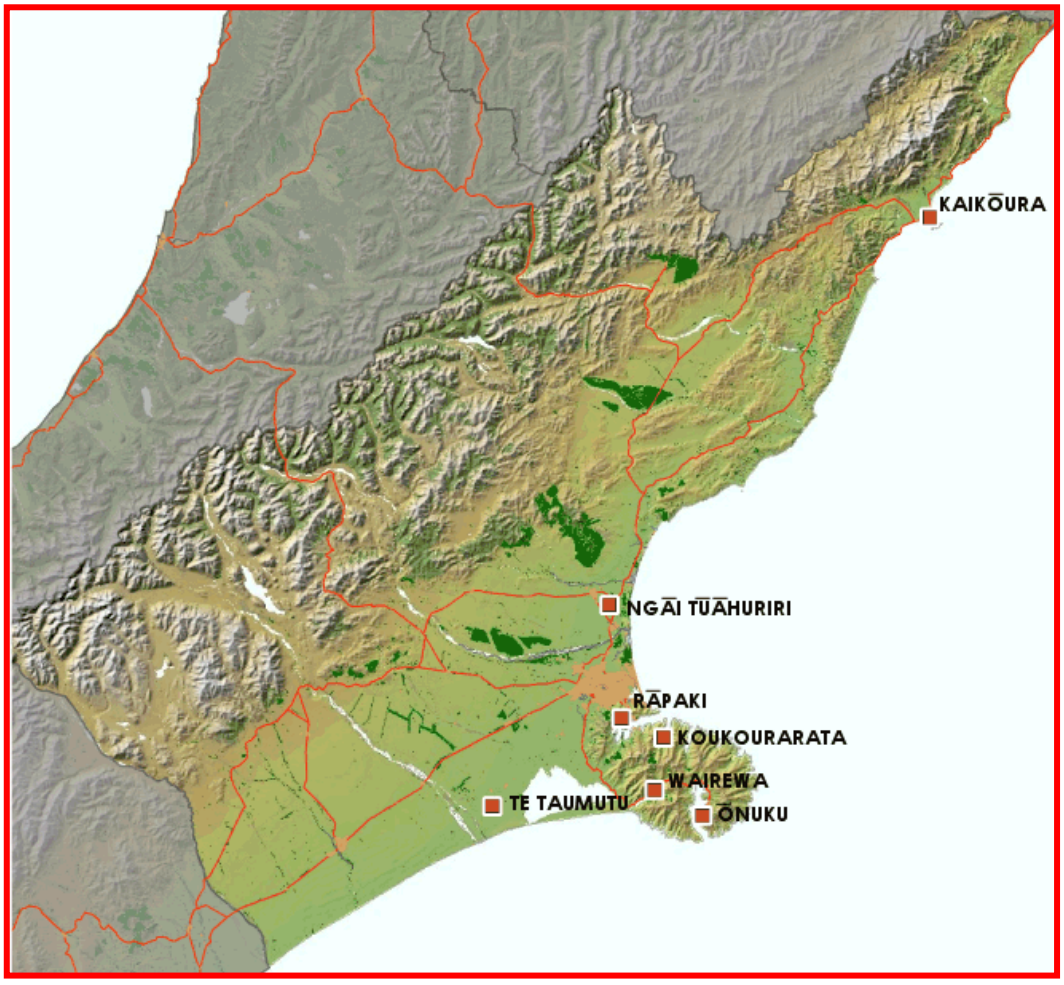
District Annual Plan 2008/2009

Canterbury District Health Board



Canterbury
District Health Board
Te Poari Hauora ō Waitaha

DISTRICT ANNUAL PLAN
1 July 2008 – 30 June 2009

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1. Executive Summary

Statement from the Chairman and Chief Executive

We are pleased to present our District Annual Plan for the 2008/09 financial year. This document reflects our continued commitment to promoting, enhancing and facilitating the health and wellbeing of the people of Canterbury.

In 2004 the Canterbury District Health Board (DHB) developed its District Strategic Plan and chose five Core Directions, five Strategic Health Gain Priorities and four Disease Priorities as specific areas of focus. These local strategic priorities are coupled with national objectives and expectations to set our long-term direction and goals. The following District Annual Plan outlines the activity planned in 2008/09 that will contribute to meeting those goals.

Over the past year the Canterbury DHB has achieved some excellent outcomes and results against local and national DHB priorities. These achievements are highlighted throughout this document to demonstrate the journey the DHB is on to improve the health of our population and they provide a foundation for making further progress in 2008/09.

We will continue our journey by building on these foundations and working to meet our service and financial commitments and performance goals.

In light of increasing demand, an ageing population and financial pressure from wage settlements, consumable costs and inflation we must accelerate change in the way we work in order to achieve our commitments. We will focus on the continued development of patient centred models of care and the redesign of patient pathways to better manage acute demand and the burden of long-term (chronic) conditions. The DHB will also seek to improve organisational fitness and focus on quality and patient safety to meet our responsibility to the Canterbury community.

This change will require the DHB, other DHBs in the southern region, the Ministry of Health (Ministry), Primary Health Organisations, local health and disability providers, community and primary organisations and other Government agencies to work together to maintain and improve health outcomes for our population.

We will be looking at all aspects of our business to determine how we can be more cost effective while continuing to achieve our vision and goals. Trade-offs and prioritisation will be increasingly required to ensure commitments are realised. The way forward includes a range of efficiency and effectiveness initiatives, regional and national initiatives, service reconfiguration and outcome focused investment. The DHB will continue to focus on the development of joint pathways between primary and secondary care to improve the patient journey and reduce duplications and delays across the whole of the health sector.

We will also be focused on clinical quality in terms of the flow of patients through our services. This approach is founded on the recognised principles of 'lean thinking' and the basis that delays in patients care at any stage of the patient journey create risk and provide poorer health outcomes, in addition to higher costs. Our commitment to shared decision making through a clinical governance process, founded on partnerships between management and clinical leaders, will ensure that strategic and operational decisions are fully informed and are as effective as possible.

Achievement of our vision requires the DHB to find better ways of working, to develop collaborative models of service delivery, support a sustainable health workforce and to provide leadership in the sector. The DHB is reliant on support from the Ministry, other DHBs, Government and non-Government agencies, community and primary providers and our community to achieve the goals and objectives we have set, and we acknowledge the support and collaboration that allows us to improve outcomes for our population. We look forward to working in partnership to achieve greater progress and change in the coming year.

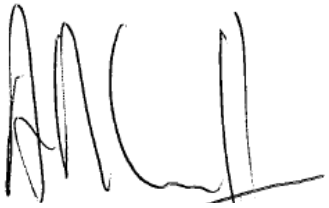
Signatories

Alister James

Chairman

Gordon Davies

Chief Executive



Hon David Cunliffe

Minister of Health

2. Introduction

This Chapter:

- Provides a summary of the Canterbury DHB's role and responsibilities;
- Provides an outline of how the DHB functions and operates; and
- Explains the purpose of this document.

2.1 The Canterbury DHB

The Canterbury DHB is the second largest of the twenty-one DHBs in New Zealand (NZ) by population and the largest by geographical area. The DHB district covers Kekerengu in the North, Rangitata in the South and Arthur's Pass in the West and comprises the six Territorial Local Authorities of Kaikoura, Hurunui, Waimakariri, Christchurch City, Selwyn and Ashburton.

The Canterbury DHB is also the largest employer in the South Island with over 8000 staff across 14 hospitals and numerous community bases.

The DHB's prime responsibility is to work within the funding allocated by Government to improve, promote and protect the health and independence of its population. Like all DHBs, the Canterbury DHB:

- ***Plans*** in consultation with stakeholders and its community, the strategic direction for health and disability services in the Canterbury district;
- ***Funds*** health and disability services provided in Canterbury, through more than 800 service contracts with health and disability service providers;
- ***Provides*** health and disability services, encompassing women's and children's services, medical and surgical services, mental health, older person's health, and rural health services, laboratory and hospital support services and rehabilitation services; and
- ***Promotes*** community health and well-being through health promotion, health education and population health programmes.

In 2004, while developing its long-term vision for its District Strategic Plan 2005-2010, the Canterbury DHB selected five Core Directions, five Health Gain Priorities and four Disease Priorities around which to concentrate efforts to improve health outcomes. These strategic priorities were selected through a health needs assessment and public consultation process and are coupled with national expectations to set the DHB's objectives and goals and to plan its actions and activity each year. From this process the DHB also developed a vision and set of values. [1]

2.2 Vision and Values

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

[1] *All DHB documents and strategies can be found on the Canterbury DHB website, www.cdhb.govt.nz.*

2.3 Shared Decision Making

DHB's have three key roles, each with different responsibilities: a Governance role, Funder role and Provider role. The Canterbury DHB has a governance and organisational structure to enable it to carry out its responsibilities to its community effectively and efficiently in all three of its roles.

The Role of the Board

The Board undertakes the Governance role for the Canterbury DHB and is responsible to the Minister of Health for the DHB's overall performance. Seven Board members are elected by the DHB's community and four are appointed by the Minister of Health. There are two Māori Board members.

The Board's role is to:

- Set long-term strategic direction, consistent with Government objectives;
- Ensure compliance with law, accountability requirements, Crown expectations and the requirements of the New Zealand Public Health and Disability (NZPHD) Act.
- Monitor the financial and non-financial performance of the DHB;
- Appoint the Chief Executive and maintain that employer relationship; and
- Maintain appropriate relationships with the Ministers, Parliament, Māori groups and the Canterbury community.

The Board has three Statutory (mandatory) Committees comprised of a mix of both Board members and community representatives who meet regularly throughout the year: [2]

- *The Hospital Advisory Committee* - monitors the financial and operational performance of the DHB's hospitals and specialist services, as well as assessing strategic issues relating to those services.
- *The Community and Public Health Advisory Committee and the Disability Support Advisory Committee* (delivered through the same body of membership), provide the Board with advice on the health and disability needs of the population, how the services funded and/or provided by the DHB, along with the policies it adopts, will impact on that population, and how they will promote the inclusion and participation of people with disabilities and maximise their independence.

The Board also has two additional sub-committees specific to the Canterbury DHB. The *Finance, Audit and Risk Committee,* established to enhance the Board's governance function by providing advice on the financial operation of the DHB and monitoring risk issues and the *Remunerations and Appointments Committee*, established to deal with the employment of the Chief Executive and other industrial and employment matters.

While the responsibility for DHB overall performance rests with the Board, it has a delegation policy, assigning operational and management matters to the Chief Executive. Both the Board and Chief Executive ensure that their strategic and operational decisions are fully informed through appropriate involvement and support at all levels of the decision making process.

Māori Participation in Decision Making

The DHB is committed to engaging with Māori to facilitate genuine participation in the planning and delivery of services, particularly as they affect Canterbury's Māori population.

In the past the DHB has had an informal relationship with groups such as Manawhenua Ki Waitaha and Te Rūnanga o Ngā Maata Waka and has engaged at many levels with Māori providers and Māori community groups. [3]

In March of 2008 the DHB signed a Memorandum of Understanding with Manawhenua Ki Waitaha as a first formal step to enabling the participation of Māori in DHB decision making and in the planning and delivery of health and disability services. The Memorandum of Understanding commits the DHB to regular meetings with, and reporting to, Manawhenua Ki Waitaha as a pathway to shared decision making.

The DHB's Māori Health Plan, approved in 2007, also commits the DHB to establishing formal relationships with Māori representative groups beyond Manawhenua Ki Waitaha, such as Taura Here community groups.[4]

In collaboration with Manawhenua Ki Waitaha the DHB will explore mechanisms to facilitate greater participation of Māori at a governance level. Possibilities for such participation may include a Māori governance/advice board providing advice to the DHB's Board and allowing Māori opportunities to engage with the Board of the DHB.

The DHB will continue to consult with Māori communities at appropriate levels of operations and to provide Māori with opportunities to engage and feedback to the DHB.

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[2] *In accordance with the NZPHD Act, meetings where the Board or any of its Statutory Committees make decisions are open to the public to attend as observers. Notice of meetings is available on the DHB's website www.cdhb.govt.nz.*

[3] *Manawhenua ki Waitaha is a representative group which comprises of seven Ngāi Tahu Rūnanga.*

[4] *Taura Here refers to all other collective pan-tribal Māori groups.*

Quality and Patient Safety Council

In 2002 the Quality and Patient Safety Council was established to promote quality improvement within the DHB. The Council provides governance for the organisation with respect to quality and patient safety and provides advice to the Chief Executive on these issues. The Council also promotes the sharing of information and establishment of best practice.

The Quality and Patient Safety Council facilitates continuous improvement and looks to offer support and guidance to positively influence quality care. The Council also identifies key issues for quality improvement and promotes the development of appropriate information systems for monitoring and reporting on quality and supports and promotes training and education programmes.

The Council sponsors both the DHB's Quality Strategic Plan and the DHB's Quality and Innovation Awards and has developed key policies, which promote quality and patient safety (the culture of patient safety policy, open disclosure policy and the no blame incident/accident reporting policy).

There are 19 members on the Council including representatives from primary, secondary and community health and disability service providers and representatives from the community.

Clinical Board

Alongside quality and patient safety, clinical governance places a responsibility on the Chief Executive to have effective mechanisms in place for planning, monitoring and managing the quality of clinical care and for meeting identified targets for quality and budget objectives.

The Clinical Board was established in 2003 to give a focus to clinical leadership and to take a lead in developing clinical governance systems within the Canterbury DHB.

The Clinical Board is a multi-disciplinary DHB-wide clinical forum consisting of clinical representatives from the primary, secondary and community sectors and consists of 26 members; 17 of whom are elected.

The Board provides oversight of the DHB's clinical activity and advice to the Chief Executive and is charged with having a proactive role in setting clinical policy and standards and encouraging best practice and innovation. The Clinical Board will also support the DHB's vision and values and will provide a leadership role for the organisation.

Consumer Council – Health Services Planning

The DHB has established, or is involved with, a number of consumer and community reference groups, working parties and advisory groups which provide advice and input on the development of plans and strategies. This includes a number of Māori and Pacific groups to ensure Māori and Pacific input into decision-making to improve the delivery of health and disability services and to reduce inequalities in health status.

In 2007, as part of the DHB's focus on long-term health services planning, the DHB established a Consumer Council to provide input into decision making as part of its Health Services Planning Programme. The Consumer Council will give focus to a true partnership model that will provide a strong and viable voice for the community and consumers in health service planning and service delivery.

The Consumer Council consists of 15 representatives nominated by consumers and consumer lobby/advocacy groups and covers nine key areas; family health, older persons' health, disabilities, Māori health, Pacific health, chronic conditions, mental health, rural communities and primary care. Networks are currently being established to support each representative in their role and facilitate communication with a wide range of individuals and groups within the Canterbury community.

2.4 Organisational Structure

Charged with responsibility for organisational matters the Canterbury DHB's Chief Executive is supported by the Executive Management Team which includes General Managers of Planning and Funding, Community and Public Health and of various Corporate Services Divisions (refer to Appendix 1 for an Organisational Chart).

At this level support is also provided by the Executive Director of Māori and Pacific Health, Chief Medical Officer and Executive Director of Nursing, who provide clinical and cultural leadership and oversight of patient safety and quality.

Planning and Funding Health and Disability Services

The Planning and Funding division delivers against the Funder role of the DHB and is responsible to the Chief Executive for planning and funding health and disability services in Canterbury and determining how best to use DHB funding to meet the needs of the community. This involves assessing the population's health needs and, in consultation with the community, deciding on the mix, range and volume of services to be provided.

The core Funder activities of the DHB are:

- Determining the health and disability status and needs of the Canterbury population;

- Planning, prioritising and implementing national health and disability strategies in relation to those local needs;
- Involving stakeholders and the community through consultation and participation;
- Undertaking service contracting; and
- Monitoring, auditing and evaluating service delivery.

Using the funding available from Government, the DHB (through the Planning and Funding division, in the Funder role) then contracts with the organisations or individuals who can best provide health and disability services to meet the needs of the population. This includes contracting with the DHB's Hospital and Specialist Services in the Provider role.

The Canterbury DHB will enter into co-operative agreements/arrangements with other people/organisations to assist the DHB in meeting its objectives, enhancing health or disability outcomes for people or enhancing efficiencies in the health sector. The DHB may also negotiate and enter into service agreements in terms of Section 25 of the NZPHD Act for another person or organisation to provide services on behalf of the DHB.

The Planning and Funding division manages these service contracts or agreements and initiates specific health improvement projects. Partnerships are built with community agencies and organisations, service providers and other DHBs to develop integrated continuums of care, promote innovation, meet any identified gaps in service delivery and improve health outcomes. This division is also responsible for ensuring the Canterbury population has access to specialist services that are delivered by other DHBs (and not in Canterbury) and for monitoring and managing the flow of funds for these 'out-of-district' services.

Providing Health and Disability Services

The Canterbury DHB's Hospital and Specialist Services (HSS) division undertakes the DHB's Provider role and provides inpatient and outpatient services, community services and day programmes, across six service divisions: Medical and Surgical Services; Mental Health Services; Rural Health Services; Women's and Children's Services; Older Person's Health and Rehabilitation Services; and Hospital Support and Laboratory Services (refer to Appendix 2 for an overview).

The DHB's 14 hospitals are managed by the HSS division, and while the majority of hospital and specialist services are provided from these hospitals some specialist services are delivered from community bases or through out-reach clinics. A significant proportion of the DHB's HSS mental health services are provided in community settings.

Funding for the HSS division is primarily provided via a service level agreement with the Planning and Funding division. However, the HSS division also holds, and delivers against, service contracts with external funders, such as the Accident Compensation Corporation (ACC).

The volume and variety of services provided by DHBs depends on their relative size, with some providing more secondary and tertiary (specialist) level services than others. Because of the size of the Canterbury DHB it provides an extensive range of secondary and specialist services.

Some of the specialist services provided by the HSS division are also provided to people from outside the Canterbury district; coming from DHBs where these specialist services are not available. Those other DHBs are responsible for meeting the costs of the services provided to their population; referred to as 'inter-district' services or Inter-District Flows (IDFs). These IDFs are closely monitored to ensure the Canterbury DHB's ability to provide for its own population is not affected by demand from other districts.

Working with Other Health and Disability Service Providers

In addition to the DHB's HSS Division, there are a range of other providers who the DHB contracts with to provide health and disability services across the Canterbury district.

These providers include a mix of private, religious, welfare, Government and Non-Government Organisations (NGOs). The services provided include primary care services (general practice and nursing services, community, pharmacy and laboratory services), mental health, public health, child health, oral health, family health and maternity services, services for older people, disability and rehabilitation services, residential support and rest home services, Māori and Pacific health services and hospital and specialist services.

The DHB actively works with other providers of health and disability services in a cooperative way for the benefit of the Canterbury population, seeking input in important areas of policy development or for significant projects.

Partnerships with Primary Health Organisations

The DHB also contracts with Primary Health Organisations (PHOs) who are a key vehicle in implementing the NZ Primary Care Strategy; seeking to achieve improvements in health outcomes, reduce inequalities and meet national expectations.[5]

[5] *The NZ Primary Care Strategy is available on the Ministry of Health's website www.moh.govt.nz.*

There are five PHOs in the Canterbury district and over 95% of the Canterbury population is enrolled with one of these five PHOs. Canterbury's PHOs work in a collaborative model with each PHO taking a 'lead' role in the implementation of different projects and initiatives. This provides the Canterbury population with collaborative primary care services that a more competitive service model might not. The DHB meets regularly with the five PHOs to jointly address key issues and plan future initiatives and PHO and general practice representatives work alongside the DHB on a number of advisory boards and working parties to ensure appropriate input into DHB plans and strategies.

The DHB values its PHO relationships and work closely with the PHOs on areas such as acute demand management, after hours care, the management of long-term conditions, and health promotion and population health initiatives to improve health outcomes for the population and reduce unnecessary or avoidable hospital admissions.

Public Health Partnerships

Community and Public Health (CPH) is the public health division of the Canterbury DHB. CPH provides a public health service on behalf of three DHBs: the Canterbury DHB, South Canterbury DHB and West Coast DHB and works across 12 Territorial Local Authority areas: Kaikoura, Hurunui, Waimakariri, Selwyn, Christchurch City, Ashburton, Timaru, Waimate, McKenzie, Grey, Buller and Westland.

Over the last few years, the policy environment around public health has been evolving and driving change. Government policy now emphasises the necessity of:

- Public health activities organised to achieve outcomes identified by DHBs in their District Strategic Plans;
- Public health competent DHBs; the whole of the DHB taking a public health approach rather than this being solely the domain of the public health units; and
- Commitment to a whole of Government approach; recognising that many different arms of Government (i.e. health, education, social development) impact on health outcomes. Government services are expected to work more collaboratively to improve health outcomes.

In line with the whole of Government approach CPH delivers public health services in partnership with a large number of other organisations with an interest in public health including PHOs, Territorial Local Authorities, NGOs and statutory agencies. Developing and sustaining relationships with these organisations is vital to helping to improve and sustain the health and wellbeing of the population.

The CPH division has recently restructured to more closely align itself with the changing policy environment within which it protects population health and promotes future wellbeing. The division concentrates its work into five programme areas: Information and Capacity Building; Emergency Response and Communicable Disease Control; Healthy Physical Environments; Chronic Disease Prevention and Alcohol-Related Harm, and Developmental Health.

2.5 The Purpose of the District Annual Plan

The Canterbury DHB is required to produce a District Strategic Plan and review this Plan every three years. The last Plan was developed in 2004 and describes the DHB's long term objectives and goals for the period 2005-2010.

In developing its District Strategic Plan the DHB established a set of strategic priorities where additional focus will better meet the needs of the community and improve the health status of the Canterbury population (refer to section 4).

The District Strategic Plan provides the basis for each District Annual Plan which is designed to show:

- Intended activity and outputs for the coming year and how these relate to the DHB's long-term Strategic Plan;
- How that activity will contribute towards meeting local priorities and national expectations;
- The funding proposed for those activities and outputs;
- Financial and non-financial performance forecasts;
- Expected capital investment and any anticipated service change;
- Identified risk and assumptions; and
- How the DHB's performance will be monitored, measured and reported.

This District Annual Plan has been developed through an interactive process involving stakeholders, DHB staff and management, the DHB Board and the Ministry. Where possible, the document identifies joint responsibilities and the collaborative activity needed to improve health outcomes for the Canterbury population.

In addition to this District Annual Plan the DHB is also required to produce a Statement of Intent which provides a statement of forecasted service and financial performance for the coming three years. The Statement of Intent presents a set of performance indicators around each of the DHB's Strategic Priorities outlining the targeted improvements the DHB intends to make against medium-term outcomes indicators. Because the District Annual Plan is closely aligned to the Statement of Intent, it should be read in conjunction with that document.

3. Operating Environment

This Chapter:

- Provides a summary of the current make-up of the Canterbury population and the key health trends and health needs of the population;
- Provides a summary of the current environment in which the Canterbury DHB operates, which influences the choices it makes; and
- Provides a context for the actions and activity planned for the coming year.

3.1 Overview of the Canterbury Population

In September 2004 the DHB completed its second comprehensive Health Needs Assessment bringing together information describing the Canterbury population and the health status of Canterbury residents. The DHB plans to undertake a review and update of its Health Needs Assessment in 2008/09.

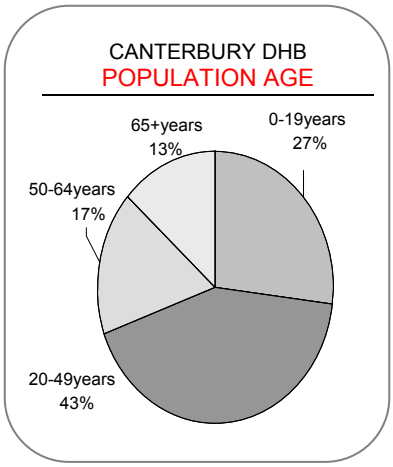
The material presented in the following two sections is drawn from the DHB's 2004 Health Needs Assessment and the most recent 2006 Census completed by Statistics NZ.

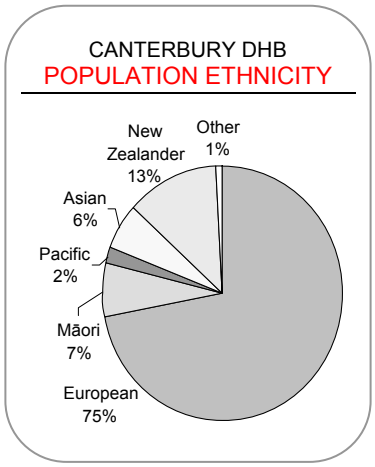
Canterbury's usual resident population, at the 2006 Census, was 466,416 with Statistics NZ predicting that this would rise to 529,150 by 2016. The latest 2006 figures show that Māori make up 7.2% of the Canterbury population, Asian people 6.1% and Pacific people 2.2%. Ngai Tahu was the largest identified iwi in Canterbury, followed by Nga Puhi and Ngati Porou. The main Pacific ethnic groups are Samoan, Tongan, Cook Island Māori and Niuean.

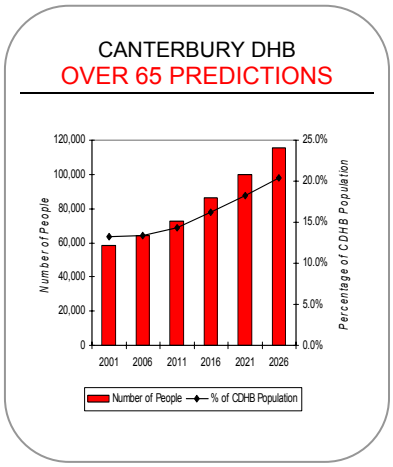
The DHB's Health Needs Assessment reported that just over a quarter (27%), of the Canterbury population lives outside the urban Christchurch boundary. There are differing degrees of rurality but approximately 7,000 people (1.5% of the population) live in remote areas and have to drive for more than an hour for primary health care services. Most people identifying as Māori, Asian or Pacific live in Christchurch City.

2006 figures show around 14% of the population is aged between 15 and 24 years. This is similar to the national figure. As with the national population, an increasing percentage of the child and youth populations are Māori, Asian and Pacific. These ethnic groups have younger populations in general and latest figures show that while 34% of the total Canterbury population is under 25 years old - approximately 55% of the Māori population is aged under 25 and around 60% of the Pacific population in Canterbury is under 30 years of age. There are proportionately almost twice as many Pacific children as non-Pacific children under the age of 10 in the Canterbury district.

Poorer health status is linked with high degrees of deprivation and the 2006 Census showed Canterbury had around 100,000 people living in NZ Deprivation Deciles 8, 9 and 10 (the highest levels of deprivation). Specific local figures from the 2004 Health Needs Assessment reported that the percentage of Māori and Pacific people living in these areas was higher, with 43% of Pacific and 30% of Māori in deciles 8, 9 and 10 compared to 17% of Asians and 15% of Europeans. Eighteen per cent of Canterbury's under 15 age group were living in deciles 8, 9 or 10. With a significant proportion of Canterbury's child and youth populations living in these higher decile areas the DHB has identified child and youth health as the first of its five long-term Health Gain Priorities.







The 2006 Census shows 13% of the total Canterbury population is aged over 65. This is a slightly higher proportion of elderly than is seen in the total New Zealand population, with latest national figures showing 12% of the country's population aged over 65. Two of Canterbury's rural areas, Kaikoura and Ashburton, continue to have even higher percentages of the population aged over 65 (15% and 16% respectively).

While there are fewer older Māori and Pacific people in New Zealand, with the lower life expectancy due in part to higher morbidity rates through diabetes and cardiovascular disease, the percentage aged over 65 will rise - with the number of Māori over 65 expected to increase from 1.3% in 2001 to 3% by 2021.

Addressing the health needs of Canterbury's ageing population is one of the DHB's key challenges over the coming years and is the second of the DHB's five long-term Health Gain Priorities.

3.2 Key Health Trends

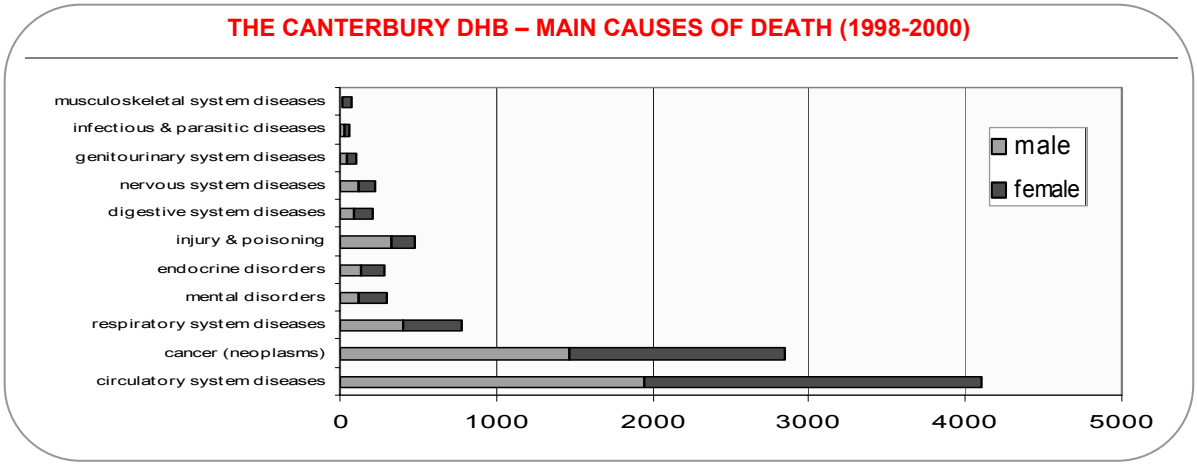
In order to address the health needs of its community it is important for the DHB to understand the health status of its population and the conditions and illnesses, which are prevalent in the Canterbury district. This understanding has assisted the Canterbury DHB in selecting all of its long-term Strategic Priorities.

The health status of residents in most areas in Canterbury is the same as, or better than, the national health status. Canterbury also has the highest life expectancy at birth of all the countries DHB districts (77.8 years).

The main causes of death in Canterbury are diseases of the circulatory system (ischaemic heart disease, stroke, heart attack), cancers and respiratory diseases.

Diabetic complications (such as heart disease, blindness and kidney failure) are also major contributors to the burden of disability experienced by people from middle age, particularly Māori and Pacific people, who are proportionately at higher risk of diabetes and its associated complications.

The prevalence of these diseases is reflected in the DHB's choice of Cancer, Diabetes, Cardiovascular Disease and Respiratory Disease as its four identified Disease Priorities for the next five to ten years.



A number of conditions which result in death or disability (including diabetes) are attributable to risk factors: smoking tobacco, not being physically active, poor nutrition, alcohol consumption or recreational drug use. The 2002/03 NZ Health Survey reveals that most New Zealanders believe they have very good health. However, more than half of all adults are overweight, half do not get thirty minutes of exercise a day and 20% of people aged over 45 report having been diagnosed with cardiovascular disease. [6]

Tobacco smoking is a major risk factor for disease and a preventable cause of death. Canterbury's average smoking rates (23%) are lower than that of NZ as a whole, where the average rate is 25% for most age groups. However, nearly 9,000 people over the age of 35 are admitted to hospital in Canterbury every year with smoking related illnesses costing the district's hospitals around $23 million annually.

Disease prevention and the management of long-term (chronic) conditions are also included in the Canterbury DHB's five Health Gain Priorities with an emphasis on healthy eating, active living, smoking cessation, intersectoral collaboration and the development of integrated continuums of care. The DHB has also developed a framework for the management of long-term conditions.

Timely and consistent primary health care can help prevent disease development, complications and hospitalisations. Ambulatory sensitive admissions to hospital are those which result from diseases and conditions which are sensitive to

[6] *The NZ Health Survey can be found on the Ministry website, www.moh.govt.nz.*

interventions delivered through primary care. It is considered that a good percentage of these admissions are avoidable.

In Canterbury, socio-economically deprived people are hospitalised with potentially preventable conditions at almost twice the rate of those less-deprived. Canterbury's hospitalisation rates for childhood asthma are high, as are the notified rates of pertussis (whooping cough). Māori and Pacific children (an increasing percentage of Canterbury's younger population) also have high rates of hospitalisation for vaccine-preventable diseases, and higher rates of tooth decay and glue ear than other Canterbury children.

Primary Health is also one of the DHB's five Health Gain Priorities and working with PHOs the Canterbury DHB intends to focus on earlier intervention, improving equity of access to health services, the prevention and management of long-term conditions and addressing acute demand.

Suicide rates in Canterbury are no higher than the national average but continue to be of concern especially for males. Although not a priority area, the DHB will continue to implement national and local solutions for improved mental health services and equity of access for consumers.

Māori and Pacific Profile

Māori are twice as likely to develop diabetes and on average develop diabetes nine years earlier than their counterparts of other ethnicities. Māori children also have high hospital discharge rates for asthma, particularly in Canterbury where overall rates for children under five are higher than national averages.

Pacific people are more likely than other ethnicities to be admitted to hospital for diseases of the skin and conditions related to pregnancy. The high rate of tobacco smoking amongst Pacific youth aged 15-24, is a particular concern and is much higher than the average rates in Canterbury.

Improving the health of the Māori and Pacific populations is critical in Canterbury, as throughout NZ, given that on average these ethnic groups have the poorest health status. Nationally and regionally a range of health strategies acknowledge the importance of improving Māori and Pacific health outcomes in order to reduce and eventually eliminate health inequalities which have a negative impact on these groups. To add local focus the Canterbury DHB has included Māori Health amongst its five Health Gain Priorities.

3.3 Demand Pressures

There is an increasing demand for health services in Canterbury. The ageing and growing population and the increasing burden of long-term conditions are amongst factors which have contributed to this rising demand.

Between 2001 and 2006 the population of the Canterbury region grew by 9.5% and the number of people over the age of 65 increased by 10.8% and those over 85 by 20.8%. With utilisation of health services tending to increase with age, Canterbury's growing older population will result in increased demand for services in the coming years.

In 2006/07 there were approximately 65,900 inpatient and day case medical and surgical discharges from DHB hospitals. This represents an increase of 14% over the last five years. While some of this growth is explained by increases in the population, demand from other DHBs within the Southern Region for the provision of tertiary and specialist level services has also contributed to these increases.

The number of discharges for acute services has increased by 16% over the last five years representing a significantly faster growth than the population. This increase in demand for acute service is also reflected in the increasing attendances at the Christchurch Hospital Emergency Department. In 2001/02 there were approximately 64,100 attendances and in 2006/07 approximately 71,900 - a 12% increase.

3.4 Financial Pressures

The DHB is committed to planning and funding health services that best meet the needs of the Canterbury population and to achieving the strategic objectives and health targets as set-out in this document.

The DHB has to achieve this within a capped budget and a breakeven financial position. Demand pressures, cost pressures and the cost of new technologies make this a significant challenge. Recent health sector wage settlements have been well above the rate of funding and in the past few years an unprecedented level of investment had been made in staff wages; partly to cope with service pressures and partly to recognise anomalies around international wage rates. This trend of high wage increases will need to be contained in the future as the roll-on effect will otherwise be a reduction in patient services in order to fund higher wage bills.

As the population ages health and disability service needs increase and technology developments (including pharmaceuticals) provide newer, better, but often more expensive interventions. The demand pressure for newer more expensive services further increases the financial pressure facing the DHB.

A number of these issues, or pressures, have been highlighted as 'risks' to the DHB's performance and the magnitude of the challenge ahead can be summarised as follows :

As a Funder of services the DHB will need to:	As a Provider of services the DHB will need to:
▪ Constrain expenditure to within funding received. ▪ Re-allocate funding between discretionary and non-discretionary services to manage demand driven growth, while providing provider incentives to minimise/manage the growth in demand. ▪ Ensure that the DHB receives the right funding for the services delivered.	▪ Ensure resources are used wisely to meet increasing demand and deliver the maximum health care benefits (particularly with international competition for resources). ▪ Reduce waste and improve the quality of patient care by adopting a 'lean' approach. ▪ Collaborate with primary and community based providers to manage acute demand and long-term conditions.
Key Pressures on Expenditure	
▪ Forecast Consumer Price Index is higher than the rate of funding increase received - inability to fund services at a rate higher than the funding received. ▪ Increasing demand from an increase in population and an ageing population – cost of the increasing demand for services exceeding available funds. ▪ Funding for new technology has been assumed to be from savings generated. ▪ Funding provided for some services is less than the cost of providing those services. ▪ Increasing demand from other DHBs for tertiary and specialist services has to be balanced with that of Canterbury residents.	▪ Wage settlement above funding increase received – pay increase, step movements, allowances and the costs of additional conditions of employment. ▪ Difficulty recruiting staff for highly specialised areas and incurring more expensive locums and bureau staff. ▪ Industrial Action - service delivery risks, inability to meet health targets due to strike action and meeting the costs of contingency planning. ▪ Expectation that new technologies will be adopted to deliver new advances in healthcare. ▪ Increase compliance costs with changes in legislations, policy and health standards. ▪ Clinical training prices don't cover the total cost of training or keep pace with national collective award increases. ▪ Increases in ACC levies and increased coverage.

3.5 Funding Strategy - Allocation of Funds 2008/09

During the 2008/09 year the DHB will face significant financial pressure resulting from wage settlements, inflationary pressures, increased demand and increased costs in terms of technology and consumables. The DHB's funding strategy must therefore balance the use of additional demographic funding to meet these financial pressures against the need to further invest in services that support improved health outcomes for the Canterbury community.

During the coming year the DHB will seek to position itself to deliver its key objectives and goals, while recognising the projected financial pressure in 2008/09 and beyond. Investment in service developments over the coming year, while limited, will be focused in three key areas:

- Service developments that improve the continuum of care between the primary and secondary sectors;
- Service developments that reduce costs or service demand; and
- Service developments that improve the health of the population and support the achievement of Health Targets.

