Statement of Intent 2014-2018

Incorporating the Statement of Performance Expectations 2014/15

THE CANTERBURY HEALTH SYSTEM

Working together to make it better

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

STATEMENT OF INTENT

Produced July 2014
Pursuant to Section 149 of the Crown Entities Act 2004

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

Statement of Responsibility

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 designated as a Crown Agent under the Crown Entities Act 2004 and is responsible to the Minister of Health for a geographically defined population.

This Statement of Intent (incorporating the Statement of Performance Expectations) 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 long-term goals and objectives and describes what the DHB intends to achieve in 2014/15 in terms of improving the health of its population and delivering on the expectations of the Ministry of Health.

The Statement of Intent also contains financial forecast information for the current and three subsequent years: 2015/16, 2016/17 and 2017/18.

The Statement of Intent is extracted from the DHB's Annual Plan and presented to Parliament as a separate public accountability document. It 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. Clinically led local and regional alliances have been established as vehicles for implementing system change and improving health outcomes. This includes the large-scale Canterbury Clinical Network (CCN) District Alliance and the South Island Regional Alliance.

In line with this approach, the actions outlined in this document present a picture of the joint commitment between the Canterbury DHB and its alliance partners to improve the health of the Canterbury community and deliver the expectations of Government. The full work plans of the workstreams under the Canterbury Clinical Network District Alliance can be found on the CCN website: www.ccnweb.org.nz.

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

In signing this Statement of Intent, 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 2014 to 30 June 2018.

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

Murray Cleverley
Chairman Canterbury DHB

Steve Wakefield
Deputy Chairman Canterbury DHB

Date: November 2014

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Part I – Overview

A message from the Chairman & Chief Executive

Keeping Cantabrians well and healthy and in their own homes and communities.

The Canterbury DHB is charged by Government with overall responsibility for working within the funding allocated to improve, promote and protect the health and independence of the Canterbury population. As both the major funder and provider of health and disability services in Canterbury, we are strongly motivated to do the very best we can to deliver the most efficient services possible and to ensure those services are effective in improving the health and well-being of the people living in our community.

Our vision is a truly integrated health system that keeps people healthy and well in their own homes by ensuring the right care and support is provided in the right place at the right time by the right person.

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

We collaborate with our health system alliance partners under the Canterbury Clinical Network and work closely with key stakeholders, agencies, provider organisations and our community to decide what services are needed and how best to use the funding we receive to improve the health of our population and enhance efficiencies across the whole of the Canterbury health system.

We work closely with our five colleague District Health Boards and support the work of the South Island Regional Alliance in streamlining patient pathways, and improving the quality and coordination of care. Canterbury's innovative electronic solutions for sharing clinical information and connecting up the system; such as HealthPathways and our electronic shared cared record view and electronic referral management system are now being extended to the whole South Island.

We have a particular focus on connecting Canterbury with the West Coast DHB. Shared executive functions and an integrated clinical workforce, enabled through the development of Transalpine Services, will help to improve the health of the West Coast population and enhance efficiencies across both health systems.

We also work with the Ministry of Health and national Entities including Health Workforce NZ, the Health Quality & Safety Commission, National Health Committee and Health Benefits Limited to develop and implement national initiatives to improve outcomes for patients and the system.

Our Reality

Like all health systems world-wide we are facing the challenges of an increasing demand for services, rising treatment costs and workforce shortages with an ageing population and an ageing work force.

In Canterbury we are also contending with the consequences of New Zealand's largest natural disaster.

The earthquakes have displaced people from their homes, communities and usual support networks. Our population and our workforce 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.

Three years on demand trends are changing, there are worrying signs in terms of the mental health and wellbeing of young people and families in Christchurch. The long term impacts on our population's health and well-being cannot be accurately predicted because Canterbury's experience is unique, particularly in terms of the extended nature of the crisis we have faced.

What we do know is 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. The complexity of this will increase markedly as the development of our new hospital facilities accelerates. Our workforce is tired and showing measureable signs of fatigue in the face of the on-going pressures both at home and at work.

The unique circumstance created by the timing differences between the recognition of insurance proceeds and the eventual spend adds further complexity. The total overall cost of the earthquakes is still an unknown factor and we expect the cost impacts to continue to influence and distort our financial results for the next several years. These costs appear in various types of expenditure, from the securing of external capacity to support our service delivery through to emergency repairs and maintenance.

Our Innovation

Responding to these multiple challenges has required Canterbury to focus on the short term management of the resources and capacity available - whilst maintaining a longer term strategic vision. We have been able to harness an internal capacity to innovate to meet the immediate challenge of ensuring constrained resources are utilised to their maximum effectiveness. This has required a vigilant focus on productivity and the continual improvement of systems and services to ensure the DHB is achieving the highest level of output possible.

Other health systems and government organisations have benefited from Canterbury's innovations. Canterbury's HealthPathways system is now being used in 17 health systems across Australia and New Zealand. Our Design Lab is used by many Canterbury based organisations and government departments as a place to develop new ideas and test solutions that meet the Government's desire for

Better Public Services. Visitors come from all over the world, including the United Kingdom's National Health Service, specifically to experience and learn from the Canterbury Health Systems. We were gratified to be invited to present our approach at the first World Health Organisation Forum (WHO) on Innovation in Ageing in Kobe, Japan late last year.

But while striving for greater productivity, the DHB must also work towards the longer-term goal of reorienting the health system to support our population to stay well, with greater care delivered in community settings closer to people's own homes.

Alongside the hospital redevelopments at Christchurch and Burwood we are working with general practices to facilitate the development of number of integrated family health centres that will bring a new range of services closer to people and reduce the need for hospital visits and residential care. The communities of Kaikoura, Rangiora and Ashburton are also looking forward to their new purpose designed facilities that will better support service delivery in their communities.

Overall we expect that a reorientation of service delivery around a single point of continuity, which for most people will be general practice, will enable us to deliver a health system able to withstand future demand.

We can see the impact of our approach in the reduction in numbers of older people requiring hospital and aged residential care. Last year more than 25,000 people received acute care free in the community when they would otherwise have gone to hospital. Analysis shows that Canterbury's acute hospital admissions were 20,000 less than would be expected if we were at the New Zealand average.

The Future

Canterbury has a unique opportunity to create a health system that is purpose designed for our future and consistent with our vision. Rarely has a whole health system been given the opportunity to move past the constraints of the past and build new infrastructure that clearly supports future service models.

With the Government's support the DHB is redeveloping facility capacity as an element of the wider plan for moving the whole of the Canterbury health system to a more productive and sustainable configuration. With over 47,000m^2 of building space being demolished and substantive repairs to be completed, we are also taking the opportunity created by the insurance proceeds to rebuild broken infrastructure in a way that supports our vision. Our partner organisations in health care delivery are equally focused on using this opportunity to build infrastructure that supports an integrated health system focused around the people we all support.

Public health, primary care and community health services provide the context in which hospital and specialist services must operate. Equally, the provision of modern, effective specialist care will support the ongoing journey of transformation in community based health services. We need the whole of the system to be working for the whole of the system to work.

The DHB's holistic approach to health service design means that facility redevelopment is an integral part of the plan for the future of health care in Canterbury.

However, even as we focus on rebuilding our damaged infrastructure we remain committed to improving our performance, meeting national targets, living within our means and, most importantly, ensuring the ongoing delivery of efficient and effective health services.

Continuing to connect our system to improve the continuity of care, minimise duplication and waste and reduce the time people spend waiting remain key focus areas for the Canterbury health system.

In light of our immediate challenges, we are increasing our emphasis on vulnerable population groups particularly children and young people, our older population, those struggling with mental health issues and our Māori population. We are collaborating with education, social services and justice to wrap care around those with more complex conditions, and lives, who need more support and intervention. We are also working across our system to achieve the expectations of government for better public health services.

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 will be making sure we are not just delivering more services, but more of the *right services* – delivered in the *right place* at the *right time* by the *right person*.

Murray Cleverley
Chairman Canterbury DHB

David Meates
Chief Executive Canterbury DHB

Date: November 2014

Introducing the Canterbury DHB

The Canterbury DHB is the second largest DHB in the country by both geographical area and population size - serving 482,181 people (11.4% of the New Zealand population) and covering 26,881 square kilometres and six Territorial Local Authorities.

The DHB is the single largest employer in the South Island, employing over 9,000 people across the DHB's hospitals and community bases. A similar number of people are employed in delivering health and disability services in Canterbury – either funded directly or indirectly by the Canterbury DHB.

As a large tertiary DHB, Canterbury also has a significant role to play as regional provider. Each year, close to 4,000 people from outside the region travel to Canterbury for specialist services that other DHBs do not deliver.

1.1 Our role and function

The Canterbury DHB receives funding from Government with which to purchase and provide health and disability services for the Canterbury population. In accordance with legislation, and the objectives of the DHB, we use this funding to:

Plan the strategic direction of the Canterbury health system and determine the services required to meet the needs of our population, in partnership with clinical leaders and our alliance partners and in consultation with other DHBs, service providers and our community.

Fund the majority of the health services provided in Canterbury, and through our collaborative partnerships and relationships with service providers, ensure services are responsive, coordinated and focused on what is best for the patient and the system.

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

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

1.2 Our operating structure

Our Board is responsible to the Minister of Health for the overall performance of the DHB and delivers against this responsibility by setting 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 requirements and maintains relationships with the Minister of Health and the Canterbury community.[1]

Four advisory committees assist the Board to meet its responsibilities. These committees are comprised of a mix of Board members and community representatives. As part of our commitment to shared decision-making, external providers and clinical leaders also regularly present and provide advice to the Board.

While responsibility for the DHB's overall performance rests with the Board, operational and management matters have been delegated to the Chief Executive. The Chief Executive is supported by an Executive Management Team, who provide clinical, strategic, financial and cultural input into decision-making and have oversight of patient safety and quality.[2]

Since July 2010, Canterbury has formally provided executive and clinical services for the West Coast DHB, with a shared Chief Executive, a growing number of joint appointments and shared corporate divisions including: finance, human resources, information technology, public health and planning and funding.

Planning and funding health services

The DHB's role includes determining how best to use the funding we receive from Government to improve the health, wellbeing and independence of our population. In line with Canterbury's vision, we do not do this in isolation. We work with other providers, agencies, organisations, stakeholders, consumers and our community to understand our population's health need.

Through this collaboration, we ensure that services are people-centred, integrated and sustainable. Our collaborative partnerships also allow us to share resources and reduce duplication, variation and waste across the whole of our health system to achieve the best health outcomes for our community.

Our Planning and Funding Division holds and monitors alliance agreements and service contracts with the organisations and individuals who provide health services to the Canterbury population. This includes an internal service agreement with our Hospital and Specialist Services Division and almost 1,000 service contracts and agreements with community providers, including the three Primary Health Organisations (PHOs), private hospitals, laboratories, mental health service providers, home based support providers and rest homes.

Providing health and disability services

As an 'owner' of hospital and specialist services, the DHB directly provides a significant share of the health and disability services delivered in Canterbury. We provide these services through our Hospital and Specialist

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

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

Services Divisions: Medical and Surgical, Mental Health, Rural Health, Women's and Children's, Older Persons' Health and Rehabilitation, and Hospital Support and Laboratory Services.[3]

This is no small responsibility. In 2012/13 there were 87,241 presentations in our Emergency Departments, 86,681 medical and surgical inpatients discharged from our hospitals, 17,066 elective surgeries performed, 5,778 babies delivered, 152,865 consultations with our community based specialist mental health services and 618,162 specialist outpatient appointments.

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. The Canterbury DHB currently own and manage 15 hospitals and more than 18 community bases.

Promoting our population's health and wellbeing

Our Community and Public Health Division provides public and population health services and supports initiatives that focus on keeping people well. This work includes improving nutrition and physical activity levels and reducing tobacco smoking and alcohol consumption through service contracts and collaborative ventures such as 'Healthy Christchurch'.

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.

However, good health is determined by many factors and social determinants that sit outside the direct control of the health system. Our partnerships with other agencies (including local and regional councils, the Canterbury Earthquake Recovery Authority, Housing NZ, the Accident Compensation Corporation and the Ministries of Justice, Education and Social Development) are also vital in supporting the creation of social and physical environments that reduce the risk of ill health.

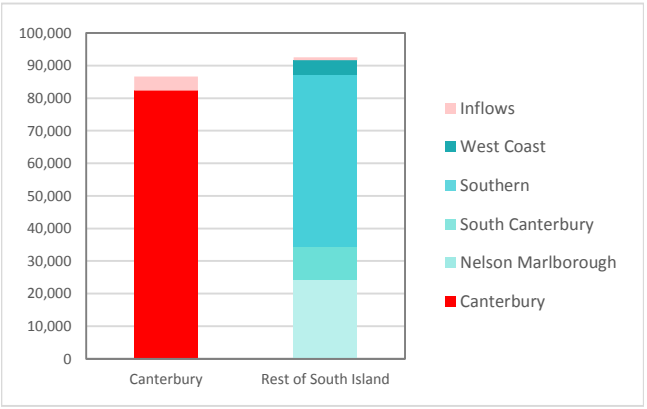
1.3 Our regional role

While our responsibility is primarily for our own population, the Canterbury DHB also 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 & youth inpatient mental health services; forensic services; neonatal services; paediatric neurology; gynaecological oncology; specialist diabetes and respiratory services; cardiothoracic; haematology/oncology; neurosurgery; plastics; gastroenterology; 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.

Annual hospital discharges by South Island DHB.



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 that include a number of clinically-led transalpine service pathways.

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

1.4 Our 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 required by legislation, we will engage with the Minister and seek prior approval before making any significant service change, capital investment or disposing of Crown land. We will also comply with consultation expectations communicated to us.

The Crown Entities Act requires DHBs to report annually to Parliament on their performance, as judged against our Statement of Performance Expectations. We publish this account as our Annual Report, available on our website.

In addition, DHBs have a number of other reporting obligations under the Crown Entities Act and Operational Policy Framework. This includes financial and non-financial service performance reporting provided to the National Health Board including:

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

We also meet requirements with respect to the provision of data for national collections, including: the national health index, national minimum dataset, national booking reporting system, national immunisation register, national non-admitted patient collection and national ethnicity reporting.

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

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 allocating resources across our health system. This information also helps us to understand the factors affecting our performance and to identify areas for focus and improvement.

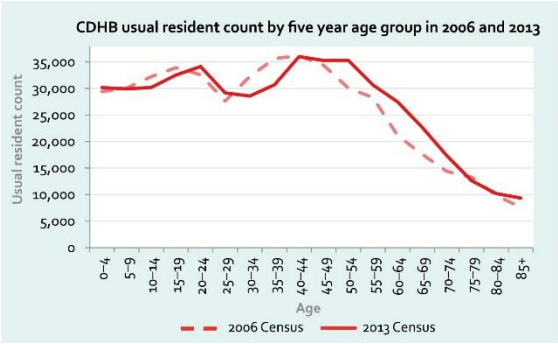
2.1 Population profile

Canterbury remains the second largest DHB in New Zealand by population and was home to a usually resident population of 482,181 people at the 2013 Census. While there was an initial drop in our population after the earthquakes, the census shows that our population has continued to grow. Our population was up from 466,404 in 2006 (an increase of 3.4%).[4]

Our population also continues to age and this is the factor that presents the biggest challenges to our health system. While our younger population decreased slightly between 2006 and 2013, there was significant growth in our older population groups.

In 2013, 15% of our population (72,192 people) were aged over 65 - higher than the national rate (14.3%) and 1.6% higher than in 2006. Of those, 7% (32,190) were over 75.

As we age, we develop more complicated health needs and multiple conditions, meaning we consume more health resources and are more likely to need specialised services. 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, infrastructure and finances.



Ethnicity is also a strong indicator of need for health services and our population is becoming more ethnically diverse. In 2013 8.2% of our population identified as Māori, 7.5% as Asian and 2.6% as Pacific.

We must consider the unique health needs of each of our population groups in our planning for the future. Our Māori and Pacific populations, for example, are younger and have a different age structure and growth pattern with 43.7% of our Māori population under 20 years of age, compared to 25.5% of the total population.

2.2 Health profile

Although our population has a higher life expectancy than other parts of New Zealand, the leading causes of death in Canterbury are similar. Cardiovascular diseases, including heart disease and stroke, are the leading cause of death, followed by cancers and respiratory diseases such as Chronic Obstructive Pulmonary Disease (COPD).

Diabetes is the ninth highest cause of death, but also an underlying factor for cardiovascular disease and contributes significantly to avoidable mortality.

In terms of demand for hospital 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 ease demand.

Canterbury's leading causes of avoidable hospital admission are gastroenteritis/dehydration; angina and chest pain; upper respiratory; and ear, nose and throat infections. Although lower than the national rate, falls are also a major cause of avoidable admission.

Health behaviour and risk factors

The negative health outcomes associated with risk factors such as poor diet, hazardous drinking and tobacco smoking place considerable pressure on our health system. Smoking is also a substantial contributor to socio-economically based health inequalities.

The most recent New Zealand Health Survey found that:

- Over one quarter (27%) of our adult population are classified as obese.
- On average, our population is less likely to drink in a hazardous manner (10% vs. 15% nationally), but this still amounts to one in every 10 adults.
- 15% of our population currently smoke - lower than the national average of 18%. However, smoking rates amongst Māori are significantly higher.

Social and economic factors, such as education, housing and income, are also widely accepted as contributing greatly to a person's health. While deprivation in Canterbury appears to have lowered between the 2006 Census and the 2013 Census, 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.

[4] Unless referenced, data is based on Ministry of Health mortality and demographic data and 2013 Census results. The Census results slightly under-count the population, with final adjusted population estimates due in August 2014. A further summary on the Census results is attached as Appendix 3.

Household overcrowding is an area of concern, which can lead to an increased risk of infectious illnesses such as rheumatic fever, meningococcal disease, influenza and ear, nose and throat infections. According to the 2013 Census, 3.2% of our households are overcrowded and over 17% of our Pacific households are overcrowded.

2.3 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. This affects not just the DHB, but almost every health and social service provider in Canterbury.

Our population remains unsettled. Many people are still living in temporary or crowded accommodation and moving about the city while they wait for repairs 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 also 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.

Demand pressures

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.

Mental health and behavioural disorders are the sixth most common cause of death in Canterbury, and the prolonged stress of the earthquakes and ongoing recovery issues is having a marked psychological impact on our population.

We are beginning to see a significant increase in demand for specialist mental health services, especially for young people. In the last two years there has been: a 20% increase in new presentation to specialist adult mental health services, a 35% increase in new presentations to psychiatric emergency services and a 40% increase in new presentations to Child & Youth Specialist Services.

Cross-sector strategies are being put in place to address this growing need. We are working closely with our primary care partners and the Ministry of Education to provide stress and anxiety support for young people in our schools and increase access to brief intervention counselling and support in the community.

Cross sector work is also focused on reducing alcohol harm with a number of collective workplace initiatives planned, inter-agency collaboration on alcohol harm reduction and additional investment in alcohol intervention counselling.

Accommodation is also a critical factor for patient flow in our services, with an increasing number of patients (particularly mental health clients) 'stuck' in services with no place to go.

