2011/12 Actual $'000	2012/13 Forecast $'000	2013/14 Plan $'000	2014/15 Plan $'000	2015/16 Plan $'000
Income					
Ministry of Health revenue	1,368,276	1,415,786	1,408,932	1,441,936	1,475,599
Patient related revenue	49,395	44,642	45,335	48,970	52,086
Other operating income	47,551	33,269	31,416	31,217	33,671
Interest income	7,337	8,450	7,020	5,520	4,020
Total Income	1,472,559	1,502,147	1,492,703	1,527,643	1,565,376
Operating Expenses					
Employee benefit costs	583,814	608,186	624,240	638,570	653,255
Treatment related costs	139,908	128,229	129,852	131,250	133,019
External service providers	581,045	594,006	605,000	611,188	616,696
Depreciation & amortisation	46,453	49,986	51,007	53,064	55,287
Interest expenses on loans	4,529	6,023	6,324	6,419	6,515
Other expenses	101,798	101,046	87,781	86,469	87,104
Total Operating Expenses	1,457,547	1,487,476	1,504,204	1,526,960	1,551,876
Operating surplus before capital charge	15,012	14,671	(11,501)	683	13,500
Capital charge expense	15,055	14,671	13,500	13,200	13,500
Surplus / (Deficit)	(43)	-	(25,001)	(12,517)	-
Other comprehensive income	14,297	-	-	-	-
Total Comprehensive Income	**(14,340)**	**-**	**(25,001)**	**(12,517)**	**-**

7.8 Group statement of financial position

	30/06/12 Actual $'000	30/06/13 Forecast $'000	30/06/14 Plan $'000	30/06/15 Plan $'000	30/06/16 Plan $'000
CROWN EQUITY					
General funds	131,154	127,432	150,572	276,228	475,767
Revaluation reserve	131,404	131,404	131,404	131,404	131,404
Retained earnings / (losses)	(77,233)	(77,233)	(102,234)	(114,751)	(114,751)
TOTAL EQUITY	**185,325**	**181,603**	**179,742**	**292,881**	**492,420**
REPRESENTED BY:					
CURRENT ASSETS					
Cash & cash equivalents	52,293	108,161	39,651	43,649	81,405
Trade & other receivables	57,959	85,852	50,852	44,705	44,705
Inventories	8,493	7,338	7,338	7,338	7,338
Investments	74,329	5,682	5,682	-	-
TOTAL CURRENT ASSETS	193,074	207,033	103,523	95,692	133,448
CURRENT LIABILITIES					
Trade & other payables	123,088	123,015	23,015	127,015	127,015
Capital charge payable	485	485	485	485	485
Employee benefits	152,422	148,066	148,066	154,791	154,791
Borrowings	30,000	30,000	30,000	30,000	30,000
TOTAL CURRENT LIABILITIES	305,995	301,566	301,566	312,291	312,291
NET WORKING CAPITAL	(112,921)	(94,533)	(198,043)	(216,599)	(178,843)
NON CURRENT ASSETS					
Investments	54,650	54,933	61,933	7,000	7,000
Property, plant, & equipment	349,700	334,048	437,365	623,957	785,704
Intangible assets	939	1,221	53	89	125
Restricted assets	14,538	15,012	15,012	15,012	15,012
TOTAL NON CURRENT ASSETS	419,827	405,214	514,363	646,058	807,841
NON CURRENT LIABILITIES					
Employee benefits	6,919	6,916	6,916	6,916	6,916
Restricted funds	15,012	15,012	5,012	15,012	15,012
Borrowings	99,650	107,150	114,650	114,650	114,650
TOTAL NON CURRENT LIABILITIES	121,581	129,078	136,578	136,578	136,578
NET ASSETS	**185,325**	**181,603**	**179,742**	**292,881**	**492,420**

7.9 Group statement of movements in equity

	30/06/12 Actual $'000	30/06/13 Forecast $'000	30/06/14 Plan $'000	30/06/15 Plan $'000	30/06/15 Plan $'000
Total Equity at Beginning of the Period	198,815	185,325	181,603	179,742	292,881
Total Comprehensive Income	(14,340)	-	(25,001)	(12,517)	-
Other Movements					
Contribution back to Crown	-	(3,722)	(1,861)	(1,861)	(1,861)
Contribution from Crown - Earthquake operational support	-	-	25,001	12,517	-
Contribution from Crown - Capital Projects	850	-	-	115,000	201,400
Total Equity at End of the Period	**185,325**	**181,603**	**179,742**	**292,881**	**492,420**

7.10 Group statement of cashflow

	2011/12 Actual $'000	2012/13 Forecast $'000	2013/14 Plan $'000	2014/15 Plan $'000	2015/16 Plan $'000
CASH FLOW FROM OPERATING ACTIVITIES					
Cash provided from:					
Receipts from Ministry of Health	1,274,084	1,282,624	1,290,637	1,346,496	1,377,964
Other receipts	194,981	185,377	230,046	177,627	183,392
Interest received	7,337	8,450	7,020	5,520	4,020
	1,476,402	1,476,451	1,527,703	1,529,643	1,565,376
Cash was applied to:					
Payments to employees	573,508	612,545	624,240	631,845	653,255
Payments to suppliers	822,752	823,549	822,633	820,760	836,819
Interest paid	4,363	6,104	6,324	6,419	6,515
Capital charge	18,926	14,455	13,500	13,200	13,500
GST - net	(2,983)	982	-	-	-
	1,416,566	1,457,635	1,466,697	1,472,224	1,510,089
Net Cashflow from Operating Activities	**59,836**	**18,816**	**61,006**	**57,419**	**55,287**
CASH FLOW FROM INVESTING ACTIVITIES					
Cash was provided from:					
Sale of property, plant, & equipment	-	-	-	-	-
Receipt from sale of investments	-	67,890	-	60,615	-
	-	67,890	-	60,615	-
Cash was applied to:					
Purchase of investments & restricted assets	112,513	-	7,000	-	-
Purchase of property, plant, & equipment	42,400	34,616	153,156	239,692	217,070
	154,913	34,616	160,156	239,692	217,070
Net Cashflow from Investing Activities	**(154,913)**	**33,274**	**(160,156)**	**(179,077)**	**(217,070)**
CASH FLOW FROM FINANCING ACTIVITIES					
Cash provide from:					
Equity Injection	850	-	25,001	127,517	201,400
Loans Raised	54,650	7,500	7,500	-	-
	55,500	7,500	32,501	127,517	201,400
Cash applied to:					
Loan Repayment					
Equity Repayment re FRS-3	-	3,722	1,861	1,861	1,861
	-	3,722	1,861	1,861	1,861
Net Cashflow from Financing Activities	**55,500**	**3,778**	**30,640**	**125,656**	**199,539**
Overall Increase/(Decrease) in Cash Held	(39,577)	55,868	(68,510)	3,998	37,756
Add Opening Cash Balance	91,870	52,293	108,161	39,651	43,649
Closing Cash Balance	**52,293**	**108,161**	**39,651**	**43,649**	**81,405**

7.11 Summary of revenue and expenses by arm

	2011/12 Actual $'000	2012/13 Forecast $'000	2013/14 Plan $'000	2014/15 Plan $'000	2015/16 Plan $'000
Funding Arm					
Revenue					
MoH Revenue	1,322,216	1,368,882	1,359,120	1,390,779	1,422,766
Patient Related Revenue	-	-	-	-	-
Other	-	-	5,000	1,000	1,000
Total Revenue	1,322,216	1,368,882	1,364,120	1,391,779	1,423,766
Expenditure					
Personnel	-	-	-	-	-
Depreciation	-	-	-	-	-
Interest & Capital charge	-	-	-	-	-
Other - Personal Health	956,808	964,953	991,264	1,009,243	1,029,330
Other - Mental Health	137,489	137,017	142,216	144,441	146,763
Other - Disability Support	226,095	234,528	237,923	241,091	244,531
Other - Public Health	1,973	2,314	2,076	2,107	2,144
Other - Maori Health	1,883	1,892	1,887	1,915	1,950
Other - Governance & Admin	-	201	-	-	-
Total Expenditure	1,324,248	1,340,905	1,375,366	1,398,797	1,424,718
Net Surplus/(Deficit)	**(2,032)**	**27,977**	**(11,246)**	**(7,018)**	**(952)**
Other Comprehensive Income	**-**	**-**	**-**	**-**	**-**
Total Comprehensive Income	**(2,032)**	**27,977**	**(11,246)**	**(7,018)**	**(952)**
Governance & Funder Admin					
Revenue					
MoH Revenue	-	-	-	-	-
Patient Related Revenue	-	-	-	-	-
Other	1,939	3,106	3,180	3,244	3,309
Total Revenue	1,939	3,106	3,180	3,244	3,309
Expenditure					
Personnel	4,787	6,550	6,948	7,052	7,157
Depreciation	3	13	108	108	108
Interest & Capital Charge	-	-	-	-	-
Other	(2,851)	(3,457)	(3,876)	(3,916)	(3,956)
Total Expenditure	1,939	3,106	3,180	3,244	3,309
Net Surplus/(Deficit)	**-**	**-**	**-**	**-**	**-**
Other Comprehensive Income	**-**	**-**	**-**	**-**	**-**
Total Comprehensive Income	**-**	**-**	**-**	**-**	**-**

Provider Arm					
Revenue					
MoH Revenue	789,263	793,602	820,178	838,766	860,855
Patient Related Revenue	47,623	41,978	42,275	45,848	48,901
Other	54,721	41,478	33,316	35,615	36,567
Total Revenue	891,607	877,058	895,769	920,229	946,323
Expenditure					
Personnel	579,027	601,636	617,292	631,518	646,098
Depreciation	46,450	49,973	50,899	52,956	55,179
Interest & Capital Charge	19,584	20,694	19,824	19,619	20,015
Other	244,557	232,732	221,509	221,635	224,079
Total Expenditure	889,618	905,035	909,524	925,728	945,371
Net Surplus/(Deficit)	**1,989**	**(27,977)**	**(13,755)**	**(5,499)**	**952**
Other Comprehensive Income	(14,297)	-	**-**	**-**	**-**
Total Comprehensive Income	**(12,308)**	**(27,977)**	**(13,755)**	**(5,499)**	**952**
In House Elimination					
Revenue					
MoH Revenue	(743,203)	(774,876)	(770,366)	(787,609)	(808,022)
Patient Related Revenue	-	-	-	-	-
Other	-	-	-	-	-
Total Revenue	(743,203)	(774,876)	(770,366)	(787,609)	(808,022)
Expenditure					
Personnel	-	-	-	-	-
Depreciation	-	-	-	-	-
Interest & Capital Charge	-	-	-	-	-
Other	(743,203)	(774,876)	(770,366)	(787,609)	(808,022)
Total Expenditure	(743,203)	(774,876)	(770,366)	(787,609)	(808,022)
Net Surplus/(Deficit)	**-**	**-**	**-**	**-**	**-**
Other Comprehensive Income	**-**	**-**			
Total Comprehensive Income	**-**	**-**	**-**	**-**	**-**
CONSOLIDATED					
Revenue					
MoH Revenue	1,368,276	1,387,608	1,408,932	1,441,936	1,475,599
Patient Related Revenue	47,623	41,978	42,275	45,848	48,901
Other	56,660	44,584	41,496	39,859	40,876
Total Revenue	1,472,559	1,474,170	1,492,703	1,527,643	1,565,376
Expenditure					
Personnel	583,814	608,186	624,240	638,570	653,255
Depreciation	46,453	49,986	51,007	53,064	55,287
Interest & Capital Charge	19,584	20,694	19,824	19,619	20,015
Other	822,751	795,304	822,633	828,907	836,819
Total Expenditure	1,472,602	1,474,170	1,517,704	1,540,160	1,565,376
Net Surplus/(Deficit)	**(43)**	**-**	**(25,001)**	**(12,517)**	**-**
Other Comprehensive Income	(14,297)	-	-	-	-
Total Comprehensive Income	**(14,340)**	**-**	**(25,001)**	**(12,517)**	**-**