The DHB will seek to change the way that it funds services to ensure funding arrangements are supportive of service change, rather than working against the efforts of frontline staff. This funding strategy will establish funding approaches that:

- Improve the DHB's ability to achieve change within secondary care and across the primary/secondary continuum;
- Focus hospital and specialist services on the delivery of key activities and outcomes rather than focusing on counting outputs at a detailed level;
- Provide an increased focus on efficiency, effectiveness and value for money;
- Initiate and support service development in priority areas and ensure services located in hospital settings complement community based services; and
- Improve the understanding and tracking of funding commitments and the potential impact of service development on forecasted requirements.

The initial step in this work is a change in the use of the Price Volume Schedule for contracting with the HSS division. From the beginning of the 2008/09 year the DHB will utilise a volume schedule for defining and monitoring service volumes matched with an expenditure budget. This work will support innovative and more effective service delivery led by frontline clinical staff in partnership with management.

The DHB will also seek in the coming year to move funding streams to support a smooth patient journey between primary and secondary care and to support the integration of services. The DHB will look at patient pathways in key priority areas including joint primary/secondary respiratory pathways and diabetes pathways and a number of other areas signalled through the work streams of its Referrals Project and key priority areas.

Alongside this approach, and in accordance with its Crown Funding Agreement requirements, the DHB aims to:

- Facilitate timely and fair access to appropriate health services for its population;
- Continue to fund a range of services similar to those funded in 2007/08;
- Work with contracting processes that treat internal and external providers fairly;
- Undertake service development to improve health outcomes, in line with the goals outlined in the NZ Health Strategy, NZ Māori Health Strategy and the NZ Disability Strategy;
- Meet service coverage requirements in the Operational Performance Framework and Service Coverage Schedule;
- Apply the Nationwide Service Framework, where appropriate, when entering into service agreements and utilise nationally consistent service specifications; and
- Allocate mental health ring-fenced funding to mental health services (including alcohol and other drug services). [7]

Value for Money

A significant part of the DHB's funding approach is centred on the need to ensure that the investments made are returning value for money, that operations are effective and efficient and that the DHB is being as productive as possible. Cost and demand pressures in a limited funding environment make this imperative.

The Canterbury DHB is committed to ensuring that the services funded are evidence based and to give priority to interventions that provide the most benefit relative to the resources used. The DHB will continue to focus on the reduction of inequalities in health status and support the development of new services in areas where investment will influence positive changes in the health of its population.

A variety of productivity measures and benchmarking processes are used to assess and promote service quality and efficiency and these will continue to be developed and applied in 2008/09. These measures include caseload and consultation evaluations, consumer satisfaction, complaints and timeliness. The DHB monitors overall productivity through resource utilisation and the value of services provided compared to the costs of providing those services.

The DHB also takes an ongoing approach to reviewing its infrastructure costs and, where appropriate, initiatives will be implemented to manage and/or reduce these costs. Effectiveness, productivity and quality initiatives such as the Improving the Patient Journey Programme, improvements in bed management systems and elective services management have enabled the DHB to reduce over-crowding and wait-times despite an overall growth in demand and the DHB will continue to seek improvements in quality and effectiveness in this manner.

In the coming year the focus will include:

- Implementation of the DHB's Improving the Patient Journey Programme;
- Implementation of the DHB's framework for managing long-term conditions;
- Implementation of the recommendations of the review of Acute Demand and After Hours Cover;
- Implementation of the Referrals Project including collaborative arrangements around elective services and the development of joint primary/secondary pathways;
- Continued review of service delivery models and pathways to improve access, reduce duplication, provide for a better use of resources and increase the range of treatment options;
- Continued review of consumables usage and supply chain processes particularly inventory and purchasing;
- Continued review of the introduction of any new treatment regimes and costs of new technology;
- Continued review and evaluation of employee cost control processes, nursing workforce costs, treatment-related costs and review of leave management and roster activity;
- Ongoing review of provider contracts to achieve the best outcomes possible for the public funding invested;
- Ongoing non-clinical support services reviews and consolidations; and
- Implementation of any reviews, reconfigurations or initiatives arising from the completion of a Health Services Plan for the Canterbury DHB – matching best location and best provider to treatment and delivery.

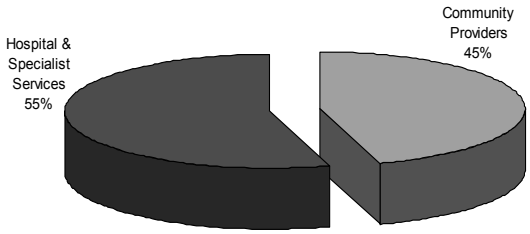
[7] *The Crown Funding Agreement, Operational Policy Framework, Service Coverage Agreement and National Service Framework are the accountability documents between the Ministry and DHB, under which all DHBs operate.*

In undertaking this work the DHB will also be looking at the associated benefits, including improved service quality, adoption of best practice and long-term service sustainability. Clinical input will be key to ensuring quality and patient safety, accessibility and a reduction in inequalities are considered and factored in the decision making process alongside productivity, effectiveness and value for money.

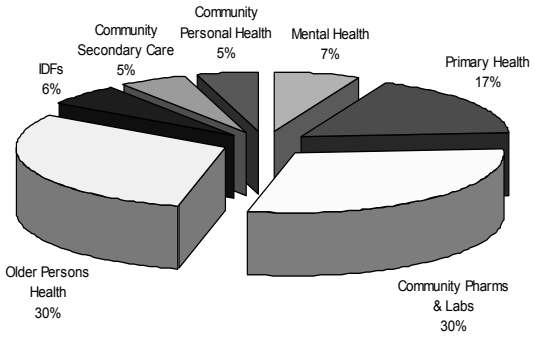
Funding Allocations

The following diagrams indicate how the Canterbury DHB's funding is allocated for 2008/09: [8]

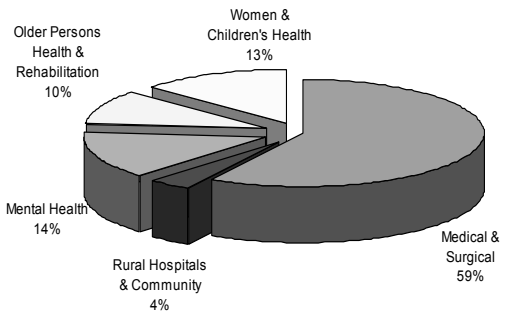
Overall Funding Split by Provider Type



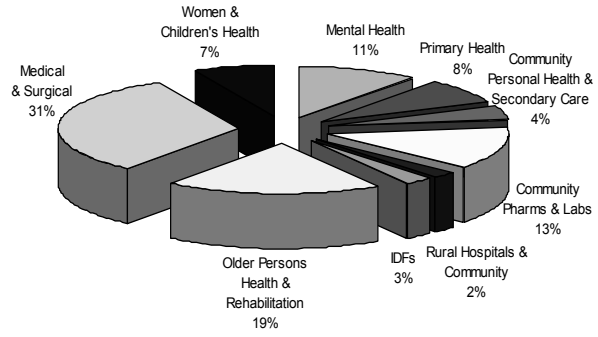
Community Service Providers Funding Split



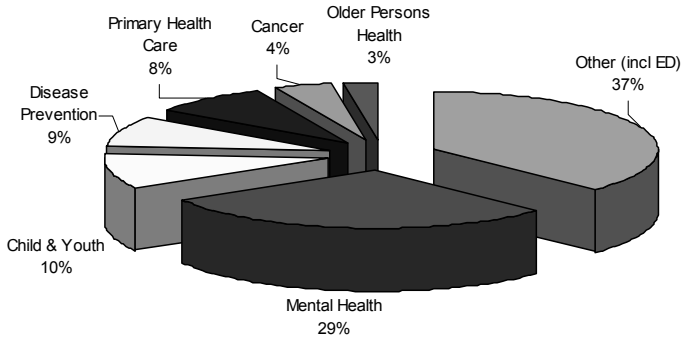
Hospital and Specalist Services Funding Split



Total Funding Split



New Investment 2008/09 - Total Funding Split



[8] *Note these funding graphs do not include the additional electives funding announced in May 2007.*

4. Strategic Priorities

This Chapter:

- Outlines the DHB's Strategic Priorities, chosen during the development of its District Strategic Plan;
- Highlights the alignment between local priorities and national priorities and the expectations of the Minister of Health for 2008/09; and
- Outlines how the DHB will monitor and report on its performance over the coming year.

4.1 The DHB's Priorities and Direction

The DHB established its set of Strategic Priorities during the development of its long-term District Strategic Plan in 2004. These Strategic Priorities took into consideration the health needs of the Canterbury population, feedback from the community and stakeholders and the revenue available to the DHB. The DHB also considered national health trends and national expectations and priorities when establishing these Strategic Priorities.

While activity around the DHB's Health Gain and Disease Priorities will focus on improving health outcomes for the population and reducing inequalities; its is progress on the initiatives and programmes under the DHB's Core Directions that will enable the DHB to build the foundations essential to driving change and improvements in its challenging environment.

Health Gain Priorities:

- Child and Youth Health;
- Older People's Health;
- Māori Health;
- Primary Health; and
- Disease Prevention and Management.

Disease Priorities:

- Cancer;
- Cardiovascular Disease;
- Diabetes; and
- Respiratory Disease.

Core Directions:

- Improve the Health and Wellbeing of our Community;
- Find Better Ways of Working;
- Work Together;
- Develop our Healthcare Workforce; and
- Be a Leader in Health.

4.2 The Minister of Health's Expectations

When planning actions and activity to meet local priorities, the DHB must consider the Minister of Health's expectations.

The annual Planning Package (between the Ministry and DHBs) ensures that there are agreed guidelines for accountability, clear annual expectations, and priorities and parameters for DHB planning. The Package also ensures that the requirements of relevant legislation are met and helps to maintain national consistency across the sector.

In signalling expectations for the coming year the Minister has focused on opportunities for enhanced performance, increased output, quality improvement and effective management of long-term strategic priorities.

Productivity gains and improved value for money are seen as essential, as is the sharing of effective innovations and sector-wide improvements. The need for a reduction in disparities between population groups is also emphasised.

The benefits to be made from further collaboration between DHBs and across the health systems are seen as yet to be fully explored and the Minister has highlighted benchmarking, joint procurement, workforce planning and improved use of technology as areas for focus.

The Minister has also added support for clinical governance and constructive engagement, signalling the need for strategic relationships between clinicians and management, between primary and secondary sectors and between DHBs and the Ministry.

The Minister's specific priorities for 2008/09 are:

- *Value for Money* – better value for money provides more health care for more New Zealanders;
- *Getting Ahead of Chronic Conditions* – maintaining the pace of programme implementation;
- *Reducing Disparities* – especially for Māori and Pasifika populations;
- *Child and Youth Health* – implement current programmes and build on the well child review;
- *Primary Health* – improve the interface through planning and working together with PHOs;
- *Infrastructure* – especially workforce development and coordinated information systems; and
- *Health of Older People* – continuing to give priority to new service models.

4.3 Monitoring and Reporting Performance - National Health Targets

DHBs are required to monitor and report on their performance. The Canterbury DHB meets its obligations through a number of internal and external reporting methods and structures.

- Monitoring and reporting against a mix of financial and non-financial performance indicators, performance goals and targets set in the District Annual Plan, the Statement of Intent and yearly publishing of an Annual Report.
- Monitoring and assessment of the quality of services provided by the HSS Division and external providers; via service agreements. Monitoring includes reporting adverse incidents, routine quality audits, consumer surveys, service reviews and issues-based audits.
- Reporting to the Ministry against its service contract requirements (the Crown Funding Agreement and Operational Policy Framework) including: monthly financial reporting, ad-hoc service and disease specific reports such as data relating to elective surgical services and waiting times and quarterly performance reporting against performance, quality indicators and national performance indicators.

The Ministry has established a number of Indicators of DHB Performance to focus DHBs on priority health areas, to monitor activity and to compare DHB performance. The Canterbury DHB's Indicators of Performance for 2008/09 are attached to this document (refer to Appendix 3).

These Indicators reflect the accountability that the DHB has for improving service performance and improving the health status of its population. However, there are a number of indicators in this mix where the DHB's ability to influence the outcome is not through direct funding but through influencing other funders or providers and in some cases influencing its community. Where the DHB is the Funder and is contacting through a third party for delivery of outputs there is more of a risk around meeting targets, as the DHB cannot directly control the outputs of external providers and is reliant on contracting methods, facilitation and the development of partnerships to achieve goals.

For the quantitative indicators local targets have been set for the 2008/09 year based on expectations expressed by the Ministry, the latest national data and the latest Canterbury DHB specific data.

Alongside the Indicators of DHB Performance a core set of national health indicators or 'Health Targets' have been established by the Ministry for all DHB's; in alignment with national priorities.[9]

It is anticipated that the collective focus on these Health Targets will drive performance improvement in the sector, incorporating shared learning and collaboration. The national Health Targets and the Ministry's long-term expectations are summarised in the following table. The activity the DHB has planned to deliver on these Health Targets is outlined in Section 5.6.

[9] *Information regarding the Health Targets can be found on the Ministry's website www.moh.govt.nz.*

Health Targets - Ministry Expectation (long-term)		Aligned DHB Priority
Improving immunisation coverage	Progress towards 95% of two year olds fully immunised.	Child and Youth Health (6.1.1)
Improving oral health	Progress towards 85% adolescent oral health utilisation.	
Improving elective services	Each DHB will maintain compliance in all Elective Services Patient Flow Indicators (ESPIs). Each DHB will set an agreed increase in the number of elective service discharges, and provide the amount of service agreed.	Elective Services (7.1.1)
Reducing cancer waiting times	All patients will wait less than six weeks between first specialist assessment and the start of radiation oncology treatment (excluding category D).[10]	Cancer (6.2.1)
Reducing ambulatory sensitive (avoidable) hospitalisations	There will be a decline in admissions to hospital that are avoidable or preventable by primary health care for those aged 0-74 across all population groups.	Child and Youth Health (6.1.1) Primary Care (6.1.4)
Improving diabetes services and cardiovascular disease (CVD)	There will be an increase in the percentage of people in all population groups, estimated to have diabetes, accessing free annual checks. There will be an increase in the percentage of people in all population groups, on the diabetes register, who have good diabetes management. There will be an increase in the percentage of people in all population groups who have their CVD risk assessed.	Diabetes (6.2.3) Cardiovascular Disease (6.2.2)
Improving mental health services	At least 90% of long-term clients will have up to date relapse prevention plans.	Mental Health (7.1.2)
Improve nutrition Increase activity Reduce obesity [11]	DHB activity will support sector-wide national health targets to increase: the proportion of infants exclusively and fully breastfed (74% at six weeks, 57% at three months, 27% at six months); and the proportion of adults (15+) consuming at least three servings of vegetables/two servings of fruit per day (70% vegetables, 62% fruit).	Disease Prevention and Management (6.1.5)
Reduce the harm caused by tobacco	DHB activity will support sector-wide national health targets to: Increase the proportion of 'never smokers' among Year 10 students by at least 3 percent (absolute increase) over 2007/08 (baseline 57.9%) with an increase for both Māori and Pacific Year 10 'never smokers' that is greater than that for European; and Reduce the prevalence of exposure of non-smokers to Second Hand Smoke (SHS) inside the home to less than 5% with a reduction in the prevalence of exposure of non-smokers to SHS inside the home for Māori and Pacific that is greater than that for European.	

[10] *The wait time is defined as the time between the specialist decision to commence radiotherapy and the start of treatment. The measure reflects groups A, B and C - group D patients have planned treatment (either as part of a trial or because of given protocols) and therefore may have to wait to start treatment and are not included in targets.*

[11] *The nutrition, activity and obesity targets and the tobacco targets are national targets which the Ministry and all DHBs are jointly contributing towards. The DHB will contribute to achieving these targets on a local level, by implementing its HEHA Ministry Approved Plan and its Tobacco Control Plan.*

5. Key Focus for 2008/09

This Chapter:

- Highlights the activity the DHB has planned to define new and improved ways to provide services.
- Highlights the activity the DHB has planned to ensure it has the supportive infrastructure to make those changes happen and ensure those changes can be sustained.
- Highlights where the DHB is placing particular focus to achieve progress against national Health Targets.

This District Annual Plan outlines the DHB's planned activities against its strategic priorities and against national expectations. Without limiting the importance of these priorities and expectations the DHB has identified a number of key programmes for particular focus in the coming year. These programmes will provide the DHB with the best opportunity to improve health outcomes for its population and to meet the challenges it faces in terms of demand, cost pressures and national expectation.

The key focus areas for the DHB in 2008/09 are:

- Improving Organisational Fitness;
- Supporting Patient Centred Models of Care;
- Managing Acute Demand;
- Managing Long-Term Conditions; and
- Achieving National Health Targets.

All five areas are inter-related and the first four relate to programmes or initiatives developed under the DHB's Core Directions. These programmes focus on building the foundations needed to enable change and empower the DHB to make improvements in its strategic priority areas and meet national Health Targets.

Improving organisational fitness, implementing patient centred models of care and managing acute demand and long-term conditions are all critical components in the strive for long-term sustainability. Longer-term planning for health services across all of these areas is critical in terms of future sustainability but also in enabling the DHB to ensure that the right services are provided, at the right time, in the right place and by the right provider.

Improving the patient journey and building continuums of care between primary and secondary services have a crucial role to play in the reduction of acute demand and in managing the burden of long-term conditions (particularly the disproportionate burden which falls on Māori and Pacific people, older people and those in lower income groups).

As the DHB moves forward, and predicted workforce shortages develop, regional and local planning will be integral in meeting the growing demand for health and disability services. The focus placed on national Health Targets is reflective of the Minister's emphasis on a shared planning approach and much of the activity planned to achieve national priorities will involve primary, secondary and community service providers taking a wider-patient centred approach to improving the health status of the Canterbury population.

5.1 Improving Organisational Fitness

Long-Term Goal – Where do we want to be?

The DHB aims to ensure the provision of efficient, effective, quality health services and to make best use of available resources to improve the health status of Canterbury's population.

What are the Challenges – What will we do to succeed?

The Canterbury DHB is the major provider of health services in Canterbury. With funding constraints, workforce shortages and increasing demand, the need for service planning, service reconfiguration and the development of innovative models of care is becoming increasingly evident.

To remain clinically and financially sustainable the DHB must ensure that the investments it makes are returning benefits, that operations are effective and efficient, that the DHB is as productive as possible and is making best use of its funding. The DHB's focus on rationalising the supply chain to reduce associated operational costs is an example how better management of non-core business activities can release funding for patient centred activity.

A significant productivity challenge for the DHB is managing variation of service, processes, quality and resources. Variation in the patient journey has a particular impact on quality and time both for the patient and for staff. Emphasis on reducing variation in practice and processes creates a more focused approach to managing patient outcomes in an efficient and effective manner.

The DHB has actively taken on the tools, techniques and philosophies of 'Lean Thinking' and 'Constraint Theory' to engage the organisation in identifying improvement opportunities which will reduce variation and improve the patient journey.[12] The core principles of Lean Thinking are:

- Identify the Value: Looking at patient journeys through the health system in an 'end to end' and connected way, to identify what adds value to the patient outcome and what does not, and where opportunities exist to reconfigure the journey to remove waste and improve flow.
- Create Flow: Remove large batches of activity through the system, the principle being batches mean delays for patients, which is a waste and adds no value to the patient outcome.
- Remove Waste: There are seven key wastes that prevent flow from occurring - defects, waits, over processing, inventory, motion, transportation and over production. From a patient perspective the focus is on where waste is occurring, that if removed can aid a better journey and outcome for the patient.
- Pull the Flow: Move patients through the system by having the next process in the chain requesting the patient as soon as it is ready.

The focus of Constraint Theory is identifying the points in the system that prevent patient flow from occurring and either improving capability or regulating the rest of the system to the constraint point. This is a particular challenge in a public health system where individual specialties operate independently of each other even though they share similar resources (such as theatre, radiology, nursing resource and beds). The net effect of this environment is variation in practice, processes and service from one patient experience to another

Lean Thinking is increasingly being used in the health sector as a means to improve patient flow and patient safety and most importantly as a means of empowering the health workforce to make continuous workplace improvements. Combining this approach with the DHB's proven production planning tools will enable the Canterbury DHB to balance hospital and specialist services activity in a resource constrained environment.

Being an effective leader in health services, particularly in an environment of change, requires more than tools and techniques. A key challenge for the DHB is the need to align, enable and empower both the leadership and the workforce to constructively engage with the emerging challenges. Alignment comes from having clarity of purpose and direction; enablement from skills and knowledge of business principles, and empowerment from permission giving and knowledge sharing. In 2007/08 the DHB invested in two significant pieces of work called Vision 2020 and Xcelr8 targeted at alignment, enablement and empowerment. Both initiatives are part of a longer term programme for supporting leadership development.

Actions and Success to Date:

- Vision 2020 - In February 2007 a series of unique workshops were held, aimed at bring together a group of people from across the health sector in Canterbury to assess organisational needs for the emerging years to 2020. The material that emerged from the initial workshop formed a draft organisational development plan.
- Xcelr8 Programme - Xcelr8 (pronounced accelerate) is a DHB led management development programme to focus frontline leaders on the tools and skills needed to operate in a changing environment. Two Xcelr8 programmes have been developed and run: Xcelr8 targeted at frontline clinical and operational leaders; and Xcelr8+ targeted at

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

senior clinical and operational leaders. Both programmes share common learning material and emphasis, but are tailored to a different audience, with the aim of developing organisational leadership and engaging the workforce.

- The Supply Chain Initiative - Begun in 2007/08 this initiative is focused on reviewing and improving the supply chain throughout the DHB. The core focus is reducing the costs of managing the supply chain by reviewing and implementing change across all activities from purchasing behaviour and delegations, suppliers, distribution and stock holding practices as well as procurement and purchasing. In the first five months of the programme $4m (annualised savings) have been achieved from a total consumable and capital spend of approximately $200m.

Next Steps in 2008/09:				
WHAT	**HOW**		**WHEN**	**WHO**
Key Priorities	**Approach**	**Outputs for 2008/2009**	**Quarter[13]**	**Lead**
Engage the organisation and the Canterbury community in improvement priorities.	Provide a clear organisation vision and development plan goals.	Vision 2020 communicated to secondary and primary care sectors.	Q1	GM SP
		Vision 2020 message incorporated in the District Strategic Planning process.	Q3	GM P&F
	Continue investment in learning consistent with organisation priorities: Lean Thinking and Constraint Theory.	Lean Thinking Workshops completed.	Q2-Q4	GM SP
Progress the Supply Chain Initiative.	Review the organisational supply chain and existing spend to identify opportunities and implement change and improvement.	Review of supply chain continues with implementation of operational priorities identified.	Q1-Q4	GM SP
Ensure the provision of effective and efficient services.	Continue identification of opportunities to centralise, consolidate or improve business processes associated with clinical support services.	Assessment of administration processes undertaken to identify opportunities to reduce process steps or introduce technology improvements.	Q4	GM SP

[13] *Q1 refers to July to September 2007, Q2 to October to December 2007, Q3 January to March 2008 and Q4 April to June 2008.*

5.2 Supporting Patient Centred Models of Care

Long-Term Goal – Where do we want to be?

The Canterbury DHB aims to ensure that capital investment and workforce planning support the delivery of patient centred models of care that and make the best use of available resources. The DHB aims to create an organisation of joined-up health services focused around patient services and clinical outcomes from 'end to end' and across the community, primary and secondary sectors. The patient journey through the health system will be timely, seamless between providers, provide consistent quality, and offer the best quality outcomes.

Supporting patient centred models has been driven under the DHB's Core Direction – Finding Better Ways of Working.

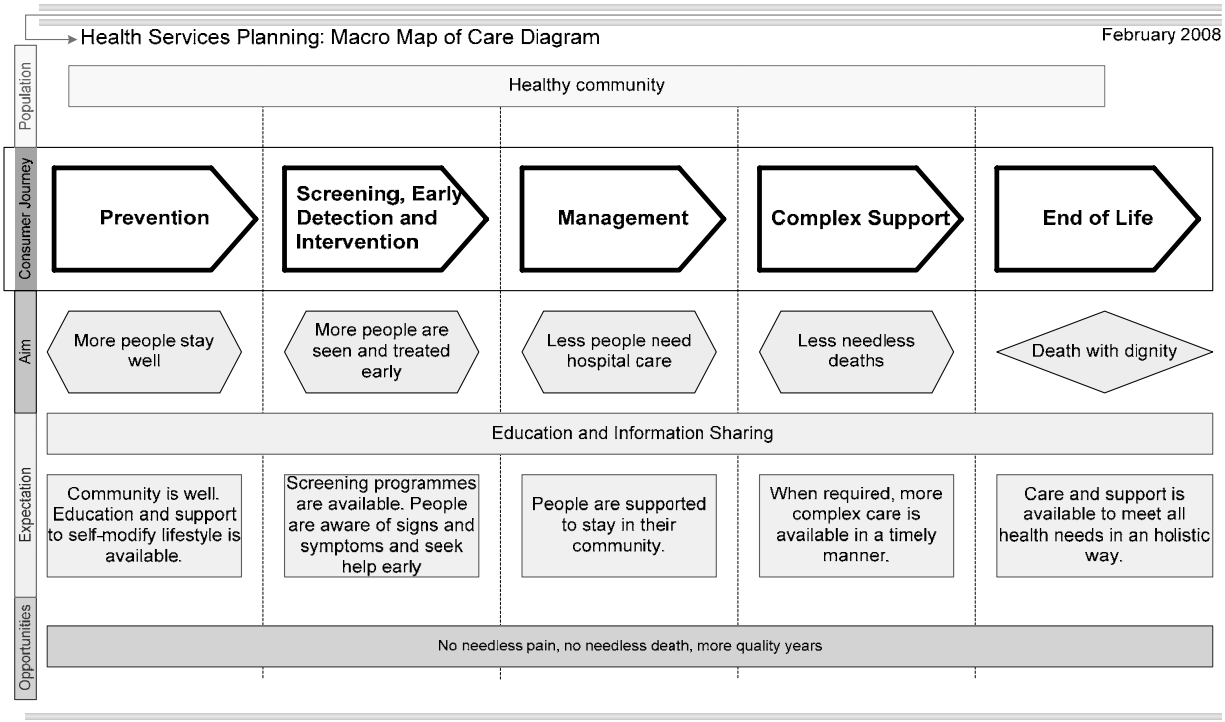
What are the Challenges – What will we do to succeed?

In achieving this goal the DHB has defined a patient centred model of care, is identifying opportunities for implementing the model and is working to establish key directions to ensure investment in resources will support the model. The DHB has primarily achieved these key directions through two programmes, the Improving the Patient Journey programme and the Health Services Planning programme.

The key directions for investment to support patient centred models of care will seek to:

- Optimise health outcomes and encourage innovation while 'living within the DHB's means';
- Develop and consolidate health care services in appropriate locations/settings, that provide sustainable levels, access and quality of services delivered;
- Ensure services located in hospital settings will complement community based services;
- Support a patient-centred focus for health services rather than a episodic care focus and promote the patient as leader in their own care;
- Provide an equitable distribution of services, based on the needs of our population; and
- Minimise barriers in access to services, co-locating services where possible and undertaking service re/development in locations that are accessible.

These key directions will also support a Facilities/Site Master Plan enabling the DHB to undertake any major facility redevelopment in an informed manner and to reconfigure service delivery models to match best location for the delivery of services.



Actions and Success to Date:

Health Services Planning Programme

This Programme has allowed the DHB to take a participative approach and bring together consumers, providers and funders of health services to develop a holistic view of health. Key successes have been:

- The development of over arching model of care for health services planning;
- Delivery of a range of condition specific, population specific and geographic specific workshops that have brought together the views of consumers, providers and funders; and
- Establishment of a Consumer Council to guide the development and implementation of future health service plans.

Improving the Patient Journey Programme

This Programme has been a significant improvement programme for the DHB over the last four years. The core focus is improving the flow of patients through the hospital setting by removing delays and wastes to patient time. The programme has evolved to include a number of key sub-programmes:

Emergency Department Programme (now called Project RED): The goal of the Project is to ensure that the Christchurch Hospital Emergency Department remains fit for purpose over the next five years. Significant pressure has been placed on the Department staff by the number of patient hours spent there and the growing patient complexity (largely from an aging population):

- Approval has been given for a $5m expansion of the Department, including significant reconfiguration of the existing layout, and increased staffing levels to accommodate changes in patient flow that will better support quick turn-around of lower complexity patients (these patients will now be treated via a dedicated service area, no-longer waiting behind more complex patients).
- Triage 2 response times have been improved. The DHB's performance against Australasian standards had been sitting around 40% and implementation of a number of improvements has improved performance. Post midnight and weekends is a key focus area to improve the overall measure.
- An investment in mapping and clarifying all the potential patient pathways through the Department has also commenced to ensure patients are moved in the most efficient and timely manner to the most appropriate point of care. This work will take twelve months to complete.

Surgical Programme: The main focus of the surgical programme has been on providing access to acute theatres, with goal that no patient waits longer than 24 hours from decision to operate:

- An additional four-hour session a day has been implemented without disrupting other theatre sessions or theatre allocations. A plan to implement the required acute theatre hours has been formulated for both operational and financial ratification.
- A twelve bedded Surgical Assessment and Review Area (SARA) has been developed to provide acute general surgery patients with a similar rapid response process that the successful Acute Medical Assessment Unit (AMAU) has done for medical patients.
- Introduction of pre-admission process changes for the Burwood Orthopaedics Department (including nurse pre-admissions) have reduced pre-admission and decision-making steps significantly, freeing up both surgeon and anaesthetic time and most importantly, reducing pre-admission steps for patients.

Other Programmes

- Releasing Time 2 Care: This programme has been modelled based on the Flinders Medical Centre and the British National Health Service (NHS) Productive Ward experience; where both parties have discovered at least 20% (some cases 40%) of time spent in the Ward environment can be released to provide more patient time. Four pilot wards have been selected to commence in February 2008 with a focus on effective, quality service delivery.
- Ashburton and Rural Health Services Integrated Model of Care: A number of successes have been achieved to improve the patient journey and to provide accessible services in Ashburton including: increased specialist outpatient clinics and the commencement of gynaecology day/short stay surgery. Ashburton Hospital has also achieved a shorter average length of stay and there have been an increase in the number of births at the Ashburton Maternity Centre. In the coming year the DHB will continue to finalise the implementation of the Model.

Redesigning Patient Centred Pathways

The DHB is also committed to improving access to elective services with the focus on the patient and provision of certainty for patients about their treatment, timeliness of that treatment and fairness of treatment prioritisation. The DHB is focused on improving performance of elective services booking and prioritisation systems (measured by national Elective Services Patient Flow Indicators (ESPIs)) and meeting Government expectations around the provision of elective services.

During the process of achieving ESPI compliance the Canterbury DHB identified that a more robust system was necessary for sustaining compliance and achieving clarity, timeliness and fairness. An Elective Services Accountability Framework was developed to provide a transparent and accountable system of electives management, where roles and responsibilities are defined, performance is monitored and measured and improvements achieved and sustained in a structured and supported manner.

This framework is supported by an Elective Services Steering Group which governs both transactional activities (ESPI compliance) and the transformational activities that will deliver to the key policy areas

Transactional Activities

During 2007/08 the DHB has achieved and sustained ESPI compliance at a DHB level and made significant improvements at service level. This activity will be further supported by a more robust monitoring and reporting framework designed for service level use and to assist Service Managers, Clinical Directors and GP Liaisons to improve prioritisation practice and the matching of promises to patients with current capacity to see and treat. Patient flow modelling will inform capacity restraints and new patient pathways will be introduced (refer to page 36 ESPIs Health Target).

Transformational Activities

The challenge going forward is to create shared vision and ownership across Canterbury's health sector in order to create capacity, improve access and reposition services through reconfiguration and efficiency gains to:

- Deliver services within contracted volumes and improve capacity within existing resources;
- Communicate to patients and referrers the likelihood of service;
- Develop strategies to deliver elective services within current resources and improve milestones;
- Address inequalities by targeting increased elective services to procedures below national intervention rates;
- Collect information to identify future demand/need; and
- Identify and develop new initiatives to improve patient pathways.

The (Canterbury Community-based) Referrals Project was established to provide a platform for delivering the transformational electives goals in an objective and collaborative way. It is jointly sponsored by the Elective Services Steering Group and Canterbury's five PHOs and involves wide representation from primary and secondary care and the community. The aim is to design a consistent electives referral management process and pathway that informs alternative models of care and increases access to services. Unmet need in the community will be more appropriately measured by a specific focus on the gaps as determined by the community and general practice, which in turn will inform funding decisions and application of electives initiative funding allocations.

GPs and hospital specialists are providing clinical input and leadership in the design and implementation of the pathways and new models of care with a project methodology of constant communication where: clinicians develop models for each specialty; clinicians, management and the Funder develop a framework for the new model; business cases are submitted to the DHB for each specialty; incremental implementation of new models takes place; and project team membership is representative and inclusive.

There are currently three pilot services: Respiratory, Gynaecology and Musculoskeletal, (the work-streams are set out in Appendix 4 and the respiratory work for 2008/09 is set out in Section 6.2.4). Piloting initiatives to improve access to diagnostics will also commence in 2008/09. These initiatives will enable the GP Liaisons in general surgery, gynaecology and orthopaedics to budget hold at the referral gateway for radiology. The aim is to enable evaluation of new pathways where the need for a referral or hospital visit is avoided by ready access to diagnostics, enabling patients to remain in the care of general practise. These initiatives are party funded by the Ministry's Improving Patient Pathways Pilot and will be fully evaluated for evidence of improved health outcomes and increased access to services.

Next Steps in 2008/09:				
WHAT	**HOW**		**WHEN**	**WHO**
Key Priorities	**Approach**	**Outputs for 2008/2009**	**Quarter**	**Lead**
Implement the health services planning model of care.	Through a participatory approach - work with consumers, providers and funders of health services to implement the model of care in priority areas.	Opportunities for implementing the model of care are identified and prioritised.	Q1	GM P&F
		Opportunities for change are progressed (prioritising those related to the management of long-term conditions).	Q2-Q3	
		The Consumer Council's role in the planning and implementation processes is established.	Q4	
Implement key facilities directions.	Based on key facilities directions develop a Facilities/Site Master Plan considering the role and function of all DHB facilities, including rural hospitals.	Facilities directions from Health Services Planning are identified.	Q2	GM CS
		Facilities/Site Master Plan underway including appropriate stakeholder and community consultation.	Q4	
Implement key workforce directions.	Based on key workforce directions consider options for workforce configurations and a DHB workforce plan.	Workforce directions from Health Services Planning are identified.	Q2	GM HR
		Workforce plan underway including appropriate community consultation.	Q4	
Continue implementation of the Improve the Patient Journey Programme.	Implement the Project RED Programme: Rejuvenating the Christchurch Hospital Emergency Department to equip it for growing patient numbers and complexity over the next five years.	New building extensions commissioned.	Q1	GM MS
		Patient pathways approved/implemented.	Q3	
		Full staffing levels achieved and rosters assessed against patient demand.	Q2	
		90% of patients spend less <4 hours in the Emergency Department.	Q4	
	Improve access to acute theatres and balance surgical demand to theatre and bed capacity.	Revised acute theatre schedule implemented.	Q1	GM MS EDON
		Revised booking plan implemented, along with revised theatre schedules in line with surgical and bed demand.	Q3	
	Improve discharge activity to facilitate the flow of patients.	Patient discharges are improved to free up beds for incoming patients.	Q2	GM MS
		Services are redesigned to deliver a more supportive discharge for patients.	Q1	GM P&F
	Implement the Releasing Time 2 Care Programme: Improving the ward environment by applying Lean Thinking principles to remove waste, decrease variation and standardise processes.	Complete ward pilots.	Q2	EDON
		Ward standardisation implemented organisation wide.	Q3	
		Patient tracking boards implemented organisation wide.	Q4	
		Staff tracking in Medical/Surgical division completed.	Q4	
Continue implementation of the Integrated Model of Care for Ashburton Health Services.	Provide appropriate and accessible quality health services for the Ashburton District.	Health services are integrated, with enhanced health professional collaboration, across community, primary secondary sectors.	Q1-Q4	GM RHS
	Consider means of extending training support, professional development and learning for the rural workforce.	Proposal for a Centre for Rural Health and Hospital Education prepared.	Q4	GM RHS

5.3 Managing Acute Demand

Long-Term Goal – Where do we want to be?

The DHB aims to ensure that the right service is provided to the right patient, at the right time, in the right place and by the right provider.

Managing acute demand is driven under the DHB's Core Direction – Working Together.

What are the Challenges – What will we do to succeed?

More than 70,000 people present at the Christchurch Hospital Emergency Department each year and many of these people do not need to receive hospital or specialist level care. Attendance numbers have grown at an average level of 3% or 1,900 attendances annually. A significant portion of this growth has occurred in the lower triage levels (where people do not require hospital or specialist level care) along with growth in the number of 'self' referrals and ambulance referrals to the Emergency Department.

Uncontrolled growth (or acute presentations) puts at risk the DHB's ability to deliver the desired level of elective services (through staffing and resources shortages) and to manage within budget. It is thought that growth in acute demand can be minimised through initiatives focused in areas such as public education, effective after hours care, rapid access to advice and diagnostics, improved age residential care and alternate models of care for ambulance call-outs.

In 2006 the DHB undertook a Review of Acute Demand and After Hours Cover in Primary Care. This Review outlined a number of key recommendations and identified ten projects for implementation. These included a primary health care public education and information programme, enhanced telephone advice for the general public, alternative rapid response service or pathways, a variety of community based acute care services and an After Hours Direction Paper. The DHB is working in collaboration with the primary and community sectors to implement the recommendations of the Review and the After Hours Direction Paper.