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.

Facilities pressures

Canterbury has received approval for the Business Case for the redevelopment of Christchurch and Burwood Hospitals. However, it will be 2018 before the redevelopments are complete. Despite converting office space into wards, 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 12,000 rooms were damaged.

There will be several years of major disruption as we shift and relocate services to make required repairs and wait for the redevelopment to bring additional capacity online. This will continue to restrict our capacity, increase inter-hospital patient transfers, fragment services and clinical teams and put additional pressure on our workforce.

While the redevelopment process is underway, it is important that we make carefully considered decisions on the repair of current facilities to ensure safety and service continuity – without over-investing in facilities that do not have a future role.

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

Fiscal pressures

Government has given clear signals that DHBs need to live within their means and rethink how they deliver improved health outcomes in more cost-effective ways.

Numerous factors contribute to fiscal pressures: the increasing demand for services including diagnostics and residential care; rising treatment related and infrastructure costs and the rising costs of wages and salaries. Our ability to contain cost growth within affordable levels is made more difficult by increasing public and government expectations, the costs of new technology and demand for a seven-day-a-week service.

The total overall cost of the earthquakes is also an unknown factor. It is apparent that there is a significant level of remedial work needed which will not be covered by the insurance proceeds and we are still unable to accurately determine the final interplay between repair costs, insurance recovery, the impact of new Building Codes, construction inflation and cost escalations.

There are also complexities associated with the timing differences between the recognition of insurance proceeds and the actual spend in regard to repairs.

While fiscal pressures will be an increasing challenge, the Canterbury DHB is committed to operating within our funding allocations with reduced reliance on earthquake funding support from the Ministry of Health.

2.4 Critical success factors

The following areas are where the greatest gains can be made in improving health outcomes for our population and the viability of our health system. They also represent the major factors critical to our success, where failure would significantly 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 continue to connect our system electronically as well as organisationally to enable us to identify and target populations with the highest need, ensure continuity of care and the provision of care closer to home to reduce acute events and hospital admissions and reduce duplication and waste across our system.

Reducing acute demand

Acute (urgent or unplanned) admissions are the most significant source of pressure on health resources. Canterbury has already reduced the growth rate of acute medical admissions to well below national rates, avoiding over 20,000 acute admissions into our hospitals. With the loss of bed capacity after the earthquake we would be in real trouble had we not already made in-roads into reducing acute demand; by recognising when people need support earlier and providing appropriate alternatives to a hospital admission, in people's own homes and communities.

Left unchecked, acute demand can quickly 'crowd out' elective (planned) services - increasing waitlists and adversely affecting service quality.

Managing long-term conditions

A substantial portion of acute admissions are due to exacerbation of a long-term condition. The prevalence of long-term conditions (such as heart disease, diabetes and respiratory disease and depression) continues to grow. This is a worldwide pattern associated with an ageing population and lifestyle choices.

It is critical that we continue get ahead of escalating disease prevalence and support people to better manage their conditions and to stay well and healthy – intervening earlier to reduce the need for complex intervention, hospital admission or early entry into residential care.

Without improving the way long-term conditions are managed, we simply will not have the workforce or infrastructure 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.

This includes developing a sustainable 24-7 health service response to reduce delays in diagnosis and treatment and to eliminate barriers to improved patient flow.

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, the engagement of health professionals in prioritisation and service improvements and the introduction of electronic and 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 will enable the provision of services closer to home – including the development of Community Hubs and Integrated Family Health Centres.

With major shifts in our population, following the earthquakes and significant growth in Waimakariri, Selwyn and Ashburton districts the DHB will also focus on ensuring the provision of sustainable and integrated services in these areas. Construction is about to begin on a new Rangiora Community Hub and Ashburton developments are also underway.

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 and the needs of our communities.

Part II – Long-Term Outlook

Our Strategic Direction

What are we trying to achieve?

3.1 Our strategic context

Although they may differ in size, structure and approach, DHBs have a common goal: to improve the health of their populations by delivering high quality, accessible health care. With increasing demand for services, workforce shortages and rising costs, this goal is increasingly challenging and the whole of the New Zealand health system faces an unsustainable future.

In 2010 the National Health Board released *Trends in Service Design and New Models of Care*. This document provided a summary of international responses to the same pressures and challenges facing the New Zealand health sector, to help guide DHB service planning.[5]

International direction emphasises that faced with increasing demand, rising costs and workforce shortages; 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.
4. Managed specialisation, with a shift to consolidate the number of tertiary centre/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.

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

These shifts can only be achieved with the support of connected and integrated clinical networks and multidisciplinary teams and are consistent with the changes being driven across the Canterbury health system to meet the needs of our population.

These shifts are also consistent with the changes being driven across the South Island by the regional alliance of the five South Island DHBs.

3.2 The Canterbury vision

The focus on a whole of system approach and an integrated, connected 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 our hospitals. At its core, our vision is dependent on achieving a truly integrated, 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 redesigning the way we deliver health services, putting the patient at the centre of everything we do, reducing the time people spend waiting for treatment and improving outcomes for our population.

With a foundation of strong clinical leadership and the establishment of cross-sector alliances to support joint planning (including the large scale Canterbury Clinical Network District Alliance) we have been able to drive considerable transformations across our health system.

Together we are focused on the delivery of a clear direction and vision for our health system that includes:

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

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

The integrated approach adopted across Canterbury has demonstrated in a relatively short period of time how effective a whole-of-system response can be. The health and system outcomes we are seeing as a result of our commitment have been striking.

More people are healthier and take greater responsibility for their own health.

- More eight-month-olds are receiving their primary course of immunisations - 93% of all eight-month-olds are fully immunised.
- More of our vulnerable populations are receiving influenza vaccinations - 33% of under eighteen-year-olds were vaccinated in 2013, up from 19% in 2012 and 75% of over 65-year-olds were vaccinated.
- More people are receiving advice and support to stop smoking - 95% of all hospitalised smokers. In primary care we are now reaching 65% of all current smokers up from 34% last year.

More people are being supported to stay well in their own homes and communities.

- Our Acute Demand Management Service is easing pressure on our hospitals with 25,374 acute episodes of care managed in the community rather than in our hospitals in the last year.
- Our Community Rehabilitation Enablement and Support Team (CREST) provides a range of home-based rehabilitation packages to support people to leave hospital sooner or avoid admission altogether. In 2012/13, CREST supported close to 2,000 older people in their own homes.
- Our Falls Prevention Service supports older people at risk of falls and takes an integrated approach to reduce harm and hospitalisation. The service responded to 1,613 referrals in 2012/13.
- Our Brief Intervention Counselling Service meant that more than 700 young people and 5,000 adults were able to access mental health support from their general practice in 2012/13.

More people are receiving timely and appropriate care closer to their own home.

- More people are having skin lesions removed in general practice rather than in hospital. Average waits for skin lesion removal have dropped from 196 days in 2007 (when the service began) to under 53. Over 2,000 people accessed the service in 2013/14.
- More people are accessing respiratory services in the community rather than waiting for hospital appointment. Over 1,500 people received a spirometry test and almost 200 people accessed community-based pulmonary rehabilitation.
- Increasing numbers of people are also accessing diabetes services in the community with over 700 people receiving additional diabetes self-management support and almost 6,000 diabetes retinal screens being delivered.

More people are receiving timely hospital care.

- More elective surgery is being delivered in Canterbury than ever before, with 17,066 electives delivered in 2013/14, up from 16,494 in the previous year and 14,974 two years ago.
- Fewer people are being acutely admitted to hospital, with acute demand analysis showing 20,000 fewer events that expected based on the national average.
- People are waiting less for treatment - 95% of patients were admitted, discharged, or transferred from our Emergency Departments within six hours and 100% of patients waited less than four weeks for radiation therapy or chemotherapy treatment.

The 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. The HealthPathway system has been so successful it is now being rolled out across 17 other health system in New Zealand and Australia.
- Over 80% of our hospital referrals from general practice are now received electronically through the Electronic Referrals Management System.
- eSCRV now enables all of the health professionals involved in a patients care to access important information to improve clinical decision making and reduce duplication across our system.

While the outcomes to date have been impressive, our challenges are not short-term pressures to which there is a 'quick fix' solution. 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.

While many of our challenges are the same as those 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 our population in the wake of the earthquakes.

With capacity tightly restricted, we expect to contract private capacity to deliver some elective surgical services over the short term while we manage repairs to our facilities and complete the redevelopment of our hospitals. It is also likely that the way in which some community services are delivered will be reconsidered to allow for providers' capacity constraints.

In spite of our operating challenges, we will continue to harness innovation and motivate our workforce to improve productivity, systems and services and ensure that we are achieving the highest level of output possible.

We are fortunate that Canterbury has a strong collective vision and system-wide clinical alliances. These collaborative partnerships kept our health system together through one of the worst natural disasters in our country's history and we are confident we can continue to meet our challenges and take the next leap forward in the transformation of our health system

3.3 National direction

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.

The ultimate health sector outcomes are that all New Zealanders lead longer, healthier and more independent lives and the health system is cost-effective and supports a productive economy.

DHBs are expected to contribute to meeting health sector outcomes and Government commitments to provide *'better, sooner, more convenient health services'* by: increasing access to services and reducing waiting times; improving quality, patient safety and performance; and providing better value for money.

Alongside these longer-term national strategies and commitments, the Minister of Health's annual 'Letter of Expectations' also signals annual priorities for the health sector – most specifically with regards to the delivery of better public services and performance against the national health targets. [6]

The Canterbury DHB is committed to making continued progress against national priorities. Activity planned over the coming year to deliver on national expectations is part of the focus of the Canterbury Clinical Network (CCN) District Alliance and prioritised by the Alliance Workstreams and the DHB's Service Divisions.

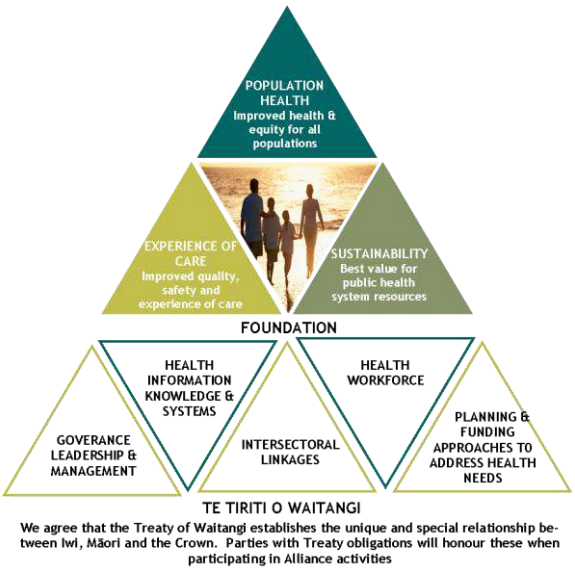
3.4 Regional direction

In delivering its commitment to '*better, sooner, more convenient health services*' the Government also has clear expectations of increased regional collaboration and alignment between DHBs.

The South Island Alliance was established in 2011 to formalise the partnership between the five South Island DHBs. In 2013, the region's DHBs agreed to further develop this approach with a framework that aligns all regional activity to agreed goals. The '*best for patients, best for system*' framework has become '*Best for People, Best for System',* supporting a focus on the whole population. The shared vision has also been revised to include disability to ensure key population groups are identified within the framework.

A sustainable South Island health and disability system focused on keeping people well and providing equitable and timely access to safe, effective, high-quality services, as close to people's homes as possible.

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. The South Island DHBs are committed through the Alliance to making the best use of all available resources, strengthening clinical and financial sustainability and ensuring equitable access to services for our populations.



The Canterbury, Nelson Marlborough, West Coast, South Canterbury and Southern DHBs form the South Island Alliance - together providing services for 1,004,380 people (23.7%) of the total NZ population.

The success of the Alliance relies on improving patient flow and the coordination of health services across the South Island - achieved 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

Closely aligned to the national direction, the shared outcomes goals of the South Island Alliance are:

- Improved health and equity for all populations.
- Improved quality, safety and experience of care.
- Best value for public health system resources.

Regional activity is implemented through service level alliances and workstreams. There are seven priority areas: Cancer, Child Health, Health of Older People, Mental Health, Information Services, Support Services and Quality and Safety.

Regional activity will is also focused on: cardiology, elective surgery, neurosurgery, public health, stroke and major trauma services. Regional asset and workforce planning, through the South Island Regional Training Hub, will contribute to improved delivery in all service areas.

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.

Canterbury also contributes by leading the delivery of regional activity including the continued rollout of HealthPathways, Heath Connect South, the eReferrals Management Solution, InterRAI assessment tool and the development of regional care protocols.

Our commitment in terms of the regional direction is outlined in the Regional Health Services Plan, available from the South Island Alliance website: www.sialliance.health.nz.

[6] *The Minister's Letter for 2014/15 is attached as Appendix 7.*

Measuring Our Progress

How will we know if we are making a difference?

DHBs are expected to deliver against the national health sector outcomes: '*All New Zealanders lead longer, healthier and more independent lives'* and '*The health system is cost effective and supports a productive economy*' and to meet Government commitments to deliver '*better, sooner, more convenient health services*'.

As part of this accountability, DHBs need to demonstrate whether they are succeeding in meeting those commitments and in improving the health and wellbeing of their populations. There is no single measure that can demonstrate the impact of the work DHBs do, so a mix of population health and service performance indicators are used as proxies to demonstrate improvements in the health status of the population and the effectiveness of the health system.

In developing its strategic framework, the South Island DHBs identified three high-level strategic regional goals. To achieve these goals, we have agreed a number of key strategies which will be achieved through the delivery of regional initiatives and the collective activity of all five South Island DHBs. A comprehensive indicator set is currently under development, to sit alongside the regional strategic framework and enable evaluation of regional activity.

While the regional framework is developed, the South Island DHBs have identified four collective outcome goals where individual DHB performance will contribute to regional success - along with a core set of associated outcomes indicators, which will demonstrate whether we are making a positive change in the health of our populations. These are long-term outcome indicators (up to 10 years in the life of the health system) and as such, the aim is for a measurable change in health status 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 acute medical admission rates.

- *Outcome 2: People with complex illnesses have improved health outcomes.*

  A reduction in avoidable mortality rates.

  A reduction in acute readmission rates.

- *Outcome 3: People experience optimal functional independence and quality of life.*

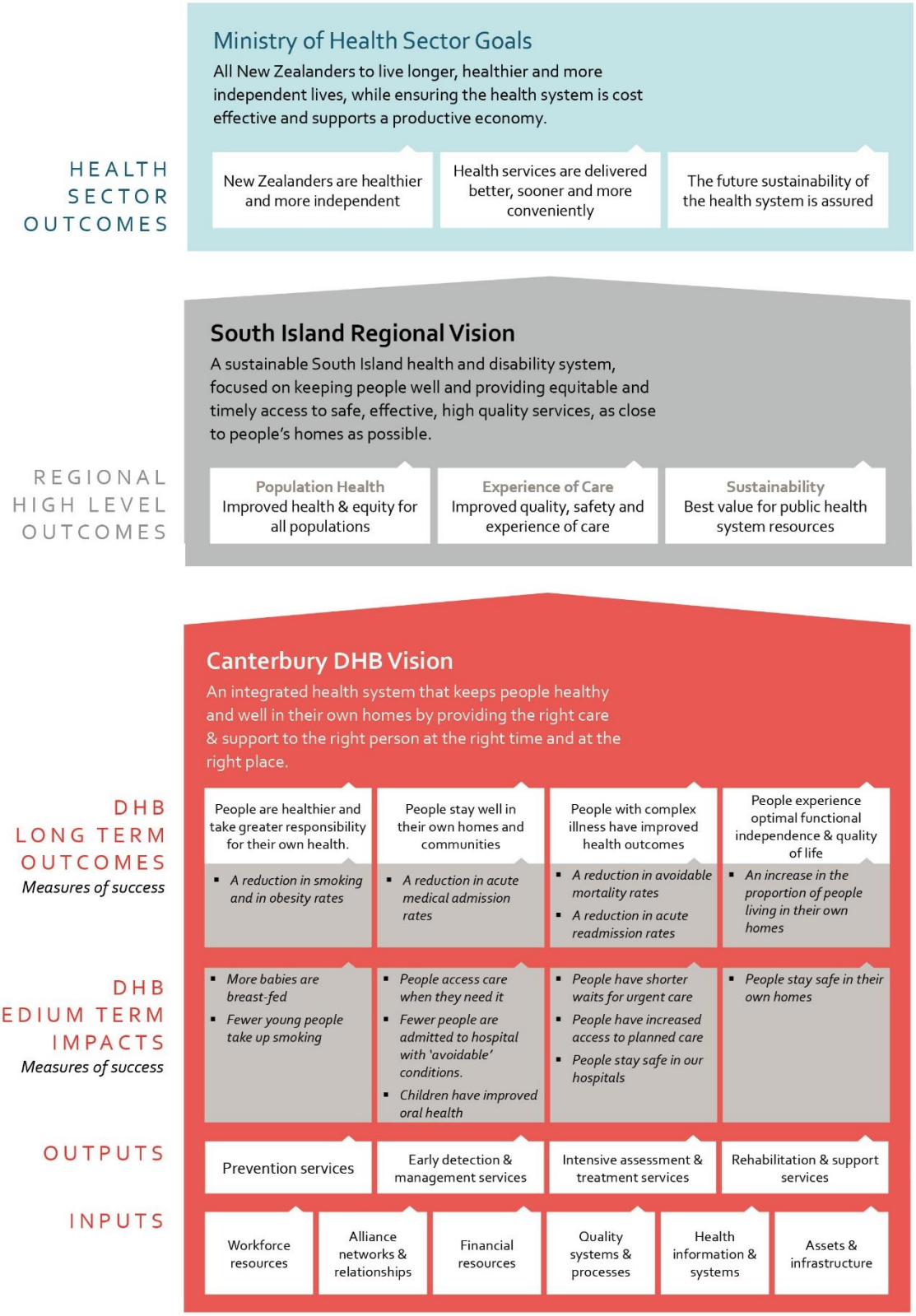
  An increase in the proportion of the population living in their own homes.

Each of the South Island DHBs has also identified a set of associated medium-term indicators of performance. Because change will be evident over a shorter period of time, these impact measures have been identified as the 'headline' or 'main' measures of performance, and each DHB has set local targets to evaluate their performance over the next four years. These indicators will sit alongside the DHB's Statement of Performance Expectations and be reported against in the DHB's Annual Report at the end of every year.

The following intervention logic diagram demonstrates the value chain: how the services that an individual DHB chooses to fund or provide (*outputs*) will have an *impact* on the health of their population and result in the achievement of desired longer-term regional *outcomes* and the expectations and priorities of Government.[7]

[7] *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.*

Overarching intervention logic



STRATEGIC OUTCOME GOAL 1

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

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 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. Long-term conditions are also more prevalent amongst Māori and Pacific Islanders and are closely associated with significant disparities in health outcomes across population groups.