Appendices

Further information for the reader

Appendix 8.1 – Glossary of terms

Appendix 8.2 – Approval of the Minister of Health

Appendix 8.3 – Objectives of DHB

Appendix 8.4 – Organisational chart and system governance overview

Appendix 8.5 – Overview of hospital and specialist services

Appendix 8.6 – Minister's Letter of Expectations

Appendix 8.7 - Canterbury's commitment to national health targets

Appendix 8.8 – CCN Summary Work Plan 2013/14

Appendix 8.9 – DHB Performance Monitoring Framework

Appendix 8.10 – Statement of Accounting Policies

References

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

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

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

8.1 Glossary of terms

ACC	Accident Compensation Corporation	Crown Entity set up to provide comprehensive no-fault personal accident cover for New Zealanders.
	Acute Care	Management of conditions with sudden onset and rapid progression.
ARC	Aged Residential Care	Residential care for older people, including rest home, hospital, dementia and psycho-geriatric level care.
B4SC	B4 School Check	The final core WCTO check, which children receive at age four. The free check allows health concerns to be identified and addressed early in a child's development for the best possible start for school and later life.
CCN	Canterbury Clinical Network District Alliance	An alliance of Canterbury health professionals whose initial focus is the implementation of the 'Better, Sooner, More Convenient' business case, which began in 2009.
	Capability	What an organisation needs (in terms of access to people, resources, systems, structures, culture and relationships), to efficiently deliver outputs.
CVD	Cardiovascular Disease	Diseases affecting the heart and circulatory system, including: ischaemic heart disease, rheumatic heart disease, cerebrovascular disease and other forms of vascular and heart disease.
COPD	Chronic Obstructive Pulmonary Disease	A progressive disease process that most commonly results from smoking. Chronic obstructive pulmonary disease is characterised by difficulty breathing, wheezing and a chronic cough.
	Continuum of Care	Exists when a person can access responsive services matched to their level of need at any time throughout their illness or recovery.
CPH	Community and Public Health	The division of the DHB that provides public health services.
	Crown agent	A Crown entity that must give effect to government policy when directed by the responsible Minister.
	Crown Entity	A generic term for a diverse range of entities referred to in the Crown Entities Act 2004. Crown Entities are legally separate from the Crown and operate at arm's length from the responsible or shareholding Minister, but are included in the annual financial statements of the Government.
CFA	Crown Funding Agreement	An agreement by the Crown to provide funding in return for the provision of, or arranging the provision of, specified services.
	Determinants of Health	The range of personal, social, economic and environmental factors that determine the health status of individuals or populations.
	Effectiveness	The extent to which objectives are being achieved. Effectiveness indicators relate outputs to impacts and to outcomes. They can measure the steps along the way to achieving an outcome and test whether outputs have the characteristics required for achieving a desired objective or government outcome.
ERMS	Electronic Request Management System	A system available from the GP desktop enabling referrals to public hospitals and private providers to be sent and received electronically. Developed in Canterbury, it is now being rolled out South Island-wide.
ESPIs	Elective Services Patient flow Indicators	A set of indicators developed by the Ministry to monitor how patients are managed while waiting for elective (non-urgent) services.
FSA	First Specialist Assessment	(Outpatients only) The first time a patient is seen by a doctor for a consultation in that speciality. This does not include procedures, nurse or diagnostic appointments or pre-admission visits.
HbA1c	Haemoglobin A1c	Also known as glycated haemoglobin, HbA1c reflects average blood glucose level over the past 3 months.
HCS	Health Connect South	A shared regional clinical information system, a single repository for clinical records across the South Island.
HEEADSSS		An assessment provided to students attending teen parent units, alternative education facilities and decile 1 to 3 high schools that covers Home environment; Education/employment; Eating/exercise; Activities and peer relationships; Drugs/cigarettes/alcohol; Sexuality; Suicide/depression/mood; Safety; and Spirituality.
	Impact	The contribution made to an outcome by a specified set of goods and services (outputs), or actions, or both. Normally describes results that are directly attributable to the activity of an agency. Impact measures should be attributed to DHB outputs in a credible way and represent near-term results expected from the outputs delivered.
	Input	The resources (e.g. labour, materials, money, people, technology) an organisation uses to produce outputs.
IDFs	Inter District Flows	Services (outputs) provided by a DHB to a patient whose place of residence is in another DHB's region. Under PBF, each DHB is funded on the basis of its resident population; therefore, the DHB providing the IDF will recover the costs of that IDF from the DHB who was funded for that patient.

InterRAI	International Resident Assessment Instrument	A comprehensive geriatric assessment tool.
	Intervention	An action or activity intended to enhance outcomes or otherwise benefit an agency or group.
	Intervention logic model	A framework for describing the relationships between resources, activities and results, which provides a common approach for planning, implementation and evaluation. Intervention logic focuses on being accountable for what matters: impacts and outcomes.
LMC	Lead Maternity Carer	The health professional a woman chooses to provide and coordinate the majority of her maternity care. Most LMCs are midwives, though GPs and obstetricians may also be LMCs.
	Morbidity	Illness, sickness.
	Mortality	Death.
NHI	National Health Index	An NHI number is a unique identifier assigned to every person who uses health and disability services in NZ. A person's NHI number is stored on the NHI along with their demographic details. The NHI is used to help with the planning, coordination and provision of health and disability services across NZ.
NGO	Non-Government Organisations	In the context of the relationship between Health and Disability NGOs and the Canterbury DHB, NGOs include independent community and iwi/Māori organisations operating on a not-for-profit basis, which bring a value to society that is distinct from both Government and the market.
OPF	Operational Policy Framework	An annual document endorsed by the Minister of Health that sets out the operational-level accountabilities all DHBs must comply with, given effect through the CFA between the Minister and the DHB.
	Outcome	A state or condition of society, the economy or the environment, including a change in that state or condition. Outcomes are the impacts on the community of the outputs or activities of Government (e.g. a change in the health status of a population).
	Output Class	An aggregation of outputs of a similar nature.
	Outputs	Final goods and services delivered to a third party outside of the DHB. Not to be confused with goods and services produced entirely for consumption within the DHB (internal outputs or inputs).
PBF	Population-Based Funding	Involves using a formula to allocate each DHB a fair share of the available resources so that each Board has an equal opportunity to meet the health and disability needs of its population.
	Primary Care	Professional health care received in the community, usually from a general practice, covering a broad range of health and preventative services. The first level of contact with the health system.
PHO	Primary Health Organisation	PHOs encompass the range of primary care practitioners and are funded by DHBs to provide of a set of essential primary healthcare services to the people enrolled with that PHO.
	Public Health	The science and art of preventing disease, prolonging life and promoting health and efficiency through organised community effort.
	Purchase agreement	A documented arrangement between a Minister and a department/organisation for the supply of outputs.
	Regional collaboration	Refers to DHBs across geographical 'regions' planning and delivering services (clinical and non-clinical) together. Four regions exist: Northern, Midland, Central and Southern. The Southern region includes all five South Island DHBs (Canterbury, Nelson Marlborough, South Canterbury, Southern and West Coast DHBs). Regional collaboration sometimes involves multiple regions, or may be 'sub-regional collaboration' (DHBs working together in a smaller grouping of two or three DHBs, e.g. Canterbury and West Coast).
	Secondary Care	Specialist care that is typically provided in a hospital setting.
SIA(PO)	South Island Alliance (Programme Office)	A partnership between the five South Island DHBs working to support a clinically and financially sustainable South Island health system where services are as close as possible to people's homes.
SSP	Statement of Service Performance	Government departments, and Crown entities from which the Government purchases a significant quantity of goods and services, are required to include audited statements of service performance with their financial statements. These statements report whether the organisation has met its service objectives for the year.
	Tertiary Care	Very specialised care often only provided in a smaller number of locations
	Vision 2020	Canterbury's vision for our future health system, developed through system-wide engagement in 2007 to find solutions to the challenges our health system faced: if we didn't actively transform our system, by 2020 Canterbury would need 2,000 more ARC beds, 20% more GPs and another Christchurch Hospital.
WCTO	WellChild/Tamariki Ora	A free service offering screening, education and support to all New Zealand children from birth to age five.

8.2 Approval of the Minister of Health

Office of Hon Tony Ryall
Minister of Health
Minister for State Owned Enterprises

26 SEP 2013

Mr Bruce Matheson
Chair
Canterbury District Health Board
PO Box 1600
CHRISTCHURCH 8140

Dear Mr Matheson

Canterbury District Health Board 2013/14 Annual Plan

This letter is to advise you that together with the Minister of Finance, I have approved and signed Canterbury District Health Board's (DHB) 2013/14 Annual Plan for one year.

I appreciate the significant work that goes into preparing such a thorough annual planning document and I thank you for your effort. I look forward to seeing your progress over the course of the year.

While recognising these are tight economic times, the Government is dedicated to improving the health of New Zealanders and continues to invest in key health services. In Budget 2013, Vote Health received the largest increase in government spending, demonstrating the Government's on-going commitment to protecting and growing our public health services.

Better Public Services (BPS): Results for New Zealanders
The Prime Minister has set ten whole-of-government key result areas. The health service is responsible for leading increased infant immunisation and reduced incidence of rheumatic fever. We are also involved in the key result areas of reducing the number of assaults on children, increasing participation in early childhood education and supporting the implementation of the white paper on vulnerable children.

DHBs are expected to actively engage and invest in these key result areas. Your DHB has included step targets in your Annual Plan to contribute to the Prime Ministerial challenges. Achieving these is not negotiable.

It is important that your board works closely with other social sector organisations and initiatives, including Whānau Ora.

National Health Targets
Your plan includes a good range of actions that will lead to improved or continued performance against the health targets. The target set has remained stable for 2013/14 allowing you to build on the results from the 2012/13 year.

Canterbury DHB is performing well in most health target areas. However, in the year ahead I would like Canterbury DHB to particularly focus attention on maintaining the recent pattern of improving performance for the Better help for smokers to quit target, and the More heart and diabetes checks target. Current performance remains disappointing in these two areas and I'd like to see Canterbury perform at the top of the league where it belongs.

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

Quality Framework

I recently wrote to DHBs emphasising the need to maintain a focus on the quality and safety of services, both within hospitals and in wider services such as aged residential care and mental health. Ensuring quality will be an on-going focus for us all in the health sector. I'd like DHBs to use the framework that was provided to help shape DHB quality discussions. Also, that DHBs will produce a 'dashboard' of key quality and safety measures to regularly monitor performance and produce Quality Accounts in 2013.

Care Closer to Home

DHBs should increase their focus on integration, particularly with respect to primary care, ensuring the scope of activity is broadened and rate of improvement is increased. I look forward to seeing an integrated approach driving service development, delivery and improved overall system performance; and in preparing to implement integration changes currently under development with the sector. Canterbury is working hard in this area and I appreciated reading the King's Fund evaluation of your efforts. Congratulations.

I am pleased to see an enhanced commitment to tangible actions in your Annual Plan to show how you will achieve real increases in access to diagnostic and treatment services for primary care and service shifts 'closer to home'. Canterbury will continue to work in partnership with primary care, using Alliances to drive service reconfiguration and improved system performance.

I am pleased to see your DHB has developed your Annual Plan through your current Alliance. It is positive that, in addition to committing to continue meeting the minimum requirements for integration outlined in the Planning Guidance that you committed to increase your number of electronic pathways including shared records, e-referrals and e-responses while increasing and broadening the range of health professionals developing services through your Alliance.

Health of older people

The Government wants DHBs to continue to work with primary and community care to deliver integrated services and improve overall quality of care for older people. I am pleased to see that you have developed an Annual Plan which undertakes to meet the Government's expectations for the coming year. Notably, the implementation of a local dementia pathway that follows the national framework, the management of the risk of variable service quality of home and community support services, and proactive use of your HOP specialists to advise and train health professionals in primary and aged residential care. You have also committed to review your wraparound services, roll out the Comprehensive Clinical Assessments in aged residential care facilities, and to establish a fracture liaison service.

Regional and National Collaboration

Greater integration between regional DHBs supports more effective use of clinical and financial resources. I'd like DHBs to make significant progress in implementing their Regional Service Plans, including actions for identified Government priorities and your agreed regional clinical priorities. It is evident from your Annual Plan that your DHB is working to realise the benefits of regional and sub-regional collaboration, and that this influences your local service planning. I look forward to seeing delivery on your agreed Regional Service Plan actions.

Guidance on national entity priorities was provided to all DHBs in April, for inclusion in final 2013/14 Annual Plans, following the successful completion of the Health Sector Forum lead work between the Ministry, national entities and DHBs. Ministers expect that your DHB will deliver on these commitments, as included in your plan financials. Attached is a summary of National Entity Priority Initiatives that shows your DHB's commitments for 2013/14. I look forward to observing progress on the delivery of these priorities.

Living within our means

DHBs are required to budget and operate within allocated funding and to identify specific actions to improve year-on-year financial performance in order to live within their means. This includes seeking efficiency gains and improvements in purchasing, productivity and quality aspects of your DHB's operation and service delivery. Improvements through national, regional and sub-regional initiatives should continue to be a key focus for all DHBs.

I note that you are planning for a deficit of $25.0M for 2013/14, $12.5M for 2014/15 and breakeven for 2015/16. Your annual plan is approved for the 2013/14 year, subject to a satisfactory savings plan being provided to the NHB by 18 October 2013 and monthly reporting to the NHB on earthquake costs and recoveries.

Budget 2013

The expectation is that you will deliver on Budget 2013 initiatives. The Ministry of Health will discuss these more fully with you and develop monitoring arrangements during 2013/14.

Annual Plan Approval

My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the NHB. All service changes or service reconfigurations must comply with the requirements of the Operational Policy Framework and the NHB will be contacting you where change proposals need further engagement or are agreed subject to particular conditions. You will need to advise the NHB of any proposals that may require my approval as you review services during the year.