The management of acute demand also has close links to the reduction of Ambulatory Sensitive (avoidable) Hospital admissions; one of the DHB's national Health Targets - the aim being to provide effective and efficient primary and community-based services and early intervention, to avoid unnecessary hospitalisations.

Actions and Success to Date:

- Implementation of a variety of community-based services targeted at managing people in an acute or sub-acute state in the community. These initiatives included acute community nursing, acute observation, packages of care, equipment initiatives, access to rapid diagnosis, free general practice services, and acute service coordination. The DHB is committed to these initiatives which will see an investment of over $15M in the next three years.
- Implementation of a Public Education and Information Programme, providing information on where to go when you need health assistance. The Programme slogan is "1, 2, 3, Where Should I Be" with the branding: 1 = GP, 2 = After Hours and 3 = Emergency Department and aims to encourage people to make a conscious decision about where they should go to receive suitable treatment and is supported by a media campaign and media articles.
- Undertaking of sustainable modelling to determine the level of funding PHOs and the DHB should contribute to after hours cover to ensure current services remain sustainable. This work is currently being assessed with a view to working collaboratively to support future pathways.

Next Steps in 2008/09:				
WHAT	**HOW**		**WHEN**	**WHO**
Key Priorities	**Approach**	**Outputs for 2008/2009**	**Quarter**	**Lead**
Work to reduce unnecessary referrals to the Emergency Department and to assist people to present to the most appropriate service to meeting their need.	Establish systems to support general practice teams to better manage patients in the primary setting.	Opportunities to enhance access to specialist advice quickly and efficiency are identified.	Q2	GM P&F
	Improve public telephone advice services to back up appropriate and timely referral.	Opportunities to enhance services are identified.	Q2	
	Identify alternative models of care to ensure people received the right level of care.	Alternative referral pathways are identified and supported to reduce the need to transport people to hospital when they may not require hospital level care.	Q2	
	Raise awareness of when to seek care health and where to access the most appropriate assistance.	The impact of the '*1, 2, 3 Where Should I Be?* campaign is evaluated and future communication pathways determined.	Q1-Q2	GM P&F
	Identify opportunities for improving acute care services in residential settings and enable older people to remain in residential care facilities during episodes of acute care.	Specific aged care services to support and improve acute care services in residential settings are developed.	Q1	GM P&F
		A programme to raise awareness of alternative services, support and possible acute care intervention is implemented.	Q2	GM P&F
	Work with PHOs to improve after hours services and service provision in the Canterbury district.	Financial barriers to after hours services analysed and considered, in both urban and rural settings, and collaborative proposals for minimising these barriers developed.	Q1-Q4	GM P&F PHOs
		Agreement reached on the on provision of after-hours primary care services in Ashburton, in line with the Integrated Model of Care for Ashburton Health Services.	Q1-Q3	
		PHOs supported to implement service improvements in after hours care.	Q2-Q4	

5.4 Managing Long Term (Chronic) Conditions

Long-Term Goal – Where do we want to be?

The DHB aims to provide a healthcare system that promotes good health and supports people with long-term (chronic) conditions. The DHB will reach across the continuum of care by developing evidence based integrated care pathways, improving communication systems and enhancing workforce capacity. The system will improve the delivery of care for service users, their families/whānau and carers, who will be empowered and supported to live with their long-term conditions and to self-manage that condition.

Managing the burden of long-term conditions is driven under the DHB's Core Direction – Finding Better Ways of Working and under its individual Disease Priorities: Cancer, Cardiovascular Disease, Diabetes and Respiratory Disease. Prevention is also a focus in the management of long-term conditions and as such, actions and activity under the DHB's Health Gain Priority, Disease Prevention and Management will also contribute to this work.

What are the Challenges – What will we do to succeed?

Long-term conditions affect the lives and wellbeing of many New Zealanders and can cause significant distress for them, their families/whānau and their carers. Long-term conditions also account for a significant number of potentially avoidable presentations at hospital emergency departments and admissions and readmissions to hospital and specialist services. With an ageing population, this burden will increase.

The World Health Organisation (WHO) estimated that more than 70% of health care funds are spent on chronic conditions and that globally, 60% of all deaths are due to chronic conditions. It is estimated that by the year 2020 approximately 80% of the disease burden in the developed world will be attributable to long-term illness.

Long-term conditions are also a barrier to independence and participation in the workforce and in society. Good management of long-term conditions can make a real difference by helping to prevent crises and deterioration and enabling people to attain the best possible quality of life.

Actions and Success to Date:

The DHB has developed a Strategic Framework for Managing Long-term Conditions, irrespective of the specific diagnosis. The framework will support integrated care across: chronic disease groups; community, primary and secondary care, across the spectrum of care, across all age groups; and all population groups.

Key elements of the framework are:

- Supporting self responsibility and capability for self management;
- Supporting coordinated integrated care;
- Strengthening workforce capacity and capability;
- Improving information systems; and
- Evaluating and monitoring services, service delivery and outcomes.

The DHB's Health Services Planning service mapping process undertaken in 2007/08 identifies distinct steps in the patient journey for those with long-term conditions and specifies the aims, expectations and opportunities at each step of that journey. A key focus will be ensuring patients receive treatment in the most appropriate setting, supporting service delivery in community settings and reducing the use of hospital based services where appropriate. This work will be used to inform the DHB's focus on managing Long-term Conditions.

Next Steps in 2008/09:				
WHAT	**HOW**		**WHEN**	**WHO**
Key Priorities	**Approach**	**Outputs for 2008/2009**	**Quarter**	**Lead**
Ensure buy-in and support for implementing the Framework for managing long-term conditions.	Engage stakeholders and our clinical workforce in the integration of the Framework across sectors and across service streams.	Key clinical stakeholders identified to support the integration of the Framework and ensure active support and leadership.	Q1-Q4	GM P&F
Promote and enable healthy lifestyles.	Implement the DHB's Healthy Eating, Healthy Activity Action Plan.	Refer to Section 6.1.5: ▪ Reduction in the uptake of smoking; ▪ Improved nutrition/healthy eating; and ▪ Increased physical activity.	Q1-Q4	GM P&F
Improve sector infrastructure to enable the development of new models of care for long-term conditions and determine the most appropriate treatment sites.	Work to develop improved and robust information and knowledge systems.	Opportunities for more integrated information systems are identified.	Q3-Q4	GM P&F
		'Decision support' and 'expert system' tools to assist clinical decision-making are piloted.	Q1-Q4	
	Work to increase workforce capacity and capability for managing the burden of long-term conditions.	Workforce training is supported to enable the delivery of integrated services that cross disciplines and sectors.	Q1-Q4	
		The role of case management is supported to ensure a coordinated approach to care for people with long-term conditions.	Q1-Q2	
Improve the sectors' responsiveness to the needs of people with long-term conditions.	Develop management guidelines for priority long-term conditions.	Patient pathways are developed to ensure an integrated approach to meeting the health needs of people with long-term conditions.	Q1-Q4	
	Support self responsibility and the capability for self management.	Support for people with long-term conditions is provided to improve self-management and empower a change in lifestyle.	Q1-Q4	

5.5 Improving Quality and Patient Safety

Long-Term Goal – Where do we want to be?

The Canterbury DHB aims to continuously improve the quality and safety of our health and disability services to enable improved health outcomes for the people of Canterbury.

Improving quality and patient safety is driven under the DHB's Core Direction – Being a Leader in Health.

What are the Challenges – What will we do to succeed?

The environment in which the health and disability sector operates is not static. There are constant changes in population demographics, technological advancements, models of care, and the expectations of communities and funders. To effectively respond to these changes, our sector needs to foster innovation and quality improvement. Essential to innovation and improving services is the ability to foster, seek out, test, develop and disseminate new methods, skills, tools and concepts.

There are a number of initiatives taking place within the Canterbury DHB that support and encourage the use of innovation and quality improvement to improve service delivery. The opportunity exists to build on this momentum, to provide leadership and to engage staff in these processes and initiatives.

The DHB has established a Quality and Patient Safety Council and a Quality Strategic Plan to promote quality and patient safety throughout Canterbury's health sector and has developed the Quality and Innovation Awards to recognise and publically acknowledge excellent quality, innovation and improvement initiatives generated by DHB staff and community-based services. The DHB has also recently established the position of Medical Director of Patient Safety. This new role will work alongside quality leaders and DHB staff seeking to eliminate the harm that can occur to patients in hospital settings and to promote the DHB's focus on quality and patient safety.

Priority 1 and 2 of Goal 1 of the DHB's Quality Strategic Plan are focused on improving patient safety and effective incident management. Incident management is an effective mechanism for systematically identifying and managing problems and failures in the system and for informing the development of preventive strategies and the redesign of patient care processes to eliminate repeated harm. This will be a key focus for the DHB in the coming year.[14]

National emphasis centres on the priorities of the Quality Improvement Committee (QIC) and the aim to establish a nationally focused and coordinated approach to quality improvement and quality and safety within public hospitals. Five key programme areas have been identified and national projects will be established around each area over the coming year. The Canterbury DHB will work in collaboration with other DHBs on these projects and will share the innovation and quality initiatives already being development and implemented locally.

Actions and Success to Date:

- Development and approval off of the Canterbury DHB Quality Strategic Plan 2007-2010, based on national and international literature research and obtaining Ministry approval. The Plan is available on the DHB intranet with a tool enabling interactive capture of comments, ideas and initiatives regarding the achievement of the goals within the Plan.
- Enhancement of the Canterbury DHB Quality and Innovation Awards Programme - to date 86 projects have been entered into the programme, many of which have gone on to achieve national success.
- Appointment of the position of Medical Director of Patient Safety.
- Development of functional requirements document and tender process for a new Incident/Event Management Software System for the DHB's HSS Division.

[14] *The DHB's Strategic Quality Plan can be found on its website, www.cdhb.govt.nz.*

Next Steps in 2008/09:				
WHAT	**HOW**		**WHEN**	**WHO**
Key Priorities	**Approach**	**Outputs for 2008/2009**	**Quarter**	**Lead**
Improve the management of healthcare incidents. (*Goal 1 of the DHB Quality Strategic Plan*)	Evaluate a standardised incident management software system to assist in addressing ongoing identification, management and mitigation of serious clinical risk to the quality and delivery of health and disability services and to support the national approach to consistent management of healthcare incidents.	Vendor evaluation process for new standardised incident management system completed.	Q1	EDON
		Decision on implementation made.	Q2	
		Collaboration with the national QIC and with other DHBs on the national project around the Management of Healthcare Incidents.	Q1-Q4	
Contribute to the five national QIC Quality Improvement Programme projects to provide a focused and coordinated approach to quality improvement.	Work with the QIC to take a national collaborative approach to addressing quality and safety within public hospitals in five identified priority areas: ▪ Optimising the Patient Journey; ▪ Management of Healthcare Incidents; ▪ Infection Prevention and Control; ▪ National Mortality Review Systems; and ▪ Safe Medications Management.	National project outputs and timeframes set nationally, following the formation of the five project groups.	Q4	EDON CMO
		Local outputs will be based on the priorities set nationally, however current initiatives being progressed in these areas include: ▪ Improve the Patient Journey (refer to section 5.3); ▪ Education programme for key policies (open disclosure, no blame incident/ accident reporting and culture of patient safety); ▪ Patient Identification Projects for improving safety - barcoding of wrist bands, and correct site, correct patient and correct procedure projects; ▪ Establishment of a DHB wide Infection Control Strategy Group and Strategy; ▪ Implementation of programmes to improve medicines management (refer section 6.1.2).	Q4	
Foster innovation and quality improvement.	Develop an innovation hub model that ensures the DHB has a coordinated approach to developing a culture where innovation can flourish.	Establishment of Project Leadership Group for the development of an Innovation Hub.	Q1	EDON CMO GM P&F
		Project plan developed and approved.	Q2-Q3	
		Innovation Hub implementation phase.	Q4	
	Continue the DHB's Quality Innovation Awards Programme and channel applications into other external quality and innovation awards programmes.	Successful completion of 2008 programme.	Q2	EDON CMO
		DHB projects selected into national award programmes.	Q4	

5.6 Achieving National Health Targets

Long-Term Goal – Where do we want to be?

The DHB aims to promote, enhance and facilitate the health and well-being of the people of Canterbury.

What are the Challenges – What will we do to succeed?

The Canterbury DHB is committed to achieving the national Health Targets as set out in this following section. However, the DHB's ability to achieve the local targets set against each Target is dependant on the assumptions set out in Section 9.3 of this document, remaining true. A number of additional factors beyond the DHB's control will also play a large part in the achievement of these Health Targets. These include community lifestyle, housing, social influences and clinical workforce polices in other countries, to highlight a few.

If factors beyond the control of the DHB prevent achievement of the Health Targets, the DHB will take appropriate corrective actions and aim to achieve the next best outcome, in light of any change in circumstances.

The DHB is conscious that the Health Targets provide an opportunity to stand back and look at the health system as a whole and cover health improvements across a whole range of areas, spanning prevention and early intervention through to access to hospital and secondary services. In this sense, achievement of the Health Targets is a reflection of how the health system in Canterbury is impacting on the lives of the Canterbury population and the DHB is committed to achieving better outcomes for its population.

Health Target	Improve Immunisation Coverage

Why - Rationale/Intervention Logic

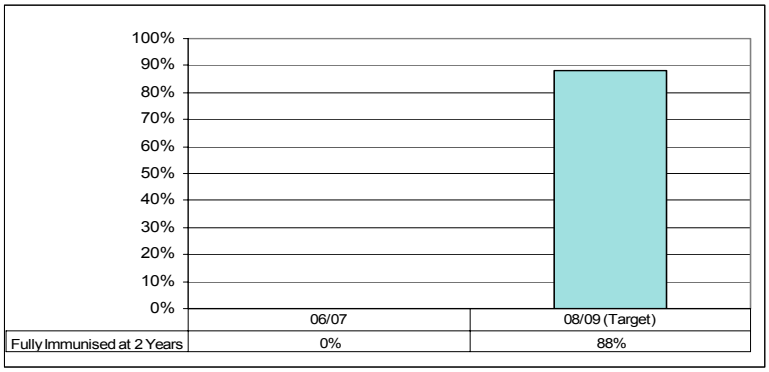
- Diseases that are preventable by vaccination have a significant effect on the health of New Zealand children, particularly Māori and Pacific children who suffer from higher rates of vaccine-preventable diseases.
- Immunisation is one of the most cost-effective and successful preventative health interventions known and is an important component in keeping both children and adults free from preventative disease.

Next Steps in 2008/09:

WHAT	HOW		WHEN	WHO
Key Priorities	**Approach**	**Outputs for 2008/2009**	**Quarter**	**Lead**
Improve immunisation coverage, increasing the number of two year olds fully immunised.	Implement the recommendations of the DHB's Immunisation Direction Paper with a key focus on strengthening the primary care and PHO leadership role.[15] Review current strategies to improve childhood immunisation uptake and identify opportunities to extend these.	A collaborative approach to improving immunisation rates is supported through the Canterbury Immunisation Governance Group.	Q1-Q4	GM P&F PHOs
		Opportunities for improving the interface between stakeholders are taken.	Q2-Q3	
		Opportunities are identified to improve enrolment rates at birth.	Q1-Q2	
		Immunisation data is reviewed to determine the reasons for drop-offs in immunisations and delays in timeliness.	Q1-Q2	
		Systems and opportunities are identified and supported to maintain and improve timeliness of vaccinations.	Q2-Q4	
		Alternative pathways are investigated in order to reach children in priority groups and promote completion of scheduled immunisations.	Q2-Q4	

Measure

Target		Actual 2006/07	Target 2008/09
An increase in the percentage of children fully immunised at age two – with progress towards 95%.[16]	Māori	na	88%
	Pacific	na	88%
	Other	na	88%
	Total	na	88%



[15] *The DHB's Immunisation Direction Paper is still in draft and is out for consultation. Some changes in timeframes and actions may arise after consultation, however the DHB's approach will hold true as will its commitment to improving immunisation rates.*

[16] *These figures are taken from the eligible population on the National Immunisation Register (NIR). At year-end 2006/07 none of the children on Canterbury NIR had yet reached age two.*

Health Target	Improve Oral Health

Why - Rationale/Intervention Logic

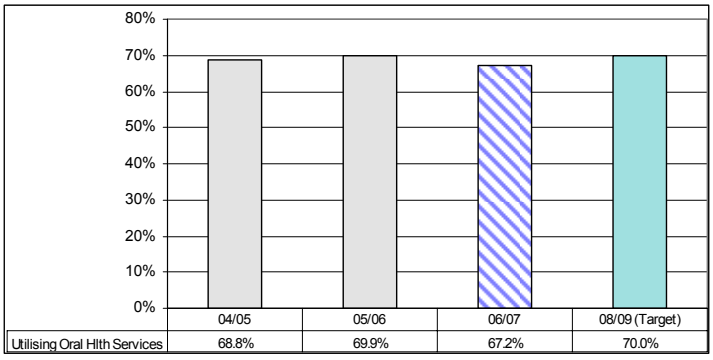
- Regular dental care during adolescence has life-long benefits. However many adolescents, especially high risk groups, do not seek oral health care beyond year 8 (age 12-13), despite this being a free service.
- Māori children are three times more likely to have decayed, missing or filled teeth than the national average. Reductions in these inequalities will minimise pain and suffering from oral disease and help to lesson the impact of poor oral health and a continuation of those inequalities into adulthood.
- Water fluoridation can significantly reduce tooth decay in children, however less than 5% of children in Canterbury have access to fluoridated water. Enrolments in dental programmes and oral health promotion are a key focus.

Next Steps in 2008/09:

WHAT	HOW		WHEN	WHO
Key Priorities	**Approach**	**Outputs for 2008/2009**	**Quarter**	**Lead**
Increase the percentage of adolescents (13-17 years) utilising oral health services.	Improve the interface with private dentists, dental therapists, dental assistants and primary care to support free adolescent dental services.	Adolescent Oral Health Promotion Initiative targets high-needs children.	Q1-Q4	GM P&F
		Awareness is raised amongst private dentists of the requirements of the DHB and the national Health Targets.	Q1-Q2	
		Joint initiatives with dentists in specific service areas, such as non-attending adolescents, are supported.	Q2-Q4	
	Work with adolescent dental care providers to ensure service coverage is sustainable.	Current utilisation patterns are evaluated to determine the level of coverage in Canterbury and to identify gaps in service provision for high-need adolescent groups.	Q1-Q2	GM P&F GM OPH&R GM RHS
		Current funding mechanisms are viewed to ensure sustainable service delivery within available resources and access to dental care for those with the greatest need.	Q1-Q2	
		Opportunities for shared provision or employment are identified; such as dental teams in rural communities.	Q3-Q4	
	Raise awareness of the availability of the 'free' service and the importance of good oral health.	Health promotion implemented, taking advantage of regional and national plans to enhance effects and avoid duplication.	Q1-Q4	GM P&F GM CPH
		Opportunities are identified to promote oral health messages alongside HEHA messages.	Q1-Q4	

Measure

Target[17]	Actual 2006	Target 2008
An increase in the percentage of adolescents utilising oral health services - with progress towards 85%.	67.2%	70%



[17] *These results are provided by HealthPac on a calendar year. The DHB's ability to deliver against this target is also dependant on timely Ministry sign-off for the DHB's Oral Health Business Case to allow for scheduled implementation of the Oral Health Reform.*

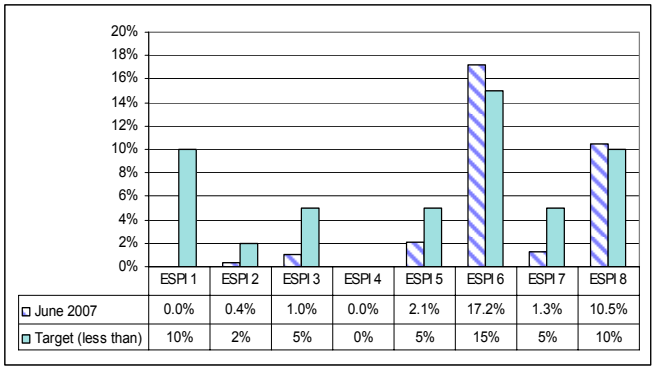
Health Target	Improve Elective Services			
Why - Rationale/Intervention Logic				
▪ To achieve the principles of clarity, timeliness and fairness by providing a transparent and accountable system of elective services management, where roles and responsibilities are defined and understood; performance monitored, measured and supported; and improvements to the patient journey achieved and sustained in a structured manner. ▪ To implement and maintain policy, process and systems that provide the Canterbury community with the confidence that patients referred for assessment or treatment will be consistently prioritised according to their need and ability to benefit, within available funding.				
Next Steps in 2008/09:				
WHAT	**HOW**		**WHEN**	**WHO**
Key Priorities	**Approach**	**Outputs for 2008/2009**	**Quarter**	**Lead**
Ensure the delivery of agreed increased elective volumes.	Meet the significant challenge of increasing capacity to deliver increasing activity and increasing theatre capacity and staffing levels through: ▪ Identifying opportunities for increased efficiencies within current surgical resources; ▪ Contracting external providers to deliver additional volumes in the short term; and [18] ▪ Working to increase the DHB's internal capacity for key service areas (medium term).	Capacity planning processes completed and internal baseline capability defined for each service.	Q1	HSS GMs GM P&F
		Information from the Referrals Project's unmet need work stream is combined with discharge analysis to inform elective funding decisions.	Q1-Q4	
		Gaps between internal capability and desired service level delivery targets are identified and external contracts secured to deliver additional volumes.	Q1-Q4	
		Medium term plans for service expansion approved and GP-led service implementation commenced: Plastic surgery, skin lesions clinics and musculoskeletal assessment to inform First Specialist Assessment (FSA) requirements and gynaecology mirena and prolapse pathways delivered in community settings.	Q2-Q4	
Use an acceptable prioritisation process within each speciality to determine need and ability to benefit.	Specialities will meet the principles of clarity and fairness and ensure treatment is delivered according to the assigned priority by using national or registered validated local tool/s and having a defined documented process for assigning priority and treating patients accordingly.	Demonstrated evidence of: ▪ Commitment to improving prioritisation; ▪ Clear prioritisation process; and ▪ Treatment decisions linked to assigned priority.	Q1-Q4	HSS GMs
Streamline patient flow and increase capacity while maintaining ESPI Compliance.	Improve access and the quality of the patient journey in ways that will lead to sustainable efficiencies by: ▪ Further developing the Electives Monitoring and Reporting Framework; and	Data integrity improvement programme in place to produce National Booking Reporting System reports on a real time basis and define and agree business rules for all internal reporting.	Q1	HSS GMs
		Key Performance Indicator reporting introduced to identify and encourage patient flow efficiencies and capacity release in the areas of FSA to Follow-up ratio and FSA to Surgery ratio.	Q1	

[18] *These actions assume that the DHB can outsource delivery to private providers at a cost which doesn't exceed the available funding. The DHB acknowledges that there is a risk to delivery of its electives initiative volumes if service delivery can not be secured in a private setting.*

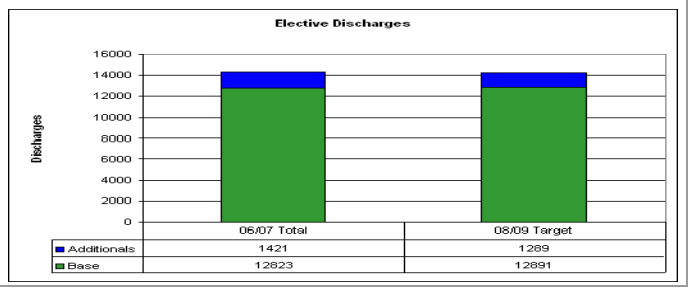
.	▪ Placing greater emphasis on the needs of service users and how this can shape services.	Engagement of staff on the value of capturing patient and carer feedback and committing to the principles of clarity, timeliness and fairness.	Q1-Q4	HSS GMs GM P&F
Support joint initiatives with primary care to improve patient flow and the measurement of unmet need.	Engage the community in the challenges associated with prioritisation of limited resources, measure unmet need in the community to inform future funding allocation and develop alternative referral pathways and facilities to best utilise resources by: ▪ Establishing a joint primary/secondary referrals initiative to work collaboratively across all sectors involved in the management of elective referrals; and ▪ Removing traditional boundaries to ensure service delivery is patient centred and delivered in the most appropriate setting.	Development of integrated pathways for Respiratory, Gynaecology and Orthopaedic patients.	Q1-Q4	
		The measurement of unmet need determines future service configuration and location.	Q1-Q4	
		Tools are developed or sourced to improve communication and information sharing between primary and secondary care.	Q1-Q4	
		GPs and hospital specialists provide clinical input and leadership in the design and implementation of the new models of care.	Q1	
		Initiatives to improve access to diagnostics are piloted and evaluated with opportunities to improve service pathways identified.	Q1-Q3	

Measure

Target		**Actual 2006/07**	**Target 2008/09**[19]	
			MoH	**DHB**
Compliance with all Elective Services Patient Flow Indicators (ESPIs).	ESPI 1	100%	>90%	>92%
	ESPI 2	0.4%	<2%	<1.6%
	ESPI 3	1.0%	<5%	<4%
	ESPI 4	Nil	=0%	=0%
	ESPI 5	2.1%	<5%	<4%
	ESPI 6	17.2%	<15%	<12%
	ESPI 7	1.3%	<5%	<4%
	ESPI 8	89.5%	>90%	>92%



Target		**Planned 2006/07**	**Target 2008/09** [20]
Delivery of the agreed increased number of elective services discharges.	Base	12,823	12,891
	Est. Add	1,421	1,289
	Total	14,244	14,180



[19] *Nationally Ministry expectations have set ESPIs compliance targets which all DHBs must achieve in order to receive additional electives funding – these are referred to as the MoH Targets. Alongside this the Canterbury DHB has set internal 'buffers' seeking a higher level of achievement to drive continuous improvement and to demonstrate our commitment to improved transparency and fairness – two of the key goals of the Elective Services Project.*

[20] *Delivery of these volumes is dependant on the DHB's ability to secure the capacity required to deliver increased volumes within available funding. These indicative volumes may be adjusted as the DHB refines its understanding of the unmet need in its community and the specialty level capacity available in both the public and private sectors.*

Health Target	Improve Cancer Waiting Times

Why - Rationale/Intervention Logic

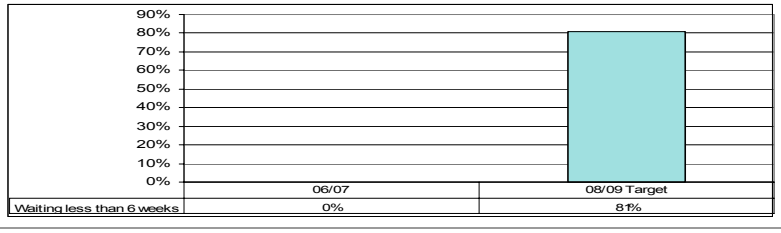
- One in three New Zealanders will have some experience of cancer, either personal or through a friend or relative. Māori and Pacific people have higher cancer incidence rates compared to other populations. Māori are 18% more likely to be diagnosed but nearly twice as likely as non-Māori to die from cancer. Timely treatment of cancer is important to improve outcomes and provide a better quality of life.

Next Steps in 2008/09:

WHAT	HOW		WHEN	WHO
Key Priorities	**Approach**	**Outputs for 2008/2009**	**Quarter**	**Lead**
Build the infrastructure and capacity to deliver timely cancer treatment.	Work to ensure that DHB recruits and retains key staff to ensure timely delivery of radiation therapy.	Employment of up to four new graduates through the Radiation Therapy Graduate Programme.	Q1-Q4	GM MS GM P&F
		Options are explored for increasing workforce flexibility to increase current linear accelerator capacity and to develop a long-term workforce plan to back sustained capacity.	Q1-Q4	
		Employment of a Lung Cancer Coordinator to support a multidisciplinary focus.	Q1-Q2	
	Consider current process and systems to ensure opportunities for efficiencies are identified and realised.	Waiting time data provided on a monthly basis with exception notes where wait-times exceed recommendations - to target improvements.	Q1-Q4	GM MS
		Work to provide ethnicity data against wait-times.	Q2-Q3	
		Lean thinking processes are applied to internal processes including combined chemotherapy and radiation therapy patients, to improve the cancer pathway and reduce wait-times for patients.	Q1-Q4	
	Consider patient flow across the southern district to increase joint short-term capacity.	The capacity of South Island DHBs and Capital and Coast DHB is identified to ensure equity of access and wait-times - with clarification around population catchments.	Q1-Q4	GM MS
		Initiatives to spread the treatment load and reduce treatment wait-times identified.	Q1-Q4	
	Initiate the process for the replacement of the the DHB's aged Linear Accelerator (T3) to ensure capacity to provide treatment.[21]	Timeline is established for T3 replacement.	Q1-Q2	GM MS
		Risk assessment and contingency options are identified to manage capacity during down-time.	Q1-Q2	
		Business Case is developed for T3 replacement.	Q1-Q2	
		Business Case for replacement and loan facility submitted for Ministry approval.	Q2-Q3	
	Initiate the process for establishing a fourth, Linear Accelerator to sustain capacity.	Business Case is developed for establishment of fourth Linear Accelerator.	Q1-Q3	GM MS GM P&F
		Business Case for fourth Linear Accelerator and loan facility submitted for Ministry approval.	Q3-Q4	

Measure

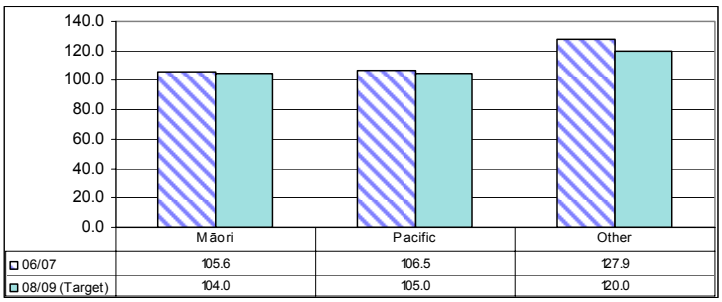
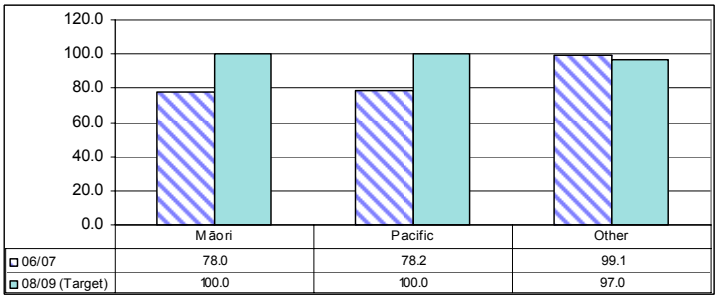
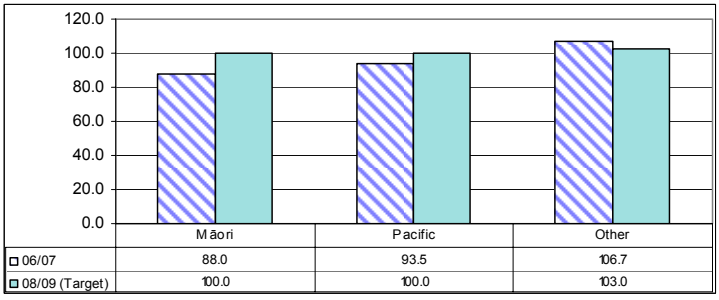
Target [22]	Actual 06/07	Target 2008/09
All patients wait less than six weeks between FSA and the start of radiation oncology treatment (excludes category D).	na	81%



[21] *Linear Accelerator machines treat cancers using high energy x-rays.*

[22] *The DHB did not measure this target in 2006/07 – results at six months 2007/08 demonstrate a performance of 81%. The DHB is committed to achieving the national Health Target of 100% of patients (excluding category D) waiting less than six weeks. However we believe that during 2008/09 significant effort will be required to maintain current performance. Planned outputs for 2008/09 will explore opportunities to utilise capacity available in other cancer centres and best endeavours to make progress towards 100% target.*

Health Target	Reduce Ambulatory Sensitive (avoidable) Hospital Admissions			
Why - Rationale/Intervention Logic				
▪ Vulnerable populations have higher rates of avoidable or unnecessary hospital admissions. These admissions can indicate poor access to effective primary and social services. ▪ Nationally rates of avoidable hospital admissions are disproportionate higher for Māori and Pacific groups and in Canterbury it is the rates for 0-4 years where performance is above the national average. ▪ Reducing the number of avoidable hospital admissions, provides the potential to free up health resources (including staff and funding resources) allowing them to be directed to other priority areas.				
Next Steps in 2008/09:				
WHAT	**HOW**		**WHEN**	**WHO**
Key Priorities	**Approach**	**Outputs for 2008/2009**	**Quarter**	**Lead**
Reduce Ambulatory Sensitive Hospital (ASH) Admissions for 0-4 year olds.	Support the Child Health Project in HSS Women's and Children's Services to improve the child's journey through the service.	Triage process for outpatient referrals are revised to improve the quality of referrals and pathways of care - led by GP Liaison.	Q1-Q4	GM W&C GM P&F
		Patient pathways for the acute management of children are developed through the Child's Acute Assessment Area.	Q1-Q4	
		Possible alternative models of care for children in outpatients are identified i.e. nurse specialist care or specialist input to GP care.	Q3-Q4	
		The development of integrated Child Development Services is scoped and a proposal is developed to support one entry point for assessment.	Q2-Q4	
	Improve the interface between primary and secondary services to identify opportunities for improved models of care and service delivery.	The GP Liaison roles (HSS Child Health Services and PHO Services) are redefined and supported to identify opportunities to improve care and ensure high needs children are appropriately managed in hospital and community settings.	Q1-Q4	GM W&C GM P&F
Reduce ASH Admissions for 0-74 year olds.	Improve medicines management for those people on more than 14 medications to reduce hospital admissions.	A process is established with the Ministry to identify PHO enrolled patients on 14 or more medications.	Q3	GM P&F
		A medicines management process is piloted in primary care to improve the management of patients on 14 or more medications.	Q3-Q4	
	Improve the interface between primary and secondary services to identify opportunities to ensure the delivery of patient care in the most appropriate settings.	Joint primary/secondary care arrangements established to develop services for people with respiratory disease (refer to section 6.2.4).	Q1-Q4	GM P&F GM MS GM RHS PHOs
		A joint primary/secondary care pathway for patients with COPD is developed and implemented (refer to section 6.2.4).	Q4	
	Ensure the population receives the most appropriate level of care for their needs.	The Acute Demand Management Programme is enhanced (refer section 5.3).	Q1-Q4	GM P&F

Measure				
Target [23]		**Actual 2006/07**	**Target 2008/09**	
A reduction in ASH rates for children 0-4 years (ISR).	Māori	105.6	≤104	
	Pacific	106.5	≤105	
	Other	127.9	≤120	
Target		**Actual 2006/07**	**Target 2008/09**	
A reduction in ASH rates for those 45-64 years (ISR).	Māori	78.0	< 100	
	Pacific	78.2	< 100	
	Other	99.1	≤ 97	
Target		**Actual 2006/07**	**Target 2008/09**	
A reduction in ASH rates for those 0-74 years (ISR).	Māori	88.0	< 100	
	Pacific	93.5	< 100	
	Other	106.7	≤ 103	

[23] *Ambulatory Sensitive Admissions are based on admissions for 37 combined conditions including: Asthma, Dehydration, Diabetes, Ruptured Appendix, Stroke, Angina, Gastroenteritis and 'Failure to Thrive'. The DHB's targets reflect the intention to move towards the national average for all age groups in line with Ministry expectations. In some cases the DHB is already achieving better than the national average and the targets may look as if the DHB is aiming to reduce performance, however this is not the case - the aim is to reflect the intention to focus on those groups where performance is poor in comparison to other DHB districts.*

Health Target	Improve Diabetes Services

Why - Rationale/Intervention Logic

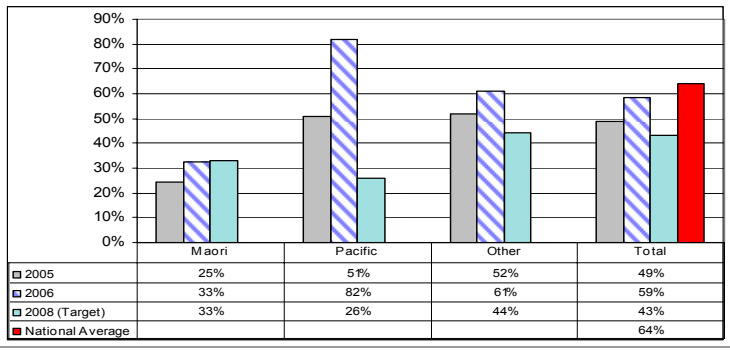
- Diabetes is a significant cause of ill health and premature death in New Zealand. The prevalence of diagnosed diabetes across the population is currently estimated at around 4.6 percent. However Māori and Pacific people have rates of diabetes around three times higher than other New Zealanders. Reducing the incidence and impact of diabetes is therefore a key focus in reducing inequalities in health status and outcomes.
- An increase in the proportion of people (with diagnosed diabetes) who have an annual diabetes checks indicates access to care and an increase in the proportion of those people with good diabetes control indicates the quality or effectiveness of that care. In Canterbury we are currently below the national average in terms of the number of annual diabetes checks being undertaken and a clear focus is needed to increase these rates.