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

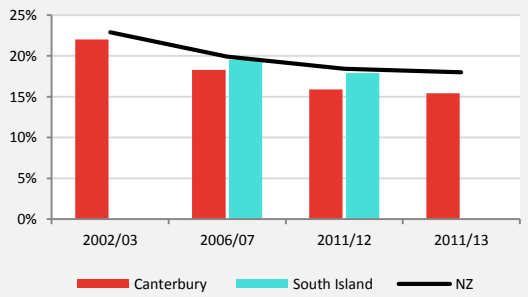
We will know we are succeeding when there is:

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.[8]

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

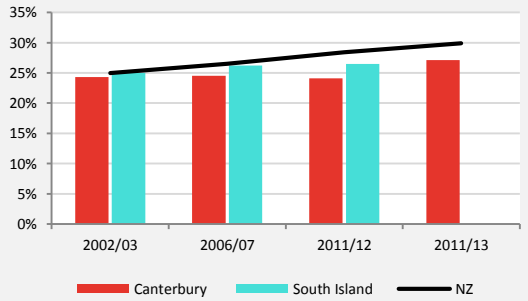


A reduction in obesity rates.

- *There has been a rise in obesity rates in New Zealand in recent decades. The 2011/13 NZ Health Survey found that 30% of adults and 10% of children are now obese. This has significant implications for rates of cardiovascular disease, diabetes, respiratory disease and some cancers (the leading cause of death in Canterbury), 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.[9]

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



[8] *The NZ Health Survey was completed by the Ministry of Health in 2002/03, 2006/07, 2011/12 and 2012/13. However results by region and DHB are subject to availability. Results for 2011/12 and 2012/13 surveys were combined in order to provide results for smaller DHBs – hence the different time periods presented. Results are unavailable by ethnicity. The 2013 Census results for smoking (while not directly comparable) demonstrate rates for Māori, while improving, are still high, with 30.7% of Canterbury Māori (15+) being regular smokers down from 40.2% in 2006.*

[9] *'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

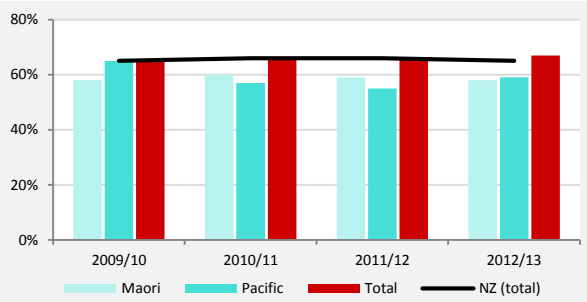
Over the next four years, we seek to make a positive impact on the health and wellbeing of the Canterbury population and contribute to achieving the longer-term outcomes we seek. The following headlines indicators will be used annually to evaluate the effectiveness and quality of the services the prevention services DHB funds and provides.

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 and the bonding of mother and baby.*
- *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.[10]

The percentage of babies exclusively or fully breastfed at 6 weeks.	Actual 12/13	Target 14/15	Target 15/16	Target 16/17	Target 17/18
	66%	68%	70%	72%	74%

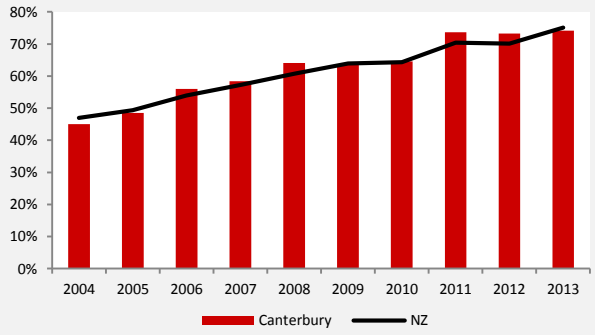


Fewer young people take up tobacco smoking.

- *Most smokers begin smoking by 18 years of age, and the highest prevalence of smoking is amongst younger people. Reducing smoking prevalence across the total population is therefore largely dependent on preventing young people from taking up smoking.*
- *A reduction in the uptake of smoking by young people 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.[11]

The percentage of 'never smokers' amongst Year 10 students.	Actual 2013	Target 2014	Target 2015	Target 2016	Target 2017
	74%	75%	>75%	>75%	>75%



[10] *This data is provide nationally from the Ministry of Health and is Plunket only data. This does not include local WellChild/Tamariki Ora breastfeeding results. The target is based on national Well-Child standards for breastfeeding at 6 weeks.*

[11] *The ASH survey is run by Action on Smoking and Health and provides an annual point prevalence data set: www.ash.org.nz. A national result for 2013 was not available at the time of publication.*

STRATEGIC OUTCOME GOAL 2

4.2 People stay well in their own homes and communities

Why is this outcome a priority?

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.

General practice can deliver services sooner and closer to home and prevent disease through education, screening, early detection, diagnosis 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 terms of improving the management of care for people with long-term conditions and reducing the exacerbations of those conditions and the complications of injury and illness.

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

OUTCOME MEASURES LONG TERM

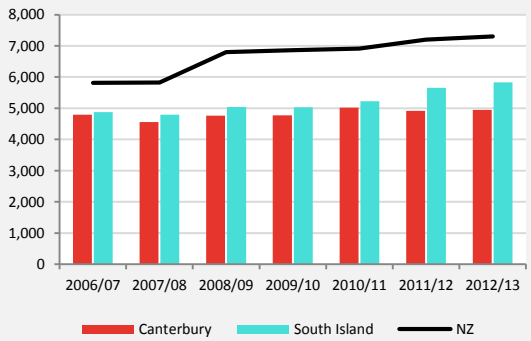
We will know we are succeeding when there is:

A reduction in acute medical admission rates.

- *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.*
- *Acute (urgent) 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 acute or complex intervention. They can also be used to indicate the population's access to appropriate and effective care and treatment in the community.*
- *Reducing acute hospital admissions also has a positive effect on productivity in hospital and specialist services - enabling more efficient use of resources that would otherwise be taken up by a reactive response to demand for urgent care.*

Data sourced from National Minimum Data Set.

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



IMPACT MEASURES MEDIUM TERM

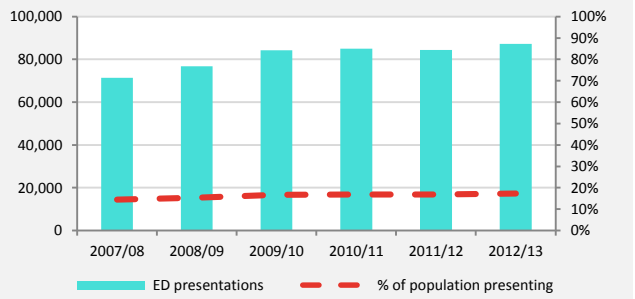
Over the next four years, we seek to make a positive impact on the health and wellbeing of the Canterbury population and contribute to achieving the longer-term outcomes we seek. The following headlines indicators will be used annually to evaluate the effectiveness and quality of the early detection and management services the DHB funds and provides.

People access 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 at the right time, 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 care options to more appropriately manage and support people in the community.*

Data sourced from individual DHBs.[12]

The percentage of the population presenting at ED.	Actual 12/13	Target 14/15	Target 15/16	Target 16/17	Target 17/18
	17%	<18%	<18%	<18%	<18%

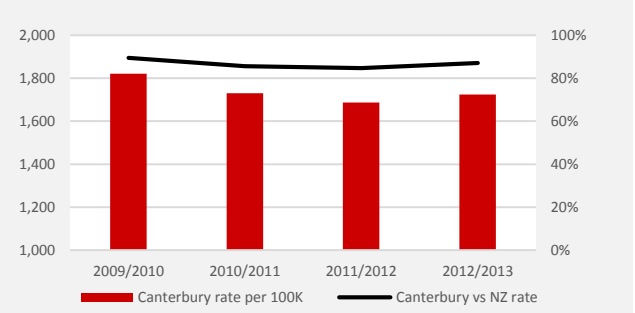


Fewer people are admitted to hospital with conditions considered 'avoidable' or 'preventable'.

- *A number of admissions to hospital are for conditions which are seen as preventable through appropriate early intervention and a reduction in risk factors.*
- *A reduction in these admissions provide an indication of the quality of early detection, intervention and disease management. It also frees up hospital resources for more complex and urgent cases.*
- *The key factors in reducing avoidable admissions are integration between primary/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. [13]

The ratio of actual expected avoidable hospital admissions for our population (<75).	Actual 12/13	Target 14/15	Target 15/16	Target 16/17	Target 17/18
	87%	≤95%	<95%	≤95%	≤95%

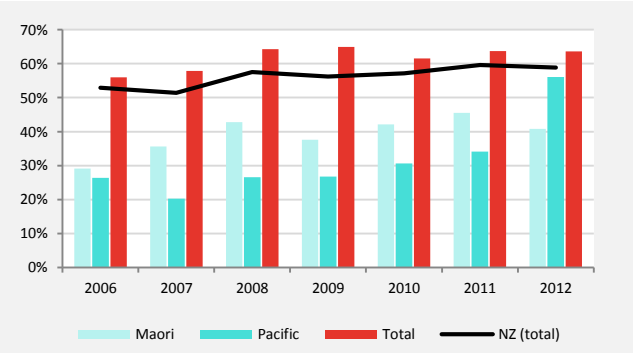


Children have improved oral health.

- *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 and health outcomes.*
- *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.*
- *The target for this measure have been set to hold the total population rate steady while placing particular emphasis on bring the rates for Māori and Pacific children up.*

Data sourced from Ministry of Health.

The percentage of children caries-free at age 5 (no holes or fillings).	Actual 2012	Target 2014	Target 2015	Target 2016	Target 2017
	64%	≥63%	65%	>65%	>65%



[12] *The proportion of the population 'presenting' at ED is defined by the Ministry of Health national ED health target.*

[13] *This measure is based on the national performance indicator SI1 and covers hospitalisations for 26 identified conditions including asthma, diabetes, angina, vaccine-preventable diseases, dental conditions and gastroenteritis. It is defined as the standardised rate per 100,000 population, and the target is set to maintain performance at below 95% of the national rate. There is currently a definition issue with regards to the use of self-identified vs. prioritised ethnicity, while this has little impact on total population results it is having a significant impact on Māori and Pacific results against this measure hence they have not been displayed. The DHB is working with the Ministry to resolve this issue.*

STRATEGIC OUTCOME GOAL 3

4.3 People with complex illness have improved health outcomes

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 in slowing the progression of illness and improving health outcomes by restoring functionality and improving the quality of life.

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. Shorter waiting lists and wait times are seen as indicative of a well-functioning system that matches capacity with demand by managing the flow of patients through services and reduces demand by moving the point of intervention earlier in the path of illness.

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 have a negative impact on the health of our population.

OUTCOME MEASURES LONG TERM

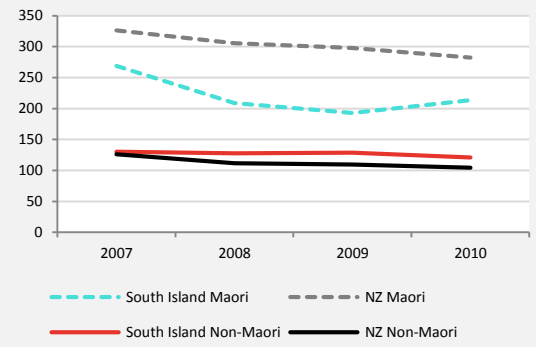
We will know we are succeeding when there is:

A reduction in avoidable mortality rates.

- *Timely and effective diagnosis and treatment are crucial to improving survival rates for complex illnesses such as cancer and cardiovascular disease. Early detection increases the options for treatment and the chances of survival.*
- *Premature mortality (death before age 65) is largely preventable with lifestyle change, earlier intervention and safe and effective treatment. By detecting people at risk and improving the treatment and management of their condition, the more harmful impacts and complications of a number of complex illnesses can be reduced.*
- *A reduction in mortality rates can be used as a proxy measure of responsive specialist care and improved access to treatment for people with complex illness.*

Data sourced from MoH mortality collection 2010 update.[14]

Outcome Measure: The rate of all-cause mortality for people aged under 65 (age-standardised per 100,000).

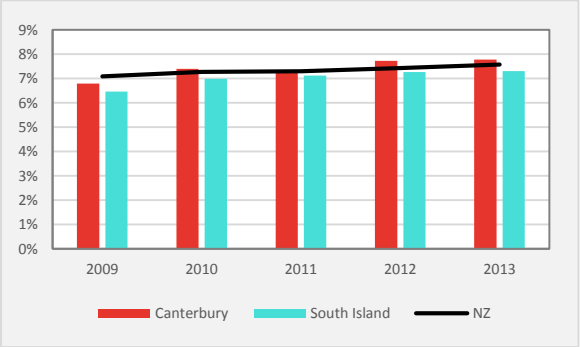


A reduction in acute readmission rates.

- *An unplanned acute hospital readmission may often (though not always) occur as a result of the care provided to the patient by the health system.*
- *Some 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.*
- *Reducing acute readmissions can therefore be used as a proxy measure of the effectiveness of service provision and the quality of care provided.*
- *Acute readmissions 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.[15]

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



[14] *The data presented is the most current available sourced from the national mortality collection which is four years in arrears.*

[15] *This data is provided by the Ministry of Health and the DHB has identified a number of data inconsistencies compared to local calculations particularly with regards to patient transfers between hospitals being coded as readmissions. The DHB is working to resolve this issue.*

IMPACT MEASURES MEDIUM TERM

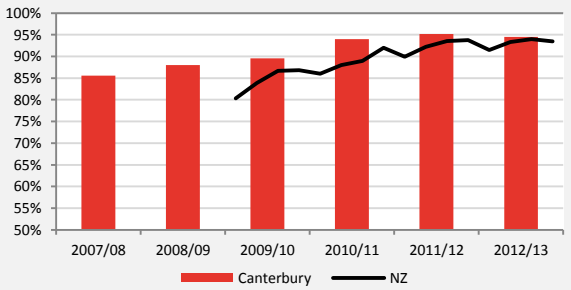
Over the next four years, we seek to make a positive impact on the health and wellbeing of the Canterbury population and contribute to achieving the longer-term outcomes we seek. The following headlines indicators will be used annually to evaluate the effectiveness and quality of the intensive assessment and treatment services the DHB funds and provides.

People have shorter waits for acute (urgent) care.

- *Emergency Departments (EDs) are important components of our health system and a barometer of the health of the hospital and the wider system.*
- *Long waits in ED are linked to overcrowding, longer hospital stays and negative outcomes 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 span not only the hospital but the whole health system. In this sense, this indicator is indicative of how responsive the whole system is to the urgent care needs of the population.*

Data sourced from individual DHBs.[16]

The percentage of people presenting at ED - admitted, discharged or transferred within six hours.	Actual 12/13	Target 14/15	Target 15/16	Target 16/17	Target 17/18
	95%	95%	95%	95%	95%

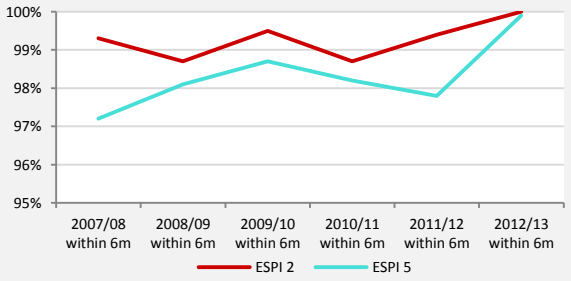


People have increased access to planned care.

- *Elective (planned) 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.[17]

Wait time (months) referral to First Specialist Assessment (ESPI 2).	Actual 12/13	Target 14/15	Target 15/16	Target 16/17	Target 17/18
	<6	<4	<4	<4	<4
Wait time (months) commitment to treatment (ESPI5).	<6	<4	<4	<4	<4

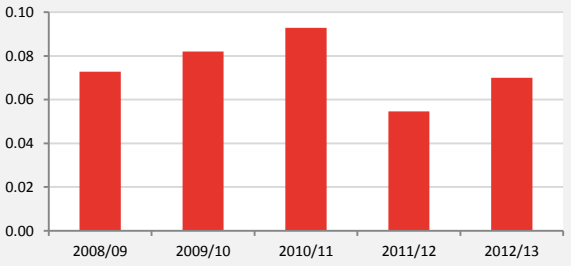


People stay safe in our hospitals.

- *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 patients are more likely to have a prolonged hospital stay, loss of confidence, conditioning and independence and an increased risk of institutional care.*
- *Achievement against this measure is also seen as a proxy indicator of the engagement of staff and clinical leaders in improving processes and championing quality.*

Data sourced from individual DHBs.[18]

The rate of SAC level 1 and 2 falls in Canterbury Hospitals.	Actual 12/13	Target 14/15	Target 15/16	Target 16/17	Target 17/18
	0.07	0.07	0.06	0.06	0.06



[16] *This measure is based on the national DHB health target 'Shorter stays in Emergency Departments' introduced in 2009/10.*
[17] *The Elective Services Patient Flow Indicators (ESPIs) have been established nationally to track system performance and DHBs receive individual performance reports from the Ministry of Health on a monthly basis. National average performance data is not made available. The wait time target for 2014/15 is mixed - being a maximum of 5 months for Q1 and Q2 and a maximum of 4 months from January 2015.*
[18] *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. This measure differs from previous years as quality initiatives are being introduced to prevent falls in all services, not just for those aged 65+.*

STRATEGIC OUTCOME GOAL 4

4.4 People experience optimal functional independence and quality of life

Why is this outcome a priority?

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 improving quality of life, such as pain management or palliative services.

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 across the system.

OUTCOME MEASURES LONG TERM

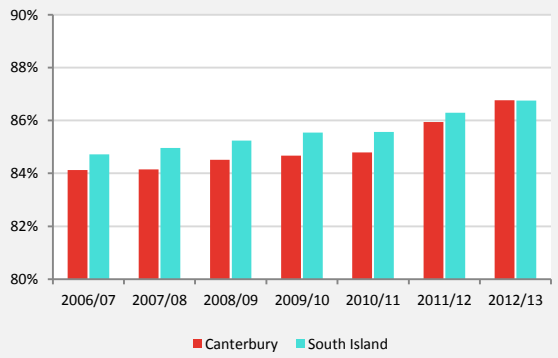
We will know we are succeeding when there is:

An increase in the proportion of the population living 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 is also a more expensive option, and resources could be better spent providing appropriate levels of home-based support to help people stay well in their own homes.*
- *An increase in the proportion of people supported in their own homes can be used as a proxy measure of how well the health system 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 population (75+) living in their own home.



IMPACT MEASURES MEDIUM TERM

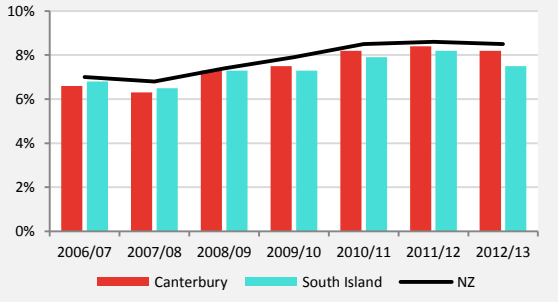
Over the next four years, we seek to make a positive impact on the health and wellbeing of the Canterbury population and contribute to achieving the longer-term outcomes we seek. The following headlines indicators will be used annually to evaluate the effectiveness and quality of the rehabilitation and support services the DHB funds and provides.