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

I would like to thank you, your Board and management for your valuable contribution and continued commitment to delivering quality health care to your population and wish you every success with the implementation of your 2013/14 Annual Plan. I will be monitoring your progress throughout the year and look forward to seeing your achievements.

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

Yours sincerely

Hon Tony Ryall
Minister of Health

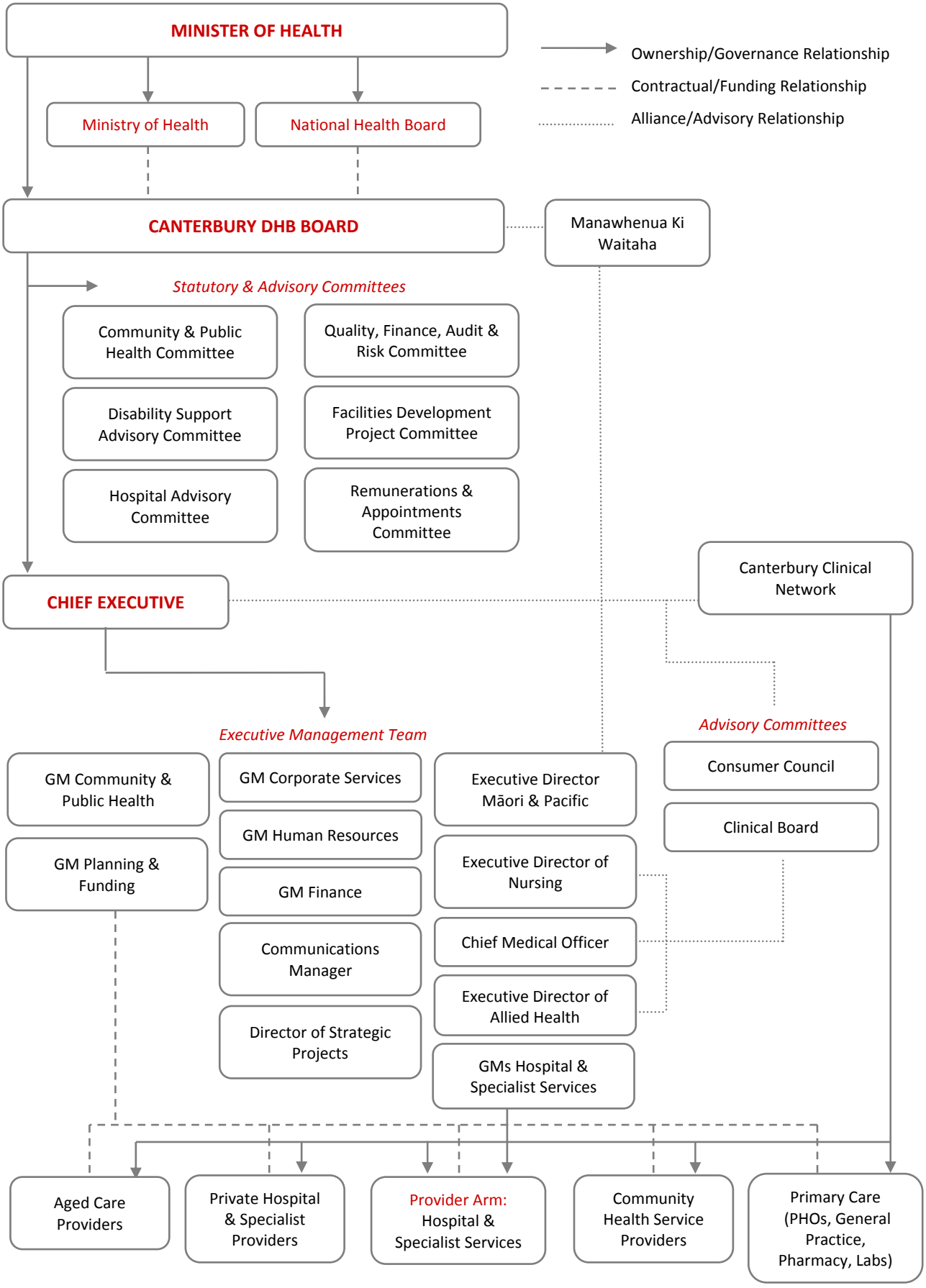
8.3 Objectives of a DHB – New Zealand Public Health and Disability Act (2000)

Part 3: Section 22:

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

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

8.4 Canterbury DHB organisational and system governance overview



8.5 Overview of hospital and specialist services

HOSPITAL SUPPORT AND LABORATORY SERVICES

Cover support services such as: medical illustrations, specialist equipment maintenance, sterile supply, patient and staff food services, cleaning services and travel and waste contracts. These Services also cover the provision of diagnostic services through Canterbury Health Laboratories (CHL) for patients under the care of the Canterbury DHB and offer a testing service for GPs and private specialists. More than 20 public and private laboratories throughout NZ refer samples to Canterbury Health Laboratories for more specialised testing, and CHL is recognised as an international referral centre.

MEDICAL AND SURGICAL SERVICES

Cover medical services: general medicine, cardiology/lipid disorders, endocrinology/diabetes, respiratory, rheumatology/immunology, infectious diseases, oncology, gastroenterology, clinical haematology, neurology, renal, palliative, hyperbaric medicine, dermatology, dental and sexual health. They also cover surgical services: general surgery, vascular, ENT, ophthalmology, cardiothoracic, orthopaedics, neurosurgery, urology, plastic, maxillofacial and cardiothoracic surgeries and the services of the day surgery unit. Medical and Surgical Services also cover: emergency investigations, outpatients, anaesthesia, intensive care, radiology, nuclear medicine, clinical pharmacology, pharmacy, medical physics and allied health services. The Christchurch Hospital has a busy Emergency Department, treating around 84,000 patients per annum.

SPECIALIST MENTAL HEALTH SERVICES

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

OLDER PERSONS' SPECIALIST HEALTH AND REHABILITATION SERVICES

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

ASHBURTON AND RURAL HEALTH SERVICES

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

WOMEN AND CHILDREN'S HEALTH SERVICES

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

8.6 Minister's Letter of Expectations

Office of Hon Tony Ryall

Minister of Health
Minister for State Owned Enterprises

28 JAN 2013

Mr Bruce Matheson
Chair
Canterbury DHB
PO Box 1600
CHRISTCHURCH 8140

Dear Bruce

Letter of expectations for DHBs and subsidiary entities for 2013/14 year

Thank you for the contribution you and your staff are making to a better public health service. Public and patient confidence in health services continues to improve.

The government will be investing more money in Health this budget. This contrasts with the ongoing cuts in health spending in many parts of the world.

In this context the government continues to expect **better, sooner, more convenient** healthcare for patients and communities within constrained funding increases.

Better Public Services: Results for New Zealanders

The Prime Minister has set ten whole-of-government key result areas. The health service is responsible for leading increased infant immunisation and reduced incidence of rheumatic fever. We are also involved in the key result of reducing the number of assaults on children and supporting the implementation of the white paper on vulnerable children.

DHBs are expected to actively engage and invest in these key result areas. Your DHB has been given step targets to contribute to the Prime Ministerial challenges. Achieving these is not negotiable.

It is important Boards work closely with other social sector organisations and initiatives, including Whanau Ora.

National Health Targets

Good progress is being made on the three patient access targets. More effort is needed on the three preventive targets. DHBs are expected to include clear and specific plans for achieving all the national health targets in their Annual Plans, including the use of general practice-specific incentives where appropriate. You must demonstrate appropriate performance management arrangements for PHOs. You should show your local primary care networks are involved in, and explicitly endorse, your targets plan and your preventive targets plan in particular.

Patients' time is a valuable non-renewable resource. Timely access improves outcomes, is preferred by patients and saves cost. The government has made clear its ambitious objectives to further shorten waiting times for surgery, diagnostics, cardiac and cancer care. Your DHB is expected to meet these objectives.

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

Care Closer to Home

Integrating primary care with other parts of the health service is vital for better management of long term conditions, mental health, an aging population and patients in general. This is achieved through better coordinated health and social services and the development of care pathways designed and supported by community and hospital clinicians. The outcome is patients treated closer to home with fewer acute and unplanned hospital admissions.

DHBs are expected to focus much more strongly on service integration across the health system particularly showing how this will be done with primary care. This includes integrated family health centres, primary care direct referral to diagnostics, clinical pathway development, and sharing of patient controlled health records.

Health of Older People

Your DHB is expected to work with primary and community care to provide integrated services for older people that support their continued safe, independent living at home particularly to avoid a hospital admission and after a hospital discharge. DHBs should continue working with the Ministry on implementing government commitments to improving home care, stroke and dementia care.

Regional and National Collaboration

There are significant financial and clinical gains to be derived from regional DHBs working together. I expect DHBs to progress much faster implementing Regional Service Plans. This includes delivering on regional workforce, IT and capital objectives that are set and monitored in the NHB dashboard.

Further improvements in quality, efficiency and cost control will come from accelerating DHBs national work with Health Benefits Limited, Health Workforce NZ and the Health Quality and Safety Commission. More information on this will be forthcoming.

Strong clinical leadership and engagement has been pivotal to the gains made so far and remains essential.

Living within our means

The government is determined to return to surplus in 2014/15. Like the public health service as a whole, your DHB must contribute by lifting productivity and keeping to budget. DHBs are obliged to operate within their agreed financial plans. Your DHB must have detailed and defensible plans to improve financial performance year on year. The supply of equity and debt is constrained so Boards should prioritise capital investment more rigorously and fund from internal sources.

As agents of the Crown, you and your Board must assure yourselves that you have in place the appropriate clinical and executive leadership needed to deliver on the government's objectives. The performance of chief executives must be monitored against these expectations.

I appreciate the effort you and your teams are making. Thank you. Please share this letter with your clinical leaders and local primary care networks.

Yours sincerely

Hon Tony Ryall
Minister of Health

8.7 Canterbury's commitment to the national Health Targets

Shorter Stays in Emergency Departments

Government expectation

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

Canterbury contribution – see page 25

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

Improved Access to Elective Surgery

Government expectation

More New Zealanders have access to elective surgical services, with at least 4,000 additional discharges nationally every year.[89]

Canterbury contribution – see page 31

16,861 elective surgical discharges will be delivered in 2013/14.

Shorter Waits for Cancer Treatment

Government expectation

All people ready for treatment wait less than four weeks for radiotherapy or chemotherapy.[90]

Canterbury contribution – see page 34

100% of people ready for treatment wait less than four weeks for radiotherapy or chemotherapy.

Increased Immunisation

Government expectation

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

Canterbury contribution – see page 40

90% of all eight-month-olds will be fully vaccinated by 1 July 2014.

Better Help for Smokers to Quit

Government expectation

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

Canterbury contribution – see page 35

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

More Heart and Diabetes Checks

Government expectation

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

Canterbury contribution – see page 28

Progress towards **90%** of the eligible population having had their CVD risk assessed by 1 July 2014.

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

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

8.8 CCN summary work plan 2013/14

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTION (MEASURABLE)**	**EVIDENCE**
What is our aim?	*What action will we take to make this happen?*	*How will we demonstrate achievement?*
1. Accelerate the Acute Demand Service Level Alliance's Progress.		
Continue to develop and refine community-based acute demand services.	1.1. Continue to develop and refine acute demand services to target patients with the greatest capacity to benefit and support those with a high level of need to access appropriate urgent care in the community rather than in hospitals.	≥20,500 urgent care packages provided in the community during the year to the end of Q1. ≥21,000 by Q2 ≥21,500 by Q3 ≥22,000 urgent care packages provided in the community by end of Q4.
	1.2. Engage St John Ambulance crews to use the Ambulance Referral Pathway and acute demand services to safely manage appropriate patients in the community. (With the key focus around COPD during winter months).	≥250 patients utilise the ambulance referral pathway by Q2. ≥400 patients utilise the ambulance referral pathway by Q4.
	1.3. Enable proactive management of vulnerable patients in the community, including community observation and increased access to urgent diagnostics.	Ambulatory sensitive (avoidable) hospital admissions (0-74) maintained at <1,883 per 100,000
	1.4. Continue to promote calling general practice as first point of contact (phone) 24/7.	Rate of acute medical admissions maintained at <5,000 per 100,000.
	1.5. Continue utilisation by children under six for free after hours access in line with national timeframes. 1.6. Support GP practices to provide a free afterhours nurse phone advice and triage service.	100% of the population under six have access to free after hours care.
OBJECTIVE	**ACTION (MEASURABLE)**	**EVIDENCE**
2. Consolidate the Aged Care Workstream's Progress.		
Enable older adults to live well at home and in their community and increase the well-being of older adults in Canterbury.	2.1. Continue to ensure early intervention to support people with deteriorating health / complex conditions.	Early intervention supported by CREST programme.
	2.2. CREST (Community Rehabilitation and Enablement Support Team) will expand to maximum capacity.	≥2200 older people supported by CREST by Q4. A 20% reduction in acute admissions for people supported by CREST services. A 10% reduction in readmissions for people supported by CREST services[91].
	2.3. Work with providers to align workforce capacity with expansion of CREST services.	
	2.4. Enhance the effectiveness of relationships between CREST, General Practice and OPHSS teams to support increased referrals from primary care.	≥500 direct referrals from GPs by Q4.
	2.5. Establish utilisation baselines for Maori, Pacific, Asian communities and identify opportunities to improve access.	Establish baseline by Q1.
	2.6. Review CREST model to meet the needs of more rural communities and further expand access.	Draft rural strategy by Q3.
	2.7. Monitor core quality measures - including consumer, general practice and other stakeholder satisfaction with CREST services.	Survey results analysed by Q2. Survey results indicate GPs are satisfied and aware of ways to communicate with CREST teams
Improve community care of people with early dementia. Memory assessments and early management of dementia occurs in the community.	2.8. Champion use of the HealthPathways Cognitive Impairment Pathway.	Review pathway by against national framework by Q4. ≥100 new referrals from GPs to Alzheimer's Canterbury by Q4. Increased numbers completing the WIAS programme. (Baseline =21 carers.)
	2.9. Review the Cognitive Impairment Pathway for consistency with the national framework.	
	2.10. Monitor the use of the pathway and GP referrals for CT scans, scripts for cholinesterase Inhibitors and referrals to Alzheimers Canterbury.	
	2.11. Expand 'Walking in Another's Shoes' (WIAS) dementia training for Carer beyond ARC to Community Services.	
	2.12. Identify opportunities to increase social connectedness for at risk older adults and their carers.	Stocktake by Q1. Opportunities identified by Q2.
	2.13. Monitor access to day care, carer relief and respite.	
	2.14. Develop a pathway to identify isolated older adults with depression earlier and provide appropriate support.	Pathway established by Q3.