Next Steps in 2008/09:

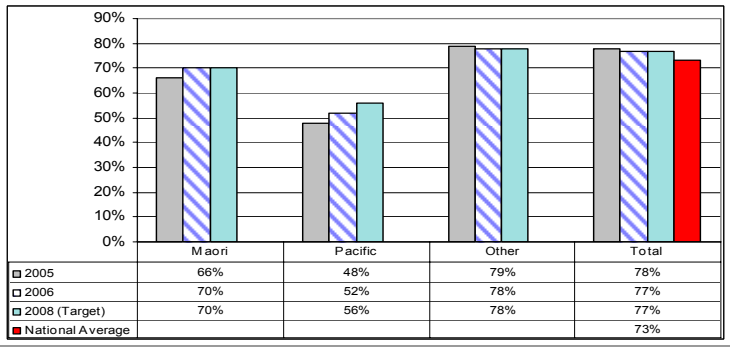
WHAT	HOW		WHEN	WHO
Key Priorities	**Approach**	**Outputs for 2008/2009**	**Quarter**	**Lead**
Increase the uptake of free annual diabetes reviews (checks).	Work with PHOs and the Local Diabetes Team to improve the management of diabetes and to target populations most at risk of diabetes to improve equity for all population groups.	Work with the Local Diabetes Team to identify opportunities to raise awareness of the importance and availability of free annual diabetes checks.	Q1-Q4	GM P&F LDT
		A consumer consultation/survey is completed identifying issues and barriers to the uptake of free checks, feedback on current service delivery and recommendations for change.	Q1	GM P&F
		Opportunities are identified to improve the uptake of annual checks by Māori and Pacific people as high needs groups.	Q2-Q4	
		Diabetes workforce development for general practice teams is supported.	Q3-Q4	GM P&F PHOs

Measure

Target [24]		**Actual 2006**	**Target 2008**
An increase in the % of people, estimated to have diabetes, receiving free annual diabetes checks	Māori	33%	>33%
	Pacific	82%	>26%
	Other	61%	>44%
	Total	59%	>43%



Target		**Actual 2006**	**Target 2008**
An increase in the % of people on the diabetes register who have good diabetes management (HBA1c=8.0% or less).	Māori	70%	≥70%
	Pacific	52%	≥56%
	Other	78%	≥78%
	Total	77%	≥77%



[24] *The 2008/09 targets are affected by an increase in the number of our population expected to have diabetes. In 2007/08, 8,032 annual diabetes checks were delivered and the aim is to increase this to 8,620 checks in 2008/09.*

Health Target	Improve Mental Health Services

Why - Rationale/Intervention Logic

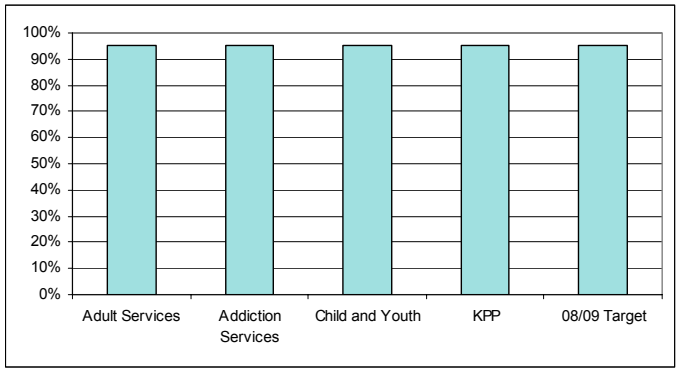
- Relapse Prevention Plans identify early relapse warning signs for people with mental illness. The Plans identify what people can do for themselves and what mental health services can do for them.
- Long-term clients are defined as adults who have been using secondary care mental health services for two years or more and children and young people using services for one year or more. It is important to access if these clients needs are being met and if services are having the intended results.

Next Steps in 2008/09:

WHAT	HOW		WHEN	WHO
Key Priorities	**Approach**	**Outputs for 2008/2009**	**Quarter**	**Lead**
Ensure that long-term clients have up-to-date relapse prevention plans.	The DHB will work collaboratively to contribute to a national and regional approach to providing comparative and consistent mental health services which meet the needs of the population.	Standardised definition for 'long-term' client agreed nationally.	Q1	MoH
		Regular reporting against the DHB definitions established with progress towards use of national definitions.	Q1	GM MH
		Awareness of the importance of this target and the provision of relapse plans for all long-term clients established.	Q2-Q2	
		Services where performance is below target are identified and steps to ensure compliance are taken.	Q2-Q4	
		Audit of acute inpatient usage of HSS mental health services by long-term clients is undertaken.	Q4	

Measure

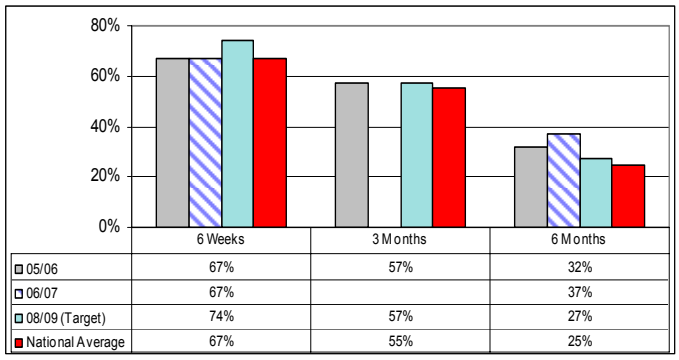
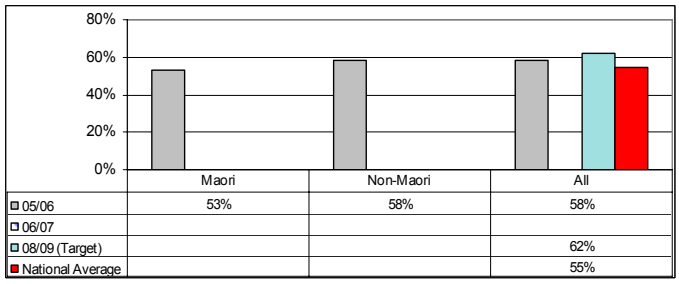
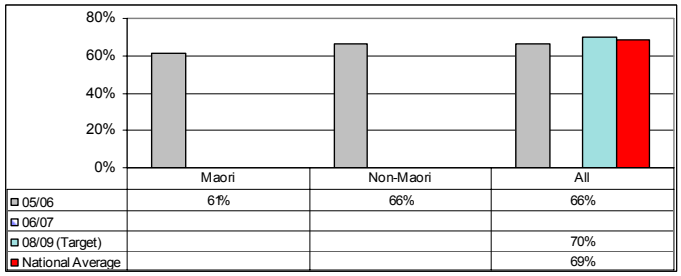
Target [25] [26]		Actual 2006/07	Target 2008/09
An increase in the percentage of long-term clients with up-to-date relapse prevention plans.	20 years+ (excluding addictions only)	na	95%
	20 years+ (addictions only)	na	95%
	Child and Youth	na	95%
	KPP only	na	95%
	Total	na	95%



[25] *The DHB will work with the Ministry to establish clear definitions around 'long-term clients' and has requested clarification on methods of ensuring consistency of definition against this target – particularly for child and youth clients.*

[26] *The DHB did not measure this indicator in previous years there is therefore no baseline data for 2006/2007. KPP refers to the Knowing the People Planning Project which identifies those people with enduring mental illness and tracks their progress against ten elements of recovery from employment status through to use of hospital services. There are currently 320 people in this programme.*

Health Target	Improve Nutrition, Increase Physical Activity and Reduce Obesity			
Why - Rationale/Intervention Logic				
▪ Good nutrition, physical activity and maintaining a health body weight are fundamental to health and to the prevention of disease and disability at all ages. The foundations for a healthy life are laid in infancy and childhood. ▪ Breastfeeding contributes positively to infant and maternal health and influences the likelihood of obesity later in life. ▪ Vegetable and fruit consumption has been found to be protective against cardiovascular disease and some common cancers, and may contribute indirectly to maintaining a healthy body weight.				
Next Steps in 2008/09:				
WHAT	**HOW**		**WHEN**	**WHO**
Key Priorities	**Approach**	**Outputs for 2008/2009**	**Quarter**	**Lead**
Develop Baby Friendly Communities to support increased breastfeeding rates.	Implement the DHB's Breastfeeding Action Plan (BAP) to support priorities to develop Baby Friendly Communities.	Breastfeeding Advocacy Service established to support the BAP priorities.	Q1	GM P&F
		Community-based peer support programmes increased.	Q1-Q4	
		Access to community-based Lactation Consultants improved.	Q2	
	Continue to promote breastfeeding within HSS neo-natal and child health services.	Continued commitment to HSS provision of lactation consultant services for new mothers needing additional assistance.	Q1-Q4	GM W&C HSS
		Consistent messages ensured through the provision of breastfeeding lectures and education to HSS child health staff.	Q1-Q4	
Improve nutrition awareness and increase fruit and vegetable intake. Increase physical activity levels and assist people to maintain a healthy weight.	Implement the DHB's Healthy Eating, Healthy Activity (HEHA) Ministry Approved Plan in key prioritised settings: Schools/Early Childhood Centres; Primary care/general practice settings; and Māori/Pacific communities.	Opportunities provided for an additional 10% of Canterbury schools and early childhood services to receive Nutrition Funding to support the implementation of national Nutrition Guidelines.	Q2 Q4	GM P&F
		Percentage of Health Promoting Schools in Canterbury increased to 33%.	Q4	
		Increased number of Appetite for Life courses delivered in primary care settings.	Q1-Q4	
		Consistent HEHA messages provided through the HEHA Communications Plan.	Q1-Q4	
		Community action projects identified and funded to empower and enable Māori and Pacific people to achieve HEHA goals.	Q2	
	Support workforce development to increase HEHA capability and capacity in the Canterbury district. Support quality and consistency in HEHA messages through Professional Development.	Capability and capacity in the Māori and Pacific activity and nutrition workforce increased through provision of a physical activity and nutrition and professional development training.	Q2-Q4	GM P&F
		Primary care capacity to deliver HEHA and lifestyle change messages enhanced through training practice nurses and community support workers to deliver the Appetite for Life programme.	Q2-Q4	GM P&F PHOs
	Work to identify and address gaps in service delivery that could hinder HEHA outcomes.	Further enhance services for at-risk children (overweight and obese).	Q2	GM P&F
	Work to develop linkages with the food industry in Canterbury to support HEHA outcomes.	Initiatives to promote and support the implementation of the Food and Beverage Classification System identified.	Q2-Q4	GM P&F

Measure				
Target		**Actual 2006/07**	**Target 2008/09**	
An increase in the percentage of babies exclusively/ fully breastfed.[27]	6 wks	67%	74%	
	3 mths	na	57%	
	6 mths	37%	27%	
National Target [28]		**Actual 2006/07**	**Target 2008/09**	
An increase in the proportion of adults (15+) consuming at least three servings of fruit a day.		58%	62%	
An increase in the proportion of adults (15+) consuming at least two servings of vegetables a day.		66%	70%	

[27] *No 3mth figure was provided by Plunket for this year.*

[28] *The DHB's only measurement for this indicator is using statistics from the NZ Health Survey collected nationally by the Ministry. This survey is currently being collected for the second time and is repeated every three years. These are national targets towards which the DHB contributes by implementing its HEHA Ministry Approved Plan.*

Health Target	Reduce the Harm Caused By Tobacco

Why - Rationale/Intervention Logic

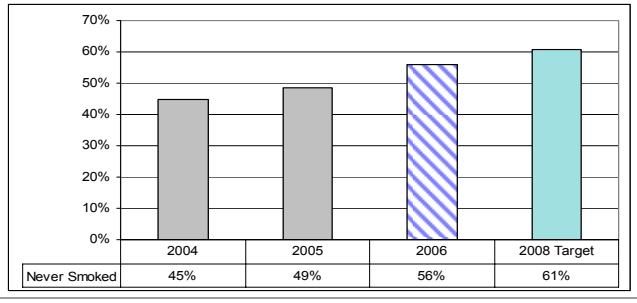
- Smoking kills an estimated 5000 people in New Zealand every year, including deaths due to second-hand smoke exposure. Around 1500 of these deaths occur in middle age. Smoking is a major contributor to inequalities in health. It is the main cause of lung cancer and chronic obstructive pulmonary disease and is a major cause of heart disease, strokes and a variety of other cancers.
- The highest prevalence is amongst young New Zealanders aged between 15 and 29, with almost one in every four teenagers aged 15-19 currently smoking. The average age of smoking initiation in adolescents is 14.6 years.

Next Steps in 2008/09:

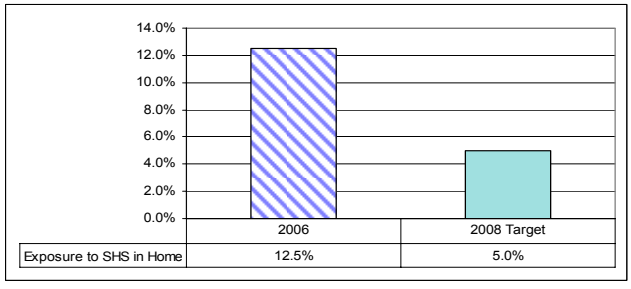
WHAT	HOW		WHEN	WHO
Key Priorities	**Approach** [29]	**Outputs for 2008/2009**	**Quarter**	**Lead**
Reduce the harm caused by tobacco.	Implement the DHB's Tobacco Control Plan and deliver against the key actions in that plan: Reduce the uptake in smoking; Support increased quit attempts; and Ensure legislative compliance with the 1990 Smokefree Environments Act.	Primary and secondary clinical champions are engaged to support smokefree activity.	Q1	GM CPH
		The coordination of Canterbury Smokefree Providers is supported.	Q1-Q4	
		Smokefree programmes within Canterbury PHOs are further developed and supported.	Q1-Q4	GM P&F
		Smoking initiation amongst young people is reduced by addressing smoking in families.	Q1-Q4	GM CPH
		A Canterbury regional Smoking Cessation Services Plan is developed.	Q1	
		Compliance with the Smokefree Act.	Q1-Q4	
	Promote smokefree lifestyles to the Māori community through Auahi Kore initiatives and the Aukati Kai Paipa programme.	Māori are engaged at Marae meetings and presented the impacts of cessation across generations with links to HEHA initiatives.	Q1-Q4	GM CPH
		One new urban Marae has a designated smoking area or is (ideally) smokefree.	Q4	
		Two Papatipu Rununga Marae have designated smoking areas or are (ideally) smokefree.	Q4	

Measure

National Target	Actual 2006/07	Target 2008/09
An increase in the proportion of 'never smokers' among Year 10 students by at least 3% with an increase for both Māori and Pacific that is greater than that for European.	56%	61%



National Target	Actual 2006/07	Target 2008/09
A reduction in the prevalence of exposure of non-smokers to Second Hand Smoke inside the home with a reduction for Māori and Pacific that is greater than that for European.	12.5%	<5%



[29] *These outputs are based on the DHB's Tobacco Control Plan which is current in draft and yet to go to consultation, this may alter some of the key priorities or timeframes identified here however the DHB approach and commitment to the national targets will stand.*

6. Progress against Our Strategic Priorities 2008/09

This Chapter:

- Outlines what the DHB is trying to achieve in each of its identified Strategic Priority areas;
- Summarises the progress already made in working towards improved outcomes for the Canterbury population;
- Indicates where new investment will be made;
- Sets out the actions and outputs planned in the coming year to contribute to continued progress, both in terms of local and national priorities; and
- Identifies how the DHB will measure its performance.

6.1 Health Gain Priorities – Improving the Health of Our Community

The DHB's Strategic Health Gain and Disease Priorities are a mix of population, service and disease based approaches and they represent the areas where the DHB believes there is potential to make improvements in the health status of its population and in the delivery or effectiveness of the services provided.

These local strategic priorities align well with national focus and the DHB will take a 'common purpose' approach to national priorities, being committed to implementing those strategies and policies developed nationally that are a priority for the Canterbury population.

The Ministry's Health Targets promote a sector-wide focus and the DHB has adopted these indicators with a commitment to improve outcomes in these key areas. The DHB will also make use of opportunities to work regionally to improve the management of long-term conditions and acute demand and to plan for long-term sustainability in the health sector. This commitment to partnership and collaboration is outlined throughout this document.

It should be noted that the actions and activity presented relate to work centred on the DHB's strategic priority areas chosen during the development of its District Strategic Plan in 2004. Within those areas the DHB has presented a focus on what it will be doing differently in 2008/09, a focus on new initiatives and investment and on changes to service delivery, service models or to practice. The DHB's work plans and workload for the coming year are much wider that that which is presented in this document.

The DHB's approach to making progress in all areas of its work will be consistent. The DHB will:

- Promote messages related to improved lifestyle choices, physical activity and nutrition and the reduction of risk behaviours, obesity and smoking cessation to improve population health;
- Work collaboratively with the primary and community sectors, with the community and with external organisations to ensure an integrated and patient centred approach to care and the development of robust long-term disease continuums; and
- Work with providers and community agencies to reduce inequalities in health status through increased equity of access and improved uptake of services across population groups more at risk and with the highest need.

6.1.1 Child and Youth Health

Long-Term Goal – Where do we want to be?

The DHB aims to demonstrate improve health outcomes for its younger population, particularly for those children and young people in high needs groups or those living in environmentally disadvantaged situations. The DHB also aims to ensure that children and young people have improved access to health and disability services.

Increasing breastfeeding rates and immunisation coverage, reducing ambulatory sensitive (avoidable) hospital admissions and improving oral health are national priorities and are Ministry Health Target for DHBs.

What are the Challenges – What will we do to succeed?

The demographic mix of Canterbury's younger population is changing with increasing numbers of Māori and Pacific children. Māori and Pacific children have higher rates of tooth decay and glue ear and higher rates of hospitalisation for vaccine-preventable diseases. Māori are more than twice as likely to develop diabetes as other population group. The DHB needs to work to ensure services meet the needs of these groups and to reduce inequalities in access and outcomes.

Behaviour patterns established in adolescence have a significant impact on long-term health outcomes. Young people need to be encouraged and enabled to make healthy choices and to access health services to maintain good health.

The DHB is committed to promoting healthier lifestyles and reducing risk behaviours and sees the importance of targeting interventions to populations at highest risk and at times where long-term benefits are greatest (antenatally and during childhood and adolescence).

The Baby Friendly Hospital Initiative, HSS Smokefree Pregnancy Services, a robust Maternity Strategy and the development of a Breastfeeding Action Plan will all contribute positively to promoting a healthy start in life.

Increasing immunisation rates is a key focus as a cost-effective means of avoiding preventable disease and long-term illness. The national target is to achieve 95% of two year olds fully immunised and the DHB will need to work closely with PHOs and outreach services to increase Canterbury immunisation rates, particularly for Māori and Pacific children and 'at risk' children in lower socio-economic areas.

Improved utilisation of effective primary health services is an important factor in reducing preventable hospitalisation for younger population groups. A national 'zero fees for under 6's' funding stream was introduced to reduce the barriers to accessing primary care services for those families with children under six years of age. The DHB will support this initiative and other Ministry funded programmes which strengthen the relationship between families and the health sector, improve the wellbeing of children and reduce unnecessary or avoidable hospital admissions.

The DHB's oral health focus recognises oral health as a precursor to on-going well-being in adulthood. While the rate of tooth decay in five-year-olds has improved, children living in lower socio-economic areas and Māori and Pacific children still have poorer oral health on average. With less than 5% of children in Canterbury having access to fluoridated water, enrolments in dental programmes is a key focus along with good oral health promotion.

In terms of its youth population the DHB will continue to implement the recommendations of its Youth Health Position Paper aiming to provide a safer and more supportive environment for young people, and to promote improvements in mental and physical health and wellbeing.

In line with its Youth Health Position the DHB aims to assist young people to maintain good health throughout their lifetime and support them to make informed decisions about risk behaviour. Christchurch students have high smoking rates and tobacco smoking amongst Pacific youth aged 15-24 is a particular concern. The DHB will continue to support smoking cessation programmes and will work collaboratively to prevent the uptake of smoking and to reduce youth smoking rates (refer to section 6.1.5). The DHB will work to improve nutrition and physical activity levels through implementation of the HEHA Strategy (section 6.1.5) and will work with the Ministry to implement the national Human Papillomavirus (HPV) Vaccination Programme (section 6.2.1).

The DHB will also seek to minimise barriers to community and hospital based services and deliver care in appropriate environments to meet the objectives of its Youth Health Position and will work to improve utilisation of oral health services by adolescents, and improve access to mental health services through continued implementation and enhancement of a single-point-of-entry for child and youth services (section 8.1.2).

Actions and Success to Date:

- Successful training session run for Māori and Pacific health workers around breastfeeding issues and a jointly funded DHB/PHO breastfeeding group for young mothers based at Early Start to reach high need mothers and their families (refer to section 6.1.5 for breastfeeding).
- Inclusion of two year old immunisations in the PHO Performance Management Programme as a financial performance target to incentivise increased immunisation rates and the establishment of Immunisation Coordination Services to provide oversight of immunisation services, quality and education.

- Establishment of Child Health Liaison Worker roles to work with general practice teams and families to facilitate health gains for children and reduce health disparities within enrolled PHO populations. These roles will also help to make the best use of current resources by maintaining links with, but not duplicating, existing funded services.
- Successfully applications from 46 general practices in Canterbury who now receive additional funding to ensure children within their enrolled population receive access to free general practice services.
- Securing of Ministry funding for an under-5's PHO-based Oral Health Promotion initiative. This is a similar service to the PHO-based Adolescent Oral Health Promotion Project, but with a focus on under-5s.

Next Steps in 2008/09:

WHAT	**HOW**		**WHEN**	**WHO**
Key Priorities	**Approach**	**Outputs for 2008/2009**	**Quarter**	**Lead**
Improve immunisation coverage, increasing the number of two year olds fully immunised.	Implement the recommendations of the DHB's Immunisation Direction Paper with a key focus on strengthening the primary care and PHO leadership role. Review current strategies to improve childhood immunisation uptake and identify opportunities to extend these.	A collaborative approach to improving immunisation rates is supported through the Canterbury Immunisation Governance Group.	Q1-Q4	GM P&F PHOs
		Opportunities for improving the interface between stakeholders are taken.	Q2-Q3	
		Opportunities are identified to improve enrolment rates at birth.	Q1-Q2	
		Immunisation data is reviewed to determine the reasons for drop-offs in immunisations and delays in timeliness.	Q1-Q2	
		Systems and opportunities are identified and supported to maintain and improve timeliness of vaccinations.	Q2-Q4	
		Alternative pathways are investigated in order to reach children in priority groups and promote completion of scheduled immunisations.	Q2-Q4	
Reduce ASH admissions for 0-4 year olds.	Support the Child Health Project in HSS Women's and Children's Services to improve the child's journey through the service.	Triage process for outpatient referrals are revised to improve the quality of referrals and pathways of care - led by GP Liaison.	Q1-Q4	GM W&C GM P&F
		Patient pathways for the acute management of children are developed through the Child's Acute Assessment Area.	Q1-Q4	
		Possible alternative models of care for children in outpatients are identified i.e. nurse specialist care or specialist input to GP care.	Q3-Q4	
		The development of integrated Child Development Services is scoped and a proposal is developed to support one entry point for assessment.	Q2-Q4	
	Improve the interface between primary and secondary services to identify opportunities for improved models of care and service delivery.	The GP Liaison roles (HSS Child Health Services and PHO Services) are redefined and supported to identify opportunities to improve care and ensure high needs children are appropriately managed in hospital and community settings.	Q1-Q4	GM W&C GM P&F
Implement national screening and coordination services to improve early intervention and the foundations for well-being and to reduce inequalities in	Work with the National Screening Unit to implement the national Newborn Hearing Screening Programme.	First Newborn Hearing Screenings occur to identify newborns with hearing impairments for early intervention.	Q1-Q2	GM P&F
		Newborns in Canterbury routinely screened.	Q4	
	Work with PHOs and child health providers to implement the national B4 School Checks Programme.	First B4 Schools screen to occur to identify physical and psychosocial issues that can be addressed before children starts school.	Q1-Q2	GM P&F PHO
		Children in Canterbury routinely screened.	Q4	
	Develop a DHB Violence	Endorsement of the Programme established.	Q1	GM P&F

health status longer-term.[30]	Intervention Programme in line with national guidelines and expectations.	Violence Intervention Coordinator appointed.	Q1	
		Implementation Plan developed and first phase of implementation underway.	Q2-Q3	
Increase the percentage of adolescents (13-17 years) utilising oral health services.	Improve the interface with private dentists, dental therapists, dental assistants and primary care to support free adolescent dental services.	Adolescent Oral Health Promotion Initiative targets high-needs children.	Q1-Q4	GM P&F
		Awareness is raised amongst private dentists of the requirements of the DHB and the national Health Targets.	Q1-Q2	
		Joint initiatives with dentists in specific service areas, such as non-attending adolescents, are supported.	Q2-Q4	
	Work with adolescent dental care providers to ensure service coverage is sustainable.	Current utilisation patterns are evaluated to determine the level of coverage in Canterbury and to identify gaps in service provision for high-need adolescent groups.	Q1-Q2	GM P&F GM OPH&R GM RHS
		Current funding mechanisms are viewed to ensure sustainable service delivery within available resources and access to dental care for those with the greatest need.	Q1-Q2	
		Opportunities for shared provision or employment are identified, such as dental teams in rural communities.	Q3-Q4	
	Raise awareness of the availability of the 'free' service and the importance of good oral health.	Health promotion implemented, taking advantage of regional and national plans to enhance effects and avoid duplication.	Q1-Q4	GM P&F GM CPH
		Opportunities are identified to promote oral health messages alongside HEHA messages.	Q1-Q4	
Improve child oral health outcomes.	Implement the DHB's Under-5 Oral Health Promotion Initiative to enable early intervention.	Project plan completed for the Initiative after robust collaboration with stakeholders.	Q1	GM P&F
		Appointment of a Promotion Coordinator.	Q2	
Implement the Ministry's Oral Health Reform to upgrade and realign oral health services with current best practice and safety standards.[31]	Implement the DHB's Business Case for Investment in Oral Health Services with a focus on prevention, early intervention and accessibility.	Business Case and implementation plan signed-off by the Ministry.	Q1	GM OPH GM P&F
		DHB wide communication plan implemented to inform stakeholders of service changes.	Q2	
		Commissioning of the 1st stage of fixed and mobile facilities completed.	2009/10	GM CS GM OPH
	Implement workforce and data system reviews to support service changes to support the Oral Health Reform.	Review of new roles is complete and implemented to support service changes.	Q1-Q3	GM OPH
		Career structure for dental therapist supports professional leadership.	Q2-Q4	
		New dental information systems implemented and provision of robust and timely data is achieved.	Q4	

[30] These early intervention programmes (funded nationally by the Ministry) will assist in reducing inequalities in health outcomes. The programmes will identify behavioural, developmental or health concerns that may adversely affect a child's ability to learn in school or function in social environments and will provide appropriate and timely referrals to promote improved long-term health and social benefits and reduce inequalities that might carry into adulthood.

[31] The DHB's ability to deliver against these actions is dependant on timely Ministry sign-off for the DHB's Oral Health Business Case to allow for scheduled implementation. Any delay in the implementation of the Oral Health Reform will also affect the DHB's ability to improve child and youth oral health rates and the utilisation of oral health services by adolescents.

6.1.2 Older People's Health

Long-Term Goal – What do we want to achieve?

Through the implementation of it's Healthy Ageing, Integrated Support Strategy the Canterbury DHB aims to demonstrate improved health outcomes for older Canterbury residents, to deliver positive health outcomes, and meet increasing demand, within available resources.

What are the Challenges – What will we do to succeed?

Canterbury's population is ageing and this increase in population numbers will drive an increased demand for health and disability services. As people get older their health problems are likely to be more complicated, the impact more serve and prolonged, and they are also more likely to suffer from long-term (chronic) conditions.

The number of older Māori and Pacific people is also increasing. These population groups often experience age-related conditions prior to 65 and are over-represented in terms of the health problems and conditions experienced by older people including: diabetes, cardiovascular disease and respiratory disease.

The Canterbury DHB spends more on residential care services than other DHBs and long-term these levels of expenditure are not sustainable.[32] Between 5-6% of Canterbury's population aged over 65 live in residential care with the remainder living at home. Of the 94% living at home, approximately 16% of these people have some form of assistance in place in any one month. The DHB will need to concentrate on innovative and cost-effective initiatives to support the increased demand of its ageing population and the growing cost of residential services. Many older people prefer to age in their own homes and this 'ageing in place' philosophy requires access to effective and flexible home-based support services that can meet capacity and are under-pinned by a sustainable workforce.

The Canterbury DHB has in place a local Aged Care Strategy *Healthy Ageing, Integrated Support* as a means of implementing the national Health of Older People Strategy. The local Strategy is aligned with the DHB's Core Direction, Finding Better Ways of Working, and with the development of integrated continuums of care, patient centred models and the management of long-term conditions. The emphasis is on flexible, holistic, quality and needs-based care provided in the community to assist older people to stay well and to remain in their own homes.

In order to 'age in place' older people need to be safe in their homes and to maintain good health for longer. To successfully enable good health and the DHB will focus on and effective health promotion campaigns covering physical activity, nutrition, disease prevention, oral health, elder abuse and falls prevention. Around 1,000 older people are hospitalised annually in Canterbury as a result of injury due to accidental falls and the impacts from a fall can include: death, prolonged hospital stay, loss of confidence, restriction on social activities, loss of independence and increased risk of institutional care. Falls prevention is a key focus for the DHB in the coming year.

Effective primary and disability support services are also important in keeping people well and avoiding preventable hospital admissions - including effective screening and medication management. We also need to make the best use of specialist services with a strong community base, coordinated assessment, improved access to surgery and enhanced end-of-life care options and palliative care services. Improving the coordination between community, primary and secondary services will be a key focus for the coming year.

The DHB will continue to increase community based services, with the introduction of Community Support Worker roles and an increase in stand-alone day support facilities, and will collaborate with primary and community providers to provide a smooth transition between services and emphasise a restorative/rehabilitation approach. The DHB will also continue to work on positive relationships with providers; particularly around capacity, quality improvement and workforce development.

Actions and Success to Date:

- Development of a new model of CARE for the delivery of specialist community health services for older people. The CARE model aims to strengthen the primary/secondary interface and ensure older people receive appropriate and effective care in a home-based or community setting. The model was developed after a review of the Needs Assessment and Service Coordination and Coordinator of Services for the Elderly and supports both local and national strategy direction. [33]
- The InterRAI (International Home-based Assessment Instrument) roll-out in the DHB's HSS division with the aim of providing consistency in the assessment process and evidence based evaluation. The tool also has potential for improving care planning in residential care settings.
- Collaboration with community pharmacies to roll out the Medicines Use Review Service. This Service targets patients with long term conditions, those on multiple medications and those with multiple prescribers to ensure safe medication use and reduce avoidable hospital admissions.

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[32] *The Canterbury DHB's funding share received for the over 65 age group is approximately 12% of the national total, while our proportion of the total funding spent on Aged Residential Care is closer to 16%. This differential would indicate that the proportion of people over 65 living in resident care in Canterbury is higher than the national average.*

[33] *CARE – Care and Rehabilitation of the Elderly Model.*

- Supporting Canterbury PHOs to increase the enrolment of patients in CarePlus programmes and work towards a target of 75% of their enrolled populations receiving the flu vaccine in the over 65 age group. Patients over the age of 65 are more at risk of contracting the flu virus and complications from this.

Next Steps in 2008/09:				
WHAT	**HOW**		**WHEN**	**WHO**
Key Priorities	**Approach**	**Outputs for 2008/2009**	**Quarter**	**Lead**
Strengthen the interface between community, primary and secondary care services to ensure people receive appropriate and effective quality care in a home-based or community setting.	Improve the coordination between community, primary and secondary care services to support a continuum of care with the patient at the centre.	Services are redesigned to deliver a more supportive discharge for patients.	Q1	GM OPH GM P&F
		Referral pathways for older people are improved between HSS divisions.	Q3	
		Inter-disciplinary teams/clusters and specialist nursing resources support continuums of care.	Q3-Q4	
		Referral pathways, assessment processes and coordination between community support services are simplified.	Q4	
	Enhance the responsiveness of community based services and support quality improvement.	Capacity in specialist community-based services is enhanced to undertake assessment, coordination, review and treatment functions.	Q2	GM OPH
		Links between assessment and coordination services and primary care are re-established.	Q2	
		Quality improvement programmes implemented in home-based support services and residential care services.	Q3-Q4	GM P&F
		Allocation of cost effective and responsive community support packages enhanced.	Q2-Q4	
	Continue to develop InterRAI and evaluate the potential for improving care planning in residential care settings.	A pilot of the InterRAI Assessment Tool is undertaken by residential providers.	Q1	GM P&F
		The Pilot is evaluated and recommendations on the rollout of InterRAI are presented.	Q4	
	Continue to focus on improved medicine management for older people.	A process is established with the Ministry to identify PHO enrolled patients on 14 or more medications.	Q3	GM P&F
		A pilot medicines management process is initiated for patients on 14+ medications.	Q3-Q4	
Focus on health promotion, injury prevention and rehabilitation support for older people to keep them safe and well in their own homes and to support the 'ageing in place' focus.	Collect, analyse and use falls-related data to inform clinical best practice improvement in Hospital and Specialist Services.	Best clinical practice is identified in the minimisation/prevention of serious falls.	Q2	GM OPH
		Falls minimisation/prevention strategies are integrated into care planning.	Q3	
		Fall rates are incorporated into clinical and patient safety indicators for HSS.	Q4	
	Increase the uptake of the flu vaccine.	PHOs are supported to maintain high levels of uptake of the flu vaccine.	Q2-Q4	GM P&F
	Support the continuum of care by enhancing services for older people with psychiatric conditions.	Design/redesign services to meet the specific needs of older clients.	Q3	GM OPH GM MH
		Memory Assessment Services enhanced.	Q2	
		A reduction in the number of clients readmitted to hospital for medication issues.	Q4	

6.1.3 Māori Health - He Korowai Oranga

Long-Term Goal – Where do we want to be?

In alignment with its Māori Health Plan the DHB aims to demonstrate that Māori and their whānau are supported to achieve their maximum health and wellbeing - *Whānau Ora*. The DHB also aims to improve health outcomes for Māori populations in Canterbury and reduce current inequalities in access to services and in health status.

What are the Challenges – What will we do to succeed?

Although progress has been made, Māori, on average, have the poorest health status of any group in NZ and are less likely to access mainstream primary and secondary health and disability services.

With an increasing Māori population in Canterbury, particularly in younger population groups, Māori community participation in service development needs to be fostered to improve the cultural responsiveness of mainstream services. This includes active participation at governance and advisory levels and a focus on Māori-led service provision and service development. In the coming year the DHB will complete an updated Health Needs Assessment for the Canterbury district and will seek to engage its Māori community in the district strategic planning process to identify key areas of inequality and prioritise areas of need.

A clear understanding of the gaps and inequalities in our health system still needs to be established in order to effectively target service gaps and improve access. This has been recognised in the DHB's Māori Health Plan where effective ethnicity data collection, health status monitoring and identification of areas of inequality are a focus in '*Direction 1: Improving Māori Health Status*'. Insufficient quality Māori health data still makes analysis and measurement of health outcomes difficult. Ethnicity data collection will continue to be a focus for the DHB with positive progress having been made over the past year to reduce the ethnicity codes '*Not Stated*' or '*Other*'. [34]

The DHB recognises in its Māori Health Plan the disproportional representation of Māori in terms of chronic conditions particularly diabetes and respiratory disease. The DHB will need to target programmes in key areas of need to reduce inequalities in access, improve utilisation of services and enable improvements in overall health outcomes.

The number of appropriately skilled Māori staff employed in the health sector and specifically in the DHB is a factor in improving the acceptability of mainstream services for Māori. The DHB will continue its commitment to the regional Māori Health Workforce Plan and initiatives within that Plan to build capability and capacity of Māori service providers and the responsiveness of its own services.

Actions and Success to Date:

- The DHB's Māori Health Plan, *Whakamahere Hauora Māori ki Waitaha*, was revised in 2007/08 and signed-off by the DHB's Board in early 2008. The Plan recognises the DHB's Treaty of Waitangi obligations within the framework of the NZPHD Act and is consistent with the directions outlined in the national Māori Health Plan, *He Korowai Oranga,* with the national Māori Health Strategy *Te Korowai Oranga*.
- The DHB's Board signed a formal Memorandum of Understanding with Manawhenua Ki Waitaha in March of 2008. This agreement aims to establish a clear relationship between the two groups and to improve Māori input into the planning and development of health and disability services in Canterbury.
- An Ethnicity Data Collection Project was introduced with the aim of improving the accuracy of ethnicity data collection. The Project focused on updating codes for all patients coded as Not Stated or Other and raising the awareness of the importance of accurate ethnicity code collection. Over 2,000 patients who previously had the codes Not Stated or Other have had their codes updated.
- Collaboration around strategies that promote healthy nutrition and increased physical activity for Māori through community-based projects have been a successful focus including: Kaikoura's Positive Vibration (focusing on overweight children) and the Hundie Club (focusing on overweight/obese adults). Training of Māori health workers in breastfeeding and nutrition issues has also been positive in ensuring that front line workers are providing consistent HEHA messages.
- Smokefree lifestyles have been promoted to improve Māori health status through Auahi Kore initiatives and the Aukati Kai Paipa programme. The Auahi Kore and Aukati Kai Paipa both use a social marketing emphasis recognising local champions to promote and reinforce smokefree lifestyles. There is also an emphasis on Marae with three Marae in Canterbury now smokefree. Aukati Kai Paipa achieved a quit rate of 20% over the past year.
- Support has continued to be provided to improve Māori provider capacity and capability through the Māori Provider Development Scheme (MPDS). The DHB has worked closely with the Ministry to disseminate funds according to the MPDS framework. Ten contracted Māori providers were funded through MPDS in 2007/08 and quality improvement remains a priority for successful funding.