People stay safe in their own homes.

- *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 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 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 12/13	Target 14/15	Target 15/16	Target 16/17	Target 17/18
	8.2%	7.9%	<7.9%	<7.9%	<7.9%



Our Organisational Capacity and Capability

What do we need to deliver our vision?

Having already identified the challenges we face and set a collective vision for the Canterbury health system, this section highlights the strengths that we have, and will continue to develop, over the next several years to support our transformation and deliver on our goals.

5.1 A patient-centred culture

Our culture is an important element in transforming and integrating our health system. To meet the needs of our population and fully achieve our vision, we need to be able to do things differently. We need a motivated workforce committed to doing the best for the patient and the system. We also need buy-in and support from our community.

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 our *HealthFirst* community publications provide our community with updates, as well as a chance to provide feedback and input into the health system's direction.

Over the last six years, we have invested in leadership and engagement programmes that encourage our workforce to ask '*What is best for the patient?*' and empower them to make changes to improve the effectiveness and efficiency of our health system. The 'Xcelr8', 'Improving the Patient Journey' and the 'Canterbury Initiative' programmes promote lean thinking approaches to service and system redesign and support the development of a culture that prioritises patient's needs. 'Particip8' and 'Collabor8' now sit alongside 'Xcelr8', and all three change leadership programmes are open to anyone in the Canterbury health system, not just DHB employees.

We further engage and empower the Canterbury health workforce through our annual Quality Improvement and Innovation Awards, which recognise excellence in quality improvement across the system.

Investing in a patient-centred culture of participation, innovation, clinical leadership and continuous quality improvement, has helped us to build up considerable momentum and support for transformation. We are committed to maintaining this momentum as we continue the transformation of our system.

5.2 Effective governance & leadership

To support good governance across our health system, we have a clear accountability and decision-making framework that enables our leaders and community to provide direction and monitor performance.

We are fortunate to have Board members who contribute a wide range of expertise to their governance role. Their governance capability is supported by a mix of experts, professionals and consumers on the Board's advisory committees, and clinical and cultural leads attend Board and committee meetings to provide advice and consultation as required.

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

Clinical participation in decision-making

Viewing clinical leadership as intrinsic to our success, we engage health professionals from across Canterbury in service redesign and the development of integrated patient pathways to improve the quality and effectiveness of our services.

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

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.

The DHB also has a Clinical Board; a multidisciplinary clinical forum that oversees the DHB's clinical activity. The Clinical 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 role in raising the standard of patient care.

Consumer participation in decision-making

There are a number of consumer and community reference groups, advisory groups and working parties in place across the Canterbury health system. Their advice and input assists in the development of new models of care and individual service improvements.

The DHB also has a 16-member Consumer Council to formally embrace the inclusion of those who use health services in their design and development. As an advisory group for the Chief Executive, the Consumer Council supports a partnership model that ensures a strong and viable voice for consumers in health service planning.

Māori participation in decision-making

Through its partnership and formal Memorandum of Understanding with Manawhenua Ki Waitaha (representing the seven Ngāi Tahu Rūnanga), the Board is able to actively engage Māori in the planning and design of health services and the development of strategies to improve Māori health outcomes.

The DHB works closely with Te Kāhui o Papaki Ka Tai, the primary care Māori reference group, whose members are focused on harnessing collective PHO activity to improve outcomes for Māori and who provide advice and support to the PHOs, DHB and the Canterbury Clinical Network.

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.

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

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 the limited resources available.

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

Effectiveness: Services should produce more of the outcomes desired, such as a reduction in pain, greater independence and improved quality of life.

Equity: Services should reduce inequalities in the health and independence of our population.

Value for money: Our population should receive the greatest possible value from public spending.

Whānau ora: Services should have a positive impact on the holistic health and wellbeing of the person and their family/whānau.

Acceptability: Services should be consistent with community values. Consideration will be given as to whether consumers or the community have had involvement in the development of the service.

Ability to implement: Implementation of the service is carefully considered, including the impact on the whole system, workforce considerations and any risk and change management requirements.

5.3 Alliances & partnerships

Canterbury Clinical Network District Alliance

We recognise that our vision is wider than just the DHB. 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.

In 2009 we established the Canterbury Clinical Network (CNN) District Alliance, a collective alliance of healthcare leaders, professionals and providers from across the health system. Under the umbrella of the District Alliance the systems key healthcare organisations (including the DHB) come together to improve the delivery of health care in Canterbury and realise opportunities to transform and integrate our health system.[19]

The overarching purpose of the CCN is to provide people with quality care closer to their 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 and workstreams to deliver these goals. The alliance streams also support the delivery of national expectations such as achievement of the national health targets.

The CNN Work Programme informs the direction of the DHB's annual work plans every year and is reflected in the DHB's Annual Plan.

Healthy Christchurch partnership

Healthy Christchurch is a DHB-led, inter-sectoral partnership based on the World Health Organisation 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.

There are currently over 200 Healthy Christchurch Charter signatories, ranging from government agencies and business networks to voluntary sector groups and residents' associations.

Much of Healthy Christchurch's current focus is 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.[20]

[19] *Refer to Appendix 6 for an overview of the CCN structure. For further information, refer to www.ccnweb.org.nz.*

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

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 sectors seeking common outcomes. The premise is that health is greatly influenced by our lifestyles and the environment in which we live, work and play.

The DHB provides leadership for the Canterbury HiAP partnership with the local and regional councils 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 ensuring coherent planning for communities, and the DHB is committed to an ongoing partnership role as the 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.

Since 2010, more than 800 telehealth consultations have taken place in a variety of specialties, including oncology, paediatrics, general medicine, plastics, orthopaedics and general surgery – providing access to specialist advice while saving many families the inconvenience of travelling long distances for treatment.

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

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 next few years, the focus will be on transalpine medical and surgical services, services for older people, mental health services and further investment in telemedicine technologies to reduce the need for travel.[21]

National collaboration

At a national level, we work with the education, social development and justice sectors to improve outcomes for our population and achieve shared goals. From this perspective we are committed to implementing national cross-agency programmes including: the rollout of the Prime Minister's Youth Mental Health Project, the Child Health Action Plan and the national Whānau Ora programme.

Canterbury DHB is working nationally alongside other DHBs, the Ministry of Health and the Accident Compensation Corporation (ACC) on a joint Spinal Cord Impairment initiative. This is a major initiative seeking to make improvements across all aspect of the patient continuum for those with spinal cord injuries.

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 will also continue to actively participate in the development and delivery of national programmes led by the National Health IT Board, Health Quality & Safety Commission, Health Workforce NZ, the National Health Committee, Health Promotion Agency, PHARMAC and Health Benefits Limited - for the benefit of our population and the wider health system.

5.4 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, with a third of the clients living on the Brackenridge Estate. As at May 2014 125 clients were being supported. Funding comes from a number of sources with the main funder being the Ministry of Health. The DHB currently owns all shares in the company however, Brackenridge is working through consideration of future ownership, with the view to transitioning to non-DHB ownership in the future.

Canterbury Linen Services Limited was incorporated as a company in 1993 and provides laundry services to DHB hospitals and a range of external clients. The Canterbury DHB owns all shares, as well as the land and buildings for which the company pays a rental to the DHB. Plant and equipment, motor vehicles and the rental linen pool are the major fixed assets of the company. The company's key output for 2014/15 is the processing (collection, laundering and delivery) of 4.74 million kilos or 13.11 million items of laundry.

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

Alongside the two operational subsidiary companies:

Canterbury together with Counties Manukau, Waitemata and Auckland DHB is an equal partner in the *New Zealand Health Innovation Hub*. The Hub works to engage with clinicians and industry to develop, validate and commercialise health technologies and services improvement initiatives that will deliver health and economic benefits to the whole of the New Zealand health system. Structured as a limited partnership, with the four foundation DHBs each having 25% shareholding, the Hub produces its own Statement of Intent which can be found at www innovation.health.nz.

Canterbury is also 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 from within the employment and ownership of the Canterbury DHB, as the *South Island Alliance Programme Office*.[22] The Programme Office is jointly funded by the South Island DHBs to provide services such as audit, regional service development and project management with an annual budget of just over $4m.

5.5 Investment in information systems

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

Our major priority is to connect up the system enabling seamless and transparent access to clinical patient information at the point of care. This will benefit patients by enabling more effective clinical decision-making, improving standards of care and reducing the risks associated with missing important information.

Canterbury has already adopted several key information solutions which are now being rolled-out regionally, such as HealthPathways, the Electronic Referral Management System, Health Connect South and eSCRV. In the next few years Canterbury will also replace three hospital based patient administration system (PICs) with one new system in line with the rest of the country.

We will continue to work closely with clinicians and stakeholders across Canterbury to ensure that the right clinical information is provided in the right place, at the right time to the right person. Full details of the regional investment in information systems can be found in the South Island Regional Health Services Plan but includes the following major initiatives.

HealthPathways provides locally developed and agreed assessment, management, and referral information to health professionals across our system. Over 600 clinically-designed pathways and GP resource pages are now available and we are supporting the adoption of HealthPathways across the rest of the South Island.

HealthInfo is a more recently developed 'sister site' to HealthPathways that provides locally approved health information for consumers. The site now has over 1,400 pages and we are expanding its content and visibility.

Health Connect South (HCS) is a clinical workstation and data repository (portal) that brings a patients clinical information into one view, providing timely information at the point of care and supporting clinical decision making. Canterbury is leading the roll-out and a single HCS record now exists between Canterbury, West Coast and South Canterbury.

The Collaborative Care Management System (CCMS) integrates clinical information and shared planning to support clinical teams to better manage individuals with complex needs and long-term conditions. There are already over 8,000 users and 4,500 care plans.

The Electronic Referral Management System (ERMS) enables general practices to send referrals electronically from their desktops. Over 80% of GP referrals to Canterbury DHB are now sent via ERMS, which carries 12,000 to 14,000 referrals every month. Canterbury is leading the rollout of ERMS across the South Island with the West Coast and South Canterbury DHBs now 'live'.

The Electronic Shared Care Record View (eSCRV) is a secure system for sharing core health information (such as allergies, dispensed medications and test results) between all the health professionals involved in a person's care, no matter where they are based. The eSCRV enables faster, safer, more informed treatment. Canterbury will lead the rollout of eSCRV across the South Island, beginning with the West Coast and South Canterbury DHBs in 2015, followed by Nelson-Marlborough and Southern DHBs.

The South Island Patient Information Care System (PICS) will be the new regional patient administration system, replacing Canterbury's three current patient administration systems with a single system and further integrating system throughout the South Island. Canterbury and the West Coast will begin to upgrade their old systems and implement the new PICS in 2016/17.

eMedications is a foundation system which promotes patient safety by improving medications management. The system has three components and is being rolled out regionally, with Canterbury to implement ePharmacy in 2014/15 and eMedications Reconciliation in 2015/16.

The National Patient Flow Project will create a new national view of wait times, health events and outcomes across the patient journey through secondary and tertiary care. Canterbury has committed to implementing Phase I (collection of referrals to specialists) in 2014/15 and Phase II (non-admitted and associated referral information including diagnostic tests) from 2015/16.

Self-Care Patient Portal – enables patients to be involved in their care and is an essential part of the national vision. Canterbury will work with the PHOs to develop Patient Portals in the coming year.

[22] *Legal transfer of the employees and assets has taken place. The company will be retained as a shell, pending dissolution.*

5.6 Investment in people

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

Like all DHBs, our workforce is ageing and we face shortages and difficulties in recruiting to some professional areas. However, 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.

The Canterbury DHB is committed to being a good employer, is aware of legal and ethical obligations in this regard. We continue to promote equity, fairness, a safe and healthy workplace, underpinned by a clear set of organisational values, including a code of conduct and a commitment to continuous quality improvement and patient safety. We will also be reviewing current HR policy and agreeing a phased implementation plan to meet the new Vulnerable Children's Legislation requirements for worker safety checks and three yearly reassessments, as this comes into effect.

However, in Canterbury's current context, it is not sufficient just to be a good employer.

Our 2013 staff engagement survey demonstrated positive levels of engagement. Results showed 70% of our workforce was 'engaged', up from 67% in 2010. Unfortunately, results also showed that 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 the increasingly complex health issues experienced by the people in their care.

Over 60% were still dealing with EQC and insurance issues and 20% identified disrupted work environments as having a negative impact on their wellbeing.

Over the next few years we will focus on building resilience through investment in employee wellbeing programmes, workplace support and counselling.

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.

In response, we have strengthened our interactive and targeted recruitment strategies, including branding, profiling, Facebook and an Alumni and Employee Referral Programme to keep people connected. 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 programme. The DHB also has a collaborative partnership with Christchurch Polytechnic offering clinical placement for students undertaking Bachelors of Nursing.

CANTERBURY DHB WORKFORCE		
DHB Total Headcount	*Turnover*	*Sick Leave*
9,282	8.7%	3.6%
81% female	8.4% nationally	3.6% nationally
Average Age	*Largest Ethnic Group*	*Diversity*
49 years	NZ European	96 ethnic groups
Largest Workforce	*Oldest Workforce*	*Terms*
Nursing 4,396	Corporate Support	47% part time
47% of workforce	Avg. Age 52 years	80% permanent

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.

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 peer support and mentoring.

Over the next year in conjunction with our primary care partners, we will begin to build an integrated approach to workforce planning that will include improved reporting, analysis and predictive modelling to help understand our whole health systems current and future needs.

Enhancing our workforce capability

Developing our existing staff is a key strategy for enhancing the capability of our system. We have recently strengthened our core development training calendar, which can be accessed by health professionals working anywhere in the Canterbury health system. We have embedded formal performance appraisals into operational management, along with support for career plans and succession planning initiatives such as talent identification to reduce gaps across our organisation.

The Professional Development Recognition Programme and the Regional Allied Health Assistant Training Programme are helping to expand the scope of existing roles and establish new ones. New advanced gerontology nurse specialist and haematology roles also reflect a more connected and capable workforce.

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. Actively supported by Health Workforce NZ, this will support career enhancement and maximise people's potential.

We have also stepped up our participation in the Health Workforce NZ sponsored Regional Training Hubs to support critical role identification and expand workforce capability through sharing of training resources. The focus over the next few years will be on Diabetes Nurse Prescribers, Sonographers, GPEP2 training for general practice registrars and implementation of the new 70/20/10 training in medical disciplines. E-learning packages will be progressively roll-out regionally and a full suite of packages will be available on-line 2015/16.

5.7 Investment in quality & 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.

The DHB is utilising the NZ Business Excellence in Health Care criteria to guide the organisation's continuous improvement efforts. A staff perception survey and focus groups review has been completed and the information gained used to strengthen organisational processes. A detailed desk audit will be completed in the coming year.

Working with the South Island Quality & Safety Alliance we are implementing a regional Incident and Risk Management system (ICNET) as part of our routine incident management process. This will provide ready access to trends in incidents and risks as well as support the completion of root cause analysis for sentinel events helping to improve process and reduce harm.

As part of our efforts to detect the deteriorating patient we will introduce an electronic patient-vital-sign early-warning system that will aid staff in detecting and communicating risk to the broader team via the patient portal. This system will make available vital signs, diabetes charts and fluid balance charts to e-prescribers, enhancing clinical decision-making.

Canterbury is committed to progressing the Health Quality & Safety Commission's (HQSC) national priority areas: reducing hospital-acquired infections, reducing harm from falls, and improving medication and surgical safety. We will continue to report and monitor our performance against the HQSC Quality and Safety Markers and engage in national pilots.

The DHB also has a set of Quality Accounts which articulate how our patient-focused culture supports our commitment to zero harm and continuous quality improvement. The Accounts contain snapshots of key activity and goals across the Canterbury health system, with particular emphasis on priority areas for the Clinical Board. These are refreshed annually.

In line with the national direction, our Clinical Board will champion quality and safety projects focused around:

Improving the 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, we will be able to improve their experience as well as their health and wellbeing. Working closely with our Consumer Council the DHB is facilitating consumer focus groups, gathering consumer stories and identifying effective methods for gathering feedback to help us improve the experience for our consumers.

Preventing healthcare-associated infections

Admission to hospital exposes patients to potential harm through healthcare-associated infection, and we are committed to minimising this risk through three specific projects, in line with the HQSC.

Hand hygiene is an important measure in the fight against healthcare-acquired infections. The 'five moments' of hand hygiene are the key opportunities for staff to dramatically reduce the risk of spreading infection.

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 and we are working with Auckland DHB and the HQSC on the national Surgical Site Infection Surveillance Programme.

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.

Preventing harm from falls

We are committed to achieving a system-wide goal of zero harm from falls with prevention in the community and in our hospitals. Reducing harm from falls is a key component in our strategies for improving the health of older people and reducing acute demand.

We will continue to invest in our community falls champion model that focuses on the delivery of falls prevention in people's homes and communities and targets older people at risk of admission to hospital.

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. We will introduce an electronic nursing patient observation system that will record falls risk. This system will revolutionise audit processes, making data visible and real time, assisting with improving adherence to protocol.

Medication and surgical safety

The use of medications always carries the risk of a side effect, allergy or other adverse outcome and we are participating in the national medicine reconciliation and electronic medicines management initiatives being driven through the HQSC. We also maintain an Adverse Drug Event Trigger Tool initiative which 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.

We are also committed to ensuring that the Safe Surgery Checklist is used in our operating theatres. The checklist will assist in improving outcomes by promoting better communication and teamwork in the operating room.

5.8 Research and innovation

A significant body of clinical research is conducted within the Canterbury DHB, with over 400 current projects on our Research Register. The Research Committee, a standing committee reporting to our Clinical Board, provides governance and advice on matters related to clinical research activities and develops research policy.

The Research Office is a shared facility funded by the University of Otago (Christchurch) and the DHB and 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 functions, such as: providing advice; supporting staff who do not work within a research-based environment; ensuring that clinical groups are adhering to the policy; and maintaining the Research Register. A major focus is also 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 and development of ideas with both a commercial potential and a positive impact on health care between.

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.

5.9 Repair and redesign of facilities

In the same way that quality, workforce and information systems underpin our transformation, health facilities can support or hamper the 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 are working in inadequate and temporary locations.

The redevelopment of the Burwood and Christchurch Hospitals 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, we have thousands of damaged rooms, causing continued disruption as we shift and relocate services to repair them. This invasive repair programme will put additional pressure on our workforce and moving services around will increase inter-hospital patient transfers and, despite our best efforts is likely to fragment clinical teams and services.

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 Ministry of Health through the nationally appointed Hospital Redevelopment Partnership Group 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 in key locations across Canterbury to further align community health facilities with the future model of care.

The business case for the redevelopment of the Kaikoura Hospital site as an Integrated Family Health Centre received Cabinet and Capital Investment Committee approval in April 2013. Detailed design plans have been completed and the DHB expects to commence construction in mid-late 2014.

The DHB will progress development of the Community Hub in Rangiora in the coming year. Detailed design plans have been completed and the first phase of construction is set to being mid-late 2014.