[91] *The 10% reduction for CREST patients is for a two year period from the beginning of the programme in April 2011.*

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTION (MEASURABLE)**	**EVIDENCE**
What is our aim?	*What action will we take to make this happen?*	*How will we demonstrate achievement?*
Reduce harm from adverse medication reactions and optimize medicines use.	2.15. Complete the implementation of the Medication Management Service (MMS).	Further outcome measures to be agreed with MMS and Pharmacy SLA. ≥2,000 older people referred to MMS.
	2.16. Establish utilisation baselines for Maori, Pacific, Asian communities and identify opportunities to improve access.	Establish baseline by Q1.
	2.17. Identify opportunities to improve access to MMS for older adults in rural communities.	Establish baseline by Q3.
Reduce harm from falls and promote 'Zero Harm from Falls' programme across the Canterbury health system.	2.18. Continue to implement clinically led fall prevention strategies that improve the integration of falls prevention activities across the whole system.	≥1,200 older people (65+) access community-based falls prevention services.
	2.19. Communicate the falls prevention approach widely to ensure providers continue to be aware of and utilise evidence-informed strategies and programmes.	10% reduction in the proportion of the older population (75+) presenting at ED as a result of a fall.[92]
	2.20. Enhance primary care team involvement in preventing falls for the elderly - specifically target elderly at risk of admission to hospital.	10% reduction in the proportion of the older population (75+) admitted to hospital as a result of a fall.
	2.21. Establish utilisation baselines for Maori, Pacific, Asian communities and identify opportunities to improve access.	Establish baseline by Q1.
	2.22. Identify opportunities to improve access to falls prevention programmes in rural communities.	Establish baseline by Q3.
	2.23. Promote 'Zero Harm from Falls' in aged residential care settings and provide an ARC-based Vitamin D Supplementation Programme.	75% of ARC residents receive Vitamin D supplements.
Phased roll out in Christchurch of the restorative home support model used by Community Support Service (CSS) providers.	2.24. Complete the rollout of the restorative home support services model across Canterbury.	65+ population readmission rate at or below national average.[93] 75+ population readmission rate at or below national average.
	2.25. Further develop service process to better define interaction with General Practice at each stage. Improve service alignment and interaction	Process defined for 34 case mix groups by Q2.
	2.26. Work with Maori and Pacific and Asian communities to develop protocols for HBSS providers to follow to ensure culturally appropriate response when working restoratively.	Specific service responses for each of these population groups in consultation with relevant representative and advisory groups identified by end of Q2.
	2.27. Process for under 65 group currently under short term.	Develop a case management model for this client group by end of Q2.
	2.28. Develop and implement a case mix model for DN	Case model developed by end Q1.
	2.29. Continue to provide health professionals in primary and aged residential care with access to specialist HOP advice and support.	Every referral received generates contact with General Practice. Quarterly reporting of OPHSS activity demonstrates an increase in contacts with GPs and ARC. Further development of the GNS role with an increase in consulting with ARC.
Improved co-ordination of care for complex frail elderly and older adults in Canterbury.	2.30. Support the establishment of new nursing roles in IFHCs ('Care Coordination' nurses).	Activity planned in Collaborative Care work plan.
	2.31. Monitor the effectiveness of 'Care Coordination' function and its interface with OPHSS community teams, other inter-disciplinary teams and 'wrap around' services for older adults.	Monitoring process established by end of Q2. 65+ population readmission rate remains at or below current rate.
	2.32. Work jointly with Collaborative Care Management System (CCMS) steering group to establish impact measures to monitor the effectiveness of Care Coordinators.	75+ population readmission rate remains at or below current rate.
	2.33. Enhance relationships by supporting regular peer review meetings between OPHSS community teams and Care Coordinators.	
	2.34. Work jointly with CCN work streams and SLAs to support use	Risk of readmission stratification underway Q1

[92] *The 10% target reduction for falls is over a two year period from the beginning of the programme February 2012.*

[93] *The definition for readmission measures is currently under review.*

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTION (MEASURABLE)**	**EVIDENCE**
What is our aim?	*What action will we take to make this happen?*	*How will we demonstrate achievement?*
	of predictive tool for case finding to identify at-risk patients most responsive to intervention.	Risk of admission stratification underway Q4.
Progressive rollout of InterRAI to Canterbury Clinicians. Aligned to South Island and national strategy.	2.35. Identify actions to support ARC providers to implement comprehensive clinical assessments using the InterRAI Long Term Care Facility (LTCF) module.	An InterRAI training plan for the LTCF module is in place (Q1).
	2.36. Work with the national InterRAI training team to ensure sufficient access to training sessions for Canterbury nurses.	InterRAI training commenced (Q2).
	2.37. Provide OPHSS Gerontology Nurse Specialists with the tools to help support ARC providers using InterRAI.	100% of ARC facilities are using or training nurses to use the InterRAI LTCF assessment tool (Q4).
	2.38. Continue to support the provision of read-only access to InterRAI for GPs, ARC, CSS and OPHSS providers.[94]	
	2.39. Engage with central TAS via the HOP Steering Group to bring forward funding to support implementation of the InterRAI LTCF module from 2014/15 to 2013/14.	Read only access available to all Canterbury General Practices by Q2.
	2.40. Providers to assess all non- complex clients and OPHSS to assess all complex clients using InterRAI.	>95% of people (65+) receiving long-term CSS have had an InterRAI assessment and have a care plan in place (Q4).
		>95% of people entering ARC have had an InterRAI assessment (Q4).
Engagement of providers in quality improvement work and capacity management.	2.41. The aged residential care sector is supported by OPHSS Gerontology Nurse Specialists to make quality improvements.	Avoidable hospital admission rate remains at or below 95% of national rate.
	2.42. Provide advice/training to ARC providers to reduce incidence/severity of pressure injuries in older adults.	Establish baselines (Q2).
	2.43. Monitor trends in pressure injuries on admission from ARC and identify areas for improvement.	
	2.44. Implement a postgraduate nursing programme with rotations in settings across the whole system to promote leadership development in ARC sector.	Six participants complete programme by Q4.
	2.45. Restorative respite care pilot service is monitored against the Evaluation Framework.	Electronic booking system for planned respite by Q2.
	2.46. Use health certification audits to ensure all new ARC admissions are examined by a GP or nurse practitioner within 2 working days of admission.	Monitoring of audits quarterly.
	2.47. Ensure CSS providers meet Sector Standards and hold a certificate of conformance with NZS 8158:2012, as part of the revised community support model.	All contracted CSS meet sector standards by Q1.
	2.48. Use national core quality measures for CSS (to be produced by the MoH) to review and improve service performance and benchmark CDHB with other DHBs.	Core quality measure baselines established by Q2.[95]
	2.49. Establish a baseline for 'inappropriate' hospital admissions and identify opportunities to reduce these.	Baseline established by Q1. CSS quality measures reviewed in Q4.
	2.50. Implement the Elder Abuse guidelines developed by the Minister of Health as part of the DHBs Family Violence Intervention Programme.	Implementation Plan developed by Q4.
	2.51. Regular QI and OMG meetings with providers.	Monthly meetings.
	2.52. Regular peer reviews to ensure proactive risk management in relation to the provision of CSS.	Quality initiatives identified in the Quality Improvement Group and the Operational Management Group of the CSSLA are implemented.
	2.53. Improve equipment availability to Community Support Service providers to better support older adults in their own homes.	ENABLE service accreditation for CREST and Falls Champions achieved by Q3.
Support the development of an integrated Fracture	2.54. Establish and implement a Fracture Liaison Service for the Canterbury population.[96]	Fracture Liaison Service established by Q4.

[94] *The InterRAI modules include: contact assessments (CA), community health assessments (CHA), minimum data set home care assessments (MDS HC) and long term care facility assessments (LTCF).*

[95] *This timeline is dependent on the MoH and HIQ establishing these measures..*

[96] *Supported by the minimum data set for hip fracture developed by the Australia NZ Hip Fracture Registry Working Group.*

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTION (MEASURABLE)**	**EVIDENCE**
What is our aim?	*What action will we take to make this happen?*	*How will we demonstrate achievement?*
Service.	2.55. Engage clinical leads in aligning preventative care for people with osteoporosis and fragility fractures (through identification, investigation and intervention) to prevent future fractures.	
Support the development of an integrated Stroke Service.	2.56. Continue to work regionally to maintain an organised acute stroke service in Canterbury that meets New Zealand Stroke Guidelines.	Plan for integration of stroke services Q1.
	2.57. Engage clinical leads in aligning the continuum of care for stroke across the whole Canterbury health system.	
	2.58. Support increased referral of people to stroke services and rehabilitation after an acute event.	
Continued roll-out of ARC Residential Recovery and Improvement Plan.	2.59. Oversee and act as an expert reference group in terms of the implementation of the pilot restorative respite service.	Incorporated in phase two of Aged Residential Care SLA work plan.
OBJECTIVE	**ACTION (MEASURABLE)**	**EVIDENCE**
3. Child and Young Person's Health		
Maintain and expand School Based Health Services.	3.1. Extend the coverage of SBHS to Decile 3 secondary schools, teen parent units and alternative education facilities.	SBHS in place in all D3 Schools (Q1).
	3.2. Review delivery of SBHS against service expectations and monitor performance through quarterly performance reports.	100% of D1, D2 and D3 schools, teen parent units and alternative education facilities have SBHS in place (Q1).
	3.3. Expand the Community Youth Mental Health Collaborative mobile service to better support schools and SBHS.	
Expand the use of HEEADSSS Wellness Checks in schools and primary care settings.[97]	3.4. Expand the provision of HEEADSSS assessment training to increase HEEADSSS assessment capacity.	Increased number of practitioners qualified to undertake HEEADSSS assessments.
	3.5. Support SBHS nurses to provide HEEADSSS assessments to all Year 9 students enrolled in the SBHS service.	100% of Year 9 students receiving HEEADSSS assessment from SBHS (Q4).
	3.6. Work with primary care to improve coordination of referrals resulting from HEEADSSS assessments.	
Support vulnerable children through improved access	3.7. Work with PHOs to ensure children under-six have access to free after hours primary care.	100% of under sixes have access to free afterhours care by Q4.
	3.8. Ensure universal access to the core WCTO services and equitable access to additional WCTO contacts.	Fewer children (aged 0-4) admitted to hospital with avoidable conditions – target <6,656 per 100,000.
	3.9. Monitor access and referral patterns for B4 School Checks to identify opportunities to improve delivery and coverage.	90% of children in deprivation Quintile 5 receive a B4SC.
	3.10. Work with PHO mobile engagement teams to improve uptake amongst Māori, Pacific and Quintile 5 children.	90% of children in deprivation Quintiles 0-4 receive a B4SC.
	3.11. Monitor access to referred services following WCTO/B4SC and implement actions to expedite service delivery.	Children referred following a B4SC are seen before their fifth birthday (Q4).
	3.12. Maintain delivery of Gateway Assessments and monitor access and referral patterns to further develop the service.	100% of children referred by CYF receive Gateway Assessments.
Implement the Children's Action Plan	3.13. Establish governance arrangements and engagement processes within the DHB and with primary and community partners regarding implementation of the Children's Action Plan.	Governance structure agreed in Q1.
	3.14. Undertake a stocktake of services for vulnerable pregnant women, children and parents across the care continuum.	Service coverage, wait times, capacity issues and gaps identified (Q2).
	3.15. Use findings from the stocktake to inform the steps that will be taken towards ensuring the right mix and intensity of services to support vulnerable pregnant women, children and parents for inclusion in 2014/15 planning.	Progress update at end of Q2.
Contribute to increased participation in quality early childhood	3.16. Identify opportunities to raise awareness of the importance of ECE and strengthen connections between frontline health services working with families with young children in ECE.	Increased participation in ECE (MoH and MoE to confirm measure).
	3.17. Contribute to MoE initiatives that help to locate, engage and retain vulnerable children in quality ECE – including the development of shared information and pathways.	Quarterly report on progress and initiatives.