[34] *The DHB's Māori Health Plan can be found on its website, www.cdhb.govt.nz.*

Next Steps in 2008/09:				
WHAT	**HOW**		**WHEN**	**WHO**
Key Priorities	**Approach**	**Outputs for 2008/2009**	**Quarter**	**Lead**
Support Māori participation in the development of health and disability services and work together to improve Māori Health.	Implement the DHB's MoU and support governance relationship mechanisms with Manawhenua Ki Waitaha.	Meetings are regularly held with Manawhenua Ki Waitaha and reports are provided quarterly.	Q1	ED M&P
		Terms of Reference are developed for Māori engagement with the DHB Board.	Q4	
	Expand the Board's understanding how Māori views and values can impact on the governance role.	Treaty of Waitangi training is provided.	Q2	ED M&P GM CS
		A mechanism is developed to demonstrate consultation with Māori for key strategies approved by the Board.	Q2	
Implement the DHB's Māori Health Plan to improve utilisation of health and disability services and to improve overall health outcomes for Māori.	Prioritise health status monitoring, disease prevention and disease management in priority areas.	Ethnicity data is provided against wait-times for radiation oncology treatment.	Q2-Q3	GM MS
		All five PHOs develop Māori Health Plans, which are approved by the DHB.	Q2	ED M&P GM P&F PHOs
		PHOs demonstrate progress in implementing their Māori Health Plans.	Q2	
		Diabetes annual check rates are improved and the gap between Māori rates and total rates is reduced.	Q4	GM P&F
	Identify Māori-led community initiatives which contribute to Whanau Ora.	Māori-led smoking cessation programmes are supported and the number of smokefree Marae is increased.	Q1-Q4	GM CPH
		Through the HEHA framework support is provided to Māori-led initiatives to improve nutrition and physical activity.	Q1-Q4	GM P&F
	Develop Māori health policy and quality frameworks.	A business case is completed for a DHB Māori Health Directorate to focus specifically on Māori health and the reduction of inequalities in health status.	Q1	ED M&P
		DHB Māori Health Directorate established.	Q4	
	Support Māori provider and workforce development.	Support continued to be provided to allocate Māori and Pacific Provider Development Funding with quality improvement as a focus.	Q1-Q4	GM P&F
		Support continues to be provided for cultural training and support for DHB staff.	Q1-Q4	ED M&P
	Promote health as a career for Māori.	A specialist recruitment service is established in Canterbury based on the service successfully piloted in 2006/07.	Q1-Q2	ED M&P GM P&F
		A road-show is taken to Canterbury schools encouraging health as a career with supporting resource materials also available.	Q2-Q4	
		Scholarships for study in primary health are allocated to 10 students in the 2008/09 year.	Q1-Q4	

6.1.4 Primary Health Services

Long-Term Goal – Where do we want to be?

The Canterbury DHB aims to demonstrate that the number of people accessing primary health services in Canterbury is increasing, particularly those people with high needs and those on lower incomes. The DHB also aims to be able to demonstrate improvements in the range and effectiveness of services provided in primary care settings.

Reducing Ambulatory Sensitive (avoidable) Hospital Admissions is a national priority and a Ministry Health Target.

What are the Challenges – What will we do to succeed?

Primary care is often the first point of contact with health services and reducing barriers to access helps people stay well. Costs are a key barrier to access for some people and hospitalisation rates for people on lower incomes are higher than the Canterbury average. The DHB will need to work closely with PHOs to reduce access barriers to primary care and will work to support innovative models of care for high-need population groups including Māori, Pacific and those in lower socio-economic groups.

The implementation of the national Primary Care Strategy will continue to be a priority to enhance the population's health by improving access to primary care and public health programmes designed to meet local needs and to reduce inequalities in access and in health status. The DHB will support PHOs to enhance services to manage long-term conditions and to improve services and develop integrated pathways of care in priorities areas including Māori Health, Diabetes and Respiratory Disease. The DHB will also work closely with the primary care sector in the management of acute demand and the provision of after hours services.

Many people experience episodes of mental illness, such as depression, anxiety, and stress disorders which can be managed in a primary rather than a hospital setting. General Practitioners may often be in a position to treat some of these issues, through early intervention treatments. The DHB will need to work to encourage and enable innovative, appropriate and effective means of treating mental illness in the primary care setting (refer to section 8.1.2).

There are more pharmacy prescriptions dispensed per person in Canterbury than the national average, for all age groups except those over 65 years. Strategies for optimising the effectiveness of community pharmaceutical and laboratory expenditure will need to be developed in collaboration with the primary and community sector to ensure long-term sustainability and to reduce wastage. During the coming year the DHB will work with local Pharmacies through the Pharmacy Guild to identify opportunities for service integration and to minimise financial barriers to pharmaceutical collections.

While there are many opportunities for the DHB to work with PHOs to improve access to, and effectiveness of, services the DHB must be conscious that increased expectation on the primary sector has resulted in the workforce becoming stretched in some areas. Recruitment into the general practice profession is currently slower than the retirement rate. The DHB will need to support sustainable workforce and education plans developed collaboratively with primary care providers. A stable rural health workforce is a particular focus.

Actions and Success to Date:

- Implementation of a variety of new primary care based services by PHOs, with a focus on support services for enrolled populations including: primary mental health services, child health liaison workers and chronic care management and an increased focus by PHOs on the area of health promotion and in implementing services to improve access. All PHOs in Canterbury are implementing specific plans to improve health promotion and provide services to improve access.
- PHO subsidy funding rollouts continued. It now costs, on average, $30 for a 25-44 year-old to attend general practice in Canterbury. The rollout also reduced pharmacy prescriptions for this age group. 46 practices in Canterbury also took advantage of additional funding to reduce general practice visits to free, for under 6's.
- Māori Health Plans were approved for three PHOs with the remaining two having Plans in draft. The Plans focus on particular initiatives to target enrolled Māori populations.
- Completion of a collaborative After Hours Direction Paper, with implementation of the recommendations beginning in 2007/08 (refer to section 5.3).
- Introduction of a variety of community-based Acute Demand Services beginning in 2007, with a focus on providing services to people in the community to prevent unnecessary hospital admissions. The contracts for these services are being delivered through the PHOs.
- Successful implementation of the Medicines Use Review within community pharmacy and transitioning of Clozapine Services from hospital to community dispensing with support from HSS Mental Health Services.

Next Steps in 2008/09:				
WHAT	**HOW**		**WHEN**	**WHO**
Key Priorities	**Approach**	**Outputs for 2008/2009**	**Quarter**	**Lead**
Support the provision of accessible primary care services that meet the needs of the Canterbury population.	Work with PHOs to support the implementation of the national Primary Care Strategy and to reduce inequalities in access to, and utilisation of, primary care services.	All PHOs have approved Services to Improve Access and Health Promotion Plans aligned to the DHBs key priority areas.	Q2	GM P&F
		All PHOs have approved Māori Health Plans in place and implementation is underway.	Q2	GM P&F ED M&P
		All PHOs have Performance Management Programme targets established and are moving towards achieving these targets. [35]	Q3 Q4	GM P&F PHOs
		PHO enrolment is maintained at over 95% of the Canterbury population with Māori enrolment rates increasing.	Q4	
Improve the primary and secondary interface to support an integrated continuum of care.	Support data sharing systems and extension of the Clinical Information Portal to improve care continuums and reduce wastage and duplication.	Timely and accurate discharge summaries from secondary to primary care are facilitated.	Q3-Q4	GM CS GM P&F
		Opportunities to improve the sharing of laboratory data are identified and facilitated.	Q3-Q4	
	Work with PHOs to develop pathways to improve the patient journey.	The Acute Demand Programme is implemented (refer to section 5.3).	Q1-Q4	GM P&F PHOs
		The Framework for Managing Long-term Conditions is implemented (refer to 5.4).	Q1-Q4	
		Joint primary/secondary pathways are established to improve the management of respiratory disease (refer to 6.2.4).	Q1-Q4	
		Joint primary/secondary pathways are established to improve the elective services referrals process (refer to 5.6).	Q1-Q4	
Establish a clear direction for the future of community pharmacy in Canterbury.	Collaborate with community pharmacy and PHOs to produce a Direction Paper looking at future funding models, service development and information sharing.	Community Pharmacy Direction Paper completed and signed-off by the Board.	Q3	GM P&F
		Implementation plan completed and recommendations undertaken.	Q4	
Improve National Health Index (NHI) recording on pharmacy prescriptions.	Undertake a project to identify the key areas where NHIs are not being recorded and develop an education programme to improve recording.	Analysis undertaken to determine where and why NHIs are not being recorded.	Q1	GM P&F CMO
		Actions to improve NHI recording defined.	Q2	
		National quality target of NHI recorded on 95% of prescriptions is reached.	Q4	

[35] *The PHO Performance Management Programme is a national programme which aims to improve the health of PHO enrolled populations and reduce disparities in health outcomes through supporting and incentivising continuous quality improvement processes. PHOs are eligible to receive performance payments as they improve their performance against indicators and targets. There are three categorises of indicators: clinical indicators (i.e. flu vaccinations, childhood immunisations); process/capacity indicators (i.e. access for high needs enrolees; and financial indicators (i.e. pharmaceutical and laboratory expenditure).*

6.1.5 Disease Prevention and Management

Long-Term Goal – Where do we want to be?

The Canterbury DHB aims to demonstrate that its community is enabled to make healthy choices through supportive physical, social, economic and policy environments that provides a greater commitment to improved health and wellbeing.

Improving nutrition, increasing physical activity and reducing obesity along with reducing the harm from tobacco are national priorities and key indicators around fruit and vegetable consumption and smoking cessation are Health Target for DHBs.

What are the Challenges – What will we do to succeed?

Long-term conditions including cancer, cardiovascular disease, diabetes and respiratory disease share common risk factors. Tobacco smoking, for example, contributes to a number of preventable illnesses resulting in a large burden of disease and is the single major cause of preventable death, however inactivity, poor nutrition and rising obesity rates also becoming major contributors. The impact of alcohol on our population's health is also widely recognised and minimising the harm caused by alcohol and other drugs is one of the 13 population health objectives of the New Zealand Health Strategy.

Healthy Eating, Healthy Activity (HEHA)

Current trends indicate that by 2011, 29% of our adult population will be obese. This has significant implications for rates of cardiovascular disease, diabetes, respiratory disease and some cancers as well as poor psychosocial outcomes and reduced life expectancy.

The HEHA Strategy is the national approach to improving nutrition, increasing physical activity and achieving healthy weight for all New Zealanders. In 2007/08 the Canterbury DHB received Ministry approval for its local HEHA Action Plan (Ministry Approved Plan or MAP) and began implementation of that MAP. The DHB is committed to its leadership role in HEHA and will continue to work across a number of key settings to build on existing services, strengthen foundations and ensure a collaborative approach to improving health and lifestyles.

Tobacco Control

In addition to the high public cost of treating tobacco related disease, tobacco and poverty are inextricably linked. In some communities, a sizeable portion of household income is spend on tobacco, resulting in less money being available for basic items such as food, education and health. Tobacco control remains the foremost opportunity to rapidly reduce inequalities and improve Māori health.

The DHB identified reducing the prevalence of smoking as a priority in 2004, prioritising smoke free environments and improved access to smoking cessation services, aiming to reducing the number of people smoking in Canterbury to 15% or less by 2010. Generally tobacco control activity in Canterbury has followed these priorities and actions however, progress has been slower and less focused than desired.

The DHB intends to renew its commitment and focus to reducing the harm caused by tobacco and has begun the development of an updated Tobacco Control Action Plan, lead by the DHB's Public Health division in collaboration with Planning and Funding division, PHOs and community organisations.

The initial development of the Plan has identified the following priority populations and environments for focus: Māori (especially young women), primary health care practitioner involvement in cessation advice, pregnant women and women of child bearing age, patients receiving secondary and tertiary health care, children and young people (especially those with parents who smoke), homes and cars and mental health consumers.

The good news is that tobacco smoking, poor nutrition and inactivity and alcohol misuse use are modifiable risk factors. The DHB will focus on population and personal health programmes that target improved nutrition and physical activity and reduced obesity and will promote programmes that reduce the uptake of smoking and increase quit levels, particularly amongst high risk groups. The DHB will also work collaboratively to minimise alcohol-related harm in Canterbury.

The foundations for good health are established early in life and the DHB will be focusing effort on promoting breastfeeding and on supporting smokefree homes to encourage this 'good start'.

Actions and Success to Date:

- 20 successful applications for the 1st round of the HEHA Nutrition Fund from 32 schools and Early Childhood Centres (ECCs) in Canterbury. This Fund is for projects which focus on implementing the Ministry of Education's Food and Nutrition Guidelines. All schools and ECCs receiving funding must also be working in a Health Promoting Schools Framework.
- More than 50 practice nurses or community support workers have been trained to facilitate Appetite for Life programmes in Canterbury. with. This ongoing training with support from dieticians and nutritionists will enable us

to ensure consistent HEHA messages are being delivered to the community. The Appetite for life course is a 6-week programme focused on helping women overcome barriers to adopting healthy behaviours, and aims to provide them with the skills, knowledge and confidence to make positive sustainable changes to their food choices and activity levels. More than a dozen, well attended courses, have already been delivered.

- In April 2004 the DHB commenced implementation of its Smokefree Policy; supporting staff smoking cessation and smokefree sites. Staff are trained to managing patient smoking, nicotine replacement therapy is available, information and encouragement to stop smoking is provided and access to a community based smoking cessation support services is provided. A steady change in culture has been evident. Teams are increasingly supporting the establishment of smokefree systems in their areas and addressing those they see smoking on DHB sites. The number of staff seeking training in managing patients who smoke is steadily increasing.
- Approval has been given by the Christchurch City Council for the trial of smokefree children's playgrounds in the Hornby. A child is seven times more likely to take up smoking later in life if they are exposed to parental smoking and smokefree children's playgrounds aim to reduce the number of times children see adults smoking and therefore the chances of them taking it up in later life. The emphasis is on peer pressure and social change rather than a ban or a bylaw. It is hoped that the trial will lead to a city-wide policy that promotes smokefree children's playgrounds across Christchurch
- The Canterbury DHB was involved in the Community Violence Reduction Project (and associated Alcohol Accord) focused on Christchurch's central city. This included the 'One-way Door' pilot for late night trading. Early evaluation of the pilot is positive with some initial evidence of reduced inner-city violence.

Next Steps in 2008/09:

WHAT	**HOW**		**WHEN**	**WHO**
Key Priorities	**Approach**	**Outputs for 2008/2009**	**Quarter**	**Lead**
Develop Baby Friendly Communities to support increased breastfeeding rates.	Implement the DHB's Breastfeeding Action Plan (BAP) to support priorities to develop Baby Friendly Communities.	Breastfeeding Advocacy Service established to support the BAP priorities.	Q1	GM P&F
		Community-based peer support programmes increased.	Q1-Q4	
		Access to community-based Lactation Consultants improved.	Q2	
	Continue to promote breastfeeding within HSS neo-natal and child health services.	Continued commitment to HSS provision of lactation consultant services for new mothers needing additional assistance.	Q1-Q4	GM W&C HSS
		Consistent messages ensured through the provision of breastfeeding lectures and education to HSS child health staff.	Q1-Q4	
Improve nutrition awareness and increase fruit and vegetable intake. Increase physical activity levels and assist people to maintain a healthy weight.	Implement the DHB's HEHA MAP in key prioritised settings: Schools/Early Childhood Centres; Primary care/general practice settings; and Māori/Pacific communities.	Opportunities provided for an additional 10% of Canterbury schools and early childhood services to receive Nutrition Funding to support the implementation of national Nutrition Guidelines.	Q2 Q4	GM P&F
		Percentage of Health Promoting Schools in Canterbury increased to 33%.	Q4	
		Increased number of Appetite for Life courses delivered in primary care settings.	Q1-Q4	
		Consistent HEHA messages provided through the HEHA Communications Plan.	Q1-Q4	
		Community action projects identified and funded to empower and enable Māori and Pacific people to achieve HEHA goals.	Q2	
	Support workforce development to increase HEHA capability and capacity in the Canterbury district. Support quality and consistency in HEHA messages through Professional Development.	Capability and capacity in the Māori and Pacific activity and nutrition workforce increased through provision of a physical activity and nutrition and professional development training.	Q2-Q4	GM P&F
		Primary care capacity to deliver HEHA and lifestyle change messages enhanced through training practice nurses and community support workers to deliver the Appetite for Life programme.	Q2-Q4	GM P&F PHOs

	Work to identify and address gaps in service delivery that could hinder HEHA outcomes.	Further enhance services for at-risk children (overweight and obese).	Q2	GM P&F
	Work to develop linkages with the food industry in Canterbury to support HEHA outcomes.	Initiatives to promote and support the implementation of the Food and Beverage Classification System identified.	Q2-Q4	GM P&F
Reduce the harm caused by tobacco.	Implement the DHB's Tobacco Control Plan and deliver against the key actions in that plan: Reduce the uptake in smoking; Support increased quit attempts; and Ensure legislative compliance with the Smokefree Environments Act 1990.	Primary and secondary clinical champions are engaged to support smokefree activity.	Q1	GM CPH
		The coordination of Canterbury Smokefree Providers is supported.	Q1-Q4	
		Smokefree programmes within Canterbury PHOs are further developed and supported.	Q1-Q4	GM P&F
		Smoking initiation amongst young people is reduced by addressing smoking in families.	Q1-Q4	GM CPH
		A Canterbury regional Smoking Cessation Services Plan is developed.	Q2	
		Compliance with the Smokefree Act.	Q1-Q4	
	Promote smokefree lifestyles to the Māori community through Auahi Kore initiatives and the Aukati Kai Paipa programme, using the Marae as the focal point and engaging with key Māori figures in the Canterbury community.	Māori are engaged at Marae meetings and presented the impacts of cessation across generations with links to HEHA initiatives.	Q1-Q4	GM CPH
		One new urban Marae has a designated smoking area or is (ideally) smokefree.	Q4	
		Two Papatipu Rununga Marae have a designated smoking area or are (ideally) smokefree.	Q4	
Minimise the harm caused by alcohol.	Work intersectorally to support cultural changes around hazardous drinking.	Active contribution is made to the Community Violence Reduction Project to drive culture change around alcohol consumption.	Q1-Q4	GM CPH
	Ensure licensed premises comply with the Sale of Liquor Act.	Regular monitoring visits are undertaken to monitor compliance with the Sale of Liquor Act.	Q1-Q4	GM CPH
		Host Responsibility Training courses are conducted for bar managers and servers.	Q1-Q4	

6.2 Disease Priorities

6.2.1 Cancer

Long-Term Goal – Where do we want to be?

The Canterbury DHB aims to demonstrate improvements in the health status of Canterbury residents at risk of developing cancer and demonstrate that those people who have developed cancer are identified early through improved screening and diagnosis. The DHB also aims to provide those people who develop cancer with appropriate and timely treatment and support care.

Reducing the wait times for cancer treatment is also a national priority and a Ministry Health Target for DHBs.

What are the Challenges – What will we do to succeed?

Cancer is the second highest cause of death and a major cause of hospitalisation in NZ. While cancers attributable to tobacco smoking are expected to decline (with declining tobacco consumption), cancers related to poor diet, lack of physical activity and rising obesity levels are on the increase.

The DHB is committed to supporting lifestyle change to reduce risk factors. However a signification reduction in risk behaviours will take some time to affect and to demonstrate reduced cancer rates.

Systems that support service improvements are needed to allow for the early diagnosis of cancer and to reduce mortality rates, including improving screening and accessible primary based intervention and education. The DHB will continue to work with PHOs to maintain screening levels in primary care.

However, it is the diagnosis and treatment of cancer where the Canterbury DHB has the most direct influence. With newer technology available earlier diagnosis is possible and cancer mortality rates are falling; however demand for treatment is increasing.

Timely cancer treatment is important to improve outcomes and provide a better quality of life for those diagnosed with cancer. Unfortunately the increase in resources has not matched the increase in demand, leading to undesirable delays in treatment particularly for radiation treatment and chemotherapy. Studies show that delays are significantly worse for Māori. In seeking to reduce wait times the DHB needs to find solutions to capacity issues including facilities, equipment, processes and workforce. The DHB will also need to provide good support to ensure Māori and Pacific populations have opportunities for equitable access to services and outcomes and to understand where the inequalities are for these population groups.

The linear accelerator is the machine that provides radiation treatment. It is a high-energy x-ray treatment unit (megavoltage) that has to be built overseas specially to order and can take a significant time to install, including transportation to New Zealand and the building of lead-lined bunkers to house the machines. The linear accelerators have a limited economic lifespan before breakdowns and part replacements begin to heavily interfere with treatment provision. One of the Canterbury DHB's three existing machines is past its recommended lifespan and needs replacing.

The DHB will also look to ensure long-term capacity to meet increasing demand by seeking to install a fourth linear accelerator. At the same time the Canterbury DHB will consider capacity issues in relation to Inter-District Flows (people from outside the district coming for cancer treatment in Canterbury). The DHB will need to collaborate with other DHBs and plan on a regional basis to build long-term capability and capacity around cancer services.

Work has begun with other South Island DHBs, on implementing the Ministry's national Cancer Control Strategy and Action Plan at both a regional and a local level. This Strategy is the first phase in the development and implementation of a comprehensive and coordinated approach to reducing the burden of cancer through prevention, early detection, diagnosis and treatment, support and rehabilitation, palliative care, data collection and research.

The establishment of the Southern Cancer Network will also assist in regional collaboration and the DHB will support the development of a Regional Cancer Plan and a regional approach to reducing inequalities and making the most efficient use of the resources available within the South Island.

Actions and Success to Date:

- The Late Effects Assessment Programme (LEAP) and clinic for children and adolescents with cancer continues. More than 80% of young people with cancer survive and as they transition into adulthood many have chronic treatment-related conditions needing long-term care. The LEAP initiative is now in its second year of operation and it is now providing a regional South Island service with outreach clinics in Invercargill, Dunedin and Nelson.

Next Steps in 2008/09:				
WHAT	**HOW**		**WHEN**	**WHO**
Key Priorities	**Approach**	**Outputs for 2008/2009**	**Quarter**	**Lead**
Build the infrastructure and capacity to deliver timely cancer treatment. [36]	Work to ensure that DHB recruits and retains key staff to ensure timely delivery of radiation therapy.	Employment of up to four new graduates through the Radiation Therapy Graduate Programme.	Q1-Q4	GM MS GM P&F
		Options are explored for increasing workforce flexibility to increase current linear accelerator capacity and to develop a long-term workforce plan to back sustained capacity.	Q1-Q4	
		Employment of a Lung Cancer Coordinator to support a multidisciplinary focus.	Q1-Q2	
	Consider current process and systems to ensure opportunities for efficiencies are identified and realised.	Waiting time data provided on a monthly basis with exception notes where wait-times exceed recommendations - to target improvements.	Q1-Q4	GM MS
		Work to provide ethnicity data against wait-times.	Q2-Q3	
		Lean thinking processes are applied to internal processes including combined chemotherapy and radiation therapy patients, to improve the cancer pathway and reduce wait-times for patients.	Q1-Q4	
	Consider patient flow across the southern district to increase joint short-term capacity.	The capacity of South Island DHBs and Capital and Coast DHB identified to ensure equity of access and wait-times - with clarification around population catchments.	Q1-Q4	GM MS
		Initiatives to spread the treatment load and reduce treatment wait-times identified.	Q1-Q4	
	Initiate the process for the replacement of the the DHB's aged Linear Accelerator (T3) to ensure capacity to provide treatment.	Timeline is established for T3 replacement.	Q1-Q2	GM MS
		Risk assessment and contingency options are identified to manage capacity during down-time.	Q1-Q2	
		Business Case is developed for T3 replacement.	Q1-Q2	
		Business Case for replacement and loan facility submitted for Ministry approval.	Q2-Q3	
	Initiate the process for establishing a fourth, Linear Accelerator to sustain capacity.	Business Case is developed for establishment of fourth Linear Accelerator.	Q1-Q3	GM MS GM P&F
		Business Case for fourth Linear Accelerator and loan facility submitted for Ministry approval.	Q3-Q4	
Implement the national Cancer Control Strategy locally.	Develop a Canterbury DHB Cancer Action Plan to implement the national Strategy on a local level.	Key priorities for action identified through a Canterbury DHB stock-take.	Q1	GM P&F
		Cancer Action Plan approved by the Board	Q2	
		Progress on implementation of key priorities demonstrated in one year evaluation.	Q4	
	Work with the South Island DHB's and the Southern Region Cancer Network to establish a Regional Cancer Plan.	Southern Cancer Network 2008/09 work plan communicated to all stakeholders.	Q1-Q2	SCN
		Regional Cancer Plan signed-off by South Island DHBs with implementation underway.	Q4	
Implement the national HPV vaccination programme.[37]	Work with the Ministry to implement the national programme.	An implementation plan is in place to provide the HPV Vaccination Programme in Canterbury.	Q1-Q2	GM P&F

[36] *The DHB will endeavour to meet treatment targets through improved utilisation of current resources. However, significant changes in wait-times will not be realised until capacity is increased through secured staffing and additional linear accelerator capacity.*

[37] *This refers to Human Papillomavirus (HPV) Programme (funded nationally by the Ministry).*

6.2.2 Cardiovascular Disease

Long-Term Goal – Where do we want to be?

The Canterbury DHB aims to demonstrate improvements in the health status of Canterbury residents at risk of developing Cardiovascular Disease (CVD) and demonstrate a reduction in the incidence and the mortality rates attributed to CVD, particularly for Māori and Pacific groups.

Implementing CVD risk assessments in primary care is a key focus for the Ministry and will be introduced as a national Health Target once baseline data can be established.

What are the Challenges – What will we do to succeed?

CVD includes coronary heart disease, other disease of the heart, circulation and stroke. It is the main cause of death in Canterbury and the incidence of CVD is likely to increase as our population ages. Canterbury has a slightly higher percentage of older people than the national average and Canterbury's Māori and Pacific populations are also on the increase. Older people, Māori and Pacific people have higher rates of CVD.

CVD is usually linked with diabetes and is strongly influenced by lifestyle choice. As with other chronic conditions, healthy lifestyles leads to a decrease in risk factors and the DHB will promote physical activity, good nutrition, weight risk reduction and smoking cessation. The DHB will also need to collaborate with primary care providers to enable CVD assessment, risk management and early intervention for high-risk patients and the development of effective population-based heart health programmes.

Increasing rates of CVD will mean an increased need for more specialised care and treatment for heart attack, stroke, heart failure, and other circulatory diseases and the DHB will have to work to ensure it has the capacity to provide people waiting for surgery for CVD with treatment within appropriate timeframes.

A plan for minimising the effects of CVD on the Canterbury population was approved by the Board in 2004. This Plan, *Canterbury Heart Health Strategy*, highlighted the importance of population-based strategies for reducing the impact and incidence of CVD and the importance of improving rehabilitation and community treatment after acute heart events. Implementation of the recommendations of this Plan will continue to direct our focus over the next year. However the DHB's Strategic Framework for the Management Long-term Conditions will also place emphasis on integration and cross-sector collaboration to achieve improvements in service delivery and the patient journey for those with CVD.

Challenges include curbing and stabilising childhood obesity rates through community, school and early childhood centre programmes. Increased screening and risk assessment will be a focus with challenges around the sharing of data and information from this process and effective use of this information to target high needs groups. The DHB will also increase partnerships, collaborations and alliances across the health sector in order to develop future initiatives to reduce the risk of CVD and to ensure long-term capacity and capability in managing increased demand.

Actions and Success to Date:

- In the past year the DHB has trialled the home-based Heart Guide Aotearoa Programme and anecdotal feedback would suggest that this was a successful undertaking; particularly in terms of the increased collaboration between primary and secondary services. The DHB now awaits the outcomes of the national evaluation.
- The DHB also established an organised stroke services in the past year.

Next Steps in 2008/09:

WHAT	HOW		WHEN	WHO
Key Priorities	**Approach**	**Outputs for 2008/2009**	**Quarter**	**Lead**
Increase CVD risk assessment.	Work with PHOs to target populations most at risk of CVD and to provide CVD risk assessment.	Support PHOs to develop CVD Readiness Plans and mechanisms for sharing data on CVD risk assessment screening with the DHB.	Q1-Q4	GM P&F PHOs
Enhance rehabilitation services.	Support the continuum of care by enhancing community-based stroke rehabilitation services to support existing hospital-based stroke units.	Community stroke rehabilitation service established to compliment existing services.	Q2-Q3	GM OPH
		Redesign/realign the services provided and the location in which they are provided.	Q2-Q3	
		Increased patients are receiving stroke rehabilitation services in the community.	Q4	

6.2.3 Diabetes

Long-Term Goal – Where do we want to be?

The Canterbury DHB aims to demonstrate improvements in the health status of Canterbury residents at risk of developing diabetes. The DHB also aims to demonstrate that those people who have developed diabetes are identified and treated early through improved screening, and have the skills to enable good diabetes management.

Reducing the incidence and the impact of diabetes is also a national priority and a Ministry Health Target for DHBs.

What are the Challenges – What will we do to succeed?

Diabetes is estimated to cause around 1,200 deaths per year in NZ and can lead to blindness, heart disease and kidney failure. The impact of diabetes in terms of illness and the cost to the health sector is significant.

The incidence of diabetes is increasing at an estimated 4-5%, particular for Māori and Pacific people who are disproportionately represented in diabetes statistics with rates around three times higher than other New Zealanders. Type II diabetes, most frequently diagnosed in adults, is now more common in Canterbury's children and young people. While Type I continues to be priority, it is this increase in Type II diabetes, linked to poor nutrition and smoking, that is of greatest concern.

A mixture of population and personal health preventative initiatives are needed to reduce the incidence of diabetes. The DHB will need to promote healthy lifestyles including physical activity, good nutrition, weight reduction and smoking cessation to decrease the risk factors that contribute to diabetes.

The DHB will need to collaborate with the primary sector, community providers and Māori and Pacific communities to support population health promotion and diabetes education and also to enable early intervention and increase the uptake of diabetes services including annual diabetes reviews (checks) and regular retinal (eye) screening. [38]

Preventative interventions will need to be targeted at populations with the highest risk and populations where the long-term benefit is greatest i.e. during childhood, adolescence and early adulthood. Children and pregnant women with diabetes will be an additional focus for the DHB in 2008/09.

Improvements in intervention, quality of care and diabetes awareness and education will assist in enabling cost effective diabetes management in the primary sector with less need for specialist services referral and a reduction in the longer-term complications of diabetes such as amputations and renal failure.

Alongside the DHB and PHOs the Local Diabetes Team also works to promote improvements in diabetes outcomes. The Local Diabetes Team's membership is a representative group of health professionals, community providers and consumer representatives with a vested interest in improving diabetes services. The DHB will work more closely with Canterbury PHOs, community services and the Local Diabetes Team over the coming year to facilitate opportunities to improve diabetes outcomes in the Canterbury district.

A particular joint challenge for the Canterbury DHB, the Local Diabetes Team and Canterbury PHOs is making improvements in data collection and ensuring robust data is available to enable targeted service provision and improve the planning and funding of diabetes services.

Actions and Success to Date:

- Increased funding was provided to PHOs to progress coordinated community-based approaches to diabetes, to ensure equitable access to diabetes services and to promote timely intervention including the Diabetes High Risk Foot Podiatry Project run by Partnership Health PHO and coordinated through the DHB's Diabetes Centre. A total of 203 people with diabetes and high risk feet were referred to community podiatry in the past year.
- Completion of an additional 407 free annual diabetes checks by PHOs in Canterbury, a positive increase of 5% on the previous year.
- Successful facilitation and support of numerous education courses around diabetes, nutrition, insulin and smoking cessation for student nurses, practice nurses, community workers and general practitioners in Canterbury, promoting consistent messages and quality in practice.
- Delivery of the Appetite for Life courses which promote improved nutrition and weight management and Green Prescriptions promoting active lifestyles and increased physical activity. The DHB also signed off its HEHA Plan.
- Completion of an evaluation of the planning and funding of diabetes services in the district, involving the DHB's funder and provider arms, PHOs, the Local Diabetes Team and Māori diabetes service providers. This evaluation made a number of recommendations around opportunities to improve communication, shared planning and the robustness of diabetes data.

[38] *Annual diabetes reviews are provided by GPs with funding provided for one free check per person annually.*

Next Steps in 2008/09:				
WHAT	**HOW**		**WHEN**	**WHO**
Key Priorities	**Approach**	**Outputs for 2008/2009**	**Quarter**	**Lead**
Improve diabetes data, information collection and knowledge systems.	Work with PHOs and the Local Diabetes Team to establish an integrated system for collecting and sharing diabetes data and ensuring accurate results are available for the Canterbury district.	Quarterly PHO reporting of diabetes activity established - data sharing mechanisms support information quality.	Q2	PHOs
		Current data quality reviewed and a data process map completed to identify opportunities for improvement.	Q3	GM P&F PHOs
		An improved collective information sharing process is agreed and implemented.	Q3-Q4	
Establish a clear direction for the future of diabetes in Canterbury, supporting an inclusive approach to diabetes service delivery.	Work collectively to improve sector infrastructure and responsiveness and enable the development of new models of care and alternative pathways for diabetes that improve the patient journey.	Enhanced partnerships with local stakeholders ensure joint strategic planning, goals and targets.	Q1-Q2	GM P&F LDT PHOs GM MS
		Consultative systems instigated to engage people with diabetes in the development of diabetes pathways and evaluation of services.	Q2-Q4	
		Service and funding pathways are identified to improve the patient journey.	Q4	
		A collaborative Strategic Plan for Diabetes is developed to meet national and local priorities.	Q1-Q3	
		A framework is developed to monitor service delivery, expenditure and outcomes across primary and secondary care.	Q4	
Increase the uptake of free annual diabetes reviews (checks).	Work with PHOs and the Local Diabetes Team to improve the management of diabetes and to target populations most at risk of diabetes to improve equity for all population groups.	Work with the Local Diabetes Team to identify opportunities to raise awareness of the importance and availability of free annual diabetes checks.	Q1-Q4	GM P&F LDT
		A consumer consultation/survey is completed identifying issues and barriers to the uptake of free checks, feedback on current service delivery and recommendations for change.	Q1	GM P&F
		Opportunities are identified to improve the uptake of annual checks by Māori and Pacific people as high needs groups.	Q2-Q4	
		Diabetes workforce development for general practice teams is supported.	Q3-Q4	GM P&F PHOs
Increase access to community based diabetes services to enhance diabetes prevention and improve the management of diabetes as a long-term condition.	Working with PHOs and the Local Diabetes Team, support healthy lifestyles programmes to reduce the risk and impact of diabetes.	Opportunities to incorporate diabetes education alongside other healthy lifestyle messages are identified.	Q2-Q4	GM CPH
		Options for the expansion of healthy lifestyle supports for people with diabetes are included in the review of service pathways.	Q4	GM P&F
		Current screening options are reviewed to improve the capture of at risk people.	Q2-Q4	
	Working with PHOs and hospital specialist services establish community-based retinal screening to improve access for high need population groups.	A community-based retinal screening pilot is implemented.	Q3	GM P&F PHOs
		Pathways are established for data collection and information sharing.	Q3	
	Working with PHOs enhance community based Podiatry Services.	Support is given for continuation of the community-based podiatry service.	Q1-Q2	GM P&F PHOs
		Opportunities are explored to further develop these services.	Q2-Q4	

6.2.4 Respiratory Disease

Long-Term Goal – Where do we want to be?

The Canterbury DHB aims to demonstrate improvements in the health status of Canterbury residents at risk of respiratory disease and demonstrate that those people who have developed chronic respiratory disease have access to timely treatment and an improved quality of life.

What are the Challenges – What will we do to succeed?

Respiratory disease is recognised as one of the key current and developing chronic disease burdens associated with an ageing population. Up to 100,000 people may be affected by respiratory issues within the Canterbury population including chronic obstructive pulmonary disease, asthma and sleep disorders.

There are a number of external determinants that effect respiratory health over which the DHB does not have direct control (housing, heating and air quality). The DHB will work in collaboration with Territorial Local Authorities and the Regional Council in Canterbury to support improved air quality and address key external determinants of respiratory health. Healthy lifestyle promotion also affects respiratory health and decreases the risk factors and the DHB will continue to promote increased physical activity and smoking cessation.

However the major challenge for the DHB is the development of respiratory services across the full continuum of care and integration of services, around the patient, across community, primary and secondary services.

Chronic Obstructive Pulmonary Disease (COPD) has a substantial impact on the health of New Zealanders and affects an estimated 15% of the adult population. Based on hospital admission data, the prevalence of Māori with COPD is more than twice that of non-Māori. Very closely linked to the prevalence of smoking, improvements in early diagnosis and COPD management provide a major opportunity for the DHB to reduce inequalities and improve Māori health. The early diagnosis of COPD and the management of COPD in primary care settings can be improved through collaboration with primary and community providers and the DHB will work to enable improved self-management of respiratory conditions, raise awareness of the risk factors for COPD and to promote early diagnosis.

Sleep disorders are also a significant health problem in the Canterbury region it is estimated that between 5,000 and 20,000 people suffer from sleep-disordered breathing. Obstructive Sleep Apnoea (OSA) is the most common diagnosis and has been shown to increase long-term cardiovascular morbidity and mortality and can lead to acute presentation with decompensated cardio-respiratory failure requiring prolonged hospital admission and resulting in high short-term mortality. OSA is also a major risk factor for motor vehicle accidents. With rising levels of obesity the rising incidence of OSA is leading to increased demand on specialist sleep services throughout the country. Access to higher level specialist sleep studies can be improved, and management of access better supported, by completing screening studies in primary care.

There is significant opportunity for improving interaction and developing the respective roles of primary and secondary services to support people with respiratory conditions. This involves exploring the possibility of managing both chronic and acute issues within a primary care setting, supported by a flexible and responsive secondary service. This model (facilitated as a work stream under the governance of the DHB's Referrals Project) would enable secondary services to respond to supporting primary care while focusing on specialised interventions and complex cases.