In Ashburton demolition is already underway in preparation for development of a new theatre block, acute admitting unit and ward refurbishment. Construction will be completed in 2015.

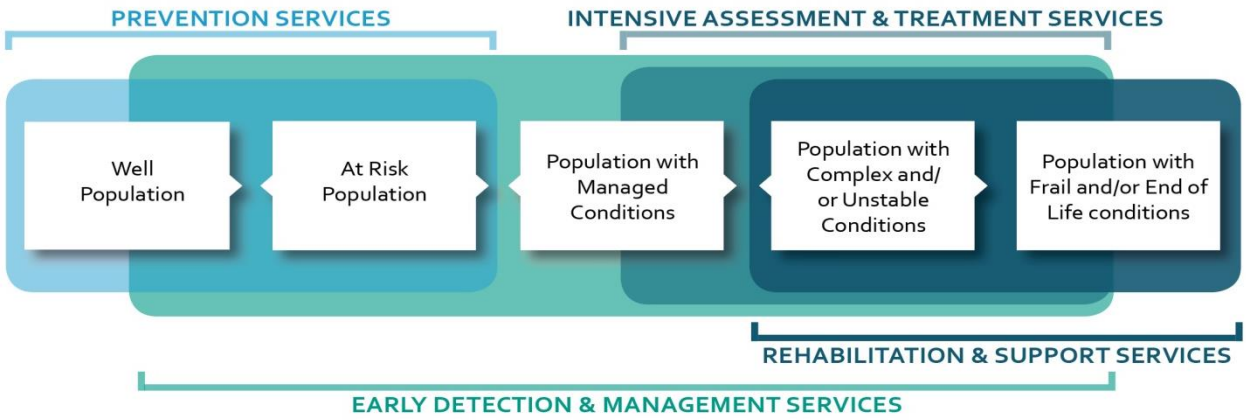
The development of the Christchurch Health Precinct is another major anchor project under the Christchurch City Rebuild. The DHB is working in a partnership with the Christchurch Central Development Unit, Universities of Canterbury and Otago and the Christchurch Institute of Technology on this project. Our outpatient, teaching and parking facilities are being considered in this master plan.

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 will consider the role of facilities, alongside strategies for the future sustainability of health services in rural communities.

Part III – Annual Outlook

Statement of Performance Expectations

What will we deliver in the coming year?



Evaluating our Performance

As both the major funder and provider of health and disability services in Canterbury, we are strongly motivated to ensure our population gets the most efficient and effective services possible.

Understanding the dynamics of our population and the drivers of demand are fundamental when determining which services to fund and at what level. Just as fundamental is our ability to evaluate whether the services we are purchasing 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 population outcomes (Section 4).

In the more immediate term, we evaluate our performance by providing a forecast of the services we will fund and provide in the coming year in order to achieve those outcomes and the standards we expect to meet. We then report actual performance against this forecast in our end-of-year Annual Report.[23]

Achieving equity of outcomes is an overarching priority for the Canterbury health system and reflects our commitment to ensuring that our population should enjoy the best possible health status.

With a growing Māori population and persistent inequalities amongst our population, this goal pervades everything we do. All of the Canterbury targets and standards are therefore set the same for all population groups with the aim of bringing performance up for all.

Specific actions with respect to improving Māori health are outlined in our Māori Health Action Plan along with performance against key indicators by ethnicity.

Choosing performance measures

In order to present a fair picture of performance, the services we deliver 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.
- Rehabilitation and Support Services.

Identifying a set of appropriate measures for each output class is difficult. We cannot simply measure '*volumes*'. 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*'.

We have therefore chose to present a mix of measures demonstrating: Timeliness (T), Coverage (C), Volume (V) and Quality (Q) - all of which help us to evaluate different aspects of our performance. Against each we have set targets to demonstrate the standard expected.

The measures chosen cover those activities we believe have the potential to make the greatest contribution to the wellbeing of our population. Others are relevant in that they represent areas where we are developing new services or expect to see a change in activity levels or settings in the coming year.

[23] *DHB Annual Reports can be found at www.cdhb.health.nz.*

Setting standards

Wherever possible, we have included past year's baseline and national results to give context in terms of what we are trying to achieve and to support evaluation of our performance. However, measures that relate to new services have no baselines and some measures relate to Canterbury-specific services for which there is no national comparison available.

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

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

This provides greater assurance that these are quality services, allowing the DHB to focus on monitoring implementation and timely and appropriate access.

It is important to note that a significant proportion of the services funded by the DHB are demand driven – such as laboratories tests, emergency care, maternity services, mental health services, aged residential care and palliative care. Estimated service volumes have been provided, not as targets to be achieved, but to give the reader context in terms of the use of resource across the Canterbury health system.

Notation

Some data is provided to the DHB by external parties and can be affected by a delay in invoicing. Rather than footnote every instance, symbols are used to indicate where this is the case: Δ indicates data that could be affected by invoicing delay and is subject to change (data for these measures was pulled on or before 10 August 2014.

A † symbol indicates where data relates to the calendar year rather than financial year.

There are also a number of national health targets where performance is tracked and reported nationally on a quarterly basis rather than annually. A ◇ symbol indicates that the baseline, national average and target refer to the fourth quarter result of that year.

Where does the money go?

The table below presents a summary of the 2014/15 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.[24]

REVENUE	TOTAL $'000
Prevention	30,658
Early detection and management	334,222
Intensive assessment & treatment	1,004,477
Support & rehabilitation	232,543
Grand Total	**1,601,900**

EXPENDITURE	TOTAL $'000
Prevention	30,841
Early detection and management	336,016
Intensive assessment & treatment	1,013,904
Support & rehabilitation	233,689
Grand Total	**1,614,450**
Surplus/(Deficit)	**(12,550)**

[24] *Note: The budgeted expenditure includes expected earthquake settlement proceeds and repair costs. These earthquake related amounts have been pro-rated across the four output classes. It should be noted that as the earthquake proceeds and costs could fluctuate significantly between years this may affect comparison of the output class information over the next several years.*

OUTPUT CLASS

6.1 Prevention services

Preventative health services promote and protect the health of the population and address individual behaviours by targeting 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.

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. At-risk and high-need 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.

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	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of babies exclusively breastfeeding on hospital discharge	Q [25]	76%	≥75%	-
Lactation support and specialist advice consults provided in community settings	V	858	>580	-
'Appetite for Life' nutrition courses provided in the community	VΔ	52	≥50	-
People accessing Green Prescriptions for additional physical activity support	V [26]	1,936	3,000	-
% of Green Prescription participants more active 6-8 months after referral	Q [27]	50%	≥50%	63%
% of smokers identified in primary care receiving advice and help to quit (ABC)	C◇	35%	90%	57%
% of smokers identified in hospital receiving advice and help to quit (ABC)	C◇	93%	95%	96%
Enrolments in the Aukati Kaipaipa smoking cessation programme	V	345	≥240	-
% of priority schools supported by the Health Promoting Schools framework	C [28]	74%	≥70%	-

Population-Based Screening Services *These services help to identify people at risk of illness and pick up conditions earlier. The DHB's role is to encourage uptake, as indicated by high coverage rates.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of four-year-olds provided with a B4 School Check (B4SC)	C [29]	86%	90%	80%
% of Year 9 students in decile 1-3 schools provided with a HEEADSSS assessment	C†[30]	99.6%	100%	-
% of women aged 25-69 having a cervical cancer screen in the last 3 years	C [31]	75%	80%	77%
% of women aged 45-69 having a breast cancer screen in the last 2 years	C [31]	82%	≥70%	72%

[25] The percentage of babies' breastfed demonstrates the effectiveness of consistent health promotion messages delivered during the antenatal, birthing and early postnatal period. Standards are based on national targets.
[26] A Green Prescription is a health professional's written advice to a patient to be physically active, as part of their health management.
[27] Results taken from national patient survey completed by Research NZ on behalf of the Ministry of Health.
[28] The Health Promoting Schools Framework addresses 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.
[29] 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.
[30] A HEADSSS assessment is provided to Year 9 students it is free and covers: Home, Education/Employment/Eating/Exercise, Activities; Drugs, Sexuality; Suicide, Safety; and Spirituality. The assessment allows health concerns to be identified and addressed early.
[31] These are national screening programmes and standards are based on national screening unit targets.

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	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of newborns enrolled on the National Immunisation Register at birth	C	98%	≥95%	-
% of children fully immunised at eight months of age	C◇	92%	95%	90%
% of eight-month-olds 'reached' by immunisation services	Q [32]	97%	95%	95%
% of eligible girls completing HPV vaccinations (i.e. receiving Dose 3)	C†[33]	43%	60%	54%
% of older people (65+) receive a free influenza ('flu') vaccination	C†	71%	75%	65%

[32] *'Reached' is defined as those children fully immunised, as well as those whose parents have been contacted and provided advice and support to enable them to make informed choices for their children but have chosen to decline immunisations or opt off the NIR.*

[33] *The baseline is the percentage of girls born in 1996 receiving Dose 3 by the end of 2012, and the target for 2014 is girls born in 1998. Canterbury's programme is slightly different to that delivered elsewhere as it is primarily general practice rather than school based. This measure differs slightly to previous years as the age-bands have been lifted to better align with the school-based programme.*

OUTPUT CLASS

6.2 Early detection and management services

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.

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. 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. 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 avoidable demand will have a major impact in freeing up hospital and specialist services for more complex and planned interventions.

OUTPUTS SHORT-TERM PERFORMANCE MEASURES

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 or uptake of services are indicative of engagement, accessibility and responsiveness of primary care services.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of the total DHB population enrolled with a Primary Health Organisation	C	96%	≥95%	96%
Avoidable hospital admission rate for children aged 0-4	Q [34]	114%	<111%	100%
Young people (0-19) accessing Brief Intervention Counselling	VΔ[35]	758	≥500	-
Adults (20+) accessing Brief Intervention Counselling	VΔ	5,023	≥3500	-
Skin lesions (skin growths, including cancer) removed in primary care	VΔ	2,358	≥2,000	-
Number of clinical HealthPathways in place across the Canterbury health system	V [36]	667	>600	-

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	2012 DHB Result	2014 Target	2012 National Average
% of pre-schools children (0-4) enrolled in DHB-funded oral health services	C†	71%	75%	70%
% of enrolled children (0-12) examined according to planned recall	T†	90%	≥90%	90%
% of adolescents (13-17) accessing DHB-funded oral health services	C†	65%	85%	73%

[34] 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. The baseline differs slightly from previously published figures (112%) due to an update of national data.

[35] The Brief Intervention Coordination Service provides people with mild to moderate mental health concerns free 'early' intervention from their general practice teams for mild to moderate mental health issues including depression and anxiety. Previous years have presented total population provided with BIC but this has been split into age groups to heighten the emphasis on young people accessing support. Results include face-2-face and phone consultations and may undercount people accessing BIC where dates of birth have not been provided.

[36] The HealthPathways website helps general practice navigate clinically designed pathways that guide patient-centred models of care.

Long-term Conditions Programmes *These services are targeted at people with high health need due to having a long-term condition and aim to reduce deterioration, crises and complications through good management and control of that condition. Success is demonstrated through early intervention, monitoring and management strategies which reduce the negative impact and the need for hospital admission.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
Spirometry tests provided in community rather than hospital settings	VΔ[37]	1,503	≥1,000	-
% of the eligible population having a CVD Risk Assessment in the last 5 years	C◇[38]	33%	90%	67%
% of the population identified with diabetes having an HbA1c test in the last year.	C [39]	86.5%	≥90%	-
% of the population identified with diabetes with acceptable glycaemic control.	Q [40]	75.6%	≥75%	-
People receiving subsidised diabetes self-management support from their general practice team when newly diagnosed with Type 2 diabetes or starting insulin	VΔ[41]	739	≥739	-

Pharmacy and Referred Services *These are services which a health professional may prescribe or refer a person to help diagnose a health condition, or as part of treatment. They are provided by allied health personnel such as laboratory technicians, medical radiation technologists and pharmacists. While pharmaceuticals are largely demand driven to improve performance, we will target primary care access to diagnostics and shorter wait times to aid decision-making and improve referral processes.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
Subsidised pharmaceutical items dispensed in the community	VΔ[42]	6.7m	est. <8m	-
Laboratory tests completed for the Canterbury population	VΔ	2.0m	est. <2.6m	-
People on multiple medications receiving a Medication Management Review	VΔ[43]	1,771	2,000	-
GP requested Community Referred Radiology tests completed	VΔ	45,555	est.>30,000	-
% of people receiving their urgent diagnostic colonoscopy within 2 weeks	T [44]	30%	75%	56%
% of people receiving their Computed Tomography (CT) scan within 6 weeks	T	89%	90%	79%
% of people receiving their Magnetic Resonance Imaging (MRI) within 6 weeks	T [45]	83%	≥80%	52%
% of people receiving their elective coronary angiography within 3 months	T	82%	90%	88%

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

[38] This refers to CVD risk assessments undertaken in primary care in line with the national 'More heart and diabetes checks' health target. The baseline differs slightly against previously published data (33%) due to timing issues.

[39] Part of good diabetes management includes an annual test of patient's blood glucose levels (via an HBA1c test) to consider and improve the management of their condition.

[40] HbA1c ≤64mmol/mol reflects an acceptable blood glucose level.

[41] Number of subsidised procedures claimed for the 2012/13 year as at February 2014 (includes late claims for the period).

[42] This measure covers all items dispensed in the community not in hospital however it may still include some non-Canterbury residents who had prescriptions filled while in Canterbury.

[43] The 2012/13 number differs slightly from the previously published number (1,694) due to late invoices

[44] All diagnostic result baselines are the June 2013 result published by the Ministry of Health. Targets are set to national standards.

[45] The DHB will use best endeavours to achieve and sustain performance against the national targets for CT and MRI however radiology support needed to achieve priorities around reducing ESPI and cancer treatment waiting times are putting additional pressure on the service - the CCN Radiology Service Level Alliance will closely monitor system pressures and waiting times.

OUTPUT CLASS

6.3 Intensive assessment and treatment services

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. A proportion of these services are driven by demand which the DHB must meet, such as acute and maternity services and others are planned where 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 or through corrective action. 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.

OUTPUTS SHORT-TERM PERFORMANCE MEASURES

Quality and Patient Safety Measures *These quality and patient safety measures apply across all services provided in West Coast DHB hospitals and are newly introduced national quality and safety markers championed and monitored by the Health Quality & Safety Commission.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
Rate of compliance with good hand hygiene practice	Q [46]	67%	80%	71%
% of hip and knee replacement patients receiving cefazolin ≥2g	Q [47]	new	95%	-
% of hip and knee replacement patients who have appropriate skin preparation	Q	new	100%	-
% of time all three parts of the surgical safety checklist are used	Q [48]	40%	90%	71%
% of inpatients (aged 75+) who received a falls assessment	Q [49]	97%	≥90%	77%

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. Utilisation is monitored to ensure service levels are maintained and to demonstrate responsiveness to need.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of women registered with an LMC by 12 weeks of pregnancy	C	73.3%	80%	63%
Maternity deliveries in Canterbury DHB facilities	V	5,778	est. 6,000	-
% of total deliveries made in Primary Birthing Units	V [50]	9%	13%	-
Baby friendly hospital accreditation of Canterbury DHB facilities maintained	Q [51]	yes	yes	-

[46] This measure is based on ward audits of the Medical and Surgical wards conducted according to Hand Hygiene NZ standards. The baseline result is taken from national Health Quality & Safety Commission (HQSC) reporting for Quarter 4 2012/13.

[47] Cefazolin ≥2g is antibiotic recommended as routine for hip and knee replacements to prevent infection complications.

[48] The surgical safety checklist, developed by the World Health Organisation, is a common sense approach to ensuring the correct surgical procedures are carried out on the correct patient. The baseline result is taken from HQSC reporting for Quarter 3 2012/13.

[49] While there is no single solution to reducing falls, an essential first step is to assess each individual's risk of falling, and acting accordingly. The baseline result is taken from HQSC reporting for Quarter 3 2012/13.

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

[51] The Baby Friendly Initiative is a worldwide programme of the World Health Organization and UNICEF to encourage maternity hospitals to deliver a high standard of care and implement best practice. An assessment/accreditation process recognises achievement of the standard.

Acute/Urgent Services *These are medical or surgical services for illnesses that have an abrupt onset or progress rapidly (they may or may not lead to hospital admission). Services include accident & emergency responses, short-stay acute assessment and observation, acute care packages, acute medical and surgical services and intensive care services.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of children under six with access to free primary care after hours	C	100%	100%	-
% of general practices providing telephone triage outside business hours	C[52]	86%	95%	-
Acute demand packages of care provided in community settings	V [53]	25,374	>25,000	-
Attendances at Canterbury Emergency Departments (ED)	V [54]	87,221	≤93,000	-
% of people waiting less than 4 weeks for radiotherapy or chemotherapy	T◇[55]	99.5%	100%	100%
Acute inpatient average length of hospital stay (standardised)	Q [56]	3.86	≤3.86	3.99

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	2012/13 DHB Result	2014/15 Target	2012/13 National Average
First Specialist Assessments provided (medical and surgical)	V [57]	60,819	est. >60,000	-
% of First Specialist Assessments that were non-contact	Q [58]	12.1%	>10%	-
Elective surgical discharges delivered (surgeries provided)	V [59]	17,066	≥17,484	-
% of elective/arranged surgeries provided as day cases.	Q [60]	57%	≥57%	-
% of people who receive their surgery on the day of admission	Q [60]	91%	≥90%	-
Elective inpatient average length of hospital stay (standardised)	Q [56]	3.19	≤3.18	3.36
Outpatient attendances	V	622,837	est. >600k	-
Outpatient 'Did not Attend' rates	Q [61]	4.4%	≤5%	-
Outpatient 'Did not Attend' rates (Māori)	Q [62]	8.6%	≤5%	-

[52] Results for 2012/13 differ from those previously stated due to a recalculation of practices which had closed and merged over the year.

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

[54] This measure is a national performance measure (the ED Health Target). As such, it counts Christchurch and Ashburton Emergency Departments. The number differs slightly to previously published number (by 20 people) due to refreshed coding.

[55] This measure is a national performance measure (PP30) and refers to all people 'ready for treatment' excluding Category D patients, whose treatment is scheduled with other treatments or part of a trial. The result differ to that previously published (100%) due to an error discovered after the Plan was published.

[56] This measure is a national performance measure (OS3). When seeking to reduce average length of hospital stay performance should be balanced against readmissions rates to ensure earlier discharge is appropriate and service quality remains high.

[57] This measure counts both medical and surgical assessments but counts only the first assessments (where the specialist determines treatment) and not the follow-up assessments or consultations after treatment has occurred.

[58] Non-contact FSAs are those where specialist advice and assessment is provided without the need for a hospital appointment.

[59] This measure is a national performance measures (the electives health target) and excludes 'arranged' cardiology and dental volumes.

[60] 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 home and it frees up hospital resources. These rates are balanced against readmissions rates to ensure service quality is appropriate. These were previously national performance measures (OS6 & OS7) discontinued at the end of 2012/13 the internal data now referenced differs slightly due to timing and standardisation issues and national averages are no longer available.