[97] *HEEADSSS (Home, Education/Employment, Eating, Activities, Drugs, Sexuality, Suicide and depression, Safety).*

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTION (MEASURABLE)**	**EVIDENCE**
What is our aim?	*What action will we take to make this happen?*	*How will we demonstrate achievement?*
	3.18. Improve the quality of B4SC data collection and reporting. 3.19. Incorporate the Quality Improvement Framework to reduce unnecessary variation in delivery of WCTO/B4SC services[98].	Findings of B4SC quality improvement letters incorporated (Q4).
	3.20. Identify where C&Y workstream aims align with 'Improving Maternity Journey' 9 opportunities (*initiate Maternity Journey Development Group and C&Y WS Core Group meeting).*	Improve early detection in antenatal period.
Ensure each young person has a 'Health Home'	3.21. Provide direction for the emerging health system of Health Hubs, IFHC's and satellite primary care providers (General Practices, Pharmacies and Allied Health).	Child & Youth workstream recommendation to CCN/CDHB on model that fits vulnerable youth health hubs models of care, to provide multiagency workspace.
Improve health services in schools.	3.22. Stocktake of current Health Services being delivered in schools (e.g. NGOs such as He Waka Tapu, Public Health and School Nursing Teams, Primary Care) working alongside Education's Pastoral Care Teams.	Child & Youth workstream recommendation to CCN/CDHB on preferred model of care for future health service delivery in schools.
Improve communication with stakeholders and whānau/families.	3.23. Develop and enhance child health 'navigator links' on Health Info and Health Pathways.	Plan in place (Q3).
	3.24. Identify opportunistic pathway providers (as per Immunisation Service Level Alliance initiatives).	Pathways identified (Q2).
Improve communication with stakeholders to improve access and navigation through the youth health system.	3.25. Agree Youth Health - HealthPathways content using our existing stakeholders' expertise and youth consultation links.	Pathways agreed in Q2.
	3.26. Develop format and delivery of information (e.g. texting/online questionnaire/gaming framework) considering current models (e.g. Youthline). Include youth consultation.	Youth accessible and friendly format and language used in information provided.
	3.27. Review format and language used through youth consultation and engagement processes.	
Provide direction for Child & Youth Health work programmes using 'CaSE' Care System Education.	3.28. Establish ongoing education rounds. (Include Identifying Vulnerable Children e.g. adapt Child Protection Alert System for DHBs into Primary Care).	Deliver at least two 'community' education sessions.
	3.29. Establish ongoing education rounds (include identifying vulnerable youth in next round).	Deliver two 'large group round' education sessions.
	3.30. Develop training including opportunistic engagement in primary care (e.g. capturing Well Child Checks at the time of immunisation appointments).	Training plan agreed (Q3).
OBJECTIVE	**ACTION (MEASURABLE)**	**EVIDENCE**
4. Continue to improve the integration between Primary and Secondary Services.		
Support the provision of the right care in the right place at the right time by the right provider.	4.1. Continue to link clinicians across the health system to build trust and ways of working together that maximise patient outcomes. Ensure that the pathways that are available are being regularly reviewed and updated to ensure that patients receive the right care at the right time from the right provider, support the reduction in waiting times and maximise the value provided by clinicians across the health sector.	Approximately 90 pathways are reviewed each quarter in live website. Review of existing HealthPathways occurs according to plan. Headline areas being planned for review are: • Q1: Haematology, Bone Health, ENT, Cognitive Impairment; • Q2: Ophthalmology, Gynaecology, Stroke, Plastic Surgery; • Q3: Orthopaedics, Endocrinology, Paediatric Surgery, Oncology; • Q4: Respiratory, Gastroenterology, Vascular Surgery, Pregnancy Medical Conditions. Narrative will be provided about the pathways reviewed over the previous quarter and how this relates to the plan.
	4.2. Patient information that is judged as trustworthy will be provided to people to support an understanding of how to stay healthy and also to support an understanding of the care being provided to them.	The number of page views will increase by 20% compared with the same quarter the previous year.
Implement the Integrated Family Health and Social	4.3. Develop and Support the implementation of 12 Integrated Family Health Centres (IFHCs) and networks within	12 IFHC / network business cases completed (Q4). Eight IFHC / network business cases accepted by

[98] *The WCTO Quality Framework is currently under development with the MoH.*

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTION (MEASURABLE)**	**EVIDENCE**
What is our aim?	*What action will we take to make this happen?*	*How will we demonstrate achievement?*
Service Network System.	Christchurch.	business owners and developments under way (Q4).
	4.4. Implementation of integrated models of care into practices forming IFHCs.	Three IFHC practice groups supported to transition to their new integrated models of care (Q4).
	4.5. Implement care co-ordination functions and management plans into practices forming IFHCs.	Three IFHC practice groups supported to implement care co-ordination and CCMS as a part of their integrated models of care (Q4).
	4.6. Establish IFHC projects in targeted areas of Christchurch city. Targeted areas defined as high demand for primary care services and limited primary care capacity to respond.	Two IFHC business case projects established in targeted areas of Christchurch (Q4).
	4.7. Adjust the integrated model of care development process to suit smaller primary care groups and deploy it.	Integrated model of care process applied to three smaller primary care groups (Q4).
	4.8. Work with other CCN workstreams to support primary secondary care integration.	Integration projects supporting IFHC activity are progressing (Q2).
	4.9. Develop operational links with other, non-health related social services to support integration of care and social services support around the patient.	Social services processes included in two IFHC integrated models of care (Q3).
	4.10. Identify the opportunities between IFHCs and Hubs as they relate to the urban IFHC groups in progress.	Opportunities identified and communicated to IFHC groups (Q4).
	4.11. An IFHC is developed in Ashburton.	Build begins by Q4.
	4.12. An IFHC is developed in Akaroa. Note that this contingent on sourcing of appropriate funding.	Build begins by Q4.
	4.13. A Healthcare Hub is developed in Rangiora.	Concept plan is developed for public consultation by Q1.
		Building begins by Q4.
OBJECTIVE	**ACTION (MEASURABLE)**	**EVIDENCE**
5. Implement the key actions of the Rural Health Workstream.		
Workforce	**Integrated, functional rural health workforce able to provide optimal primary health care.**	
	5.1. Identify models for sustainable afterhours.	Maintain a 1 in 6 GP call roster in Ashburton.
		Maintain a 1 in 4 GP call roster in Kaikoura. Report quarterly.
		Develop an agreed after hours provision model covering North Canterbury (Q3).
	5.2. Identify and develop other funding models and other clinical models of care in conjunction with existing initiatives. Meet with workforce development group and interested parties.	Rural populations continue to benefit from all services that are available to them, as at January 2013 (narrative report quarterly).
	5.3. Comprehensive skill set available in rural areas – patients able to receive all primary health care services close to home without unnecessary travel. This may involve development of Nurse led clinics and other new models of care.	
	Permanent and locum recruitment of all professional health disciplines into rural areas.	
	5.4. Locum recruitment – develop a functioning locum pool for all professional disciplines.	End of Q2. Increasing numbers of locum and permanent health professionals compared to baseline as at 31 December 2012.
	5.5. Permanent recruitment – develop a permanent recruitment strategy.	
	5.6. Engage with rural immersion programme to entice rural students to Canterbury.	Number of new trainee positions filled in rural practice – increase of 20% Dr, 20% nurse, 10% allied. (Q1, Q3)
	Supported Role extension.	
	5.7. Identify educational needs of rural providers and support appropriate delivery. Swap staff into secondary care for up-skilling.	Maintain or increase the number of health professionals participating in up-skilling.
Coordination / IT / Communication	**All rural areas electronically connected and able to communicate.**	
	5.8. Gather data from all practices as to current levels of connectedness. Liaise with CDHB Telehealth program to establish Telehealth base.	Six sites by end of Q4.
IFHC and Rural Hospitals *Considerable work is being undertaken outside of the rural work stream; this*	**Right services, right place.**	
	5.9. Develop a model of care for each rural area that incorporates primary, and community based services with a sustainable model of acute and afterhours care. This may include rural	Local model of care established and confirmed for Kaikoura by Q2.
		Akaroa by Q1.

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTION (MEASURABLE)**	**EVIDENCE**
What is our aim?	*What action will we take to make this happen?*	*How will we demonstrate achievement?*
includes IFHC development in Ashburton, Akaroa, Kaikoura and North Canterbury. The rural workstream is dovetailing in, rather than leading this work.	hospitals and/or IFHCs.	Rangiora by Q2.
	5.10. Review and development in other rural areas, not detailed in this row, will be undertaken in the following year.	Hurunui by Q3.
	5.11. Assess skill level (including PRIME) required by workforce in conjunction with rural workforce group.	All remote rural areas continue to hold a contract for PRIME services through ACC.
	Free up Christchurch hospital for specialist services.	
	5.12. Increase women birthing in primary facilities.	More women give birth in Rural primary birthing facilities (report Q2 and Q4).
Kaikoura SLA	5.13. A Kaikoura IFHC facility, providing physical and operational integration of health services, is put in place.	Build begins before Q4.
	5.14. Information transfer between providers is improved.	Kaikoura Hospital, Kaikoura Medical Centre and Te Tai o Marokura use a common patient management system before Q4.
Older Persons Health	**Enable older people to live safely in their home and own community and keep well.**	
	5.15. Ensure availability of and full use of falls prevention programme throughout Rural Canterbury. 5.16. More patients receive meals on wheels in rural communities.	More patients receive falls prevention services in Rural settings. (Quarterly versus previous year's baselines.)
		More rural meals on wheels services will be delivered.
		District and acute nursing services are combined in rural settings.
	Decreasing demand of acute hospital care and aged residential level care.	
	5.17. Rural patients will benefit from the operationalisation of CREST services in rural areas.	CREST is operational in rural areas in Q2.
	5.18. Work with the mobile medicines management team to support pharmaceutical contribution to the health of older people.	More patients receive MMS services in rural settings.
Nursing in the community	**Use of nurses for nursing. Optimise non-nursing community services.**	
	5.19. Identify alternative service delivery model that incorporates nurses, personal carers, and support workers as appropriate for the best outcome for patient and system.	Nurse led services are implemented in general practices and IFHCs in Rural Canterbury by Q1. Exploration of shared nursing services between rural areas, taking into consideration local differences by Q2.
Mental health	**To have a mental health workforce appropriately qualified working within scope of practice.** **To utilise, promote and expand the current mental health resources that are available.**	
	5.20. Foster integration, co-ordination and education for mental health providers in recommendations 5.21. Develop a mental health education team to inform Consumers.	More patients receive community based specialist mental health services.
	To support the current Mental health workforce to up-skill their services.	
	5.22. Promote access to appropriate education opportunities for mental health workers.	More education sessions are provided to rural health professions relating to anxiety, depression, etc. (Q2)
	Equity of access.	
	5.23. Supply a complete list of contacts for the IT team to include in the GP software for referrals etc.	100% of allied health providers electronically accessible by GPs and other referrers. (Q2)
	5.24. Prepare a service directory by area with the referral pathways, for all providers of that area.	All providers have an electronic and hard copy of directory for each geographical area. (Q1)
OBJECTIVE	**ACTION (MEASURABLE)**	**EVIDENCE**
6. Continue to improve Mental Health Services in Canterbury – Under the Mental Health Alliance Workstream.		
Use DHB resources effectively across the whole mental health continuum.	6.1. Undertake a gap analysis between the national Mental Health and Addiction Service Delivery Plan and Canterbury's current service provision.	Gap analysis completed as per MOH template and considered by Mental Health Leadership Workstream by Q1.
	6.2. Identify how resources will be reprioritised (where necessary) to deliver the actions expected.	Action Plan operational by Q2.
Implement the Prime Minister's Youth Mental Health Project.	6.3. Support the Child and Youth Health Work Stream to establish new models (youth hubs/services) that are responsive to the needs of young people.	Model defined by Q1.
	6.4. Adopt a stepped care model to respond to the mental health needs of youth in line with national service expectations.	Define stepped care model by Q1. Specialist consult/liaison service in place by Q1.