To meet this challenge a degree of additional funding is required for an initial period to develop both primary and secondary services prior to achieving the anticipated health outcomes and financial gains associated with lowering avoidable hospital admissions, shortening hospital length of stay and making better use of outpatient clinic time. A series of initiatives have been identified that will build the capacity of primary care to respond to acute and chronic needs, improve the appropriateness of referrals and admissions to secondary care, provide a more flexible secondary care response and make the best use of specialist respiratory and sleep expertise. The linkages with existing initiatives within primary care, particularly those for acute demand and chronic disease management, will be further developed to ensure capability to manage people with respiratory conditions.

Actions and Success to Date:

- Two respiratory disease pilot projects were funded through PHOs 2007. These services, both community-based, were targeted at improving respiratory services in rural areas and developing a patient pathway from primary to secondary care and back again.
- Reviews of cardio-respiratory outreach services, sleep services and the primary secondary care continuum for respiratory services have been completed.

Next Steps in 2008/09:				
WHAT	**HOW**		**WHEN**	**WHO**
Key Priorities	**Approach**	**Outputs for 2008/2009**	**Quarter**	**Lead**
Improve the determinants which negatively affect respiratory health and reduce risk factors.	Support agencies to improve the social and living conditions of people with respiratory disease.	Collaboration with key parties and provision of advice supports the development of a Canterbury Warm Housing Pilot Project for people with respiratory disease.	Q2	GM CPH
	Support programmes that reduce the risk factors of respiratory disease.	HEHA initiatives are implemented (refer to section 6.1.5).	Q1-Q4	GM P&F
		Smokefree and Smoking Cessation initiatives are implemented (refer to section 6.1.5).	Q1-Q4	GM CPH
Improve the management of respiratory disease and support improved health outcomes for the Canterbury population.	Establish joint primary and secondary care arrangements to better manage the development of services for people with respiratory disease.	A clinical governance group is established involving primary and secondary care clinicians.	Q1	GM P&F GM MS PHOs
		A framework is developed to monitor service delivery, expenditure and outcomes across primary and secondary care.	Q1	
	Develop pathways/programmes to improve patient self management.	A programme is developed for educating general practice regarding self management.	Q1-Q4	
	Joint primary secondary development of pathways for CPOD.	Improved access to pulmonary rehabilitation and the establishment of community clinics.	Q2	
		A COPD Pathway is rolled-out.	Q4	
		Diagnosis of COPD is improved with increased access to community delivered spirometry.	Q4	
	Joint primary secondary development of pathways for sleep disorders.	Improved access to sleep studies.	Q4	
		Improved long-term management of people with sleep disorders.	Q4	
	Joint primary secondary development of pathways to improve access to specialist advice.	GP Liaisons are used to triage referrals for FSA and provide feedback to referring GPs.	Q1	
		Access to specialist advice is provided, not requiring outpatient visit.	Q4	
	Joint primary secondary development of pathways to improve the acute management of people with respiratory conditions.	The capacity of the acute demand service to respond to people with respiratory conditions is increased.	Q1-Q4	
		Community-based joint advanced nurse practice appointments are made.	Q1	
		Advance acute management plans are established as part of the COPD pathway.	Q3	

7. Core Directions – Building Foundations for Sustainable Change

This Chapter:

- Outlines what the DHB is trying to achieve in terms of its Core Directions;
- Summarises the progress already made in building foundations to enable change;
- Sets out the actions and outputs planned in the coming year to contribute to continued progress, both in terms of local and national priorities;
- Identifies new investment that will be made; and
- Identifies how the DHB will measure its improved performance.

Cost and demand pressures have been highlighted earlier in this document and managing these demands will be central to achieving the long-term goals and objectives outlined in the DHB's District Strategic Plan.

While managing its three roles in health (governance, funder and provider), DHBs face a number of challenges.

In its District Strategic Plan the Canterbury DHB identified these challenges as:

- Working with funding and financial pressures;
- Meeting increasing demand for services;
- Building workforce capacity;
- Reducing inequalities;
- Improving access to health care;
- Reducing the impact of lifestyle diseases;
- Addressing the health issues of an ageing population;
- Focusing on effective and quality services;
- Managing community and staff expectations;
- Increasing productivity in the provider-arm (HSS);
- Working with other South Island DHBs; and
- Developing infrastructure.

In the coming year the DHB will continue to address the challenges it faces that would otherwise hamper its long-term progress. Much of the activity under the DHB's Core Directions is planned to assist with addressing these barriers to success and over the past year work has already begun which will provide the foundations to enable a change in culture and practice and allow the DHB to create opportunities to change the way it funds and delivers health services in Canterbury.

The focus in 2008/09 will be on the way in which the DHB delivers and evaluates services and with the aim of doing things better within available resources and implementing changes in models of care and delivery to enable these improvements. Health Services Planning - looking at the picture of health in the community and the community's future needs, will be central as the DHB moves forward and improves the way in which it deliver services as will a close and collaborative partnership with the primary and community sectors.

The following section outlines the activity the DHB has planned under its Core Directions (that have not already been addressed under Section 5), looking primarily at address key challenges and building foundations to enable change.

7.1.1 Developing Information Services

Long-Term Goal – Where do we want to be?

The DHB aims to provide accurate and timely patient-focused information to better inform clinical decision-making and the future planning of health and disability services. The DHB also aims to ensure the stability of its technology infrastructure and to ensure best use can be made of systems to achieve shared outcomes.

What are the Challenges – What will we do to succeed?

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

In order to deliver these requirements and to ensure long-term sustainability, the DHB's information infrastructure requires continual updating. DHBs must work regionally and nationally to drive improvements in information technology and to ensure quality standards are met. Information Management is a national priority, with DHBs taking a collective approach to implementing the Government's Health Information Strategy NZ (HIS-NZ). Regional DHB workshops have determined a collective view of the strategic importance of the various Action Zones within the Strategy and the Canterbury DHB is committed to this collective approach to make best use of national resources.

Alongside the national commitment to the implementation of HIS-NZ the DHB has also established a local Information Services Strategic Plan (ISSP) which re-enforces the objectives outlined in national strategies and involves working closely with stakeholders to implement solutions that satisfy local clinical and business requirements.

For the Canterbury DHB this includes the development of a Clinical Information System which will assist in affecting changes in practice by providing integrated and timely information at the point of care. Clinically relevant information is currently stored in multiple systems, which are not integrated. Clinical staff move from patient to patient and need mobile, wireless access to patient data and information. The approach to these two problems is to provide an integrated view of the available information through static and mobile wireless terminals. The Clinical Information System is a portal which brings into one view the clinical information held on patients and allows the entry of new data in an organised way.

The Clinical Information System has been selected, configured and successfully piloted and the significant Rollout has commenced. This includes a focus on the implementation of E-Discharges (in line with Action Zone 6 of the national Strategy) which will allow for electronic discharge summaries to be sent to GPs electronically and will significantly improve primary/secondary integration. The DHB is committed to ensuring that the benefits of improved primary/secondary communications are realised and will continue to promote the use of the Clinical Information System to clinicians.

Local priorities also include the implementation of a single patient administration system. The DHB currently supports three different patient administration systems and one of those systems the *HOMER Patient Management System,* which is used in the DHB's acute hospital settings, is approaching 'end of life'. The system is designed in archaic computer language for which it is now very difficult to recruit and retain support staff. The DHB has begun a programme of work to replace this software and to move to one single system. Implementation will focus on 'best practice' processes and will look to enhance data quality both locally and for national collection. This is a significant undertaking and the initiative will take several years to complete.

The DHB is committed to identifying and pursing initiatives to improve the quality of data collection (Action Zone 2) and training within the DHB continues to emphasise the need for National Health Index (NHI) recording and ethnicity data quality. The DHB contributes to national collections where consistency and quality of data are essential and it is anticipated that the implementation of one patient administration system will also improve data quality.

The current South Island DHB Regional Health Network (DHBOO) is administered by the Canterbury DHB and is successfully carrying increased traffic and being used to connect all the South Island DHBs along with other significant healthcare agencies. Over the coming year the DHB will seek to move the DHBOO to a national health accredited network (Action Zone 1) to support continual progress.

Next Steps in 2008/09:				
WHAT	**HOW**		**WHEN**	**WHO**
Key Priorities	**Approach**	**Outputs for 2008/2009**	**Quarter**	**Lead**
Identify a single DHB wide Patient Management System (and associated clinical applications).	Patient information split across three separate patient administration systems will be integrated into one system across the DHB's facilities. Consideration will be given to wider coverage of an integrated system to community based providers i.e. primary care.	Project initiation complete to ensure a clear vision of where the project is going.	Q1-Q2	GM CS CMO
		Robust product selection process completed, ensuring that the needs of key stakeholders are met.	Q3-Q4	
		An Implementation Plan is developed.	Q4	
Complete the implementation of the HR and Payroll System and commence rollout of the Roster Functionality.	The DHB is implementing a HR and Payroll Information Systems. Enhanced Rostering functionality will also begin.	Payroll implementation completed.	Q2	GM HR
		Rostering application configuration completed.	Q3	EDON CMO
		Rostering Roll-out commenced.	Q4	
Complete the Rollout of the Clinical Information System. (Action Zone 6)	The Rollout of the Clinical Information System will continue across all DHB divisions.	Identify new product for outpatient letters.	Q1	CMO
		Configure and implement that product.	Q2	
		Rollout of the Clinical Information System progresses with 50% Rollout completed.	Q3	
		Clinical Information System Rollout is 100%.	Q4	
Integrate the Health Practitioner Index into the DHB's clinical and administration systems. (Action Zone 3).	The Health Practitioner Index is now available but considerable effort will be required to integrate this into DHB systems and into national reporting.	Implement the Health Practitioner Index into the local Practitioner index.	Q1	GM CS
		Gradually implement the Index into the DHB's local systems.	Q2-Q4	
		Integrate nationally with changes achieved by July 2009.	Q4	
Move the South Island DHB Regional Health Network (DHBOO) to a Health Accredited Network. (Action Zone 1)	The Canterbury DHB has been the initiator of the South Island DHB Regional Health Network. Now that health accredited networks are available we must move the DHBOO to one of these networks.	Identify a suitable Health Accredited Network for DHBOO.	Q2	GM CS
		Migrate to the Health Accredited Network.	Q4	

7.1.2 Developing our Health Workforce

Long-Term Goal – Where do we want to be?

The Canterbury DHB aims to make Canterbury a preferred district for health workers in NZ by supporting flexibility and innovation, providing leadership and skill development opportunities and by being a good employer. The DHB will also encourage its workforce to lead by example by supporting healthier lifestyles and practices.

What are the Challenges – What will we do to succeed?

In aiming to achieve these goals there are a number of specific challenges around workforce; primarily that in order to sustain and deliver services long-term the DHB needs to take a coordinated approach. The DHB must consider not only its own DHB staff but the workforce of Canterbury's health sector as a whole.

Four key challenges have been identified to ensure long-term workforce capability and capacity:

- To encourage a flexible approach to reflect the changing needs of the community;
- To develop a workforce providing the right skills for the best health outcomes;
- To ensure Canterbury's health sector is a 'good place to work'; and
- To create a safe and health-promoting environment to support and retain staff.

Inevitability staffing resource is the most complex area in which to improve capability and capacity. The Canterbury DHB has embraced moves towards national and regional recruitment initiatives to fill positions where there are international shortages and has moved towards more cost effective and internet based recruitment models.

Throughout this document the DHB has indicated a number of specific initiatives to address workforce shortages and increase flexibility around service provision and traditional roles. The DHB is committed to enhancing the coordination and strategic alignment of local workforce development activity and has developed a local HR Plan including a workforce planning component. The DHB will also continue to support and participate in the implementation of an enhanced HR Management System (HRMS) in 2008 and will work to enhance strategic workforce plans in line with the outcomes of the Health Services Planning programme in 2008/09.

The DHB's established approach to learning and development will continue. The DHB offers an extensive internal organisational development programme which encompasses the professional, organisational, leadership and cultural dimensions required of its workforce and the DHB is committed to this programme. The DHB will also continue to work closely with educational institutions and clinical training agencies to support a skills mix that will meet the needs of its community.

Over the past year the DHB has delivered a Leadership and Management Development Programme Xceler8 (through its Business Development Unit). The Xceler8 programme aims to empower DHB staff to participate in change and development and to take action to improve health outcomes by valuing their input and contributions.

In terms of the wider workforce the DHB supports training for primary care teams, community support workers and train-the-trainer programmes to extend the capability of Canterbury's health workforce and to ensure the quality of programmes being delivered in the community. Examples include supporting the training of facilitators to deliver Appetite for Life Courses in the community and providing peer-support breastfeeding programmes. This commitment also ensures consistency in terms of the messages being given to the Canterbury population.

The DHB seeks to provide a workplace that supports the retention of staff and will continue to identify areas of improvement and to ensure a rewarding and positive environment. The DHB is committed to developing a workplace profile and understanding the needs and expectations of its workforce. The DHB is also committed to being a 'good employer' in terms of leadership opportunities, a positive culture for the organisation, engagement with staff, harassment and bullying prevention and the provision of a safe and healthy environment.

Over the past year the DHB has participated in the ACC Partnership Programme Audit with secondary level status maintained. A staff Health and Wellbeing Day was hosted as part of the employee wellbeing programme, with identified aspects of the programme delivered in partnership with ACC injury prevention. The DHB also continued its successful staff influenza campaign and sought to encourage healthier lifestyles providing healthy food options in staff cafeterias and vending machines and providing smoke-free workplaces.

Next Steps in 2008/09:				
WHAT	**HOW**		**WHEN**	**WHO**
Key Priorities	**Approach**	**Outputs for 2008/2009**	**Quarter**	**Lead**
Encourage a flexible approach to reflect the changing needs of our community.	Undertake practical steps, within the control or influence of the organisation, to position the DHB to maximise its future workforce including working through partnership agreements with Unions.	Immediate and impending workforce shortages are identified and discussed at local levels.	Q2	GM HR
		Locally applicable strategies are in place to manage the shortages.	Q4	
		An enhanced relationship with Immigration NZ is established to help position the DHB in terms of incoming migrants and support with migration generally.	Q1-Q4	
		Appropriate workforce reporting capability is developed to enable ongoing monitoring of workforce metrics utilising the new HRIS.	Q1	
	Participate at a national and regional level in collaborative activity on workforce issues including remuneration setting	Participation in national and regional project groups and the supply information as required.	Q1-Q4	GM HR
Develop a workforce providing the right skills for the best health outcomes to ensure long-term capability and capacity.	Establish a recruitment strategy that is specific to addressing current and future workforce needs through a range of recruitment mediums.	A recruitment advertising process that delivers suitable candidate responses at a reduced overall cost is established.	Q1	GM HR
		A candidate friendly recruitment model that generates improved efficiency and delivers more effective selection outcomes and budget control is implemented.	Q1	
Ensure Canterbury's health sector is a 'good place to work'.	Understand and target workforce support towards promoting employee engagement in the workplace.	Particular reasons why people come to work at the DHB are identified and the ability to communicate this with other potential staff is realised.	Q1-Q4	GM HR
		Expectations created as part of the recruitment and induction process are realistic and can be delivered as part of normal DHB activity.	Q2-Q4	
		Particular reason why staff leave the DHB are better understood and opportunities are identified to promote retention.	Q1-Q4	
Create a safe and health-promoting environment to support and retain staff.	Adopt a behavioural change model to affect safety behaviour and practice in the workplace in an effort to further influence employee incident levels.	A behavioural change model is adopted to improve safe behaviours within DHB.	Q1	GM HR

7.1.3 Collaboration, Communication and Partnerships

Long-Term Goal – Where do we want to be?

The Canterbury DHB recognises that its goals and objectives will not be achieved through the DHB's efforts alone and aims to achieve its vision through establishing partnerships with other agencies and organisations, providers, DHBs, consumers and its community. Through such work the DHB can share resources, combine effort, provide consistency and work to influence the social detriments of health that are external to the health system to achieve the best health outcomes for the Canterbury population.

What are the Challenges – What will we do to succeed?

The social determinants of health have a major influence on health outcomes, yet most of the direct influence over these social determinants lies outside the health system. A 'whole of Government' approach recognises that many different arms of Government have an impact on health outcomes including justice, social development and education. The Local Government Act also signals that all parts of Government service are expected to work more closely in collaboration to improve health outcomes.

The Canterbury DHB will collaborate with Territorial Local Authorities and the Regional Council on shared goals for improving intersectoral activity and delivering quality health outcomes for the Canterbury population. This work will be informed by the councils' Long Term Council Community Plans, the Greater Christchurch Urban Development Strategy, shared health needs assessment and the DHB's health service planning programme and strategic planning. The DHB will also work alongside Territorial Local Authorities to encourage consideration of environmental design as a health determinant and recognition of the importance of urban design in promoting good health.

The DHB has worked with the Christchurch City Council on the development and launch of a planning resource 'Health Promotion and Sustainability through Environmental Design – a guide for planning'. This is guide is a resource tool and framework for urban planners, designers, policy analysts and developers involved in planning urban environments which should help plan a healthier, safer and more sustainable city. The DHB will continue to work with local councils to build capacity in developing and implementing healthy public policy and promoting the use of health impact assessment where appropriate.

The DHB will work with community agencies and organisations on a shared approach to the health of our community and will continue to support intersectoral initiatives such as Healthy Christchurch which recognises that all sectors and groups have a role to play in creating a healthy city, whether their specific focus is recreation, employment, youth, transport or any other aspect of city life.[39]

The DHB has signalled its increased focus on shared decision making and will maintain its commitment to a participation model. The DHB is committed to Māori participation at a governance level and will work to implement the Memorandum of Understanding signed with Manawhenua Ki Waitaha in the past year. The DHB will also maintain its commitment to the Quality and Patient Safety Council and the Clinical Board and looks forward to increased participation from these multidisciplinary advisory groups in setting the direction for the DHB and in helping to achieving the DHBs goals and objectives and improved health outcomes.

The DHB's commitment to patient centred models of care, the management of acute demand and implementation of a framework for managing long-term conditions requires active collaboration with primary and community health care providers and integrated partnerships. The DHB will be seeking to enhance those partnerships over the coming year to progress some of our key priorities and to improve patient pathways and continuums of care.

Collaboration around pandemic planning and key issues such as winter demand will continue, where the DHB addresses communication between health providers, access to services and support and transfer of care. This planning is evidence that a partnership approach to health service delivery is growing and the focus is increasingly on patient experiences, rather than individual 'silos' of care. The DHB is pleased to be part of a sense that by 'combining forces' it can address issues more effectively.

In the past year the DHB has also committed to a Memorandum of Understanding with the Canterbury Charity Hospital Trust to support a consultative and supportive relationship between the DHB and the Trust who have a mutual goal of enhancing healthcare for Canterbury's population.

Regional collaboration and combing forces will also enable the Canterbury DHB to improve continuums of care and work towards mutual goals and the DHB will be looking to share innovation and to learn from other DHBs success. The DHB is also committed to regional planning in terms of national programmes such as implementing the Cancer Control Strategy and will look to share resources and goals and to make the best use of limited funding.

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[39] *This group began as an initiative sponsored by the DHB, the CCC, Te Runanga O Ngai Tahu, He Oranga Pounamu, Pegasus Health, the Christchurch School of Medicine and the Ministry and now involves over 200 organisations who have signed the 'Healthy Christchurch Charter'. Information on Healthy Christchurch can be found at www.healthy.christchurch.org.nz*

At a national level the DHB will be looking to work with education and justice sectors to improve outcomes for the Canterbury population with HEHA initiatives and mental health programmes crossing the sectors in an effort to meet shared goals. The DHB is committed to a number of national programmes in the coming year which will improve the health of its community including B4 Schools Checks and Newborn Hearing Screening and will work closely with the Ministry of Health to implement these programmes.

Next Steps in 2008/09:				
WHAT	**HOW**		**WHEN**	**WHO**
Key Priorities	**Approach**	**Outputs for 2008/2009**	**Quarter**	**Lead**
Share responsibility for health outcomes and work in collaboration to achieve mutual goals of improved health and well-being for the Canterbury community.	Use a multi-agency approach (through the Healthy Christchurch forum) to develop a City Health Report and Plan.	Proposal for the City Health Report prepared in consultation with project partners and presented to Healthy Christchurch Steering Committee.	Q2	GM CPH
		Project Plan written, agreed with partners and approved by Committee.	Q3	
		Project underway.	Q4	
	Collaborate with community organisations to improve the health of the community.	Collaboration on implementing HEHA initiatives (refer to section 6.1.5).	Q1-Q4	GM P&F
		Collaboration on implementing Smokefree initiatives (section 6.1.5).		GM CPH
	Collaborate across sectors to improve continuums of care and build the patient focus.	Work collaboratively to manage acute demand (section 5.3).	Q1-Q4	GM P&F
		Work collaboratively to develop Patient Centred Models of Care (section 5.2).		GM MS GM RHS
		Work collaboratively to improve the referrals process and the patient journey for respiratory patients (section 6.2.4).		GM P&F
	Work regionally to make the best use of scarce resources.	Regional Cancer Plan development supported and aligned with local actions and objectives (section 6.2.1).	Q1-Q4	GM P&F
	Commit to national programmes to improve population health outcomes.	Ministry funded nationally screening programmes implemented (section 6.1.1).	Q1-Q4	GM P&F
		Achievement of National Health Targets (section 5.6).		All

8. Other Government Priorities

This Chapter:

- Outlines what the DHB is trying to achieve to meet Ministry expectations in areas beyond those identified as strategic priorities for Canterbury;
- Summarises the progress already made in those areas to improved health outcomes;
- Sets out the actions and outputs planned in the coming year to contribute to continued progress; and
- Identifies how the DHB will measure its improved performance.

The Canterbury DHB has a number of non-negotiable obligations and responsibilities under key national health strategies, the NZPHD Act, the Treaty of Waitangi, Crown Funding Agreement and as part of the Minister of Health's yearly and ongoing expectations and priorities.

The following section addresses the specific expectations that fall outside of the DHB's identified strategic priorities, but never-the-less reflects ongoing work which is of particular interest to the Ministry and the Canterbury community.

8.1.1 Disability Support and Rehabilitation Services

Long-Term Goal – Where do we want to be?

The DHB aims to support people with disabilities to access services and to participate in service development and will demonstrate improvements in the range and effectiveness of services provided to people with disabilities.

What are the Challenges – What will we do to succeed?

The Canterbury DHB has a Disability Strategy Action Plan 2004/2007 (*Action Plan for Disability*). This Plan sets out objectives and priorities for implementing the NZ Disability Strategy at a local level. In the past year the DHB has worked to understand its progress against implementing the principles of the national Strategy including:

- Surveying HSS divisions to outline the key areas of progress under the NZ Disability Strategy;
- Scoping a project to address issues pertaining to assessment and referral of children with disabilities; and
- Conducting a survey of consumers of DHB services to better understand how the services can best meet the needs of patients and consumers.

The DHB has also completed the building of several new facilities (Christchurch Women's Hospital, the Diabetes Centre and redevelopment of Burwood Hospital) which have offered the opportunity to upgrade service delivery in terms of the needs of people with disabilities through implementation of the DHB's Accessibility Plan.

In developing its Disability Action Plan, the Canterbury DHB recognises that it cannot address every barrier over night but can take a step by step approach to practical and attitudinal changes that will benefit everyone. The DHB views the NZ Disability Strategy as a 'whole of Government strategy' of which it forms only a part and the DHB will continue to work to achieve objectives in the areas its is able to influence.

The DHB's HSS Rehabilitation Services are located at Burwood Hospital and include: the Burwood spinal unit, musculoskeletal services, brain injury rehabilitation services, pain management services and orthopaedic rehabilitation. The Burwood Spinal Unit is one of only two such units in the country and treats 60% of New Zealand's spinal injury patients. The Spinal Unit is also involved in leading international research to help spinal patients rehabilitate and adjust.

The DHBs aim is to allow more flexible service provision to best meet the needs of patients with disabilities. Current services do not provide an integrated approach to the continuum of care for patients and the DHB's focus in the coming year will cover a number of key goals:

- Strengthen outpatient and community services;
- Improve education and support for carers working in the community;
- Redesign inpatient rehabilitation services to support changing needs;
- Improve integration and coordination across the continuum of care to provide a seamless transition for patients; and
- Share responsibilities across teams and professional groups to improve outcomes.

The DHB has completed the design for a model of care for the Brain Injury Service and commenced a significant strategic planning process for the Spinal continuum of care. These will be implemented in the coming year.

Next Steps in 2008/09:				
WHAT	**HOW**		**WHEN**	**WHO**
Key Priorities	**Approach**	**Outputs for 2008/2009**	**Quarter**	**Lead**
Progress with Stage 3 of the Burwood building programme to enhance rehabilitation services.	The DHB will ensure further areas of development are planned to be continued in a staged way and that this work aligns with health services planning and facilities/site master planning work.	Scoping for Business Case is complete for key areas of development (building) on the Burwood site.	Q2	GM OPH&R GM CS
		Business Case is developed.	Q3	
Implement the model of care for Brain Injury Services (Neuro Rehabilitation) outpatient services phase).[40]	Current services will be refocused to provide an integrated approach to the continuum of care for patients across the DHB.	Agreement is reached that allows a patient flow between services and into the community that is streamlined and transparent.	Q1	GM OPH&R GM P&F
		Flexible funding packages that span the continuum of care are developed and implemented.	Q3	
		Reduced length of stay for these patients.	Q4	
Implement the model of care for the Spinal continuum.	Strategies to improve the patient journey and move patients into the community are implemented with transitional living models developed to support patients returning to independence.	A transitional model of care is agreed and implemented.	Q1	GM OPH&R
		Support groups are fully engaged and support the direction.	Q1	
		A collaborative approach around transitional living is developed and implemented.	Q2	

[40] *The proposed model is guided by the ACC Traumatic Brain Injury Guidelines, the NZ Stroke Guidelines and the Australasian Faculty of Rehabilitation Medicine Standards.*

8.1.2 Mental Health and Addiction Services

Long-Term Goal – Where do we want to be?

The DHB aims to improve access to mental health services by focusing on increasing capacity and improving access to specialist treatment, improving flexibility in mental health service delivery and providing increased community based services for those most at risk and in need. The DHB also aims to work with PHOs to develop primary mental health services and support for people affected by mild-moderate mental illness and addictions.

Improving mental health services is also a national priority and a Ministry Health Target for DHBs.

What are the Challenges – What will we do to succeed?

In 2004 the DHB's Mental Health and Addictions Strategy was completed and provided a local framework for managing access to, and delivery of, a 'System of Care' model based on advancing recovery for people with serious mental illness. This marked a shift away from tertiary and secondary services towards community-based care with increased collaboration between providers, service users and their families/whanau.

Over the last two years $4.4M additional funding has been invested in the mental health sector. The majority of this additional funding has gone to the NGO sector and has greatly expanded the range of community-based services available to those in our population with serious mental illness. The additional funding has provided a platform from which the sector can address issues such as how to improve access and ensure services are responsive to the needs of service users (Appendix 5 sets out 2008/09 Blueprint Funding Allocations).

However simplifying access pathways to services for consumers and enabling providers to provide flexible service options, while working within the nationwide service framework, is still a key challenge for the Canterbury mental health sector. This will be improved through the number of sector forums and initiatives that exist to support inter and intra sectoral development.

The DHB will also need to undertake an examination of the current range and mix of mental health services in Canterbury and critically reflect on whether this reflects the needs of the modern mental health sector. The first part of the sector to be reviewed in 2008/09 is psychiatric rehabilitation services.

Actions and Success to Date:

- Development of Mental Health Database which includes collection and analysis of detailed service activity data by unique individual, by service area. Consistent with PRIMHeD requirements this information has lead to quite dramatic changes in service behaviour and greatly enhanced planning decisions.
- Continuation of ACCESS Canterbury with recent success including the development of GP Liaison Workers whose role it is to support people severely affected by mental illness in the primary care sector; development of information sheets for GPs explaining the role of Community Support Workers and joint workforce development planning.
- Participation in the Effective Interventions Watch House Pilot. The Ministry approached the DHB to participate in a programme designed to improve identification of serious mental health and alcohol and drug conditions in the police cells. This initiative has been warmly welcomed by HSS Mental Health Services and the Christchurch Police.
- Implementation of a joint initiative between the Canterbury DHB and Te Puni Kokiri to support Māori Mental Health Providers with organisational development.
- Implementation of a Single Point of Entry for Adult and Child and Youth Services and increased consult liaison services for primary care and NGO providers to provide support with and assessment and treatment for those clients that do not require case management within specialist mental health services. These initiatives are greatly improving access processes and relationships with referrers.
- Participation in the completion of the Regional Forensic Plan to guide service development and future investment in forensic services.

Next Steps in 2008/09:

WHAT	HOW		WHEN	WHO
Key Priorities	**Approach**	**Outputs for 2008/2009**	**Quarter**	**Lead**
Ensure that long-term clients have up-to-date relapse prevention plans.	The DHB will work collaboratively to contribute to a national and regional approach to providing comparative and consistent mental health services which meet the needs of the population.	Standardised definition for 'long-term' client agreed nationally.	Q1	MOH
		Regular reporting against the DHB definitions established with progress towards use of national definitions.	Q1	GM MH
		Awareness of the importance of this target and the provision of relapse plans	Q2-Q2	

		for all long-term clients is reiterated.		
		Services where performance is below target are identified and steps to ensure compliance are taken.	Q2-Q4	
		Audit of acute inpatient usage of HSS mental health services by long-term clients is undertaken.	Q4	
Continue to build relationships across the sector and improve the integration of mental health and addiction services in recognition of the total societal solution for the best possible outcomes.	The DHB will support participation of community, primary and secondary care services (and its Planning and Funding division) in mental health specific forums to reflect cross sector priorities and issues.	Monthly Mental Health Provider Forums.	Q1-Q4	GM MH Chief of Psychiatry GM P&F
		Continued support for VOICE, Canterbury Alcohol and Drug Managers Advisory Group and Te Korowai Hinengaro Oranga Ki Waitaha to support cross sector developments.		
		Introduction of cross-agency triage and discharge processes for residential service providers.	Q1-Q4	
		Review of Psychiatric Rehabilitation Services focused on access and activity across NGO and HSS sectors and comparison of services with current best practice models. Implementation focus on service improvement and reconfiguration of resources if required.	Q1-Q4	
		Explore a Single Point of Entry for Alcohol and Other Drug Services.	Q1-Q4	
	Continued participation in integrated contracting processes with the Ministry of Social Development.	Completion of two integrated funding agreements.	Q4	GM MH
	Continued participation in regular meetings with Disability Support Services to resolve cross sector issues.	Agreed process in place with Disability Support Services for discharge of patients whose needs are primarily related to a disability.	Q1-Q4	GM MH Chief of Psychiatry GM P&F
Improve the primary - secondary interface to improve access to services and responsiveness to community and consumer needs.	The DHB will continue to develop and foster relationships with primary care providers and organisations and improve the responsiveness of its HSS services to primary care providers to enable improved care for the population.	Expand Single Point of Entry services for Adult and Child and Youth services and increase referrals going to these services.	Q1-Q4	GM HSS Chief of Psychiatry
		Increased consult liaison consultations.	Q4	
		Decreased number of admissions being admitted to acute inpatient services.	Q4	
		Development and implementation of Service Level Agreements with PHOs.	Q2	GM MH
Continue to support and develop a sustainable, skilled and flexible workforce.	Encourage the growth of a culture of continuing professional development.	Continued investment in development, education and training through contracts for workforce development.	Q4	GM MH
		Process implemented to centralise the recruitment of nurses into HSS mental health services.	Q4	GM MH EDON
	Improve the planning, prioritisation and quality of training through effective use of current resources.	Establishment of a workforce development advisory group to oversee NGO planning/investment in training.	Q1	GM MH
		Increased professional development.	Q1-Q4	
		Roll-out introductory cognitive behavioural therapy training to registered mental health professionals.	Q2	GM MH GM P&F
	Continue to participate in relevant national mental health workforce development initiatives.	Continued participation in the Werry Centre Placement Project to assist with recruitment and retention in the Child and Youth Mental Health Sector.	Q4	GM MH EDoN

8.1.3 Reducing Inequalities

Long-Term Goal – Where do we want to be?

The DHB aims to better understand the gaps in health status at a population level and to accurately and effectively target resources to reduce those health inequalities as it funds and delivers public heath programmes and health and disability services across the Canterbury district.

What are the Challenges – What will we do to succeed?

Reducing inequalities is a priority for Government and the New Zealand Health Strategy acknowledges the need to address inequalities as 'a major priority requiring ongoing commitment across the sector'. The Canterbury DHB's 2004 Health Needs Assessment and performance against DHB performance indicators demonstrate that inequalities in health status exist between different population groups in the Canterbury district.

The DHB is committed to recognising the inequalities and raising awareness of them through increased measurement of utilisation and outcomes by ethnicity, age and deprivation levels. The DHB's public health division is collaborating with other agencies and community organisations to develop systems for collecting and analysing population-based data. The DHB will look to share that data to assist in planning future services by identifying unmet need and targeting funding at programmes and initiatives to reduce health inequalities.

The DHB has chosen three Strategic Priorities where disparities in health status exist: child and youth health, older people's health and Māori health .The DHB's Disease Priorities, Cancer, Cardiovascular Disease, Diabetes and Respiratory Disease are also key areas where disparities exist and the DHB anticipates that its focus on these areas will help to reduce the gaps in health outcomes between population groups.

Throughout this document the DHB has indicated under its strategic priorities where it will provide specific targeted programmes with the aim of reducing health inequalities. These include focusing on the provision of community-based services, patient centred services, services provided in people's own homes and access to specialist services in the community and at lower cost. The DHB will also support peer support groups, train-the-trainer programmes and training and assistance to build increased capability and capacity amongst community, Māori and Pacific providers.

The Canterbury DHB recognises the deprivation levels within its district and has worked with PHOs over the past two years to reduce the cost of accessing primary care services. The DHB has also concentrated its nutrition and physical activity initiatives in lower decile schools and early childhood centres.

The DHB recognises that Canterbury's Māori and Pacific populations are increasing and has committed to the development of a Māori Health Directorate to focus attention disparity in health status between Māori and other population groups and assist in closing that gap.

The DHB also recognises inequalities and inequity in Canterbury in terms of locality and began a Review of Rural Health Services and a Review of Ashburton Health Services in 2005. The DHB is currently working through the implementation of the Ashburton Integrated Model of Care to ensure that the community has sustainable access to quality services that are provide locally.

Actions and Success to Date:

- The application of the Health Equity Assessment Tool (HEAT) to the DHB's public health programmes (through Community and Public Health) along with the application of a Māori Health Outcomes Tool and the Equity Lens.
- Training courses delivered by Community and Public Health included a full-day health inequalities training session *Health Inequalities, Working Biculturally and Social Determinant of Health* and a course for staff working with non-mainstream patients *Working with Diverse Cultures and Beliefs and Working through an Interpreter*.
- The signing of a Memorandum of Understanding to formalise Māori participation in direction setting and long-term strategy to improve health outcomes for Māori. The DHB also has further expanded its Māori Health Team with the additional of a Māori Cultural Trainer to raise awareness of cultural issues and reduce barriers to accessing health services.
- Lifestyle education including the continued implementation of smoking cessation programmes targeting Māori and Pacific populations who have higher smoking rates and Marae-based smoking cessation. Several Canterbury Marae are now smoke-free.
- Increased focus on physical activity and nutrition for Māori and Pacific populations and lower decile schools and early childhood education centres. This has included a variety of HEHA, HEAL and Health Promoting Schools activities including delivery of the Fruit in Schools programme. This programme delivers a piece of fruit to each child on each school day of the year and is aimed at promoting positive health outcomes for children from low income families. Other health messages are promoted alongside the fruit including Sunsmart and Smokefree.

Next Steps in 2008/09:				
WHAT	**HOW**		**WHEN**	**WHO**
Key Priorities	**Approach**	**Outputs for 2008/2009**	**Quarter**	**Lead**
Improve the understanding and awareness of health inequalities in Canterbury.	Strengthen the public health capacity of community groups dealing with inequalities.	The Public Health Small Grants are allocated to community groups working with Māori, Pacific and low socio-economic groups.	Q1	GM CPH
		Ongoing health promotion and evaluation support is provided to Grant recipients.	Q1-Q4	
	Provide health inequality workshops and Jigsaw Introduction to Health Promotion Training to DHB staff, NGO and PHO staff and community providers and support the use of the HEAT tool.	One Health Inequality Workshop is delivered each quarter.	Q1-Q4	GM CPH
		Three Jigsaw programmes are delivered.	Q1-Q2	
		Use of the HEAT tool is promoted throughout divisions of the DHB.	Q1-Q4	
Support funding strategies to reduce inequalities.	Funding strategies are aligned to areas of need in the Canterbury district and promote a reduction in inequalities between population groups.	An updated Health Needs Assessment is delivered and used to review the DHB's Strategic Priorities.	Q2	GM P&F
		The DHB's Prioritisation Principles are reviewed and are used to consider new funding initiatives.	Q2-Q4	
Support service development strategies that provide alternative pathways to increase utilisation by high need and at risk population groups.	Promote the patient as the centre and work to provide services that best meet the needs of the patient.	Patient centred models of care that focus on pathways to meet patient needs are supported (refer to section 5.2).	Q1-Q4	GM MS
		The use of individualised care plan models for people with long term conditions is scoped (section 5.4).		GM P&F
		The implementation of joint primary secondary pathways to increase access and alternative care options is supported (section 6.2.4),		

9. Managing Financial Resources

This Chapter:

- Outlines the DHB's financial forecast position for the 2008/09 year and the two out-years beyond this: 2009/10 and 2010/2011.