[61] This 2012/13 result differs slightly from previously published result (4.6%) due to inclusion of those people who presented but did not wait.

[62] The DNA rate presented differs slightly to that previously published (4.6%) and is now calculated as the proportion of all outpatient appointments where the patient was expected to attend but did not present themselves at the department.

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	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of young people (0-19) accessing specialist mental health services	CΔ[63]	2.6%	≥3.1%	2.8%
% of adults (20-64) accessing to specialist mental health services	CΔ	3.4%	≥3.1%	3.4%
% of people referred for non-urgent MH and AOD services seen within 3 weeks	T [64]	72%	80%	76%
% of people referred for non-urgent MH and AOD services seen within 8 weeks	T	87%	95%	91%

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 and outpatient clinics. 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	2012/13 DHB Result	2014/15 Target	2012/13 National Average
Admissions into inpatient AT&R services	V	3,101	est. >3,000	-
% of admissions into AT&R (PMH) made by direct community referral	Q	18%	20%	-
% of AT&R inpatients discharged to their own home rather than ARC	QΔ[65]	85%	>80%	-

[63] This measure is based on the national performance measure (PP26) and expectations that 3% of the population will need access to specialist level mental health services.

[64] This measure is a national performance measure (PP8). Results are provided three months in arrears, the results stated are to March 2013.

[65] 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'. These results differs from that previously published as they did not exclude patients who were ARC residents prior to AT&R admission.

OUTPUT CLASS

6.4 Rehabilitation and support services

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.

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.

OUTPUTS SHORT-TERM PERFORMANCE MEASURES (2013/14)

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	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of people referred to an organised stroke service with demonstrated stroke pathway after an acute event	C	74%	80%	-
% of people enrolled in cardiac rehabilitation services after an acute event	C [66]	25%	30%	-
People accessing pulmonary rehabilitation courses	V [67]	206	>150	-
People (65+) accessing community-based falls prevention programmes	V [68]	1,613	>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	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of older people (65+) receiving long-term home and community support services who have had a comprehensive clinical assessment using InterRAI	QΔ[69]	90%	95%	-
People accessing CREST services on hospital discharge or GP referral	VΔ[70]	1,850	2,200	-
People supported by long-term home-based support services	VΔ	8,860	est.>8,000	-
People supported by district nursing services	VΔ	7,911	est.>6,000	-

[66] *This measure counts those enrolled in Phase 2 (outpatient) Cardiac Rehabilitation on discharge.*
[67] *This measure now includes all people attending pulmonary rehabilitation (Ashburton, Christchurch, Community-based).*
[68] *This measure refers to Canterbury's Integrated Falls Prevention Service which launched in February 2012.*
[69] *InterRAI is an evidence based geriatric assessment tool the use of which ensures assessments are high quality and consistent and that people receive equitable access to support and care. This number differs from previous years after alignment to the national measure.*
[70] *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 pro-active 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	2012/13 DHB Result	2014/15 Target	2012/13 National Average
People supported by day services	VΔ	654	est. >550	-
People accessing mental health planned and crisis respite	VΔ[71]	829	est. >750	-
Occupancy rate of mental health planned and crisis respite beds	CΔ[72]	81%	85%	-
People supported with aged care respite services	VΔ	1,192	est. >1,000	-

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	2012/13 DHB Result	2014/15 Target	2012/13 National Average
People supported by hospice or home-based palliative services	VΔ	3,295	est. >2,000	-
ARC facilities trained to provide the Liverpool Care Pathway option to residents	C [73]	42	≥45	-
People in ARC services supported by the Liverpool Care Pathway	V	134	>150	-

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	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of people entering ARC having had a clinical assessment of need using interRAI	QΔ[69]	91%	95%	-
% of ARC residents receiving vitamin D supplements	C [74]	73%	75%	-
Subsidised ARC rest home beds provided (days)	VΔ[75]	573,866	est. <676,000	-
Subsidised ARC hospital beds provided (days)	VΔ	453,716	est. <507,000	-
Subsidised ARC dementia beds provided (days)	VΔ	222,445	est. >212,000	-
Subsidised ARC psycho-geriatric beds provided (days)	VΔ	69,468	est. >62,000	-

[71] This measure includes the new mental health mobile respite service, launched in 2013.

[72] 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. The result for 2012/13 differs to that previous published (85%) due to an error found in start and finish dates.

[73] The Liverpool Care Pathway is an international palliative care programme adopted nationally and reflects best-practice care.

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

[75] Results for 2012/13 differ for all ARC beds provided due to late invoices.

Meeting Our Financial Challenges

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 Canterbury's financial outlook

The Canterbury DHB, like the rest of the health sector, faces significant financial pressures from increasing service demand, rising treatment costs, wage expectations and increased public expectations – all of which must be managed within allocated funding.

Despite these pressures, Canterbury was on track to deliver a break-even financial performance. However, the earthquakes have resulted in unplanned net expenditure and costs of over $60m to date.

As a direct result of the earthquakes, Canterbury's planned financial result in 2012/13 was initially 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 was reduced to a breakeven position with the addition of planned earthquake funding support from the Ministry of Health.

Post year-end the insurance claims for the Canterbury earthquake were settled at the policy maximum $320m. This was subsequently recognised in the 2012/13 year creating a net surplus of $287m. Timing differences between the recognition of insurance proceeds and the prolonged spend in regard to repairs (both operating repairs and maintenance and capital re-instatement) will be evident for a number of financial years.

The total overall cost of the earthquakes is still an unknown factor and we expect the cost impacts to also 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.

We are still unable to accurately determine the final interplay between repair costs and insurance recovery and the impact of new Building Codes, construction inflation and cost escalation on repair costs. However, it is apparent that there is a significant level of remedial work needed which is not able to be covered by the insurance proceeds in a like for like manner.

The DHB has devised a 10 year programme of earthquake repair work in which the long-term delivery of services can be sustained and remain affordable in the context of the $320m insurance proceeds available.

This programme will require ruthless prioritisation in order for it to remain affordable as we navigate the uncertainties of repair costs and maintain safe and effective service provision for staff and patients.

We are also unable to precisely predict the likely increase in demand for services from a vulnerable population that has been under stress for more than three years. We are already experiencing significant uplift in a number of areas, such as mental health services, and are fully expecting this demand to be sustained for a prolonged period. This creates a level of financial volatility in regards to the long-term outlook; further exacerbated by revenue volatility driven by population fluctuations.

There is no 'quick-fix' solution. To ensure our health system is clinically and financially sustainable, we have focused on making decisions that are 'best for patient and best for system'. 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.

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 and duplication, avoid unnecessary expenditure and do more (and see more people) within our current resources.

7.2 Achieving financial sustainability

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

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

We are forecasting that Canterbury's base funding for 2014/15 will increase by approximately $28.6m.

This funding, whilst at '*normal*' funding increase levels, has not corrected the downward adjustment made in the year following the earthquakes (based on an estimated reduction in population which did not eventuate). The 2013 Census data, which has yet to be factored into funding calculations, points to a population which is largely in line with the pre earthquake trajectory.

Living within our means

In order to meet the needs of our population and 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.

Savings will be made not in dollars terms, but in terms of costs avoided through more effective utilisation of the resources available and reduced demand for services.

Key strategies 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.
- Integrating systems to share resources.
- Enabling clinical decision-making at the point of care to reduce delays and improve the quality of care.
- Developing workforce capacity and supporting integrated, less traditional workforce models.
- Realigning service expenditure to better manage the demand growth with reduced bed capacity.

The Canterbury DHB also actively supports the South Island Support Services Alliance to implement tighter cost controls and make purchasing and productivity improvements to limit the rate of cost pressure growth. In particular, Canterbury is taking a lead in the Procurement and Supply Chain Workstream.

In line with our decision-making principles the Support Services Workstream has a clinical lead alongside the CEO sponsor and involves clinicians in the rationalisation and standardisation of products and services to reduce clinical risk and increase engagement in the programme.

The regional Workstreams focused on Food, Laundry, Maintenance & Engineering and Clinical Engineering Services are being re-engaged in the coming year and regional work plans being identified.

Through the Regional Alliance, the DHB will also maintain and strengthen the relationship with Health Benefits Limited (HBL) to assist them in 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 an active participant on a number of HBL workstreams to provide assistance and support to external providers of solutions, particularly in regard to food, linen & laundry and supply chain services priorities.

We are also committed to supporting national entity initiatives locally to achieve mutual benefits and cost savings across the sector; the table below indicates the level of inclusion in the 2014/15 financial projections.

Out-years scenario

The current reality in Canterbury creates a high level of uncertainty and variability related to both revenue and expenditure in out-years. Our outlook depends on a number of assumptions and interrelated factors including: revenue volatility based on population shifts; changing health demands and population deprivation post-earthquake; earthquake repair cost volatility; and timing around facilities plans and costs of building repairs not covered by insurance in addition to affordability.

The DHB has 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 from those shown here.

CANTERBURY COMMITMENT TO NATIONAL INITIATIVES

2014/15	CAPITAL COSTS	OPERATING COSTS		OPERATING BENEFITS	NET OPERATING
		ONE-OFF	ONGOING		
	$'000s	$'000s	$'000s	$'000s	$'000s
Health Benefits Limited					
Finance, Procurement & Supply Chain	(1,283)	(223)	-	(671)	(894)
Human Resource Management Information Systems	-	(167)	-	-	(167)
National Health IT Board					
eMedicines Reconciliation with eDischarge	(327)	-	-	-	-
Replacement of legacy Patient Administration Systems	(6,403)	(346)	-	-	(346)
National Patient Flow	-	(195)	-	-	(195)
Self-Care Portal	-	(533)	-	-	(533)
Health Quality & Safety Commission					
Patient experience indicators			(15)		(15)
Total	**(8,013)**	**(1,464)**	**(15)**	**(671)**	**(2,150)**

7.3 Assumptions

We have made the assumption that Canterbury will run a reduced deficit for the 2014/15 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 approved by Cabinet.

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

We are also aware that there will be increased demand from a population that has been under stress for more than three years. However, there are few comparative situations we can use as a base for making assumptions about the level of this demand. We have made conservative predictions as a precautionary measure.

Revenue and expenditure have been budgeted on current Government policy settings and known health service initiatives and in preparing our forecasts, we have made the following assumptions.

- Population-based funding in 2014/15 will remain at the level indicated in December 2013.
- Fair prices will be received 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 will be cost neutral or fully funded as will any legislative changes, sector reorganisation or service devolvement (during the term of this Plan).
- The Ministry of Health will continue to fairly fund Canterbury for additional operational expenditure in relation to the earthquakes.
- Canterbury DHB's $290m earthquake settlement proceeds (transferred to the Crown to minimise capital charge expenses) will be available to be drawn down as required by the DHB to fund its earthquake repair programme. As agreed with the Ministry of Health, the revenue and equity mix of the draw-down will be flexible and based on DHB requests rather than necessarily matching the respective earthquake capital and operating repair spend for the particular year.
- 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 previous year's recognition of insurance proceeds (as required under current NZ accounting standards) these future costs are not able to be offset with the corresponding inflow of insurance proceeds, therefore creating a timing mismatch. This will continue to influence stated fiscal results for a number of years.
- Earthquake related repair programmes, as funded by insurance proceeds and internally sourced funding, will continue. Estimates of the corresponding capital, repairs and maintenance expenditure expected to take place during the term of this plan, together with an estimated of the earthquake proceeds draw-down, have been included. Due to the fluidity and timing of repair works, some fluctuations in estimates and actual spend are expected to occur.
- Revaluations of land and buildings will continue and as a result there will be further impacts on land, building and infrastructure values. The quantum of the earthquake impairment, coupled with the regular period valuation, is not yet known and no adjustment have been made for this in our forecasts.
- Work will continue on the Facilities Redevelopment Plan. Capital expenditure associated with the redevelopment that will take place during the term of this Plan have therefore been included.
- Borrowings required to fund the Facilities Redevelopment Plan 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 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.
- There will be no disruptions associated with natural disasters or pandemics. Revenue and expenditure have been budgeted on current and expected operations with no further disaster assumptions.

7.4 Asset planning and investment

National 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 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) hospital redevelopment by 2015 and Christchurch by 2018.

A business case for the redevelopment of the Kaikoura Hospital site as an Integrated Family Health Centre received Cabinet and Capital Investment Committee approval in April 2013. Detailed design plans have been completed and the DHB expects to commence construction in mid-late 2014.

The Regional Programme business case for the South Island Patient Information Care System (PICS) has been approved by Cabinet. The system will replace its current legacy Patient Administration System. The DHB is currently progressing with a detailed implementation business case and this is expected to be submitted to the National Health IT Board and Capital Investment Committee in October/November 2014.

Capital expenditure

The Canterbury DHB's capital expenditure budget totals $303m for the 2014/15 year, subject to appropriate approvals. In addition to normal clinical and operational capital requirements, this includes the following significant capital projects:

- Children's Haematology Oncology Centre (deferred from 2011/12 due to earthquake disruption).
- Ashburton Hospital rebuild, including procedure rooms and wards.
- Phase 1 of the Facilities Redevelopment Programme, focusing on the Burwood Hospital site.
- Strategic IT developments, including the upgrade of our Patient Administration System and the roll-out of the next stages of the national e-Medicines Programme, eSCRV and the Collaborative Care Management System.
- Continuation of reinstatement and alternative accommodation strategies under our 10 year earthquake recovery programme of work.

Capital expenditure associated with projects required as a result of earthquake damage to our infrastructure and that of providers we fund has been included within our capital plans. The overall impact of lengthy building delays in any of these projects, given the current construction micro-climate in Canterbury, could be a significant increase in expenditure over these projects.

7.5 Debt and equity

The Canterbury DHB currently has a $145,985m total loan facility with the Ministry of Health (formerly the Crown Health Funding Agency), which is fully drawn down. The DHB's total term debt is expected to remain at $145,895 as at June 2015.

The DHB debt level is planned to rise in out years - reflecting new loans required for the new Burwood and Christchurch facilities. The respective loans will be raised when the assets are transferred to the DHB (i.e. 2015/16 for the Burwood facility and 2018/19 for Christchurch).

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.
- Dispose of any of its assets except disposals at full value in the ordinary course of business.

The DHB is repaying $1.861m of equity annually as part of the agreed FRS-3 funding. In addition the DHB is also:

- Repaying $60m in 2013/14 and $120m in 2014/15 as equity repayment as part of the DHB's contribution towards the Burwood and Christchurch hospital redevelopments.
- Repaying $290m of the DHB's earthquake settlement proceeds in 2013/14 as an equity repayment. As agreed with the Ministry of Health, the $290m will progressively be drawn down to fund future earthquake recovery works. $20m of the $290m will be drawn down by June 2014, leaving a balance of $270m for out years.

The extent of insured damage as identified to support the insurance claim was well in excess of $518m. Despite successful negotiation which eliminated discount factors and restrictions on use, the nature of the insurance that was in place at the time of the earthquake meant a total loss capacity of $320m.

The entire $320m was able to be attained by Canterbury DHB but the total earthquake programme of works will need to be afforded from within existing the DHB's funds. The inherent shortfall between insurance proceeds and cost of reinstatement means the total Crown contribution for the Facilities Redevelopment Programme will need to remain 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 has been agreed 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 nationally appointed Hospital 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.

Accounting policies

The accounting policies adopted are consistent with those in the prior year. For a full statement of accounting policies, refer to Appendix 9.

Statement of Financial Expectations

Where will our funding go?

8.1 Group statement of comprehensive income [76]

	2012/13 Actual $'000	2013/14 Forecast $'000	2014/15 Plan $'000	2015/16 Plan $'000	2016/17 Plan $'000	2017/18 Plan $'000
Income						
Ministry of Health revenue	1,416,121	1,424,439	1,461,345	1,494,743	1,528,249	1,561,868
Patient related revenue	50,460	50,400	51,297	54,048	55,233	56,443
Other operating income	315,876	25,188	81,638	57,566	87,784	65,392
Interest income	9,417	15,122	7,620	5,370	3,950	3,890
Total Income	1,791,874	1,515,149	1,601,900	1,611,727	1,675,216	1,687,593
Operating Expenses						
Employee benefit costs	614,301	639,565	656,865	671,488	686,878	701,261
Treatment related costs	128,949	132,673	142,068	143,489	145,712	149,349
External service providers	581,265	586,046	590,499	596,741	608,805	620,313
Depreciation & amortisation	48,191	57,650	58,330	61,234	66,585	67,345
Interest expenses on loans	5,716	5,446	5,772	6,210	7,557	7,592
Other expenses	113,556	99,458	147,208	125,244	137,621	119,423
Total Operating Expenses	1,491,978	1,520,838	1,600,742	1,604,406	1,653,158	1,665,283
Operating surplus before capital charge	299,896	(5,689)	1,158	7,321	22,058	22,310
Capital charge expense	13,019	19,309	13,708	7,319	22,049	22,299
Surplus / (Deficit)	286,877	(24,998)	(12,550)	2	9	11
Other comprehensive income	(68,137)	-	-	-	-	-
Total Comprehensive Income	**355,014**	**(24,998)**	**(12,550)**	**2**	**9**	**11**

[76] *Other operating income includes planned earthquake proceeds drawn down as revenue.*

8.2 Group statement of financial position

	30/06/13 Actual $'000	30/06/14 Forecast $'000	30/06/15 Plan $'000	30/06/16 Plan $'000	30/06/17 Plan $'000	30/06/18 Plan $'000
CROWN EQUITY						
General funds	127,432	(179,431)	(276,742)	(92,603)	(89,464)	(87,325)
Revaluation reserve	199,541	199,541	199,541	199,541	199,541	199,541
Retained earnings / (losses)	209,644	184,646	172,096	172,098	172,107	172,118
TOTAL EQUITY	**536,617**	**204,756**	**94,895**	**279,036**	**282,184**	**284,334**
REPRESENTED BY:						
CURRENT ASSETS						
Cash & cash equivalents	87,039	102,974	42,808	40,783	57,516	88,011
Trade & other receivables	374,000	42,204	42,204	42,204	42,204	42,204
Inventories	7,983	8,536	8,536	8,536	8,536	8,536
Investments	2,491	1,221	1,221	1,221	1,221	1,221
TOTAL CURRENT ASSETS	471,513	154,935	94,769	92,744	109,477	139,972
CURRENT LIABILITIES						
Trade & other payables	121,389	98,704	98,704	98,704	98,704	98,704
Capital charge payable	-	-	-	-	-	-
Employee benefits	163,506	155,047	155,047	155,047	155,047	155,047
Borrowings	-	15,000	-	-	-	-
TOTAL CURRENT LIABILITIES	284,895	268,751	253,751	253,751	253,751	253,751
NET WORKING CAPITAL	186,618	(113,816)	(158,982)	(161,007)	(144,274)	(113,779)
NON CURRENT ASSETS						
Investments	54,882	35,456	2,090	2,090	2,090	2,090
Property, plant, & equipment	427,483	416,044	401,020	623,487	611,203	584,159
Intangible assets	5,038	5,811	4,506	3,205	1,904	603
Restricted assets	14,766	9,937	9,937	9,937	9,937	9,937
TOTAL NON CURRENT ASSETS	502,169	467,248	417,553	638,719	625,134	596,789
NON CURRENT LIABILITIES						
Employee benefits	7,754	7,754	7,754	7,754	7,754	7,754
Restricted funds	14,766	9,937	9,937	9,937	9,937	9,937
Borrowings	129,650	130,985	145,985	180,985	180,985	180,985
TOTAL NON CURRENT LIABILITIES	152,170	148,676	163,676	198,676	198,676	198,676
NET ASSETS	**536,617**	**204,756**	**94,895**	**279,036**	**282,184**	**284,334**