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OBJECTIVE	**ACTION (MEASURABLE)**	**EVIDENCE**
What is our aim?	*What action will we take to make this happen?*	*How will we demonstrate achievement?*
	6.5. Implement and evaluate the chosen model as one of the mechanisms to bridge the gap between community primary and secondary services. 6.6. Increase specialist consult/liaison to improve communication and responsiveness between primary and secondary care and better meet the needs of young people and their families. 6.7. Support the Collaborative Youth Mental Health Initiative to also bridge the gap between primary and specialist services.	Stepped care model implemented by Q2.
Enhance the responsiveness of primary and community mental health services.	6.8. Continue the implementation/development of the stepped care model for mental health across the wider service continuum 6.9. Enhance the Single Point of Entry service with a phone roster, ensuring a psychiatrist is available for GPs seeking advice. 6.10. Clarify criteria for entry to services and delineate the community-based options for care if the consumer is not eligible for specialist mental health services. 6.11. Expand the range of services available closer to home through continued investment in primary care.	Enhanced Single Point of Entry (SPOE) service established by Q1. Direct telephone access to psychiatrist operational by Q1. Agreed pathways developed and made available by Q4. ≥4,000 BIC sessions provided in primary care (includes EQ BIC).
Continue to monitor earthquake-related services.	6.12. Maintain ready access to programmes to support people suffering anxiety and trauma as a result of the earthquake. 6.13. Finalise the Peer Service Development Plan, including strategies for how peer support will be blended across the whole system.	≥2,000 people access EQ-related mental health services.[99] At least two actions from the plan in implementation by Q4.
Improve the responsiveness of specialist services to the needs of young people and their families.	6.14. Implement the CAF Choice and Partnership Approach to improve access and achieve phased waiting time targets. 6.15. Monitor system capacity and responsiveness to referrals to CAF and Youth AOD. 6.16. Review follow-up care for young people discharged from CAMHS and youth AOD in line with the stepped care model. 6.17. Develop a consistent process that ensures follow-up plans can be activated by primary care within three weeks of discharge. 6.18. Refine data systems to monitor the provision and use of follow-up plans, and track outcomes for young people on discharge. 6.19. Consider the role of the Collaborative Youth Mental Health Initiative in providing discharge support for young people.	75% of youth (aged 0-19) referred for non-urgent mental health or addiction services seen ≤3 weeks. 90% seen ≤8 weeks. Discharge practices reviewed by Q1. Baseline established for youth being discharged with follow-up care plans by Q4.
Continue the implementation of the Adult Mental Health Services Direction of Change.	6.20. Enhance the Single Point of Entry service with a phone roster, ensuring a psychiatrist is available for GPs seeking advice. 6.21. Enhance models and processes to support mental health services users across the continuum. 6.22. Develop a Crisis Resolution Service to enhance community care. 6.23. Develop a psychiatric consult service with MHSS nursing support in Christchurch Hospital. 6.24. Establish four integrated Multidisciplinary Locality Teams that work across inpatient and outpatient settings, operate from a shared treatment plan and provide extended service hours. 6.25. Facilitate collaboration/connection with the community, including general practice teams through the Locality Teams. 6.26. Develop extended treatment strategies for consumers with high and complex mental health needs. 6.27. Develop and implement an Evaluation Framework for the Adult Mental Health Services Direction of Change.	Direct telephone access to psychiatrist operational by Q1. Consult/Liaison Service operational by Q1. Locality Teams established by Q4. 3% of the population (20-64) access complex mental health services. ≥95% of all long-term clients have current relapse prevention plans in place (included as part of the shared treatment plan).
Continue the implementation of the Canterbury Alcohol and	6.28. Support the Alcohol Harm Reduction Coordinator to implement public health alcohol-related harm interventions. 6.29. Provide AOD brief intervention training to target workforce	AOD brief intervention training provided to 4 target groups. Central Coordination Service expanded by Q1.

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

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTION (MEASURABLE)**	**EVIDENCE**
What is our aim?	*What action will we take to make this happen?*	*How will we demonstrate achievement?*
Other Drug (AOD) Project.	groups, including: general practice, mental health corrections. 6.30. Increase centralisation of referrals by expanding the Central Coordination Service. 6.31. Implement the AOD Withdrawal Management/Respite Pathway. 6.32. Provide training to increase responsiveness of the AOD sector. 6.33. Expand the range of intervention and support service options to enable people to remain in their own homes and communities, including access to community support workers (CSW) and housing facilitation coordinators. 6.34. Continue implementation of the Co-Existing Problems Action Plan to increase sector capability to respond to people with both mental health and AOD issues. 6.35. Provide Co-Existing Problems (CEP) training across the system.	Access to CSW and increase in housing facilitation services Q1. Six introductory CEP sessions and six advanced sessions run by Q2. 75% of people (20-64) referred for non-urgent AOD services are seen in three weeks. 90% of people (20-64) referred for non-urgent AOD services are seen in eight weeks.
Implement National Policy and Action Plans to deliver Better Public Health Services		
Support the Suicide Prevention Action Plan.	6.36. Continue to support a local suicide prevention plan. 6.37. Review local suicide prevention approaches against the goals in the national Suicide Prevention Action Plan (yet to be released).	Review existing model by Q2. Alignment of goals evident in Q4.
Support the Child Health Action Plan.	6.38. Prepare to implement the actions from the Child Health Action Plan and keep informed of progress at demonstration sites. 6.39. Continue to support delivery of Gateway Assessments. 6.40. Work with the Child and Youth Workstream to complete a stock-take and gap analysis of all DHB-funded primary and community mental health services for young people.	100% of children referred by CYF receiving Gateway Assessments. Results of youth services stock-take and actions to be taken confirmed by Q2.
Support the Drivers of Crime initiative.	6.41. Engage the Collaborative Youth MH Initiative to support School Based Health Services to deliver HEEADSS Assessments. 6.42. Continue to work with Corrections and courts to increase access to AOD addition assessment and treatment.	100% of Year 9 students receive HEEADSSS assessments by Q4.
OBJECTIVE	**ACTION (MEASURABLE)**	**EVIDENCE**
7. Continue improvements for patients with long term conditions.		
Support the identification of the population most at risk of long-term conditions.	7.1. Establish a Long-Term Conditions (LTC) Development Group to appropriately integrate established condition-specific approaches to a more patient-centred LTC approach. 7.2. Develop key principles and process for proactive risk stratification. 7.3. Review current condition-specific clinical pathways in alignment with agreed LTC approach. 7.4. Enhance and integrate proactive current case management, self-management and rehabilitation programmes to increase capacity across the system.	Risk of readmission stratification underway Q1 Risk of admission stratification underway Q4. Integrated LTC pathway established in Q3.
	7.5. Further enhance the capability of the Collaborative Care Management Solution (CCMS) to facilitate the coordination of care for individuals with LTC and complex health needs. 7.6. Engage primary, secondary and pharmacy providers in managing complex patients via the Collaborative Care Programme (CCP). 7.7. Improve the management patients with complex health needs through the Medication Management Service (MMS)	Ability to create acute care plans in CCMS enabled by Q4. >2,000 people referred to MMS.
Improve the identification of people at risk of respiratory disease.	7.8. Continue to further consolidate and refine the identification of people with Chronic Obstructive Pulmonary Disease (COPD) aligning with long term conditions. 7.9. Support the use of technology to enhance delivery of respiratory services (E referrals /MedTech/web based spirometry services).	More people access spirometry tests in the community. Baseline = 1,126. Number of approved providers for spirometry is increased by end of 2013 (current baseline = 6).
	7.10. Collaborate with Maori Health providers and plan for improved access to diagnostics and respiratory services for Māori.	Risk stratification work will define expectations about rates expected given known burden of disease.

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTION (MEASURABLE)**	**EVIDENCE**
What is our aim?	*What action will we take to make this happen?*	*How will we demonstrate achievement?*
		Referral rate for Maori is at a rate expected for the burden of the disease. To be reported following Q4.
	7.11. Develop and work towards developing the CPAP model of care that promotes and supports an annual patient review in the community. This will include additional case finding through other care pathways including the hip and knee pathway and engagement with emerging IFHC developments to ensure that case finding is evident in their models of care.	Implement additional OSA/CPAP services in the community by end of Q3.
		More people access sleep assessments in the community (baseline = 827).
Ensure people receive the right care and support at the right time and in the right setting.	7.12. Continue to develop links with Public health programmes that encompass warmer homes and smoking cessation to support people most at risk of respiratory disease.	Narrative evidence will be provided in quarters 2 and 4.
	7.13. Support seamless patient care and improved access to services by enhancing respiratory services for patients in rural communities.	A plan for rural provision of sleep and spirometry assessments is being developed.
	7.14. Continue to progress the delivery of an integrated multi-disciplinary approach to the management of acute and sub-acute COPD at multiple points of intervention.	A 10% reduction in COPD admissions and readmissions compared with baseline quarters in 2011/12.
	7.15. Further develop the support for community respiratory nurses offer to general practice for COPD patients.	Reduced length of stay for non-complex patients compared with baseline quarters in 2011/12. More respiratory patients have a shared care plan than in 2011/12 (report Q3).
	7.16. Education and enhancement of skills and knowledge in managing respiratory disease and long term conditions.	The number of education sessions delivered is maintained.
	7.17. Establish a model of community based care for cystic fibrosis and bronchiectasis patients with acute pulmonary exacerbation.	Community model in place by end of Q2.
Support continued investment in rehabilitation programmes	7.18. Expand access to Pulmonary Rehabilitation (PR) programmes marketing and raising awareness in general practice.	More people access pulmonary rehabilitation in the community (baseline = 170).
Continue to improve services for patients with Diabetes in Canterbury to improve health outcomes.	7.19. Continue to implement the DCIP with identified minimum standard of care. 7.20. Align with the LTC Development Group to support identification of population with diabetes.	Analysis of the agreed indicators occurs on a quarterly basis and is shared appropriately with clinical staff. Narrative will be provided about how care is being improved using these data.
	7.21. IDSDG works with Clinical Governance Groups to agree set of outcome indicators for the population identified with diabetes 7.22. Introduce related data sets to inform and engage clinicians across the Canterbury system.	Risk stratification to support general practices teams to identify High needs/high risk of the Diabetes population by Q3.
	7.23. Monitor and report on patient activities as per baseline minimum standard of care.	Increased proportion of patients with good diabetes control (HbA1c<64mmol/mol). Increased proportion of the enrolled population with diabetes and microalbuminuria are prescribed an ACE1 or an ARB.[100]
	7.24. Access to podiatry services for diabetes high risk foot patients is improved.	More patients will access podiatry services. Base number = 1,000 (across Canterbury).
Ensure the right people receive the right care in the right setting	7.25. Continue to invest in and support programmes to manage newly diagnosed Type 2 patients and those starting insulin in the community.	More people newly diagnosed with type 2 diabetes access support in the community Q4 (baseline = 429). More people with Type 2 diabetes starting insulin in the community access support Q4 (baseline = 213).
	7.26. Continue to support the implementation and design of clinical/patient education tools and models for improving and supporting self-management of diabetes.	Conservation maps will be made available to primary care by the end of Q1.
		The number of people accessing diabetes related information on HealthInfo will increase.
	7.27. More people with diabetes access community retinal screening.	More people accessing community retinal screening over the next two years – base 5,529.
Clinicians, providers and funders work together to	7.28. On-going support to the Integrated Diabetes Service Development Group, Operational group and Christchurch	Governance structures reviewed annually.