9.1 Managing Within the Operating Budget

The Canterbury DHB will receive a funding increase of approximately $60M for 2008/09. Costs are forecast to increase by $82M. This leaves a funding shortfall of $22M in 2008/09 together with the shortfall carried forward from 2007/08 of $13M, giving a total of $35M to be filled by efficiencies or revenue enhancements. The 2008/09 forecast is summarised as follows:

	$M (GST excl)
Net Increase in Funding/Revenue (include non-Base)	59.706
Less	
Increase in Expenditure (external and CDHB Provider service)	(78.206)
Incremental Interest, Depreciation and Capital Charge	(3.500)
Estimated 2008/09 Operating Shortfall	(22.000)
Shortfall carried forwards from 2007/08	(13.000)
Gain on sale of surplus property	8.000
Required Annual Efficiencies/Revenue Enhancement	27.000
Budget Net Result after Efficiencies/Revenue Enhancement	0.000

Included in the forecast are the following key assumptions:

- Demographic and mental health blue print funding will be used to fund new services already committed. In the past, the DHB has increased the amount of services funded when it was not receiving demographic funding using one-off funding. The balance of any demographic funding after funding committed services is used to replace those one-off funding and new services have to be funded via reprioritisation of services;
- No additional costs will be incurred to deliver the objectives of the national QIC project;
- Cost to deliver additional elective surgery volumes will be within the funding received;
- The impact of new technologies will be funded from efficiencies;
- Employee cost increases will be at terms similar to the NZNO nurses MECA;
- External providers will receive funding increases similar to the base future funding track; and
- All other expenses increases will be at base future funding track

The financial pressure on the DHB as a result of wage settlements exceeding the future funding track in 2007/08 and 2008/09 means that the DHB has to seek additional efficiencies/revenue of $35M to achieve the 2008/09 break-even result. Sale of surplus property will contribute $8M but this is a 'one-off' funding which needs to be replaced by sustainable funding in future. The balance of $27M efficiencies/revenue will be achieved by a mixture of:

- Additional revenue from higher prices to match the impact of wage increases;
- Supply chain savings;
- Improving operational efficiencies and/or service reconfigurations; and
- Focusing on core activities/services.

9.2 Efficiencies and Service Reconfigurations

Included in the 2008/09 budgeted break-even results, are a number of efficiencies and/or service reconfigurations. These have been outlined earlier in this document. Examples of the initiatives to be undertaken include:

- Continued implementation of the DHB's Improving the Patient Journey Programme, patient centred models of care, the framework for managing long-term conditions, the Acute Demand Management Programme, respiratory pathways and the Referrals Project;
- Continued review and evaluation of employee cost control processes, nursing workforce costs, treatment-related costs, the costs of new technology and review of leave management and roster activity;
- Achievement of procurement/usage savings on clinical and non-clinical consumables;
- Improve collaborative arrangements with other DHBs and external providers and ongoing review of provider contracts, both internal and external; and
- Continued work around streamlining the patient journey through single points of entry and review of service delivery models and pathways.

In addition, gain on sale from the disposal of surplus assets, as approved by the Minister of Health, is an integral part of the efficiency target.

Some planned initiatives are not just to generate savings but to ensure that the DHB has sufficient staff/capacity to meet peak demands in the coming year; particularly with the increased leave entitlements recently awarded to staff. Some initiatives are longer term and are only expected to generate major savings in future years.

Initiatives will have input from clinicians, where appropriate, to ensure patient safety and related issues are adequately considered and factored in the decision making process.

9.3 Out-years Scenario

The DHB expects funding increases for out-years to be 4.3% for 2009/10 and 4.2% for 20010/11. The DHB has also assumed that it will contain total expenditure increases to be below that rate to compensate for the 2007/08 and 2008/09 years where expenditure increases exceeded the funding received. All assumptions carry risks, especially the assumptions for future wage increases. Some employment agreements already in place allow for wage increases inclusive of step progression, to be above the projected funding increase. Therefore, for the assumptions to be valid, the DHB has to ensure that some employment agreements will settle in the future at below the projected funding increase.

Should the DHB be unable to constrain cost increases to the projected funding increase, savings will be required to fund increased expenditure. The DHB may need to re-configure services and change how services are delivered to yield efficiencies. Ultimately, the DHB may need to reduce services so that it can operate within the funding received. The Health Services Planning Programme, currently underway, is expected to be completed by the end of 2008, with a view to completing a Facilities Master Plan. This project will also greatly assist the DHB to better understand where, what and how many services need to be provided in the future, thus providing the information needed by the DHB to assist it to operate within available funding while providing maximum health care to the population of Canterbury.

9.4 Asset Planning and Investment

9.4.1 Business Cases

The Canterbury DHB is planning to submit the following business cases:

- Replacement of the existing Linear Accelerator (T3) and installation of a fourth Linear Accelerator;
- Replacement of outdated Rostering System;
- Replacement/installation of the DHB's Patient Information System; and
- Replacement of Boilers in Christchurch Hospital.

The installation of the fourth Linear Accelerator is to enable the DHB to meet the radiotherapy waiting times target. In addition, as part of the Ministry's national Oral Health Strategy (Reform), the DHB had submitted a business case in 2007/08 to improve oral health services in Canterbury for children and adolescents. As these business cases have not been approved, their financial impact has not been included in the DHB's forecast.

9.4.2 Capital Expenditure

Assuming the DHB achieves break-even, the estimated capital expenditure budget for 2008/09 is $30M and will be primarily for normal asset replacement and priority new equipment. Detailed requirements, in terms of compliance with

recent Building Act changes, are yet to be finalised by Territorial Local Authorities and these may require some buildings to be rebuilt.[41]

As referred to previously, a Health Services Planning Programme is in progress. This project will guide the development of the DHB's Facilities Master Plan. The DHB is forecasting that the building replacement as part of that legislative compliance will take place after 2010/11. Several projects will require internal resourcing and prioritisation as well as regional and national prioritisation. Funding for these significant projects will be discussed with the Ministry when the full implications of legislative requirements are known.

9.5 Debt and Equity

The DHB's estimated total term debt is expected to be $88M as at June 2009. It is assumed that the available cashflow from depreciation funding will be applied to fund capital expenditure, thus deferring the need to increase loans until the major property rebuilding projects in out-years.

The current approved credit facility available through the Crown Health Financing Agency is approximately $130M. In addition, working capital of approximately $50M is financed from a private bank (Westpac).

While the DHB does not have any banking covenants required of its loans the forecast key financial ratios for the DHB would be as follows:

REQUIRED	FORECAST RATIO
Interest Cover Ratio:	Approx 9 times
Debt/Debt plus Equity Ratio:	Approx 25.7%
Shareholder Funds/Tangible Assets	Approx 46.6%

The DHB is not repaying equity and is instead retaining and investing the funds to meet future building replacement as indicated in Section 9.6.4.

9.6 Forecast Financial Statements - 2008/09 to 2010/11

The accounting policies adopted are consistent with those in the prior year. A full statement of accounting policies is an appendix to the DHB's 2008/11 Statement of Intent.

9.6.1 Forecast Group Statement Financial Performance

	2006/07 Draft $'000	2007/08 Forecast $'000	2008/09 Forecast $'000	2009/10 Forecast $'000	2010/11 Forecast $'000
Operating Revenue					
MoH Revenue	1,050,404	1,113,190	1,168,742	1,218,998	1,270,196
Patient Related Revenue	33,458	35,144	38,303	39,950	41,628
Other Revenue	27,296	28,279	35,886	28,703	29,534
Total Operating Revenue	1,111,158	1,176,613	1,242,931	1,287,651	1,341,358
Operating Expenditure					
Employee Costs	439,146	466,721	504,946	524,137	548,909
Treatment Related Costs	105,727	106,563	102,002	106,389	110,857
External Providers & IDF	433,074	482,631	497,076	516,450	538,142
Non Treatment Related & Other Costs	60,269	61,655	64,363	66,131	68,908
Total Operating Expenditure	1,038,216	1,117,570	1,168,388	1,213,107	1,266,816
Result before Interest, Depn & Cap Chrge	72,942	59,043	74,543	74,543	74,543
Interest, Depreciation & Capital Charge					
Interest Expense	(5,069)	(5,632)	(5,632)	(5,632)	(5,632)
Depreciation	(47,228)	(44,714)	(47,214)	(47,214)	(47,214)
Capital Charge Expenditure	(22,894)	(21,697)	(21,697)	(21,697)	(21,697)
Total Interest, Depreciation & Capital Charge	(75,191)	(72,043)	(74,543)	(74,543)	(74,543)
Net Operating Results	**(2,249)**	**(13,000)**	**0**	**0**	**(0)**

[41] *The timeframes for meeting the new Building Act requirements are yet to be determined by the Territorial Local Authorities. This is a national issue and not specific to the Canterbury DHB and, as such, is a significant issue for the Ministry.*

9.6.2 Summary of Revenue and Expenses by Output Class

Funding Arm

	2006/07 $'000	2007/08 $'000	2008/09 $'000	2009/10 $'000	2010/11 $'000
Revenue					
MoH revenue	1,008,495	1,070,848	1,125,958	1,174,373	1,223,698
Total Revenue	1,008,495	1,070,848	1,125,958	1,174,373	1,223,698
Expenditure					
Other - Personal Health	720,784	756,879	801,618	836,084	871,202
Other - Mental Health	109,158	116,804	122,869	128,153	133,535
Other - Disability Support	169,591	189,143	194,741	203,117	211,647
Other - Public Health	1,481	1,159	1,188	1,239	1,291
Other - Maori Health	1,081	1,358	1,392	1,452	1,513
Other - Governance & Admin	3,934	4,037	4,150	4,328	4,510
Total Expenditure	1,006,029	1,069,380	1,125,958	1,174,373	1,223,698
Net Surplus/(Deficit)	**2,466**	**1,468**	-	-	-

Governance & Funder Admin

	2006/07 $'000	2007/08 $'000	2008/09 $'000	2009/10 $'000	2010/11 $'000
Revenue					
MoH revenue	3,934	4,037	4,150	4,328	4,510
Total Revenue	3,934	4,037	4,150	4,328	4,510
Expenditure					
Personnel	2,642	2,781	2,859	2,982	3,107
Other	1,036	1,256	1,291	1,346	1,403
Total Expenditure	3,678	4,037	4,150	4,328	4,510
Net Surplus/(Deficit)	**256**	-	-	-	-

Provider Arm

	2006/07 $'000	2007/08 $'000	2008/09 $'000	2009/10 $'000	2010/11 $'000
Revenue					
MoH revenue	610,930	625,054	667,516	698,220	727,545
Patient Related Revenue	33,458	35,144	38,303	39,950	41,628
Other	27,296	28,279	35,886	28,703	29,534
Total Revenue	671,684	688,477	741,705	766,873	798,707
Expenditure					
Personnel	436,504	463,940	502,087	521,155	545,802
Depreciation	47,228	44,714	47,214	47,214	47,214
Interest & Capital charge	27,963	27,329	27,329	27,329	27,329
Other	164,960	166,962	165,075	171,175	178,362
Total Expenditure	676,655	702,945	741,705	766,873	798,707
Net Surplus/(Deficit)	**(4,971)**	**(14,468)**	-	-	-

In House Elimination

	2006/07 $'000	2007/08 $'000	2008/09 $'000	2009/10 $'000	2010/11 $'000
Revenue					
MoH revenue	(572,955)	(586,749)	(628,882)	(657,923)	(685,556)
Total Revenue	(572,955)	(586,749)	(628,882)	(657,923)	(685,556)
Expenditure					
Other	(572,955)	(586,749)	(628,882)	(657,923)	(685,556)
Total Expenditure	(572,955)	(586,749)	(628,882)	(657,923)	(685,556)
Net Surplus/(Deficit)	-	-	-	-	-

Consolidated

	2006/07 $'000	2007/08 $'000	2008/09 $'000	2009/10 $'000	2010/11 $'000
Revenue					
MoH revenue	1,050,404	1,113,190	1,168,742	1,218,998	1,270,197
Patient Related Revenue	33,458	35,144	38,303	39,950	41,628
Other	27,296	28,279	35,886	28,703	29,534
Total Revenue	1,111,158	1,176,613	1,242,931	1,287,651	1,341,359
Expenditure					
Personnel	439,146	466,721	504,946	524,137	548,909
Depreciation	47,228	44,714	47,214	47,214	47,214
Interest & Capital charge	27,963	27,329	27,329	27,329	27,329
Other	599,070	650,849	663,442	688,971	717,907
Total Expenditure	1,113,407	1,189,613	1,242,931	1,287,651	1,341,359
Net Surplus/(Deficit)	**(2,249)**	**(13,000)**	-	-	-

9.6.3 Forecast Group Statement Financial Position

	30/06/07 Draft $'000	30/06/08 Forecast $'000	30/06/09 Forecast $'000	30/06/10 Forecast $'000	30/06/11 Forecast $'000
Public Equity					
Opening Equity	287,326	268,142	253,281	253,281	253,282
Transition to IFRS	(15,074)				
Equity Repayment	(1,861)	(1,861)			
Net Result for the period	(2,249)	(13,000)	0	0	(0)
Total Public Equity	**268,142**	**253,281**	**253,281**	**253,282**	**253,281**
Current Assets					
Cash & Bank (OD)	50,633	43,712	48,716	50,931	53,144
MoH Debtor	8,854	9,000	9,000	9,000	9,000
Other Debtors & Other Receivables	14,386	16,000	16,000	16,000	16,000
Prepayments	658	800	800	800	800
Stocks	8,175	8,000	8,000	8,000	8,000
Total Current Assets	82,706	77,512	82,516	84,731	86,944
Current Liabilities					
Creditors & Accruals	74,264	70,000	70,000	70,000	70,000
Capital charge payable	13,852	5,425	5,425	5,425	5,425
GST	5,450	5,800	5,800	5,800	5,800
Interest Accrual	563	600	600	600	600
Staff Entitlement	100,545	102,000	102,000	102,000	102,000
Total Current Liabilities	194,674	183,825	183,825	183,825	183,825
Working Capital	(111,968)	(106,313)	(101,309)	(99,094)	(96,881)
Investments	11,689	11,170	26,170	41,170	46,170
Restricted Assets - Trust Fund	10,931	10,931	10,931	10,931	10,931
Fixed Assets	464,397	444,400	424,396	407,182	399,968
Total Non Current Assets	487,017	466,501	461,497	459,283	457,069
Term Staff Entitlement	(8,326)	(8,326)	(8,326)	(8,326)	(8,326)
Trust Funds Liabilities	(10,931)	(10,931)	(10,931)	(10,931)	(10,931)
Term Loans	(87,650)	(87,650)	(87,650)	(87,650)	(87,650)
Total Non Current Liabilities	(106,907)	(106,907)	(106,907)	(106,907)	(106,907)
Net Assets	**268,142**	**253,281**	**253,281**	**253,282**	**253,281**

9.6.4 Forecast Group Statement of Movement in Equity

	30/06/07 Draft $'000	30/06/08 Forecast $'000	30/06/09 Forecast $'000	30/06/10 Forecast $'000	30/06/11 Forecast $'000
Public Equity					
Opening Equity	287,326	268,142	253,281	253,281	253,282
Add/(Less):					
Equity Injection / (Repayment)	(1,861)	(1,861)	-	-	-
Revaluation of Property					
Transition to IFRS	(15,074)				
Net Result for the period	(2,249)	(13,000)	0	0	(0)
Total Public Equity	**268,142**	**253,281**	**253,281**	**253,282**	**253,281**

9.6.5 Forecast Group Statement Cashflow

	2006/07 Draft $'000	2007/08 Forecast $'000	2008/09 Forecast $'000	2009/10 Forecast $'000	2010/11 Forecast $'000
Cashflows from Operating Activities					
Cash provided from:					
MOH Receipts	1,051,140	1,113,044	1,168,742	1,218,998	1,270,196
Other Receipts	49,893	53,299	57,679	60,143	62,652
	1,101,033	1,166,343	1,226,421	1,279,141	1,332,848
Cash applied to:					
Employee Costs	424,411	465,266	504,946	524,137	548,909
Supplies & Expenses	593,859	655,080	663,442	688,970	717,907
Capital Charge Payments	12,780	30,124	21,697	21,697	21,697
Finance Costs	4,883	5,595	5,632	5,632	5,632
Taxes Paid	728	(350)	-	-	-
	1,036,661	1,155,715	1,195,717	1,240,436	1,294,145
Net Cashflow from Operating Activities	**64,372**	**10,628**	**30,704**	**38,704**	**38,704**
Cashflows from Investing Activities					
Cash provided from:					
Sale of Assets	11,315	519	10,790	-	-
Interest Received	5,146	8,510	8,510	8,510	8,510
	16,461	9,029	19,300	8,510	8,510
Cash applied to:					
Advance to JV/Trust Investments	11,304	-	15,000	15,000	5,000
Purchase of Assets	38,873	24,717	30,000	30,000	40,000
	50,177	24,717	45,000	45,000	45,000
Net Cashflow from Investing Activities	**(33,716)**	**(15,688)**	**(25,700)**	**(36,490)**	**(36,490)**
Cashflows from Financing Activities					
Cash provide from:					
Equity Injection					
Loans Raised	9,000	-	-	-	-
	9,000	-	-	-	-
Cash applied to:					
Loan Repayment					
Equity Repayment re FRS-3	1,861	1,861	-	-	-
	1,861	1,861	-	-	-
Net Cashflow from Financing Activities	**7,139**	**(1,861)**	**-**	**-**	**-**
Overall Increase/(Decrease) in Cash Held	37,795	(6,921)	5,004	2,214	2,214
Add Opening Cash Balance	12,838	50,633	43,712	48,716	50,931
Closing Cash Balance	**50,633**	**43,712**	**48,716**	**50,931**	**53,144**

10. Assumptions and Risks

This Chapter:

- Outlines the key risks for the DHB in the coming year and the strategies that the DHB has to mitigate these risks;
- Summarises the major service changes that are expected over 2008/09 and beyond;
- Outlines the assumptions the DHB has made in preparing its District Annual Plan and forecasting its financial position.

10.1 Key Risks and Mitigation Strategies

The complex nature of a DHB's activity and responsibilities exposes the organisation to a variety of risks. Broadly speaking, the DHB faces three types of risk: internal risks which can be managed directly by the DHB; risks to services run by contracted providers where the DHB must work with the providers to minimise risks; and external or environmental risks that are faced across the district or by the DHB sector as a whole. The DHB can only manage these external risks by working jointly with the primary and community sectors, Government agencies, other DHBs and with the Ministry.

The Canterbury DHB has adopted an organisation-wide approach to risk management and risk reporting, which deals with all potential areas of risks, including clinical, operational, financial and organisational for all services funded by the DHB. A comprehensive risk management process has been developed to identify and track the treatment of these risks.

Major risks are regularly reported to the management teams including: the Board's advisory committees (the Finance, Audit and Risk Committee and the Hospital Advisory Committee), the DHB's Clinical Board, Chief Executive, the Executive Management Team, HSS General Managers and corporate quality teams.

The risk management system accords with the guidelines in the current Australian and NZ Standard: Risk Management AS/NA 4360:2004 and with the DHB's obligations under the Ministry's Operational Policy Framework.

Internal reviews and audits are undertaken across the DHB to provide assurance that the controls to mitigate and reduce risk are in place and are effective. Training and assistance is provided to ensure the risk identification and management process is consistent across the DHB and is of a high standard. The Canterbury DHB continues to enhance systems to manage both the financial and non-financial service risks that it faces.

When considering the achievement of long-term goals and objectives the biggest risks facing the DHB going into 2008/09 relate to financial sustainability including increasing compliance costs, unforeseen price increases and wage increase expectations for the health sector and the increasing demand resulting from the growing burden of long-term conditions.

10.2 Anticipated Service Changes 2008/09

The past two years have been a period of development for the DHB and a number of service changes, reviews and efficiency initiatives have been scoped and developed over this time to improve capability, increase capacity and productivity and to introduce alternative service delivery models to improve effectiveness and quality. Implementation is underway on a number of these initiatives, with activity continuing in the coming years, including:

- Implementing outcomes from the Child and Adolescent Family Mental Health Services Review;
- Implementing outcomes of the Model of Care in Adult General Mental Health Services Review;
- Implementing the re-provision of residential services for those with intellectual disability and psychiatric illness;
- Implementing the recommendations of the Review of Health Services in Ashburton;
- Implementing the recommendations from the Community Laboratory Review, including changes to funding mechanisms and demand management;
- Implementing the Improving the Patient Journey Programme and Patient Flow projects;
- Implementing the Acute Demand Project and the Framework for Chronic Conditions; and
- Implementing the outcomes of the *Healthy Ageing Integrated Support* Strategy for Older People.

Service Change in 2008/09

The increases in funding the DHB will receive in the coming year will be insufficient to meet projected demand pressures and the increasing cost of service provision. Hence productivity gains will be key in meeting future demand whilst ensuring continued financial viability.

The DHB will be looking to make efficiency gains by delivering the same service in more efficient ways. The DHB will also be aiming to ensure value for money for its investments and evaluating possible service re-configurations (delivering the same outcomes through the delivery of services in different ways) that would provide a more effective or productive service for the community. These include those mentioned and referenced throughout this document, in the DHB's District Strategic Plan and the following:

- Implementation of external ministerial or national reviews, initiatives or reconfigurations to ensure consistency across the sector, equity of access and improved health outcomes such as:
  - Implementation of national School and Community Dental Clinics Model of Care;
  - Review of the funding for laboratory tests by private specialists;
  - Implementation of national Cytology changes;
  - Continued implementation of the Cataract and Orthopaedic Initiatives;
  - Continued commitment to achieving compliance in all Elective Services Patient Flow Indicators (ESPIs) and implementation of additional elective services funding;
  - Implementation of the NZ Cancer Control Strategy, the national HEHA Strategy, Primary Care Strategy and Health of Older People Strategy; and
  - Implementation of national initiatives (as funding allows) such as screening services; and
  - Ongoing review and allocation of Mental Health Blueprint Funding.
- Implementation of internal reviews, initiatives or re-configurations to improve capability, capacity, efficiency, quality and health outcomes, reflected throughout this document and including:
  - Implementation of the recommendations of the Review of Acute Demand and After Hours Cover and continued review of the interface between general practice and the ED to ensure patients are managed in the most appropriate setting;
  - Continued implementation of the Improve the Patient Journey Programme to review patient processes, reduce unnecessary waits and delays and to improve patient flows;
  - Continuation of the Health Services Planning Programme recommending reconfiguration of service delivery models to match the best location for the provision of treatment and care and informing the completion of a Facilities Master-Plan and Strategic Workforce Strategy;
  - Implementation of joint primary/secondary pathways and implementation of the work streams of the Referrals Project;
  - Continued review of staff and skill mix within services and consideration of alternative models of care to improve services delivery and the patient journey;
  - Continued implementation of our local health strategies including: the DHB's Youth Health Position Paper, Māori Health Plan, Canterbury Heart Health Strategy, Mental Health and Addictions Strategy, Information Services Strategic Plan and Quality Strategic Plan; and
  - Continued review of support services processes to align to best practice including warehousing, distribution and purchasing processes.
- Long-term consideration of service and delivery models to achieve value for money, better target inequalities in health status and lead innovation in health services delivery and to ensure sustainability of service delivery:
  - Work to reduce cost pressures to the DHB on a national and regional level;
  - Consider service provision to allow hospitals to focus on emergency and serious illness;
  - Consider the clinical and financial sustainability of some rural and metropolitan services;
  - Consider possible ownership/structure changes for subsidiary companies to provide for more appropriate future ownership and direction;
  - Identify least cost effective services and consider alternative models of care; and
  - Consider reductions in non-essential services to levels in line with other DHBs and establish service benchmarks with other DHBs to address national consistency and equity of access.

Some reviews will be implemented in 2008/09, while others will be in preparation for changes and developments in the 2009/10-year and beyond. Further detail with regard to operational efficiency and productivity initiatives is provided in the DHB's previous District Annual Plan and Statement of Intent documents.

Service reconfigurations will involve consultation with hospital or community based service providers, to determine appropriate solutions that best meet the needs of the community. Where service reconfigurations are in the area of mental health the ringfence requirements will be maintained. Any DHB service reconfiguration processes will comply with the Operational Policy Framework.

10.3 Assumptions behind this Plan

Given the significant challenges and risks faced by the DHB a number of key assumptions have been made in developing this Annual Plan. These assumptions highlight the risks that are, in the main, outside of the DHB's control. If these assumptions do not hold true this will limit the DHB's ability to improve the health of its community or may lead to adverse financial outcomes. Assumptions have been made that the DHB operating environment will not change dramatically and that funding advice provided to the DHBs will hold true.

Assumptions – *it is assumed that …*	
Operating Environment	▪ Short and mid-term direction/environment remain similar and current Government funding policies remain static. The sector will use health prioritisation tools to determine investment in new services. ▪ No industrial action will occur. In the event that any industrial action takes place, force majeure applies to health targets, ESPI and contracts with the Crown. ▪ Interest rates and exchange rates will remain within Treasury forecasts. ▪ Inflation pressures and tight fiscal outlook will require competing demands to be managed within the allocated funding and focus on achieving productivity improvements/savings. ▪ No revaluation of land and buildings will be required in 2007/08. No revaluation of land and buildings will occur in 2008/09.[42]
Baseline Funding	▪ Baseline and outyears funding will increase as per funding advice from the Ministry. ▪ Early payment status maintained - any change in this status will change all other assumptions.
Demand for Services	▪ The growth in demand for current or new services can be managed via initiatives or met through reducing delivery in other service areas (in accordance with the Operational Policy Framework).
Price Increases	▪ Contracts with suppliers and NGO providers will be settled below net FFT on average. ▪ The introduction of new drugs or technology will be funded by efficiencies within the service. ▪ The average increase in non-employee related expenditure can be kept below net FFT. ▪ The rate for capital charge will remain at 8.
Inter-District Flows	▪ Net IDF revenue can be fully realised. IDF volumes remain stable and do not decline significantly except for services where it is more appropriate for those volumes to be performed by another DHB. ▪ The price for some inter-district services will be negotiated upwards to incorporate the impact of higher wage settlements in consultation with the Ministry.
Compliance Costs	▪ The financial impact associated with any new Government or Ministry legislative, regulatory or compliance policy/initiative will be fully offset by increased funding. ▪ Any financial impact associated with changes to DSS boundaries between age related and non-age related services and any further contracts or services devolved by the Ministry will be cost neutral to the DHB.
Workforce Wage and Salary Costs	▪ Collective employment agreements will be settled below or at terms similar to the NZNO MECA. ▪ Step progression costs are assumed to be similar to historical levels. ▪ Efficiencies will be generated under the agreed Partnership programmes and tripartite agreements. ▪ Sick leave will be managed at or below current levels. ▪ The DHB will be able to recruit the required staff numbers to meet service demands as a result of the increase leave entitlements or changes to service configuration will take place to align services with available clinical workforce.
Aged Care Services	▪ Any cost increases (beyond net FFT) resulting from changes to income and asset testing thresholds will be met by additional funding provided by the Ministry.
Pharmaceutical Expenditure and Services	▪ The PHARMAC budget for community referred spending is as agreed by the DHB (basis of 2007/08 budget plus net FFT) and forecast savings on STAT dispensing and other initiatives are achieved. ▪ The budget transferred to PHARMAC for cancer drugs will be based on historical DHB funding.
Efficiency Realisation	▪ Service innovation savings realised, efficiencies achieved and cost over-runs addressed internally. ▪ Where savings from efficiency gains or service re-configurations are not sufficient to achieve breakeven, acceptable service reductions can be identified and realised in a timely manner. ▪ Projected proceeds from approved sale of surplus assets can be realised and received as planned.
Disease Burden	▪ Lifestyle, housing and other social influences play a major part in determining the health status of the community. It is assumed that other Government departments, agencies and councils are also working to the same goals. ▪ Health education/promotion initiatives influence change in risk patterns and lifestyles.
Pandemic Costs	▪ In the event of a Pandemic any increased or associated costs will be nationally funded.

[42] *The DHB's last revaluation of land and buildings took place in June 2006.*

11. Appendices

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

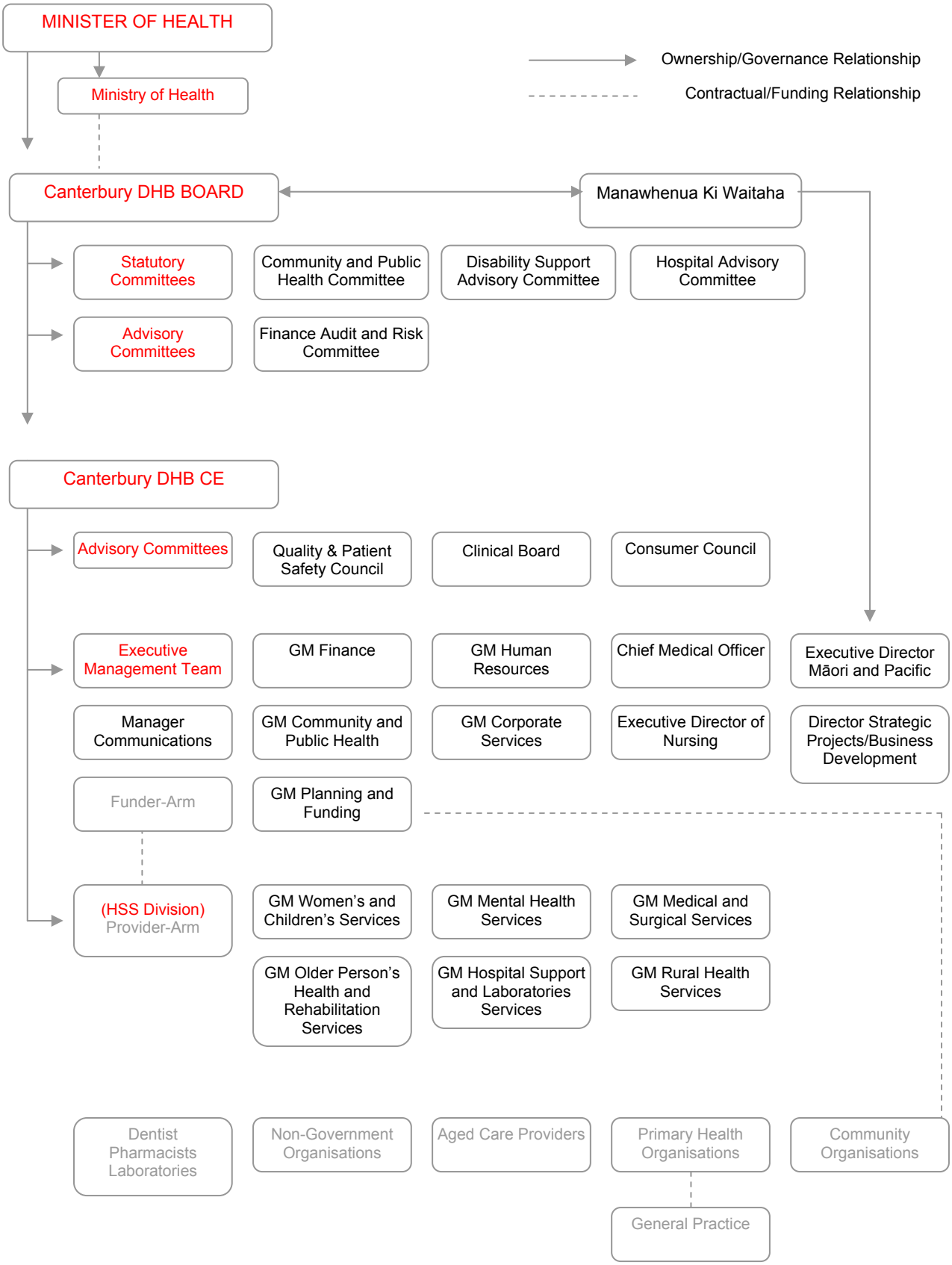
- District Strategic Plan: A Healthier Canterbury: Directions 2006.
- Canterbury DHB Statement of Intent 2006/2009.
- Health Needs Assessment for Canterbury, 2004.
- Canterbury DHB Quality Strategic Plan 2007/2010.
- Rural Health Action Plan: Rural Health in Canterbury DHB 2002.
- Māori Health Plan, *Te Whakamahere Hauora Māori Ki Waitaha* 2007/2011.
- Child Health and Disability Action Plan 2004/2007.
- Canterbury DHB Aged Care Strategy: Healthy Ageing, Integrated Support 2005.
- Disability Strategy, Action Plan for Disability 2004/2007.
- Healthy Eating, Active Living Plan 2005/2010.
- Canterbury DHB Information Strategy Strategic Plan 2005.
- Canterbury Heart Health Strategy, September 2004.
- Oral Health Strategy, September 2003.
- Pacific Health Action Plan, March 2002.
- Diabetes Strategy Action Plan (Interim), 2002.
- Mental Health and Addiction Strategy, May 2004.

All Ministry documents referenced in this Statement of Intent are available on the Ministry's website (www.moh.govt.nz).

Appendices

- Appendix 1. Organisational Chart.
- Appendix 2. HSS Division - Overview of Services.
- Appendix 3. Indicators of DHB Performance.
- Appendix 4. Referrals Project Work Streams
- Appendix 5. Priorities for Blueprint Funding.
- Appendix 6. Minister of Health's Letter of Approval.
- Appendix 7 Glossary of Terms.

11.1 Organisational Chart



11.2 HSS Division - Overview of Services

HOSPITAL SUPPORT AND LABORATORY SERVICES

Covers support services such as: medical illustrations, specialist equipment maintenance, sterile supply, Meals on Wheels and hospital maintenance. It also covers the provision of diagnostic services through Canterbury Health Laboratories (CHL) for patients under the care of the Canterbury DHB and offers a testing service for GPs and private specialists. CHL is utilised by more than 20 public and private laboratories throughout NZ that refer samples for more specialised testing and is recognised as an international referral centre.

MEDICAL AND SURGICAL SERVICES

Covers medical services: cardiology/lipid disorders, endocrinology/diabetes, respiratory, rheumatology/immunology, infectious diseases, oncology, gastroenterology, clinical haematology, neurology, hyperbaric medicine and sexual health and surgical services: vascular, cardiothoracic, orthopaedics and neurosurgery, urology, plastic and cardiac surgeries and the services of the day surgery unit. Services also cover: emergency investigations, outpatients, anaesthesia, intensive care, radiology, nuclear medicine, clinical pharmacology, pharmacy, medical physics and allied health services. The Christchurch Hospital has a busy Emergency Department treating around 72,000 patients per annum.

MENTAL HEALTH SERVICES

Our Mental Health Service is one of the two largest providers in NZ covering: child and youth, adult specialty, community services and rehabilitation services, forensic (regional), acute psychiatric and alcohol and drug services, long-term care, assessment, treatment and rehabilitation and psychiatric services for adults with intellectual disabilities. A number of community based services and mobile teams also provide mental health services (including alcohol and drug services) throughout Canterbury. A number of services have regional beds as well as providing regional consultation liaison including Forensic, Eating Disorders, Alcohol and Drug and Child Adolescent and Family Services.

OLDER PERSON'S HEALTH AND REHABILITATION SERVICES

Covers assessment, treatment and rehabilitation services, psychiatric services for the elderly and psychiatric needs assessment, generic geriatric outpatients, specialist osteoporosis clinics, meals on wheels, community specialist services including InterRAI assessment, treatment and rehabilitation for over 65 year olds. Specialist under 65 year olds assessment and treatment services for disability funded clients. The Older Person's Health Service also operates geriatric and psychogeriatric day hospitals. Rehabilitation health services cover the spinal injuries unit, musculoskeletal services, brain injury rehabilitation services, pain management and orthopaedic rehabilitation. The Burwood Spinal Unit is one of only two such units in the country, treats 60% of New Zealand's spinal injury patients and is involved in leading international research to help patients rehabilitate and adjust.

RURAL HEALTH AND COMMUNITY SERVICES

Covers a wide range of services provided in rural areas generally based out of Ashburton Hospital but also covering services provided by the smaller rural hospitals. Services include: general medicine and surgery, palliative care, maternity services, assessment treatment and rehabilitation services for the elderly and long-term care for the elderly including specialised dementia care and diagnostic services. Also offered are rural community support services: day care services, district nursing, home support, meals on wheels and clinical nurse specialist services in many areas including respiratory, cardiac, diabetes, wound care, urology, continence and stoma therapy. The Rural Health Service also operates Tuarangi Home a facility providing hospital care for the elderly in Ashburton.

WOMEN AND CHILDREN'S HEALTH SERVICES

Covers acute and elective gynaecology services, primary, secondary and tertiary obstetric services, neonatal intensive care services, pregnancy terminations (at Lyndhurst Hospital) and primary maternity services through Lincoln Maternity, Rangiora Hospital and the Burwood Birthing Unit. This service also covers children's health: paediatric oncology, paediatric surgery, child protection services, cot death/paediatric disordered breathing, community paediatrics and paediatric therapy, public health nursing services and vision/hearing screening services. The Services' neonatal intensive care unit and staff are involved in world-leading research investigating improved care for pre-term babies.

Appendix 3.

11.3 Indicators of DHB Performance

The Canterbury DHB's Indicators of DHB Performance for 2008/09 follow and are in addition to a wider set used by the Ministry within its accountability arrangements with DHBs. These arrangements, as a package, ensure there is public accountability for DHB spending.