8.3 Group statement of movements in equity [77] [78]

	2012/13 Actual $'000	2013/14 Forecast $'000	2014/15 Plan $'000	2015/16 Plan $'000	2016/17 Plan $'000	2017/18 Plan $'000
Total Equity at Beginning of the Period	185,325	536,617	204,756	94,895	279,036	282,184
Total Comprehensive Income	355,014	(24,998)	(12,550)	2	9	11
Other Movements						
Contribution back to Crown - FRS3	(3,722)	(1,861)	(1,861)	(1,861)	(1,861)	(1,861)
Contribution back to/from Crown - Earthquake settlement proceeds*	-	(270,000)	12,000	6,000	5,000	4,000
Contribution back to/from Crown - Facility Redevelopment**	-	(60,000)	(120,000)	180,000	-	-
Contribution from Crown - Operating Deficit Support	-	24,998	12,550	-	-	-
Total Equity at End of the Period	**536,617**	**204,756**	**94,895**	**279,036**	**282,184**	**284,334**

[77] **Earthquake proceeds drawn down as revenue are reflected in the Comprehensive Income Statement.*

[78] ***The negative amounts relate to the DHB's contribution to the facility redevelopment while the positive amount reflects the equity portion of the new Burwood facility asset to be transferred from the Crown to the DHB. The remaining funding of the Burwood facility asset is reflected as new loan. Transfer of the new Christchurch facility is expected in 2018/19 and hence not reflected in the financial statements.*

8.4 Group statement of cashflow

	2012/13 Actual $'000	2013/14 Forecast $'000	2014/15 Plan $'000	2015/16 Plan $'000	2016/17 Plan $'000	2017/18 Plan $'000
CASH FLOW FROM OPERATING ACTIVITIES						
Cash provided from:						
Receipts from Ministry of Health	1,286,449	1,335,045	1,357,132	1,388,133	1,419,187	1,450,298
Other receipts	187,793	497,552	237,148	218,224	252,079	233,405
Interest received	9,417	15,122	7,620	5,370	3,950	3,890
	1,483,659	1,847,719	1,601,900	1,611,727	1,675,216	1,687,593
Cash was applied to:						
Payments to employees	602,382	648,024	656,865	671,488	686,878	701,261
Payments to suppliers	831,501	852,886	879,775	865,474	892,138	889,085
Interest paid	5,638	5,446	5,772	6,210	7,557	7,592
Capital charge	13,503	19,309	13,708	7,319	22,049	22,299
GST - net	1,363	1,532	-	-	-	-
	1,454,387	1,527,197	1,556,120	1,550,491	1,608,622	1,620,237
Net Cashflow from Operating Activities	**29,272**	**320,522**	**45,780**	**61,236**	**66,594**	**67,356**
CASH FLOW FROM INVESTING ACTIVITIES						
Cash was provided from:						
Sale of property, plant, & equipment	-	-	-	-	-	-
Receipt from sale of investments	71,132	20,696	33,366	-	-	-
	71,132	20,696	33,366	-	-	-
Cash was applied to:						
Purchase of investments & restricted assets	-	-	-	-	-	-
Purchase of property, plant, & equipment	61,936	34,755	42,001	282,400	53,000	39,000
	61,936	34,755	42,001	282,400	53,000	39,000
Net Cashflow from Investing Activities	**9,196**	**(14,059)**	**(8,635)**	**(282,400)**	**(53,000)**	**(39,000)**
CASH FLOW FROM FINANCING ACTIVITIES						
Cash provide from:						
Equity Injection	-	44,998	24,550	186,000	5,000	4,000
Loans Raised	-	16,335	-	35,000	-	-
	-	61,333	24,550	221,000	5,000	4,000
Cash applied to:						
Loan Repayment	-	-	-	-	-	-
Equity Repayment	3,722	351,861	121,861	1,861	1,861	1,861
	3,722	351,861	121,861	1,861	1,861	1,861
Net Cashflow from Financing Activities	**(3,722)**	**(290,528)**	**(97,311)**	**219,139**	**3,139**	**2,139**
Overall Increase/(Decrease) in Cash Held	34,746	15,935	(60,166)	(2,025)	16,733	30,495
Add Opening Cash Balance	52,293	87,039	102,974	42,808	40,783	57,516
Closing Cash Balance	**87,039**	**102,974**	**42,808**	**40,783**	**57,516**	**88,011**

8.5 Summary of revenue and expenses by arm

	2012/13 Actual $'000	2013/14 Forecast $'000	2014/15 Plan $'000	2015/16 Plan $'000	2016/17 Plan $'000	2017/18 Plan $'000
Funding Arm						
Revenue						
MoH Revenue	1,370,375	1,377,064	1,407,217	1,439,424	1,471,714	1,504,089
Total Revenue	1,370,375	1,377,064	1,407,217	1,439,424	1,471,714	1,504,089
Expenditure						
Personal Health	958,042	984,706	1,026,338	1,044,722	1,068,180	1,091,530
Mental Health	137,096	141,382	143,796	146,563	149,934	153,382
Disability Support	234,635	235,352	238,806	243,581	248,942	254,419
Public Health	2,127	2,294	2,431	2,479	2,533	2,589
Maori Health	1,916	1,919	2,038	2,079	2,125	2,172
Governance & Admin	-	552	-	-	-	-
Total Expenditure	1,333,816	1,366,205	1,413,409	1,439,424	1,471,714	1,504,092
Net Surplus/(Deficit)	**36,559**	**10,859**	**(6,192)**	**-**	**-**	**(3)**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**36,559**	**10,859**	**(6,192)**	**-**	**-**	**(3)**
Governance & Funder Admin						
Revenue						
Other	4,077	5,004	2,256	2,301	2,347	2,394
Total Revenue	4,077	5,004	2,256	2,301	2,347	2,394
Expenditure						
Personnel	6,751	7,213	7,296	7,442	7,590	7,741
Depreciation	17	-	-	-	-	-
Other	(2,691)	(2,209)	(5,040)	(5,141)	(5,243)	(5,347)
Total Expenditure	4,077	5,004	2,256	2,301	2,347	2,394
Net Surplus/(Deficit)	**-**	**-**	**-**	**-**	**-**	**-**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**-**	**-**	**-**	**-**	**-**	**-**

	2012/13 Actual $'000	2013/14 Forecast $'000	2014/15 Plan $'000	2015/16 Plan $'000	2016/17 Plan $'000	2017/18 Plan $'000
Provider Arm						
Revenue						
MoH Revenue	798,297	826,982	877,038	898,002	919,444	941,558
Patient Related Revenue	46,840	46,048	49,197	51,906	53,048	54,214
Other	324,836	40,210	89,102	62,777	91,572	69,117
Total Revenue	1,169,973	913,240	1,015,337	1,012,685	1,064,064	1,064,889
Expenditure						
Personnel	607,550	632,352	649,569	664,046	679,288	693,520
Depreciation	48,174	57,650	58,330	61,234	66,585	67,345
Interest & Capital Charge	18,735	24,755	19,480	13,529	29,606	29,891
Other	245,196	234,340	294,316	273,874	288,576	274,119
Total Expenditure	919,655	949,097	1,021,695	1,012,683	1,064,055	1,064,875
Net Surplus/(Deficit)	**250,318**	**(35,857)**	**(6,358)**	**2**	**9**	**14**
Other Comprehensive Income	68,137	-	-	-	-	-
Total Comprehensive Income	**318,455**	**(35,857)**	**(6,358)**	**2**	**9**	**14**
In House Elimination						
Revenue						
MoH Revenue	(752,551)	(780,159)	(822,910)	(842,683)	(862,909)	(883,779)
Total Revenue	(752,551)	(780,159)	(822,910)	(842,683)	(862,909)	(883,779)
Expenditure						
Other	(752,551)	(780,159)	(822,910)	(842,683)	(862,909)	(883,779)
Total Expenditure	(752,551)	(780,159)	(822,910)	(842,683)	(862,909)	(883,779)
Net Surplus/(Deficit)	-	-	-	-	-	-
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	-	-	-	-	-	-
CONSOLIDATED						
Revenue						
MoH Revenue	1,416,121	1,423,887	1,461,345	1,494,743	1,528,249	1,561,868
Patient Related Revenue	46,840	46,048	49,197	51,906	53,048	54,214
Other	328,913	45,214	91,358	65,078	93,919	71,511
Total Revenue	1,791,874	1,515,149	1,601,900	1,611,727	1,675,216	1,687,593
Expenditure						
Personnel	614,301	639,565	656,865	671,488	686,878	701,261
Depreciation	48,191	57,650	58,330	61,234	66,585	67,345
Interest & Capital Charge	18,735	24,755	19,480	13,529	29,606	29,891
Other	823,770	818,177	879,775	865,474	892,138	889,085
Total Expenditure	1,504,997	1,540,147	1,614,450	1,611,725	1,675,207	1,687,582
Net Surplus/(Deficit)	**286,877**	**(24,998)**	**(12,550)**	**2**	**9**	**11**
Other Comprehensive Income	68,137	-	-	-	-	-
Total Comprehensive Income	**355,014**	**(24,998)**	**(12,550)**	**2**	**9**	**11**

Part IV – Appendices

Further information for the reader

Appendix 1	Glossary of terms
Appendix 2	Objectives of a DHB
Appendix 3	2013 Census summary for Canterbury
Appendix 4	Organisational chart and system governance structure
Appendix 5	Overview of hospital and specialist services
Appendix 6	Canterbury Clinical Network Alliance Structure
Appendix 7	Minister's Letter of Expectations
Appendix 8	Canterbury's commitment to National Health Targets
Appendix 9	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.health.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).

9.1 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	Services matched to the patient's level of need throughout their illness or recovery.
	Crown Agent	A Crown entity that must give effect to government policy when directed by the responsible Minister.
	Crown Entity	A generic term for a diverse range of entities referred to in the Crown Entities Act 2004. Crown Entities are legally separate from the Crown and operate at arm's length from the responsible or shareholding Minister, but are included in the annual financial statements of the Government.
CFA	Crown Funding Agreement	An agreement by the Crown to provide funding in return for the provision of, or arranging the provision of, specified services.
CREST	Community Rehabilitation Enablement and Support Team	This team supports the frail elderly who would otherwise be re-admitted to hospital or residential care. CREST is a collaboration across primary and secondary services.
	Determinants of Health	The range of personal, social, economic and environmental factors that determine the health status of individuals or populations.
ERMS	Electronic Referral Management System	A system developed in Canterbury enabling referrals to public hospitals and private providers to be sent and received electronically from the GP desktop.
eSCRV	Electronic Shared Care Record View	A secure system for sharing core health information (such as allergies, dispensed medications and test results) between the health professionals involved in a person's care, no matter where they are based.
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.
	Regional collaboration	Refers to DHBs across geographical 'regions' planning and delivering services (clinical and non-clinical). 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' (e.g. Canterbury and West Coast).
	Secondary Care	Specialist care that is typically provided in a hospital setting.
SIAPO	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
WCTO	WellChild/Tamariki Ora	A free service offering screening, education and support to all New Zealand children from birth to age five.

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

Part 3: Section 22:

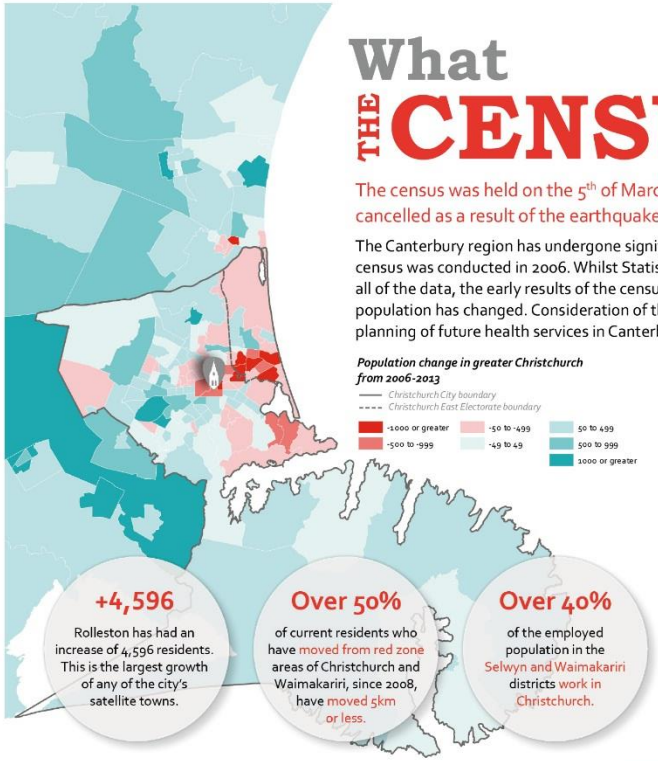
The New Zealand Public Health and Disability Act outlines the following objectives for DHBs:

- To reduce health disparities by improving health outcomes for Māori and other population groups;
- To reduce, with a view to eliminating, health outcome disparities between various population groups, by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders;
- To improve, promote, and protect the health of people and communities;
- To improve integration of health services, especially primary and secondary health services;
- To promote effective care or support for those in need of personal health or disability support services;
- To promote the inclusion and participation in society and independence of people with disabilities;
- To exhibit a sense of social responsibility by having regard to the interests of people to whom we provide, or for whom we 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.

What THE CENSUS Tells US

The census was held on the 5th of March 2013, two years after it was cancelled as a result of the earthquake on the 22nd of February, 2011.

The Canterbury region has undergone significant changes since the previous census was conducted in 2006. Whilst Statistics New Zealand is yet to release all of the data, the early results of the census indicate how the profile of our population has changed. Consideration of these changes is crucial to the planning of future health services in Canterbury.



There has been a 2% decrease in usual residents in Christchurch City, compared with 2006. Not surprisingly, there has been a significant loss in residents from the central and eastern parts of the city.

However, the census shows that residents that have moved from red zone areas within the last five years have not tended to move far away. The majority of residents that were living in red zone areas of Christchurch and Waimakariri (including the Port Hills), in 2008, have moved five kilometres or less.

The movement to the districts surrounding Christchurch has contributed to Canterbury having three of the fastest growing districts in New Zealand: Selwyn (1st), Waimakariri (3rd) and Ashburton (5th).

9,837 fewer usual residents in the Christchurch East electorate area.

16.7% increase in the usual resident population of the Waimakariri District

32.6% increase in the usual resident population of the Selwyn District

13.4% increase in the usual resident population of the Ashburton District

Our families and households

1.2% decrease in the number of families with dependent children.

9.8% decrease in one-parent families with dependent children.

1,281 more two-or-more family households than in 2006.

There has been a change in family and household composition. There has been a small decrease in the total number of families with dependent children. Interestingly, there has been a large 9.8% decrease in the number of one-parent families with dependent children. There are also 1,281 more two-or-more family households than in 2006, indicating that more families are living together in the same house.

Our population is becoming more ethnically diverse.

We now have greater proportions of Māori, Pacific and Asian ethnicities than in 2006. The percentage of Māori has increased from 7.4% to 8.2%. Overall our Māori population are younger, with 43.7% aged 0-19 (compared to 25.5% of the total Canterbury population).

8.2% are Māori.

2.6% are Pacific.

7.5% are Asian.

15.0% of our population are aged 65 years or older, up from 13.4% in 2006.

11.4% of the total New Zealand resident population live in Canterbury.

14.5% of those aged 15 years or older smoke regularly, down from 18.8% in 2006.

482,181* residents.

Our population growth

Our resident population has increased from 466,404 in 2006 to 482,181 in 2013. This is a rate of growth of 3.4%. Nationally there has been a 5.3% rate of growth.

2,841 more males aged 20-29 than in 2006.

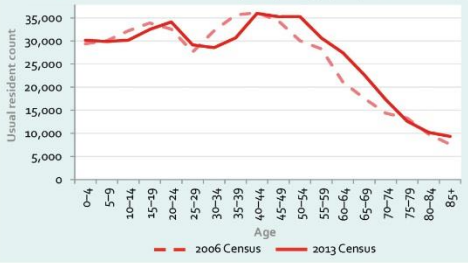
Our rebuild population

There has been a noticeable increase in the number of males aged 20-29 years of 2,841 since 2006. In comparison, there are only 228 more females of this age. This reflects the workers coming into the region for the Christchurch rebuild.

Our population is aging

Fifteen percent of our population are now aged 65 years or older. This is higher than the national percentage of people aged 65 years or older (14.3%).

CDHB usual resident count by five year age group in 2006 and 2013



What does this mean?

Our aging population

The Canterbury DHB continues to have an increasing elderly population. While progress has been made to address the needs of older people, new service models will continue to be developed.

Our rebuild population

The rebuild population will require services to meet their health needs. While most of this need will be focused on acute issues, it is important this population develops an ongoing point of access to health services by enrolment in general practice.

Population growth around Christchurch

The increased population in Christchurch's satellite towns is in both younger and older age groups. In consideration of future health services, the provision of general practice is a key requirement, as well as mobile community services that operate in people's homes and communities.

General Practice Enrolment

There was a decrease of approximately 5,000 enrolments in general practices in eastern Christchurch following the earthquakes. This is lower than the total number of residents that have left eastern Christchurch. This indicates that many people have retained general practice enrolment close to their former residence.

What we do not know*

Population estimates & projections

The current Statistics New Zealand population estimates and population projections are still based upon the 2006 Census results. Updated population estimates using the 2013 Census results will be available in August 2014. Updated population projections will be available in December 2014.

The 'real' number of rebuild workers

Our resident population only includes people that listed their usual residence as being in our region. Rebuild workers that have come from other parts of the country, or overseas, and do not consider Canterbury to be their place of usual residence, were not counted in our resident population.

Data sources: *Statistics New Zealand, Census of Population and Dwellings, 2013.*

Distance moved analysis provided by the Strategy and Planning Group – Christchurch City Council.

Canterbury District Health Board
Te Poari Hauora ō Waitaha

CENSUS

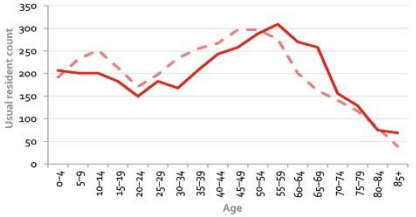
Demographic Changes By District

Canterbury District Health Board
Te Poari Hauora ō Waitaha

2006 Census — 2013 Census

Kaikoura

Usual Resident Count By Five Year Age Group In 2006 & 2013



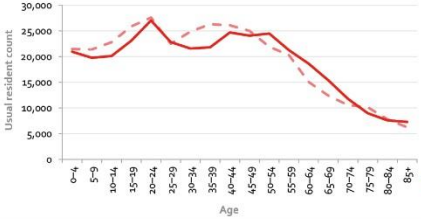
66 fewer residents in Kaikoura than in 2006.