[100] *The Ministry is currently working on a means of data capture for this measure nationally.*

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTION (MEASURABLE)**	**EVIDENCE**
What is our aim?	*What action will we take to make this happen?*	*How will we demonstrate achievement?*
improve health outcomes for patients with diabetes.	consumer group to develop an integrated local approach for people with diabetes.	
	7.29. Increase access to Diabetes Services for high risk high needs patients with Diabetes.	All patients appropriately coded in practice management systems by Q1. Risk stratification of diabetes patients in place by end of Q3.
	7.30. Promote specialist inter-disciplinary services at community IFHCs and community hubs.	IFHC and hubs agreeing models of care and linkages with specialist services.
OBJECTIVE	**ACTION (MEASURABLE)**	**EVIDENCE**
8. Improve Māori health outcomes in Canterbury		
A whole of system quality approach that promotes longer, healthier, more independent lives for Māori.	Ensure complete, accurate and consistent collection and reporting of ethnicity data for Māori across the system.	
	8.1. Training is available to all general practice teams on ethnicity data collection (based on CDHB ethnicity data collection policy).	
	8.2. Develop policy on Iwi data collection.	A PHO policy on Iwi data collection is developed by end of Q4.
	8.3. Information for CCN work streams and SLAs includes an ethnicity breakdown for Māori.	There is an increase in reports provided to the Alliance Leadership Team by work streams and SLAs that include an ethnicity breakdown for Māori (baseline = 0).
	Ensure Māori are consistently considered through the programme cycle of all CCN work streams and SLAs.	
	8.4. Deliver a cultural competency programme that includes Whānau Ora.	A plan is developed and delivery is commenced.
	8.5. Ensure reporting of information for all work streams and SLA groups has quality indicators for Māori.	There is an increase in the numbers of work streams and SLAs that have actions which deliver benefits to Māori.
Access to comprehensive, quality primary health care services that meet the needs of Māori	Improve coverage of key health programmes for Māori.	
	8.6. Support CCN work streams and SLAs to focus on improving Māori coverage in their respective programmes particularly in the areas of child and youth health, and cervical screening.	90% of eligible Māori children receive a B4SC every month by end of Q4.
		Make progress towards the national target that 80% of Māori women receive a cervical smear by end of Q4.
		60% of Māori girls born in 2000 receive HPV vaccination Dose 3 by end of Q4.
OBJECTIVE	**ACTION (MEASURABLE)**	**EVIDENCE**
9. Improve health outcomes for Pacific People in Canterbury.		
A whole of system quality approach that promotes longer, healthier, more independent lives for Pacific peoples.	Ensure complete, accurate and consistent collection and reporting of ethnicity data for Pacific peoples across the system.	
	9.1. Training is available to all general practice teams on ethnicity data collection (based on CDHB ethnicity data collection policy).	Availability is maintained.
	9.2. Information for CCN work streams and SLAs includes an ethnicity breakdown for Pacific peoples.	There is an increase in reports provided to the Alliance Leadership Team by work streams and SLAs that include an ethnicity breakdown for Pacific Peoples (baseline = 0).
	Ensure Pacific peoples are consistently considered through the programme cycle of all CCN work streams and SLAs.	
	9.3. Deliver a cultural competency programme that includes Whānau Ora.	A plan is developed and delivery is commenced.
	9.4. Ensure reporting of information for all work streams and SLA groups has quality indicators for Pacific peoples.	There is an increase in the numbers of work streams and SLAs that have actions which deliver benefits to Pacific peoples.
Access to comprehensive, quality primary health care services that meet the needs of Pacific peoples	Improve coverage of key health programmes for Pacific peoples.	
	9.5. Support CCN work streams and SLAs to focus on improving Pacific peoples' coverage in their respective programmes particularly in the areas of child and youth health, and cervical screening.	90% of eligible Pacific children receive a B4SC every month by end of Q4.
		Make progress towards the national target that 80% of Pacific women receive a cervical smear by end of Q4.
		60% of Pacific girls born in 2000 receive HPV vaccination Dose 3 by end of Q4.

OUR PERFORMANCE STORY 2013/14		
OBJECTIVE	**ACTION (MEASURABLE)**	**EVIDENCE**
What is our aim?	*What action will we take to make this happen?*	*How will we demonstrate achievement?*
10. Continue to implement "whole of health system" improvements in service provision through information technology.		
	10.1. Integrate information across the Canterbury health system on patients through providing a shared patient information portal for use by health providers at the point of care through the Electronic Shared Care Record View (eSCRV).	eSCRV view and extract installed at 95% of all General Practices (Q4).
		95% of Community Pharmacies contributing dispensing data (Q4).
		Identify further services and health providers to provide access to, and contribute information to eSCRV (Q2).
	10.2. Improve the care of long term complex patients through the use of the Collaborative Care Management Solution (CCMS) application in the Collaborative Care Programme.	Ability to create acute care plans in CCMS through HCS/ eSCRV (Q4).
		CCMS Acute care plans are available at 24 Hour Surgery, Riccarton After Hours and the Emergency Department (Q4).
		CCMS installed at a further ten health providers (Q4).
	10.3. Improve the management of medications for long term complex patients through use of the Collaborative Care Management Solution (CCMS) in the Medications Management Service (MMS).	CCMS installed for the MMS service (Q3).
		All patients for the MMS service are on CCMS (Q4).
	10.4. Improve the reliability of referrals through providing the Electronic Request Management Solution (ERMS).	>75% of all Canterbury general practitioners have access to ERMS (Q4). >75% of all general practice referrals to Christchurch Hospital are through ERMS (Q4).
	10.5. Improve the ability to manage health services provided to patients by developing referral management capability in the Electronic Request Management Solution (ERMS) beyond Community Referred Radiology.	Develop generic tools for referral review and provider allocation (Q4).
	10.6. Implement the Electronic Request Management Solution (ERMS) across the South Island.	ERMS installed and used in the West Coast, Nelson-Marlborough and South Canterbury districts (Q4).
	10.7. Provide on-demand integrated datasets to enable better across-system service provision through use of the Lightfoot sfn application.	Integrate acute demand, electronic referral and CREST datasets (Q4).
		Identify other datasets to be integrated into Lightfoot sfn (Q2).
OBJECTIVE	**ACTION (MEASURABLE)**	**EVIDENCE**
11. Continue to improve access to diagnostic services.		
Radiology Services	Develop a seamless radiology system that provides access to images and reports to relevant clinicians in both public and private sectors	
	11.1. Provide access to both images and reports through Testsafe.	100% of images and reports are available through Testsafe by the end of Q1.
	11.2. Extend eSCRV access to private specialists	eSCRV access is extended to private specialists by the end of Q4.
	Improve and enhance demand management strategies for radiology services	
	11.3. Establish a senior clinical governance group to advise on adjustments to access criteria and pathway thresholds to match demand with radiology capacity.	Clinical governance group is established by the end of Q4.
	11.4. Radiology activity reports are routinely sent to individual clinicians and departments.	75% of radiology referrers receive individual monthly activity report by the end of Q3.
	11.5. Develop initiatives to improve quality of radiology referrals.	Programme of 6 monthly education sessions on radiology referrals are in place by the end of Q2.
	Improve and enhance the patient journey	
	11.6. Develop a recommendation for the integration of radiology services with health hubs.	Radiology recommendation submitted to facilities planning group by the end of Q2.
	11.7. Extend information on radiology services available on the HealthInfo website.	Review of radiology information on HealthInfo and recommendations made by the end of Q2.
	Improve equity of access to radiology services	
	11.8. Align radiology referral and triage criteria across the Canterbury health system including primary and secondary care where appropriate.	Full alignment of appropriate referral and triage criteria in place by the end of Q2. 85% of accepted referrals for CT and 75% of accepted referrals for MRI scans receive their scan

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OBJECTIVE	**ACTION (MEASURABLE)**	**EVIDENCE**
What is our aim?	*What action will we take to make this happen?*	*How will we demonstrate achievement?*
		within six weeks (42 days).
Laboratory Services	Continue to improve access to diagnostic services	
	11.9. Review blood collection centres and implement a plan for sample collection that improves access including in rural areas. The plan will address the factors of access, location, patient enrolment status (if in a medical centre) and home visits.	A plan for Collection centres will be presented to the Laboratory SLA before Q1. The plan will be aligned to the strategy for IFHCs and Hubs.
	11.10. Laboratory tests will support the community based clinicians including general practitioners and private specialists to avoid unnecessary admissions to hospital.	95% of test results for acute demand patients are delivered within 90 minutes (Q1-4).
	11.11. Review/set parameters around reporting of results to identify: what is timely? Should patients be notified of all results? Who is responsible for reporting to patients? How will patients access interpretation of results?	Paper with KPIs based on the parameters to be presented to SLA by Q2.
	The laboratory service is integrated and seamless regardless of the lab service provider	
	11.12. Create work streams that will systematically work through all tests to ensure standardisation between labs.	Tests will be prioritised and the high priority tests will be standardised by Q1 or relevant interpretive information will be provided to requesting clinicians.
	11.13. Laboratory based medical and scientific staff will support development of Health Pathways.	Advice is communicated to referrers on best practice for testing as work streams systematically work through the test lists.
		Information on Health Pathways is informed by laboratory medical and scientific staff.
	11.14. Review requirements for the Laboratory Information System for an integrated service and recommend options for either a single LIS or integration of the two existing LIS.	LIS review completed and a decision on the recommendations made before Q1.
	A high quality and cost effective service is maintained.	
	11.15. Set up standards and audit committee with representatives of both labs. The former would define standards, and the latter create audits to test compliance with those standards.	Terms of Reference for committee agreed by Q1. Audits commence in Q2, and continue thereafter.
	11.16. Test results available to all clinicians via eSCRV. Continue to develop methods to reduce unnecessary testing, including unnecessary duplication of testing. Develop measures that reflect the proportion of appropriate testing in order to support ongoing improvement.	Develop measures of appropriate testing by Q4.
	11.17. Emergency capacity is planned for.	Both Labs present a paper on what contingency capacity is needed and proposal of how to meet that capacity by Q1.
		All test results stored in data warehouse accessible to staff from each lab in Q4.
		Lab staff trained on other's LIS, protocols.
	11.18. Laboratory service informs the health system of emerging issues and opportunities to improve clinical outcomes	Information on HealthPathways is informed by laboratory medical and scientific staff.
Implement new models for community pharmacy services.	11.19. Development of multi-disciplinary team.	Demonstration sites agree to local alliance variation.
		20 demo sites signed up by Q2.
		Relationships built with general practice teams.
	11.20. Integrated patient care.	More pharmacist time is freed to carry out work as part of the integrated clinical team. Benchmark processes in 14 sites to identify efficiencies and reduce waste by Q2.
		All pharmacy sites able to view patient health records in eSCRV by Q2.
		CCMS installed for LTC patients Q4. 20 demo sites able to pilot CCMS by end Q4.
	11.21. Reduce risk of major harm from medications.	eSCRV installed in pharmacy sites. All pharmacy sites able to view patient health records in eSCRV by Q2.
		Medication Management Service established in community pharmacy (Q1).
	11.22. Support the implementation of the national Community Pharmacy Services Agreement (CPSA).	CPSA implemented.

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OBJECTIVE	**ACTION (MEASURABLE)**	**EVIDENCE**
What is our aim?	*What action will we take to make this happen?*	*How will we demonstrate achievement?*
12. Workforce development initiatives are carried out that support changes being developed by the Clinical Network.		
	12.1. Senior RNs as Care coordinators are put in place in order to support the organised management of people with complex needs. Nurses working in these roles and who have conditions that are amenable to community based care but are at risk of requiring a hospital admission.	More coordinators are employed within primary care in Canterbury.
		Nurses working in these roles across the aged care, IFHC, rural and CCMS workstreams come together in joint forum for peer support and role development. At least three opportunities over 12 months (Q4).
		An evaluation framework of the care coordination function is developed (Q4).
		Canterbury participates as a site for trial for HWNZ national care coordination training programme (Q4).
	12.2. Pharmacists are supported to provide improved clinical services to patients through the local delivery of Medicines Use Review training and are supported to achieve accreditation to deliver these services.	More Pharmacists in Canterbury have received MUR training (target to be agreed).
		More Pharmacists in Canterbury are accredited to deliver MUR services.
OBJECTIVE	**ACTION (MEASURABLE)**	**EVIDENCE**
13. Further integrate and improve the delivery of immunisation services across the whole system. and maintain the Immunisation Service Level Alliance and Immunisation Provider Groups		
Reduce vaccine preventable diseases and increase immunisation rates and coverage.	13.1. Develop systems for seamless handover between maternity, general practice and WCTO services; 13.2. Ensure early enrolment of newborns with general practice; 13.3. Explore linkages with Child Youth and Family, MSD and other relevant social service agencies.	95% all newborn babies are enrolled on the NIR at birth.
		100% of newborns are enrolled with a GP provider by 6 weeks of age.
	13.4. Refine reporting to enable NIR to provide more direct support to general practice and better locate unvaccinated children. 13.5. Expand reporting to include general practice level coverage reports to identify and address gaps in service delivery.	85% of all 6-week-olds are fully immunised.
		90 % of all 8-month-olds are fully immunised.
		95% of all 2-year-olds are fully immunised.
	13.6. Support the Missed Event Coordinator to locate missing children; 13.7. Focus Outreach Immunisation Services on locating and vaccinating hard to reach children and reducing inequalities for tamariki Māori and children; 13.8. Identify the immunisation status of children presenting at hospital and provide missing immunisations.	Quarterly performance reports circulated to PHOs to review progress against targets.
	13.9. Implement the DHB Immunisation Promotional Plan 'Immunise for Life' and support Immunisation Week; 13.10. Maintain a Systems Resource for General Practice; 13.11. Streamline access to immunisation awareness information.	Narrative report on interagency activities to promote immunisation week (Q4).
	13.12. Link 11 year old and HPV immunisation events; 13.13. Support active pre-call programmes for HPV.	60% of girls born in 2000 receive HPV Dose 3 by end of Q4.
	13.14. Invest in free flu vaccinations for those under 18, as well as older people (65+) and pregnant women, to reduce winter demand; 13.15. Provide free Pertussis vaccinations for Pregnant Women and their Whānau.	40% of young people (<18) have a seasonal flu vaccination.
		75% of older people (65+) have a seasonal flu vaccination.