Indicator Code	Dimension of DHB Performance	Aligned DHB Strategy	Measure and Canterbury DHB Targets	Reporting Accountability
HKO-01 Local Iwi/Māori are engaged and participate in DHB decision-making and the development of strategies and plans for Māori health gain	Consultation and Collaboration	Māori Health	1. Percentage of PHOs with Māori Health Plans agreed to by the DHB **Target – 100%** 2. Percentage of DHB members that having Treaty of Waitangi training **Target – 100%** 3. Report on achievements against the Memorandum of Understanding between a DHB and its local Iwi/Māori relationship partner, and describe other initiatives achieved that are an outcome of engagement between the parties. Provide a copy of the Memorandum. 4. Report on how (mechanisms/frequency of engagement) local Iwi/Māori are supported by the DHB to participate in the development and implementation of the strategic agenda, service delivery planning, development, monitoring, and evaluation (include a section on PHOs). 5. Report on how Māori Health Plans are being implemented by PHOs and monitored by the DHB (include the names of the PHOs with Plans) OR for newly established PHOs, a report on progress in the development of Māori Health Plans (include the names of these PHOs). 6. Describe when Treaty of Waitangi training (including facilitated by the Memorandum) has, or will, take place for Board members. 7. Identify at least two key milestones from your Māori Health Plan to be achieved in 2007/08. For reporting in Q2, provide a progress report on the milestones, and for reporting in Q4, provide a report against achievement of those milestones.	ED Māori and Pacific Health Six-monthly in the second and fourth quarter.
HKO-02 Development of Māori health workforce and Māori health providers	Ownership	Māori Health	1. Report the number of (i) management (ii) clinical (iii) administrative and (iv) other FTEs held by Māori out of the total numbers of (i) management, (ii) clinical, (iii) administrative and (iv) other FTEs in the DHB respectively. **Target - The number of Māori employed by the CDHB moves closer to the % of Māori people in the Canterbury population.** 2. Provide a copy of the DHB Māori Health Workforce Plan (or regional Māori Workforce Plan), or timeframe for completion. 3. Report on achievements based on key deliverables in the DHB (or Regional) Māori Workforce Plan, or if the Plan is being developed, describe at least two key DHB Māori health workforce initiatives that the DHB has achieved.	Six-monthly in the second and fourth quarters
HKO-03 Improving mainstream effectiveness	Services	Māori Health	A report describing the reviews of pathways of care that have been undertaken in the last 12 months that focused on improving Health outcomes and reducing health inequalities for Māori. Report on an example(s) of actions taken to address issues identified in the reviews.	Six monthly, in the second and fourth quarters

HKO-04 DHBs will set targets to increase funding for Māori Health and disability initiatives	Ownership	Māori Health	1. Report actual expenditure on Māori Health Providers by General Ledger code. 2. Report actual expenditure for Specific Māori Services provided within mainstream services targeted to improving Māori health by Purchase Unit. 3. Report total actual expenditure for Iwi/Māori-led PHOs. 4. Report actual expenditure for mainstream PHO services targeted at improving Māori health. Where information is available, report a comparison between expenditure for above measures for 2007/08	Annual reports to the MoH in quarter four (not part of the monthly financial reporting template).
PAC-01 Pacific peoples are engaged and participate in DHB decision-making and the development of strategies and plans for Pacific health gain	Ownership	Improving the Health of Our Community	1. Percentage of DHB strategies and plans on which Pacific communities or representatives were consulted. **Target - 50%** 2. Percentage of DHB working groups and steering groups that included representation from Pacific communities. **Target - 50%** 3. Report the number of (i) management (ii) clinical (iii) administrative and (iv) other FTEs held by Pacific peoples out of the total numbers of (i) management (ii) clinical (iii) administrative and (iv) other FTEs respectively in the DHB. **Target - The number of Pacific people employed by the CDHB moves closer to the % of Pacific population serviced.**	Six monthly in the second and fourth quarter.
POP-01 Smoking –risk reduction.	Improving Health Outcomes	CVD Disease	The number of enrolled persons aged over 14 years with smoking status on record (by Māori, Pacific, and Other) as a % of the total number of enrolled persons over 14. **Target – The DHB is not currently able to measure this indicator through PHO Performance Monitoring.**	Annually in the third quarter.
POP-02 CVD Rehabilitation Programme	Improving Health Outcomes	CVD Disease	The number of people who have suffered Acute Coronary Syndrome who attend a cardiac rehabilitation outpatient programme (broken down into Māori, Pacific, and Other ethnic groups) as a % of the total number of people who have suffered Acute Coronary Syndrome who were admitted and discharged from hospital. **Target – The DHB's target to establish data reporting against this indicator to establish a baseline and target improved performance.**	Annually in the third quarter
POP-03 Stroke Organised Stroke Services	Improving Health Outcomes	CVD Disease	The number of people who have suffered a stroke event, who have been admitted to organised stroke services and remain there for their entire hospital stay (broken down into Māori, Pacific, and Other ethnic groups) as a % of the total number of people who have suffered a stroke event . **Target – The DHB's target to establish data reporting against this indicator to establish a baseline and target improved performance.**	Annually in the third quarter.
POP-04 Oral health - Mean Decayed, Missing, Filled Teeth score at year eight	Improving Health Outcomes	Child and Youth Health	The total number of permanent teeth of Year eight children, Decayed, Missing (due to caries), or Filled at the commencement of dental care, at the last dental examination, before the child leaves the DHB School Dental Service against the total number of children, who have been examined in the Year eight group, in that year. Describe any interpretation or technical issues and indicate whether data is generated by DHB or by the Ministry and forwarded to the DHB. Provide data by: ethnic group, fluoridation status (of school area the child attends) and mean components of DMF index. **Target - Māori 2.14-2.61 Pacific 2.03-2.48 Other 1.43 Total 1.53**	Annually in quarter three for the period 1 January to 31 December 2007.

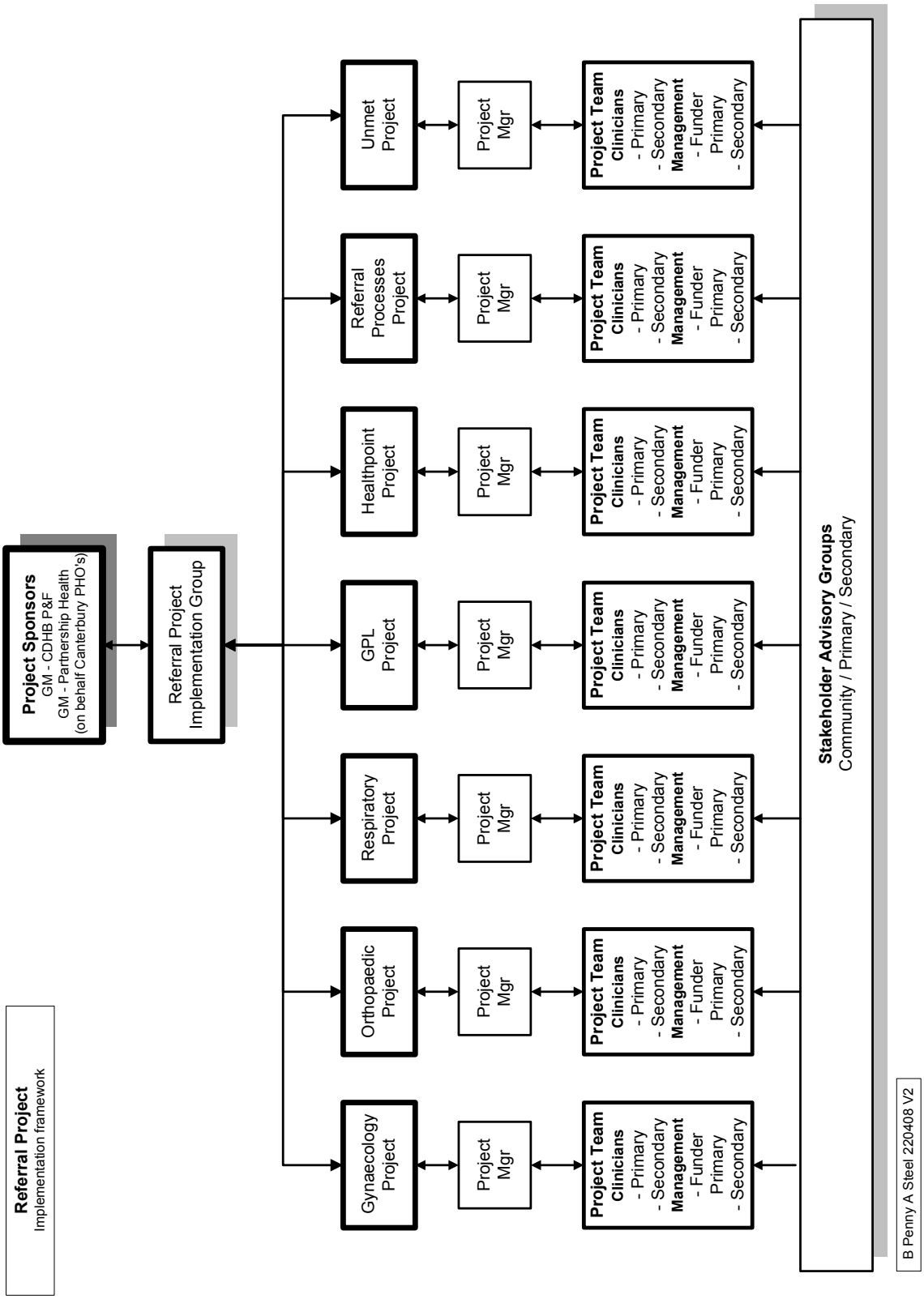
POP-05 Oral health - Percentage of children caries free at age five years	Improving Health Outcomes	Child and Youth Health	The total number of caries free children at the first examination after the child has turned five years, but before their sixth birthday, examined by the DHB School Dental Service against the total number of children who have been examined in the age five group, in the year to which the reporting relates. Provide data by: ethnic group, fluoridation status (of school area the child attends) and mean components of DMF index. **Target - Māori 27-47% Pacific 10-30% Other 64% Total 60%**	Annually in quarter three for the period 1 January to 31 December 2007.
POP-06 Improving the health status of people with severe mental illness	Services	Mental Health	The average number of people domiciled in the DHB district, seen per year rolling every three months being reported (the period is lagged by three months) against the projected population of the DHB district: Provide data by age and ethnicity for the following groupings: child and youth aged 0-19, adults aged 20-64, people aged 65+. **Target 2007/08- Māori Other Total** **0-19 2 2 2** **20-64 2.5 2.5 2.5** **65+ - (no targets as service historically funded by DSS)**	Quarterly for the period to end of previous quarter.
POP-07 Alcohol and other drug service waiting times	Services	Mental Health	DHBs will report their longest waiting time, in days, for each service type for one month prior to the reporting period. Waiting times are measured from the time of referral for treatment to the date the client is admitted to treatment, following assessment. Whilst assessment and motivational or pre-modality interventions may be therapeutic, they are not considered to be treatment. If a client is engaged in these processes, they are considered to be still waiting for treatment.	Measured, for one month, every three months. Reports due: Every quarter.
POP-08 Immunisation Coverage at 6, 12 and 18 Months	Improving Health Outcomes	Child and Youth Health	Progress towards the health target of 95% of two year olds fully immunised. The targets will be assessed on the basis of a 12 month rolling average and are required to be set for the following groups: Māori, Pacific, DHB Total. **89-93% of eligible children fully immunised at 6 months.** **89-93% of eligible children fully immunised by 12 months.** **>88% of eligible children fully immunised by 18 months.**	The indicator will be measured quarterly
POP-10 Reduced radiation oncology and chemotherapy treatment waiting times	Improving Health Outcomes	Cancer	Deliverable 1: Radiation Oncology and Chemotherapy Complete monthly templates will be supplied that measure the interval between the first specialist assessment and the start of radiation treatment and first specialist assessment and the start of chemotherapy treatment. Aim to improve wait-time performance against nationally agreed treatment standards for patients in priority categories A and B and C. Deliverable 2: Data Quality In Q4 include a report confirming the centre has undertaken a data quality audit.	Monthly supply of radiation oncology and chemotherapy wait times. Q4 report on audit.
POP-11 Family Violence Prevention	Improving Health Outcomes	Child and Youth Health	Where an overall score below 70/100 is achieved in the audits of child abuse and partner abuse responsiveness the DHB will provide a progress report on specific actions taken since the audit to progress the recommendations of the audit. **Target - Overall score of above 70/100.**	Six monthly in the second and fourth quarters.

QUA-01 Quality Systems	Services	Quality and Patient Safety	The DHB provider arm demonstrates an organisational wide commitment to quality improvement and effective clinical audit by reporting a list of key quality improvement and clinical audit initiatives and results aligned to the Goals in *Improving Quality: A Systems Approach for the NZ Health and Disability Sector (2003)*. Using the reporting template provided by the Ministry describe improvement initiatives and the effectiveness of those initiatives – in the following categorises: 1. There are more effective service outcomes for Māori by acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi, and applying the principles of participation, partnership and protection. 2. There is a shared vision towards safe and quality care that is engendered through committed leadership at all levels, which supports constant maintenance and improvement in service quality and includes Māori aspirations and priorities. 3. People are encouraged and supported to participate in the planning, delivery, and assessment of health and disability services/programmes, including active participation of Māori. 4. There is widespread awareness, understanding, and commitment to a quality improvement culture at all levels of the organisation. 5. There is evolutionary redesign of systems of care to support delivery of quality services. 6. Unexpected adverse outcomes are managed in an open and supportive manner that builds trust and confidence in the organisation, and is fair to all participants. 7. There is effective, open communication, co-ordination and integration of service activity recognising teamwork. 8. There is a supportive and motivating environment that provides the workforce with appropriate tools, including cultural competency tools, for continuous learning and ongoing improvement in planning, delivery and assessment of health and disability services. 9. Useful knowledge and information, including Māori satisfaction information and clinical evidence, is readily available and shared to support a quality-conscious culture. 10. Regulatory protections that assure safe care are in place to support people and service providers. 11. There are more effective service outcomes for Pacific people, to address where Pacific peoples have generally worse health that that of the total population.	Annual in the third quarter.
QUA 02 Improving results for People with enduring severe mental illness	Improving Health Outcomes	Mental Health	Report the number of adults (20–64 years) with enduring serious mental illness (two years or more in treatment since first contact with any mental health service (in treatment = at least one provider arm contact every three months for two years or more.) 1. Number (and %) of long-term clients in full-time work (>30 hrs). 2. Number (and %) of long-term clients with no paid work. 3. Number (and %) of long-term clients undertaking education. **Target – The DHB currently only records this information for a specific groups of clients participating in the Knowing the People Project. 1. = 3% and 2. = 85%.**	Annual in 2nd quarter.

QUA-03 Improving the quality of data provided to National Collections Systems	Ownership	Information Services	1. National Health Index (NHI) duplications – The number of NHI duplicates that require merging by NZHIS per DHB per quarter and a % of the total number of NHI records created per DHB per quarter. 2. Non-specific NHI Ethnicity – The total number of NHI records created with ethnicity status of 'Not Stated' or 'Other' per DHB per quarter as a % of the total number of NHI records created per DHB per quarter. 3. Non specific National Minimum Data Set (NMDS) Ethnicity – The total number of NMDS events created with ethnicity status of 'Not Stated' or 'Other' per DHB per quarter as a % of the total number of NMDS events created per quarter. 4. Standard versus specific descriptors in the NMDS – The number of versions of text descriptor per code per DHB as a % of the total number of codes per DHB. 5. Error Diagnostic Related Group (DRG) – The number of discharge events with an error DRG as a % of the total number of NMDS events for patient discharges per quarter. 6. Percentage of DHB-sourced records able to be successfully loaded into the National Collections data marts – The number of records associated with a specific National Collection able to successfully loaded into that National Collection per DHB per quarter as a % of the total number of records designated for a specific National Collection submitted to NZHIS per DHB per quarter DHBs need to explain ratings if performance is unsatisfactory.	NZHIS will report to DHBs on the outlined measures quarterly
QUA-04 Mental Health Provider Audit	Ownership	Mental Health	Provide a summary of mental health audit activity of the provider arm and contracted providers, specifically in terms of routine audits (those undertaken as part of a planned programme including certification audits) and issues based audits (those undertaken in response to a performance concern/failure). It is expected that on average 30% of providers will be audited in each 12 month period. If less than 30% of providers are being audited the DHB must explain the rationale for the lower rate.	Annually in the third quarter.
RIS-01 Service Coverage	Services	Better Ways of Working	A report providing information on progress achieved during the quarter towards resolution of gaps in service coverage identified in the District Annual Plan, and not approved as long term exceptions, and any other gaps in service coverage identified by the DHB or Ministry through: analysis of explanatory indicators, media reporting, risk reporting, formal audit outcomes, complaints mechanisms and sector intelligence.	Quarterly.
SER-01 Accessible appropriate services	Services	Primary Care	The age-standardised rate of General Practitioner consultations per high need person to the age-standardised rate of General Practitioner consultations per non-high need person. **Target – ≥ 1**	Quarterly.
SER-02 Care Plus Enrolled Population	Services	Primary Care	The number of each PHOs Care Plus enrolled population (broken down into Māori, Pacific peoples, and Other ethnic groups) as a % of each PHOs expected Care Plus enrolled population. **Target – 80%**	PHOs report Care Plus data quarterly.

SER-03 The proportion of laboratory test and pharmaceutical transactions with a valid National Health Index	Ownership	Primary Care	Pharmaceuticals: the number of Government subsidised community pharmaceutical items dispensed by pharmacies in the DHB district with a valid NHI submitted as a % of the total number of Government subsidised community pharmaceutical items dispensed by pharmacies in the DHB district. **Target – 95%** Laboratory tests: The number of tests carried out by community laboratories in the DHB district with a valid NHI submitted. As a % of the total number of tests carried out by community laboratories in the DHB district. **Target – 95%**	Quarterly.
SER-04 Continuous Quality Improvement and Improving Elective Services	Services	Elective Services	Standardised Discharge Ratios (SDR) for 11 elective procedures as published on the Ministry website each quarter (excluding hip and knee replacements, and cataracts covered by separate initiatives). A report demonstrating for any SDR that is more than 5% below the national average of one, i.e. a rate of less than 0.95, what analysis the DHB has done to review the appropriateness of its rate and the reason that the DHB considers the rate to be appropriate for its population, or an action plan as to how it will address its relative under delivery of that procedure.	Six-monthly, based on second and fourth quarter results.
SER-07 Low or reduced cost access to first level primary care services	Services	Primary Care	Report the number of fee increases that are above the annual statement of a reasonable standard GP fee increase that have been referred to a regional fee review committee and the number of practices who comply with the recommendations of the regional fee review committee, and in all cases where practices fail to comply the DHB applies appropriate sanctions. **Target - 100%.** The number of PHO practices that ensure public access to local information on the fees PHO practices are charging patients. **Target - 100%.** The number of PHO practices that demonstrate that all increased subsidies translate into low or reduced cost access for eligible patients as a % of the number of PHO practices in a DHB district. **Target - 100%.**	Quarterly.

11.4 Referrals Project Work Streams



11.5 Priorities for Blueprint Funding.

The Canterbury DHB has the following resources to invest in the Canterbury mental health sector in the 2008/09 year:

Blueprint Funding Name	High-level Description	Total Sought
*MHCS08A	Child and Youth Community Mental Health Services (4 FTEs), covering priority areas ▪ Eating Disorder Services for Youth) ▪ Forensic Youth Services ▪ Youth Specialty Services	$189,196 $243,027 Total $432,224
*MHCS22.1	Consumer Advisor Youth	$75,000
*MHCS08B	Youth Consult Liaison (0.5FTE)	$99,360
*MHCS06A	Adult Community Mental Health Services (9FTEs), covering priority areas ▪ Anxiety Disorder Services ▪ Adult Community Teams ▪ Community Intensive Care Service ▪ Consult Liaison Services	$874,900
*MHCS25	Māori Advisory Services (1.5FTEs)	$126,641
MHRE02	Crisis Respite (2 beds)	$118,260
	Alcohol and Other Drug Supported Landlord	$75,000
MHCR18	Alcohol and Other Drug Supported Accommodation (5 beds)	$110,000
MHCR07	Alcohol and Other Drug Residential Treatment (3 beds), priority area - women	$120,450
MHCR08	Community Integration Service (3FTEs)	$225,000
MHCS06A	Primary Mental Health Services (2FTEs)	$190,000
MHCS21.1	Anxiety Peer Support Services Consumers	$75,000
MHCS22.1	Peer Support Services Families	$150,000
MHCR16 tbc	Kāupapa Māori Services	$125,000
		$2,796,835

* To be provided by the DHB's HSS Division, all other services will be contracted within NGO and Primary Care sectors.

11.6 Minister of Health's Letter of Approval.

Hon David Cunliffe
MP for New Lynn
Minister of Health
Minister for Communications and Information Technology

16 SEP 2008

RECEIVED
29 SEP 2008
BY:

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

Dear Mr James

Canterbury District Health Board: 2008/09 District Annual Plan

I am pleased to advise you that I have signed Canterbury District Health Board's 2008/09 District Annual Plan (DAP) for three years, and that the Board has my full support for implementing this plan. I am advised that your DAP is an excellent accountability document.

I appreciate the efforts your Board and management have put in over the past year to manage your DHB in a sustainable manner while meeting the health needs of your population. I was pleased to visit the DHB recently and thank you for your impressive presentation on 'lean production' techniques to clinical services. This is an area where Canterbury DHB may be able to provide leadership across the system. I look forward to your continued efforts in the coming year.

Promoting Health

I note the emphasis your Board has placed on improving nutrition and physical activity for your population through focussed actions for 2008/09, planning alongside your Local Diabetes Team to develop initiatives, and the overall planning for better integration and collaboration in primary care.

It will be important for you to focus on increased planning for addiction and child and youth mental health services, the integration of tobacco control actions across all chronic conditions programmes, meeting agreed oral health targets, and ensuring that services for the health of older people remain clinically and financially sustainable into the future.

Parliament Buildings, Wellington, New Zealand. Telephone: 64 4 470 6667 Facsimile: 64 4 471 2360
Email: dcunliffe@ministers.govt.nz, Website: www.beehive.govt.nz

I particularly would like you to take note of the following points:

Health Targets

Health Targets have now been in existence for a full year. It has been very pleasing to see your Board take greater ownership of the targets across the various priorities and I look forward to receiving updates of your progress to achieving the targets throughout the year.

Reducing Inequalities

Your Board's commitment to reducing health inequalities is evident in the DAP but I look forward to seeing even greater evidence of its priority. It is imperative that these commitments are translated into tangible actions and measurable outcomes for the target groups.

Collaboration

I strongly encourage your Board to ensure the collaborative approaches outlined in your DAP are implemented. I expect to see examples of this collaboration to include best practice sharing between DHBs, intersectoral cooperation and constructive engagement with non-Government organisations in the sector. In particular I look to Canterbury DHB to play more of a service leadership role with smaller adjacent DHBs, in particular West Coast DHB, over time. I also expect to see a high degree of collaboration with other Southern Region DHBs.

Quality Improvement

I am pleased to see your Board has committed to the five quality improvement programmes identified by the Quality Improvement Committee, as well as undertaking a range of local and regional quality improvement initiatives. I look forward to reviewing the progress of your DHB in terms of the performance measures you have identified to track progress against the targets you have set for implementing the national and local quality improvement initiatives. I remind you that the 0.25% funding increase is a performance-linked incentive payment, and conditional on you meeting the performance measures you have implemented for these programmes.

As noted above, I am encouraged by Canterbury DHB's comprehensive approach to achieving value for money, including the Improving the Patient Journey Programme.

Service Change and Reconfiguration

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

Financial and Risk Management

It is important that you continue to manage your services within your allocated funding. I note the risks outlined in your DAP and the mitigation strategies you have identified. I expect robust financial performance and that you continue to keep the Ministry informed of emerging risks.

In particular I note your commitment to a breakeven result and that this has been achieved by incorporating $27.0M of efficiencies in the 2008/09 year. I understand the Ministry has repeatedly requested a detailed explanation of the options identified to achieve the efficiencies and to quantify savings from each efficiency plan. Your prompt response to the Ministry's request would be greatly appreciated.

I note work currently underway regarding Queen Mary Hospital.

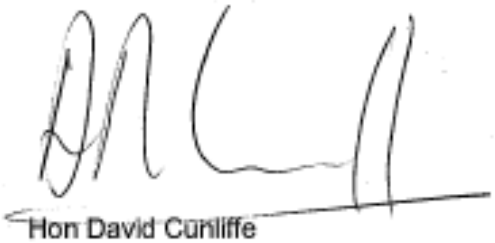
Capital

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

I wish you, your Board and management every success with the implementation of your 2008/09 DAP, and thank you for your contribution and efforts to improve the health of New Zealanders.

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

Yours sincerely



Hon David Cunliffe
MINISTER OF HEALTH

Appendix 7.

11.7 Glossary of Terms

GLOSSARY OF TERMS USED IN THIS DOCUMENT		
ACC	Accident Compensation Corporation	Crown Entity set up to provide comprehensive, 24hour, no-fault personal accident cover for all New Zealanders.
	Acute Care	The provision of appropriate, timely, acceptable and effective management of conditions with sudden onset and rapid progression that require attention.
ASH	Ambulatory Sensitive Hospital Admissions	Hospitalisation or death due to causes which could have been avoided by preventive or therapeutic programme
AT&R	Assessment Treatment and Rehabilitation	These are specialist health services for older people provided by teams of health professionals specially trained to treat illness, rehabilitate and maintain the older person's ability and mobility so that they can retain an independent lifestyle.
ALOS	Average Length of Stay	ALOS is the sum of bed days for patients discharged in the period (ie lengths of stay) divided by the number of discharges for the period.
	Blueprint Funding	Blueprint funding is allocated by Government to work to ensure the development of mental health services for the 3% of the total NZ population with moderate to severe mental illness. Service development is based on the service levels set out in the Mental Health Commission's Blueprint for Mental Health Services in New Zealand: How Things Need to Be (1998).
CAPEX	Capital Expenditure	Spending on land, buildings and larger items of equipment.
CARE	Care and Rehabilitation of the Elderly	The CARE Model was developed for the delivery of specialist community health services for older people and aims to strengthen the primary/secondary interface and ensure older people receive appropriate and effective care in a home-based or community setting.
COPD	Chronic Obstructive Pulmonary Disease	A progressive disease process that most commonly results from smoking. Chronic obstructive pulmonary disease is characterised by difficulty breathing, wheezing and a chronic cough.
	Crown Entities	A generic term for a diverse range of entities referred to in the Crown Entities Act 2004, namely: statutory entities, Crown entity companies, Crown entity subsidiaries, school boards of trustees, and tertiary education institutions. Crown entities are legally separate from the Crown and operate at arms length from the responsible or shareholding Minister(s); they are included in the annual financial statements of the Government.
CE Act	Crown Entities Act	The Act which governs Crown Entities set out in 2004.
CTA	Clinical Training Agency	The CTA provides funding for Post Entry Clinical Training programmes, are nationally recognised by the profession and/or health sector and meet a national health service skill requirement rather than a local employer need.
COSE	Co-ordinator of Services for the Elderly	An Elder Care Canterbury initiative, running in two areas of Christchurch since October 2000. Staff, working alongside GPs, are responsible for co-ordinating packages of care for older people in the community. The most important outcome of the COSE project has been the provision of an overall link between any hospital and any provider service and the GP in Christchurch.
CWD	Case Weighted Discharge	Relative measure of a patient's utilisation of resources
	Credentialling	A process used to assign specific clinical responsibilities to health professionals on the basis of their training, qualifications, experience and current practice, within an organisational context. Credentialling is part of a wider organisational quality and risk management system designed primarily to protect the patient.
CFA	Crown Funding Agreement	This is an agreement by the Crown to provide funding in return for the provision of, or arranging the provision of, specified services.
CVD	Cardiovascular Disease	Cardiovascular diseases are diseases affecting the heart and circulatory system. They include ischaemic heart disease, rheumatic heart disease, cerebrovascular disease and other forms of vascular and heart disease.
DOSA	Day of Surgery Admission	DOSA is a patient who is admitted on the same day on which they are scheduled to have their elective surgery. The admission can be as either a day case or an inpatient.
	Determinants of Health	The range of personal, social, economic and environmental factors that determine the health status of individuals or populations.
DSS	Disability Support Services	Services provided for people who have been identified as having a disability, which is likely to continue for a minimum of six months and results in a reduction of independent function to the extent that ongoing support is required.
DRG	Diagnostic Related Group	The grouping of patients in accordance with their diagnosis.

District Annual Plan	District Annual Plan	This document sets out what the DHB intends to do over the year to advance the outcomes set out in the District Strategic Plan, the funding proposed for these outputs, the expected performance of the DHB provider arm and the expected capital investment and financial and performance forecasts.
DHBNZ	District Health Board New Zealand	National representative body for all twenty-one DHBs.
DSP	District Strategic Plan	The DSP document identifies how the DHB will fulfil its objectives and functions over the next five to ten years by: identifying the significant internal and external issues that impact on the DHB and affect its ability to fulfil its mandate and purpose, acknowledging societal outcomes and identifying appropriate system outcomes as they relate to DHB population outcomes and outlining major planning and capability building
ESPIs	Elective Services Patient flow Indicators	The ESPIs have been developed by the Ministry to assess whether or not DHBs are on the right track with the Government policies on elective services.
EMT	Executive Management Team	Senior Management Team of the Canterbury DHB who report directly to the Chief Executive.
FSA	First Specialist Assessment	(Outpatients only) First time a patient is seen by a doctor for a consultation in that speciality for that reason, this does not include procedures, nurse appointments, diagnostic appointments or pre-admission visits.
	Follow-ups	Further assessments by hospital specialists.
FTE	Full Time Equivalent	An Employee who works an average minimum of 40 ordinary hours per week on an ongoing basis.
FFT	Future Funding Track	FFT is the annual percentage price increase to DHBs from the Ministry.
HbA1c	Haemoglobin A1c; also known as glycated haemoglobin.	The level of HbA1c reflects the average blood glucose level over the past 3 months.
HEAT	Heat Equity Assessment Tool	The HEAT Tool provides questions to assist people working in the health sector to consider how particular inequalities in health have come about, and where the effective intervention points are to tackle them.
HIS-NZ	Health Information Strategy– New Zealand	The Government's Health Information Strategy for all DHBs.
HNA	Health Needs Assessment	A process designed to establish the health requirements of a particular population
	Health Outcomes	A change in the health status of an individual, group or population which is attributable to a planned programme or series of programmes, regardless of whether such a programme was intended to change health status.
HealthPAC	Health Payments Agreements and Compliance	Formed from the merger of Health Benefits and the Shared Support Service Group within the Ministry. HealthPAC undertakes a number of activities based on a Service Level Agreement with the Ministry, and also provides information to several health agencies.
HPI	Health Practitioner Index	The HPI will be a comprehensive source of trusted information about health practitioners for the NZ health and disability sector. The HPI will uniquely identify health providers and organisations. This will allow health providers who manage health information electronically to do so with greater security. It will help our health sector to find better and more secure ways to access and transfer health-related information.
HPCA	Health Practitioners Competency Assurance	The purpose of the HPCA Act, which came into force on 18 September 2004, is to protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practice their professions.
HWAC	Health Workforce Advisory Committee	Committee who advises the Minister on how to ensure an adequate and responsive professional health workforce
HEAL	Healthy Eating Active Living 'Action Plan'	This Plan provides us with the platform to implement the national HEHA Strategy at a local level.
HEHA	Healthy Eating Healthy Action 'Strategy'	HEHA is the Ministry's strategic approach to improving nutrition, increasing physical activity and achieving healthy weight for all New Zealanders.
HSS	Hospital and Specialist Services	The Provider-arm of the Canterbury DHB.
ISSP	Information Services Strategic Plan	The Canterbury DHB's Plan for information services – in line with the national Health Information Strategy.
IDFs	Inter District Flows	An IDF is a service provided by a DHB to a patient whose 'place of residence' falls under the region of another DHB. Under PBF each DHB is funded on the basis of its resident population therefore the DHB providing the IDF will recover the costs of that IDF from the DHB who was funded for that patient.
InterRAI	International Resident Assessment Instrument	Comprehensive geriatric assessment tool.

KPP	Knowing the People Planning Project.	The Programme identifies those people with enduring mental illness and tracks their progress against ten elements of recovery from employment status through to use of hospital services.
LEAP	Late Effects Assessment Programme	LEAP is a clinic (and programme) for children and adolescents with cancer established to help monitor and support children and adolescents who have completed active cancer therapy.
LOS	Length of Stay	LOS is the time from admission to discharge, less any time spent on leave. It is normal to exclude boarder patients when calculating length of stay.
LTCCP	Long Term Council Community Plan	Plan that sets out the type of community the people of a region would like to live in, and the things they would like to see for their community. It shows how the Council (for that region) and other organisations will work to build that community.
MoU	Memorandum of Understanding	An agreement of cooperation between organisations defining the roles and responsibilities of each organisation in relation to the other or others with respects to an issue over which the organisations have concurrent jurisdiction.
MHINC	Mental Health Information National Collection	The national database of mental health information held by the NZ Health Information Service to support policy formation, monitoring and research.
MH-SMART	Mental Health Standard Measures of Assessment and Recovery	The aim of the MH-SMART initiative is to support recovery by promoting and facilitating the development of an outcomes-focused culture in the mental health sector. The principle means of achieving this will be by implementing a suite of standard tools to measure changes in the health status of mental health service users that is responsive to the needs of Maori and other cultures within a recovery framework.
	Morbidity	Illness, sickness.
	Mortality	Death.
NHI	National Health Index	The NHI number is a unique identifier that is assigned to every person who uses health and disability support services in NZ. A person's NHI number is stored on the NHI along with that person's demographic details. The NHI and associated NHI numbers are used to help with the planning, co-ordination and provision of health and disability support services across NZ.
NIR	National Immunisation Register	The NIR is a computerised information system that has been developed to hold immunisation details of NZ children and assist to improve immunisation rates.
NNPAC	National Non-admitted Patient Collection	Coding of outpatients – a pilot project under the national Health Information Strategy.
NASC	Needs Assessment & Service Co-ordination	NASC assists older people with long-term disabilities/ health problems (i.e. longer than 6 months) to remain living at home, safely and independently, for as long as possible. Needs Assessors complete an assessment of needs with the older person, and Service Coordinators use this assessment to develop care packages of support services to assist at home.
NZHIS	New Zealand Health Information Service	A group within the Ministry responsible for the collection and dissemination of health-related data. NZHIS has as its foundation the goal of making accurate information readily available and accessible in a timely manner throughout the health sector.
NGO	Non- Government Organisations	There are many ways of defining NGOs. In the context of the relationship between the Health and Disability NGOs and the Canterbury DHB, NGOs include independent community and iwi/Maori organisations operating on a not-for-profit basis, which bring a value to society that is distinct from both Government and the market. In reality this will mean that any profits are put back into the organisation, rather than distributed to shareholders.
OPF	Operational Performance Framework	The OPF is one of a set of documents known as the 'Policy Component of the DHB Planning Package' which sets out the accountabilities of DHBs. The OPF is endorsed by the Minister of Health and comprises the operational level accountabilities that all DHBs must comply with. These are given effect through the Crown Funding Agreements between the Minister and the DHB.
PMS	Patient Management System	PMS (secondary-care usage), or Practice Management System (primary-care usage). The system used to keep track of patients. In the case of secondary care the focus is usually on tracking the admissions, discharges or transfers of patients. In the case of primary care, the focus is on maintenance of the register.
PHARMAC	Pharmaceutical Management Agency	Agency which secures, for eligible people in need of pharmaceuticals, the best health outcomes that are reasonably achievable from pharmaceutical treatment and from within the amount of funding provided.
PBF	Population Based Funding	Involves using a formula to allocate each DHB a fair share of the available resources so that each Board has an equal opportunity to meet the health and disability needs of its population.

	Primary Care	Primary Care means essential health care based on practical, scientifically sound, culturally appropriate and socially acceptable methods. It is universally accessible to people in their communities, involves community participation, is integral to, and a central function of, the country's health system, and is the first level of contact with the health system.
PHO	Primary Health Organisation	A new development in service delivery PHOs encompass the range of primary care and practitioners and are funded by DHBs to provide of a set of essential primary health care services to those people who are enrolled in that PHO.
	Public Health	The science and art of preventing disease, prolonging life and promoting health and efficiency through organised community effort. A collective effort to identify and address the unacceptable realities that result in preventable and avoidable health outcomes, and it is the composite of efforts and activities that are carried out by people committed to these ends.
QIC	Quality Improvement Committee	The Quality Improvement Committee (formerly EpiQual) is a statutory committee established under the NZ Public Health and Disability Act 2000. It is appointed by, and accountable to, the Minister of Health. The Committee provides independent advice to the Minister on quality improvement in the health sector through monitoring of national quality initiatives and advises the Minister on how clinical outcomes may be improved through such initiatives.
Q1-Q4	Reporting Quarters	Q1 = 01 July to 31 30 September Q2 = 01 October to 31 December Q3 = 01 January to 31 March Q4 = 01 April to 30 June
	Secondary Care	Specialist care that is typically provided in a hospital setting
SISSAL	South Island Shared Services Agency Ltd	SISSAL provides a consultancy service to the South Island DHBs, and works in partnership with them on health planning and funding issues. SISSAL is funded by the DHBs on an annual budget basis to provide these services. The main services provided include contract and provider management, audit, strategy and service development, analysis, and project and change management.
Statement of Intent	Statement of Intent	The Statement of Intent covers three years and is the DHB's key accountability document to Parliament. It is a statutory obligation under the Public Finance Act. It has a high level focus similar to an executive summary, of the DHB's key financial and non-financial objectives and targets.
	STAT Dispensing	STAT Dispensing refers to all-at-once dispensing by pharmacies.
SDR	Standardised Discharge Ratio	The SDR measures the intervention rates for a selected group of procedures and compares them with the national average. If all DHBs were providing services at the same level, they would all be at 1. A SDR higher than 1 indicates that the board is providing more than the average rate in NZ, and a rate lower than 1 indicates that the board is providing less than the average rate in NZ. Intervention rate analysis does not necessarily indicate what the right rate might be, but compares individual boards with the national mean, taking board population demographics into account.
TLA	Territorial Local Authority	Local Council also known as: Regional Councils; District Councils; Territorial Local Authorities; Unitary Authorities; City Councils; Councils
	Tertiary Care	Very specialised care often only provided in a smaller number of locations
YTD	Year to Date	The 12 month period immediately prior to the date given.