17.8% of Kaikoura residents are Māori

65+ **19.4%** of Kaikoura residents are aged 65 years or older, up from 14.9% in 2006. This is the highest proportion of older people than any other district in Canterbury.

Christchurch

Usual Resident Count By Five Year Age Group In 2006 & 2013



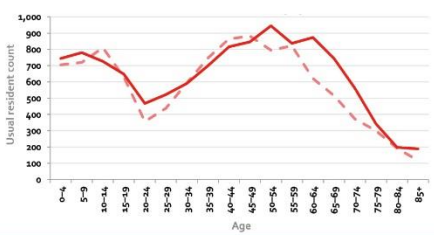
2,952 fewer families with dependent children in Christchurch.

6,987 fewer residents in Christchurch than in 2006.

5,106 fewer females in Christchurch aged 15-34 years old. There are 1,188 fewer males in the same age group.

Hurunui

Usual Resident Count By Five Year Age Group In 2006 & 2013

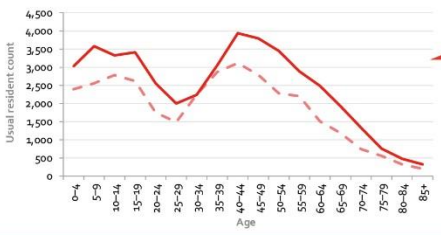


1,053 more residents in Hurunui than in 2006.

65+ **17.6%** of Hurunui residents are aged 65 years or older, up from 14.3% in 2006.

Selwyn

Usual Resident Count By Five Year Age Group In 2006 & 2013



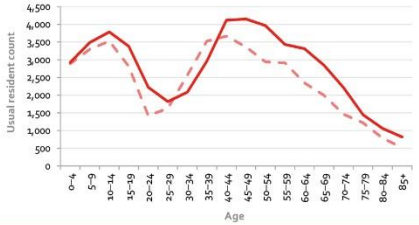
1,338 more families with dependent children in Selwyn than in 2006.

10,953 more residents in Selwyn than in 2006. This has made Selwyn the fastest growing district in New Zealand.

22.3% of Selwyn residents are under the age of 15. This is the highest proportion of any district in Canterbury.

Waimakariri

Usual Resident Count By Five Year Age Group In 2006 & 2013



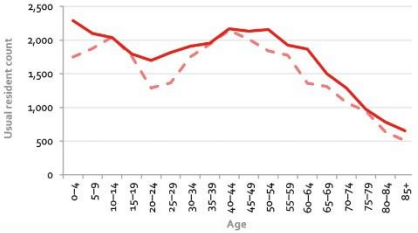
65+ **16.8%** of Waimakariri residents are aged 65 years or older, up from 13.9% in 2006.

7,155 more residents in Waimakariri than in 2006.

63% of those living in red zone areas of Waimakariri in 2008 that have moved within the last five years have stayed in the district.

Ashburton

Usual Resident Count By Five Year Age Group In 2006 & 2013



3.4% of Ashburton residents are of Pacific ethnicity, up from 1.4% in 2006. This is the highest proportion of any district in Canterbury.

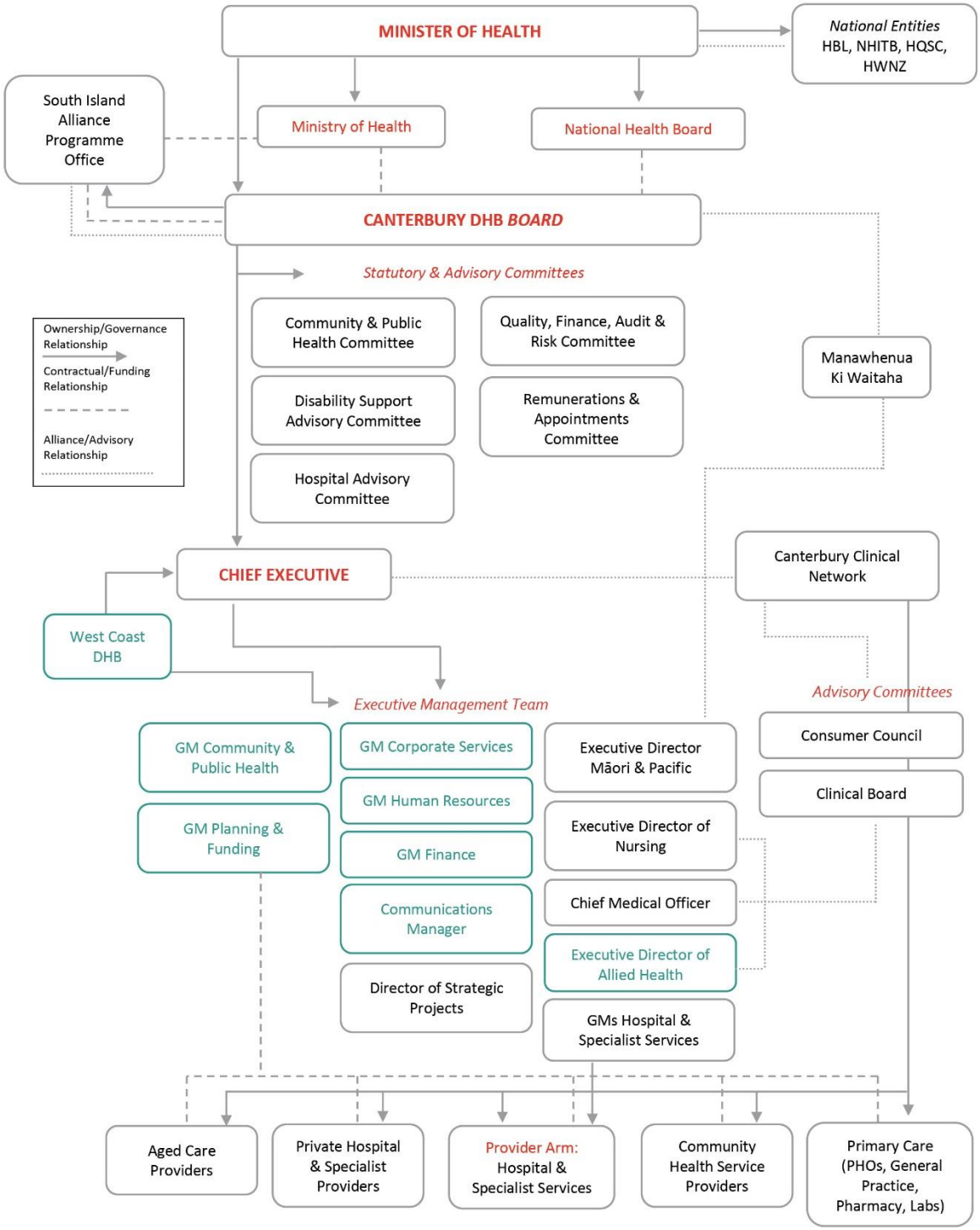
3,669 more residents in Ashburton than in 2006.

1,050 more residents in Ashburton aged 15-34 years old than in 2006.

Please note: *Due to the difference in resident populations the scale of each graph varies.*

Data source: *Statistics New Zealand, Census of Population and Dwellings, 2013.*

9.4 Canterbury DHB organisational and system governance structure



9.5 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.

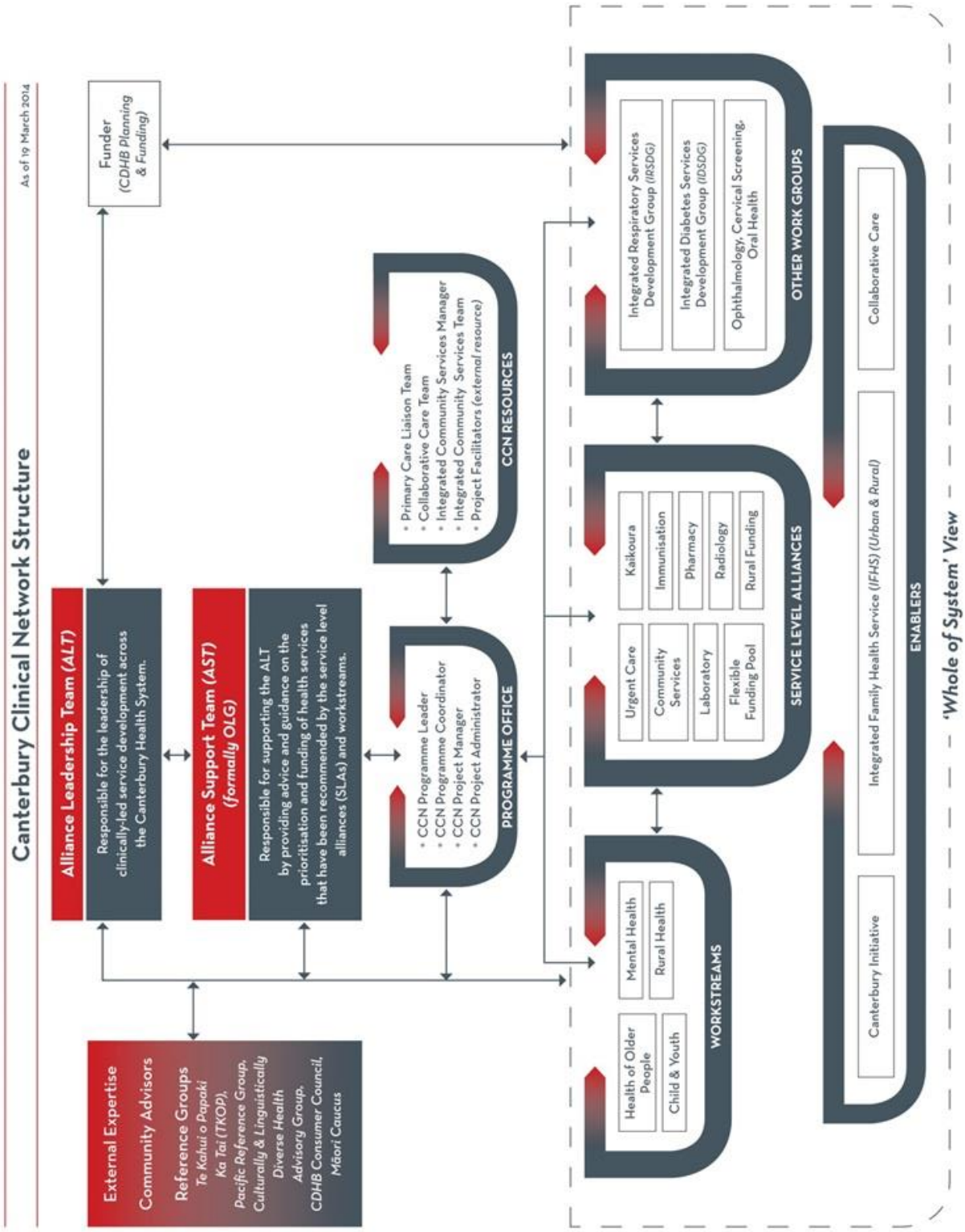
ASHBURTON AND RURAL HEALTH SERVICES

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.

9.6 Canterbury Clinical Network structure



9.7 Minister's Letter of Expectations

Office of Hon Tony Ryall

Minister of Health
Minister for State Owned Enterprises

30 JAN 2014

Mr Murray Cleverley
Chair
Canterbury District Health Board
PO Box 1600
CHRISTCHURCH 8140

Dear Mr Cleverley

Letter of Expectations for DHBs and subsidiary entities 2014/15

Public and patient confidence in the health service continues to grow strongly. Thank you to your team. This achievement is built on the four objectives of the Government's health plan: *helping families stay healthy, better performance, best use of every dollar, and a strong and trusted workforce*. In the next year we expect continued strong focus on successful implementation.

New Zealand has come through the global financial crisis in much better shape than most other countries. That's because of this government's careful and prudent financial management. Our approach has been to protect the most vulnerable in our society, and rebuild the economy's capacity to create jobs, higher incomes and security.

Despite the toughest of times, we are providing better public services within careful funding increases. This government now invests an extra $2.5 billion a year more into the public health service. And this year's budget will again see more investment in Health.

Better Public Services: Results for New Zealanders

Of the Prime Minister's ten whole-of-government key result areas, DHBs are expected to actively engage and invest in increased infant immunisation, reduced incidence of rheumatic fever, and reduced assaults on children.

It is important Boards work closely with other social sector organisations and initiatives including Whanau Ora, Children's Action Plan and Youth Mental Health. The government values the contribution of NGOs and DHBs must work with them.

National Health Targets

The national health targets have proven very successful at driving major improvements for patients: more elective surgery, faster access to emergency and cancer care, and better prevention. DHBs will provide clear and specific plans for achieving all national health targets in their Annual Plans.

In particular further work is required to achieve the three preventive targets. You must demonstrate appropriate performance management arrangements for PHOs. Poor performance must be rectified and not ignored. You should again show your local primary care networks are involved in and explicitly endorse your target achievement plans.

Your DHB is expected to help patients by meeting our objectives of shorter waiting times for surgery, diagnostics, cardiac and cancer care.

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

Care Closer to Home

New Zealanders are living longer, more sedentary lives. This means more of us have chronic conditions like diabetes, asthma, dementia, cancer and mental health disorders. The sooner doctors and nurses can detect, treat or prevent these conditions, the better they can reduce the significant burden these conditions put on both patients and the health system.

A major strategy to do this is *clinical integration* – providing joined-up care across primary and secondary services. With resources and interventions flowing to where they are most effective. So patients get their care sooner and closer to home.

DHBs must focus strongly on service integration across the health system, including integrated family health centres, primary care direct referral for diagnostics, clinical pathways and sharing of patient controlled health records.

Health of Older People

Your DHB is expected to continue working with primary and community care to deliver integrated services for older people to support their continued safe, independent living at home; particularly important are avoiding a hospital admission and care after a hospital discharge. You should continue working with the Ministry to implement our commitments to improving home care, stroke services and dementia care pathways.

Regional and National Collaboration

DHBs are expected to make further progress on implementing Regional Service Plans including workforce, IT and capital objectives. DHBs are expected to strongly support the implementation of the key Health Benefits Ltd savings programmes. Further gains in quality, efficiency and cost control will also come from your work with Pharmac, Health Workforce NZ and the Health Quality and Safety Commission. The new patient satisfaction survey is one example.

Strong clinical leadership and engagement is important and remains essential.

Living Within Our Means

To support New Zealand's recovery your DHB must keep to budget. Your DHB must have detailed and effective plans to improve financial performance year on year. Equity and capital remain constrained. As agents of the Crown you and your Board must assure yourselves that you have in place the appropriate clinical and executive leadership to deliver on the government's objectives. You and your Board must monitor and hold your CEO accountable against these expectations.

Appreciation

Again, thank you for the considerable effort you and your team are making. This makes a real difference to the quality of life of many thousands of New Zealanders. Please share this letter with your clinical leaders and local primary care networks.

Yours sincerely

Tony Ryall
Minister of Health

Attached: PM's Key Result Areas and National Health Targets

Appendix 1: Prime Minister's Key Result Areas and DHB Health Targets for 2014/15

Prime Minister's Key Result Areas – Supporting Vulnerable Children

Increase immunisation rates

Increase infant immunisation rates so that 95 percent of eight-month-olds are fully immunised by December 2014 and this is maintained through to 30 June 2017.

Rheumatic Fever

Reduce the incidence of rheumatic fever by two thirds to 1.4 cases per 100,000 people by 2017.

Assist to reduce the number of assaults on children

By 2017, halt the rise in children experiencing physical abuse and reduce current numbers by 5%.

National Health Targets for 2014/15

Shorter stays in Emergency Departments

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

Improved access to elective surgery

The volume of elective surgery will be increased by at least 4,000 discharges per year.

Shorter waits for cancer treatment / transitioning to Faster Cancer Treatment

All patients ready-for-treatment, wait less than four weeks for radiotherapy or chemotherapy.

Faster cancer treatment.

The 62-day faster cancer treatment indicator that is currently a developmental measure, will transition into a full policy priority accountability measure, and will become the next cancer health target during 2014/15. Further details including the health target definition, DHB performance expectations for 2014/15, and the process for transition will be provided at the end of February 2014.

Increased immunisation

90 percent of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time by July 2014 and 95 percent by December 2014.

Better help for smokers to quit

95 percent of hospitalised patients who smoke and are seen by a health practitioner in public hospitals and 90 percent of enrolled patients who smoke and are seen by a health practitioner in General Practice are offered brief advice and support to quit smoking. Within the target a specialised identified group will include:

- progress towards 90 percent of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer are offered advice and support to quit.

More heart and diabetes checks

90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years.

9.8 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 *Error! Bookmark not defined.*

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.[79]

Canterbury contribution – see page *Error! Bookmark not defined.*

17,484 elective surgical discharges will be delivered in 2014/15.

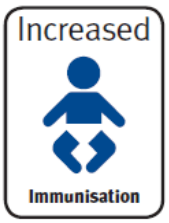
Shorter Waits for Cancer Treatment

Government expectation [80]

All people ready for treatment wait less than four weeks for radiotherapy or chemotherapy.[81]

Canterbury contribution – see page *Error! Bookmark not defined.*

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 *Error! Bookmark not defined.*

95% of all eight-month-olds will be fully vaccinated.

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 *Error! Bookmark not defined.*

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 *Error! Bookmark not defined.*

Progress towards **90%** of the eligible population having had their CVD risk assessed.

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

[80] *This national health target will change in Quarter 2 2014/15 to the Faster Tests and Cancer Treatment health target.*

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

9.9 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 7 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).

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 dollars. 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 financial liability requirements are the same as those of NZ IAS 39, except for when an entity elects to designate a financial liability at fair value through the surplus/deficit. The new standard is required to be adopted for the year ended 30 June 2016. However, as a new Accounting Standards Framework will apply before this date, there is no certainty when an equivalent standard to NZ IFRS 9 will be applied by public benefit entities.
- The Minister of Commerce has approved a new Accounting Standards Framework (incorporating a Tier Strategy) developed by the External Reporting Board (XRB). Under this Accounting Standards Framework, Canterbury DHB is classified as a Tier 1 reporting entity and it will be required to apply full public sector Public Benefit Entity Accounting Standards (PAS). These standards are being developed by the XRB and are mainly based on current International Public Sector Accounting Standards. The effective date for the new standards for public sector entities is expected to be for reporting periods beginning on or after 1 July 2014. This means Canterbury DHB expects to transition to the new standards in preparing its 30 June 2015 financial statements. As the PAS are still under development, Canterbury DHB is unable to assess the implications of the new Accounting Standards Framework at this time.
- Due to the change in the Accounting Standards Framework for public benefit entities, it is expected that all new NZ IFRS and amendments to existing NZ IFRS will not be applicable to public benefit entities. Therefore, the XRB has effectively frozen the financial reporting requirements for public benefit entities up until the new Accounting Standards Framework is effective. 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 GAAP, 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.

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 yearend 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, advance in medical technology, 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.

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