8.9 DHB performance monitoring framework

PERFORMANCE MEASURE	PERFORMANCE EXPECTATION		CANTERBURY TARGET		NATIONAL TARGET	REPORTING FREQUENCY
PP1 Workforce – improving clinical leadership	Report progress of DHB to work to improve clinical leadership and engagement across all levels of the DHB and the Regional Training Hubs.					Annual
PP6 Improving the health status of people with severe mental illness through improved access	% of the population accessing specialist mental health services	Age 0-19	3%		NA	Six-monthly
		Age 20-64	3%			
		Age 65+	NA			
PP7 Improving mental health services using relapse prevention planning	% of long-term clients with up-to-date relapse prevention plans	Adult (20+)	95%		95%	Six-monthly
		Child & Youth	95%		95%	
PP8 Shorter waits for non-urgent mental health and addiction services	% of people referred for non-urgent mental health services seen within 3 and within 8 weeks		3wks	8wks	80% within 3 weeks 95% within 8 weeks	Quarterly
		Age 0-19	75%	85%		
		Age 20-64	75%	90%		
		Age 65+	75%	90%		
		Total	75%	90%		
	% of people referred for non-urgent addictions services seen within 3 and within 8 weeks		3wks	8wks	80% within 3 weeks 95% within 8 weeks	Quarterly
		Age 0-19	75%	85%		
		Age 20-64	75%	90%		
		Age 65+	75%	90%		
		Total	75%	90%		
PP10 Oral Health DMFT Score at Year 8	DMFT score at Year 8	2013	0.82		NA	Annual
		2014	0.77			
PP11 Children caries-free at 5 years of age	% caries-free at age 5	2013	65%		NA	Annual
		2014	67%			
PP12 Utilisation of DHB-funded dental services by adolescents	School Year 9 up to and including age 17 years	2013	85%		85%	Annual
		2014	≥85%			
PP13 Improving the number of children enrolled in DHB-funded dental services	% of children (age 0-4) enrolled	2013	68%		NA	Annual
		2014	72%			
	% of children (0-12) not examined according to planned recall	2013	10%			
		2014	7%			
PP18 Improving community support to maintain the independence of older people	% of older people receiving long-term home support who have had a comprehensive clinical assessment and an individual care plan		≥95%		≥95%	Quarterly

PERFORMANCE MEASURE	PERFORMANCE EXPECTATION		CANTERBURY TARGET	NATIONAL TARGET	REPORTING FREQUENCY
PP20 Improved management for long-term conditions (CVD, diabetes and Stroke) Focus area 1: Cardiovascular disease	% of high-risk ACS patients receiving an angiogram within 3 days of admission		70%	70%	Quarterly
	% of patients presenting with ACS who undergo coronary angiography being recorded on the ANZACS QI Registry [101]		95%	95%	
Focus area 2: Stroke services	% of potentially eligible stroke patients thrombolysed		6%	6%	
	% of stroke patients admitted to a stroke unit or organised stroke service with a demonstrated stroke pathway		80%	80%	
Focus area 3: Diabetes – Management	% of enrolled people aged 45-74 with diabetes and microalbuminuria who are prescribed an ACE1 or an ARB [102]		Maintain or improve access	NA	
	% of enrolled people aged 15-74 with acceptable glycaemic control (HbA1c ≤64mmol/mol) [103]		Maintain or improve access	NA	
PP21 Immunisation coverage	% of two-year-olds fully immunised		95%	95%	Quarterly
PP22 Improving system integration	Report on delivery of the actions and milestones identified in the Annual Plan.				Quarterly
PP23 Improving wrap-around services – health of older people	Report on delivery of the actions and milestones identified in the Annual Plan.				Quarterly
PP24 Improving waiting times – cancer multidisciplinary meetings	Report on delivery of the actions and milestones identified in the Annual Plan.				Quarterly
PP25 Prime Minister's youth mental health project	Provide a written stocktake, gaps analysis and actions being considered.				Quarters 1 & 2
PP26 The Mental Health & Addiction Service Development Plan	Provide gaps analysis and report against SDP milestones.				Quarters 1, 2 & 4
PP27: Delivery of the Children's Action Plan	Report on delivery of the actions and milestones identified in the Annual Plan.				Quarterly
PP28: Reducing rheumatic fever	Acute rheumatic fever rate of hospitalisation per 100,000	South Island rate	0.5 per 100,000	10% reduction	Six-monthly
SI1 Ambulatory sensitive (avoidable) hospital admissions	DHB rate vs. national rate (per 100,000)	Age 0-4	≤118% (<6,656)	NA	Six-monthly
		Age 45-64	<95% (<1,578)		
		Age 0-74	<95% (<1,883)		
SI2 Regional service planning	A single progress report on behalf of the region, agreed by all regional DHBs.				Quarterly
SI3 Ensuring delivery of Service coverage	Report progress achieved during the quarter towards resolution of exceptions to service coverage identified in the Annual Plan, and not approved as long-term exceptions, and any other gaps in service coverage.				Six-monthly

[101] *Implementation of the ANZACS QI Register is dependent on national contracts being agreed – timeframes are anticipated. Data will be provided for the ACS measure via the South Island Alliance until the ANZACS Register is up and running.*

[102] *The Ministry is currently working on a means of data capture for this measure nationally the baseline is to be established.*

[103] *This number is to be worked up from the DHB/PHO register at the end of 2012/13 year and confirmed in Q1 this will establish a baseline.*

PERFORMANCE MEASURE	PERFORMANCE EXPECTATION	CANTERBURY TARGET	NATIONAL TARGET	REPORTING FREQUENCY
SI4 Elective services standardised intervention rates	Major joint replacement procedures	21 per 10,000	21.0 per 10,000	Annual
	Cataract Procedures	27 per 10,000	27.0 per 10,000	
	Cardiac surgery	6.5 per 10,000	6.5 per 10,000	Quarterly
	Percutaneous revascularisation	≥11.9 per 10,000	≥11.9 per 10,000	
	Coronary angiography services	≥33.9 per 10,000	≥33.9 per 10,000	
SI5 Delivery of Whānau Ora	Report progress on planned activities with providers to improve service delivery and develop mature providers.			Annual
OS3 Inpatient length of stay	Elective surgical LOS	≤3.21	NA	Quarterly
	Acute LOS	≤4.28		
OS8 Acute readmissions to hospital	% total population	At or below national average	NA	Quarterly
	% population aged 75+		NA	
OS10 Improving the quality of data provided to national collection systems	NHI duplications	3-6%	3-6%	Quarterly
	Ethnicity set to 'Not stated' or 'Response Unidentifiable' in the NHI	0.5-2%	0.5-2%	
	Standard vs. edited descriptors	75-90%	75-90%	
	Timeliness of NMDS data	2-5% late	2-5% late	
	NNPAC ED admitted events have a matched NMDS event	97-99.5%	97-99.5%	
	PRIMHD File Success Rate	98-99.5%	98-99.5%	
OP1 Mental health output delivery against plan	Volume delivery for specialist Mental Health and Addiction services is within: a) five percent variance (+/-) of planned volumes for services measured by FTE, b) five percent variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day, and c) actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan	Within 5% of plan	Within 5%	Quarterly

8.10 Statement of accounting policies

The prospective financial statements in this Statement of Intent for the year ended 30 June 2014 are prepared in accordance with Section 38 of the Public Finance Act 1989 and they comply with NZ IFRS, as appropriate for public benefit entities. FRS-42 states that the (prospective) forecast statements for an upcoming financial year should be prepared using the same standards as the statements at the end of that financial year. The following information is provided in respect of this Statement of Intent:

(i) Cautionary Note

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

(ii) Nature of Prospective Information

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

(iii) Assumptions

The main assumptions underlying the forecast are noted in Section 8 of the Statement of Intent.

REPORTING ENTITY AND STATUTORY BASE

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

Canterbury DHB has designated itself and its subsidiaries, as public benefit entities, as defined under New Zealand Equivalents to International Financial Reporting Standards (NZ IFRS).

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

The consolidated financial statements of Canterbury DHB consist of Canterbury DHB, its subsidiaries-Canterbury Linen Services Ltd (formerly Canterbury Laundry Service Ltd) (100% owned) and Brackenridge Estate Ltd (100% owned), and associate entity South Island Shared Service Agency Ltd (47% owned). From 1 December 2011, the operation and staff of South Island Shared Service Agency Ltd (SISSAL) were transferred over to Canterbury DHB and managed under the South Island Alliance Programme Office.

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

BASIS OF PREPARATION

Statement of compliance

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

Measurement basis

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

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

Functional and presentation currency

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

Changes in accounting policies

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

Standards, amendments and interpretations issued that are not yet effective and have not been early adopted

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

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

The External Reporting Board is working through a new accounting standards framework for public benefit entities. It is expected that all new NZ IFRS and amendments to existing NZ IFRS with a mandatory effective date for annual reporting periods commencing on or after 1 January 2012 will not be applicable to public benefits entities. This means that the financial reporting requirements for public entities are expected to be effectively frozen in the short-term. Accordingly, no disclosure has been made about new or amended NZ IFRS that exclude public benefit entities from their scope.

SIGNIFICANT ACCOUNTING POLICIES

Basis for Consolidation

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

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

Subsidiaries

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

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

Associates

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

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

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

Transactions eliminated on consolidation

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

Foreign currency

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

Monetary assets and liabilities denominated in foreign currencies at the balance sheet date are translated to NZD at the foreign exchange rate ruling at that date. Foreign exchange differences arising on translation are recognised in the surplus or deficit. Non-monetary assets and liabilities that are measured in terms of historical cost in a foreign currency are translated using the exchange rate at the date of the transaction. Non-monetary assets and liabilities denominated in foreign currencies that are stated at fair value are translated to NZD at foreign exchange rates ruling at the dates the fair value was determined.

Budget figures

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

Property, plant and equipment

Classes of property, plant and equipment

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

- freehold land
- freehold buildings and building fit out
- leasehold building
- plant, equipment and vehicles
- work in progress

Owned assets

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

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

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

Additions

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

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

Subsequent costs

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

Disposal of Property, Plant and Equipment

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

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

Donated Assets

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

Depreciation

Depreciation is charged to the surplus or deficit using the straight line method so as to write off the cost or valuation of fixed assets above $2,000 to their estimated residual value over their expected

economic life. Assets below $2,000 are written off in the month of purchase. Land is not depreciated.

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

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

The residual value of assets is reassessed annually.

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

Intangible assets

Software development and acquisition

Expenditure on software development activities, resulting in new or substantially improved software and processes, is capitalised if the product or process is technically and operationally feasible and Canterbury DHB has sufficient resources to complete development. The expenditure capitalised includes the cost of materials, direct labour and an appropriate proportion of overheads. Other development expenditure is recognised in the surplus or deficit when incurred. Capitalised development expenditure is stated at cost less accumulated amortisation and impairment losses.

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

Amortisation

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

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

Investments

Financial assets held for trading are classified as current assets and are stated at fair value, with any resultant gain or loss recognised in other comprehensive income.

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

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

Trade and other receivables

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

Inventories

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

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

Cash and cash equivalents

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

Canterbury DHB is party to the "DHB Treasury Services Agreement" between Health Benefits Limited (HBL) and the participating DHBs. This Agreement enables HBL to "sweep" DHB bank accounts and invest surplus funds on their behalf.

The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with HBL, which will incur interest at on-call interest rate received by HBL plus an administrative margin. The maximum debit balance that is available to any DHB is the value of one month's Provider Arm funding, less net Inter-District In-Flows, plus GST.

Impairment

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

If the estimated recoverable amount of an asset is less than its carrying amount, the asset is written down to its estimated recoverable amount and an impairment loss is recognised in the surplus or deficit.

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

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

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

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

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

other comprehensive income, a reversal of the impairment loss is also recognised in other comprehensive income.

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

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

Restricted assets and liabilities

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

Borrowings

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

Employee benefits

Defined contribution plans

Obligations for contributions to defined contribution plans are recognised as an expense in the surplus or deficit as incurred.

Defined benefit plans

Canterbury DHB makes contributions to the Defined Benefit Plan Contributors Scheme (the scheme), which is a multi-employer defined benefit scheme.

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

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

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

Annual leave, conference leave and medical education leave

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

Provisions

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

ACC Partnership Programme

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

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

Trade and other payables

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

Derivative financial instruments

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

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

Income tax

Canterbury DHB is a crown entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under section CW38 of the Income Tax Act 2007.

Goods and services tax

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

Revenue

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

Revenue relating to service contracts

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

Services rendered

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

Interest income

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

Operating lease payments

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

Non-current assets held for sale

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

Any impairment losses for write-downs of non-current assets held for sale are recognised in the surplus or deficit.

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

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

Borrowing costs

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

Critical judgements in applying Canterbury DHB's accounting policies

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

Property, plant and equipment useful lives and residual value

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

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

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

In light of the Canterbury earthquakes, Canterbury DHB has reviewed the carrying value of land and buildings, resulting in an impairment of land and buildings. Other than this review, Canterbury DHB has not made any other significant changes to past assumptions concerning useful lives and residual values.

Retirement and long service leave

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

Leases classification

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

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

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

Non-government grants

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


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