The Canterbury District Health Board

District Annual Plan 2009/2010

"Transformation – Building our Health System for 2020"

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Statement from the Chairman and Chief Executive

We are pleased to present our District Annual Plan for the 2009/10 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 identified five Core Directions, five Health Gain Priorities and four Disease Priorities as specific areas of focus. In the last two years we have worked across the sector with our clinicians and communities to build a vision of a sustainable future for the Canterbury Health System. This work is reflected in our Health Services Plan and Vision 2020 output, both of which are referred to in this document. This work will contribute significantly to the development of our next District Strategic Plan which will commence in the coming year. These local strategic priorities are coupled with national objectives and expectations to set our long-term direction and goals.

It became apparent to the Canterbury DHB some time ago, given the impact of demographic growth on the availability of workforce and on the needs of our population, that that 'business as usual' for the health system as a whole would not be sustainable now or into the future. We therefore embarked on a journey towards a system-wide transformation. We have charted a course that will require the DHB to work with clinicians, local health and disability providers, Primary Health Organisations, other DHBs, the Ministry of Health, and other Government agencies to reorient the Canterbury Health system over the next 12 months with the intent of system transformation within three years.

Canterbury has spent the past several years building the capacity, capability and relationships that are the platform for driving system-wide and clinically-led change through initiatives such as Improving the Patient Journey, Xcelr8, Vision 2020, Health Services Planning and the Canterbury Initiative. Our way forward includes a range of efficiency and effectiveness solutions, regional and national alignment, service transformation and outcome focused investment. We are prioritising the development of joint pathways across primary and secondary services to improve the patient journey and reduce duplications and delays across the whole of the health system.

We have a specific focus 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 patient care at any stage of the patient journey creates risk and provides poorer health outcomes, in addition to higher costs. Our commitment is to shared decision making through clinical governance processes, founded on partnerships between clinical leaders and management which will ensure that strategic and operational decisions are fully informed and 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 of Health (the Ministry), our colleague DHBs, Government and non-Government agencies, community and primary care providers and our community to achieve the goals and objectives we have set. 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 Canterbury DHB

David Meates

Chief Executive Canterbury DHB

Honourable Tony Ryall

Minster of Health

Approval of the Minister of Health

Office of Hon Tony Ryall

Minister of Health
Minister of State Services

0 4 AUG 2009

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

Dear Mr James

Canterbury District Health Board: 2009/10 District Annual Plan

This letter advises you that I have signed Canterbury District Health Board's (DHB) 2009/10 District Annual Plan (DAP) for three years and that the Board has my full support for implementing this plan.

I appreciate the efforts your Board and management have put in over the past year to manage your DHB in a sustainable manner. More work lies ahead to achieve long lasting sustainability. Given the severe impact of the international financial situation on the fiscal position, the 2010/11 and out-years funding increase for health will be lower than the FFT and Demographics' planning signals notified in December 2008. At the same time pressures from cost, demand, and technology remain. In this environment it is important that you achieve productivity gains and manage your services within your allocated funding. The Government's priority is for funding to be directed towards front line services.

The emphasis your Board has placed on the Government's Health Targets and priority areas is noted. Your focus on transformation, commitment to clinician-led service development and a shared decision making framework through the Canterbury Initiative in particular is to be commended. Your DHB's ability to deliver on shorter waits for cancer treatment, improved access to elective services, better diabetes and cardiovascular services and CYFs Residences have been identified as areas of concern. I require you to alleviate the risks associated with these priorities as effectively as possible.

Your Board's revised financial position following my earlier rejection of your DAP is acknowledged. I note that Canterbury DHB will achieve an additional $1.0M in efficiencies in 2009/10 above the previously submitted $48.0M of efficiencies in your DAP. This will reduce the deficit position in 2009/10 to $9.0M. Please report the progress on your efficiency programme to the Ministry.

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It is strongly recommended that your Board ensures 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 expect to see a high degree of collaboration with other South Island DHBs.

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

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

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 2009/10 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 Tony Ryall
Minister of Health

1 Introducing the Canterbury DHB

This Chapter provides a summary of the Canterbury DHB's role and responsibilities and an overview of how the DHB functions and operates, how we interact with key stakeholders and how we make decisions.

1.1 What Do We Do – The Role and Function of a DHB

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

The DHB has overall responsibility for working within the funding allocated by Government, to improve, promote and protect the health and independence of all of the population living in the Canterbury district. Our motivation is to do the very best we can to ensure our community gets the most efficient and effective services and that the services we provide or fund are delivering the best possible health outcomes.

We collaborate with our community, other health and disability organisations and key stakeholders to decide what health and disability services are needed and how to use the funding we receive to improve the health of our population and enhance efficiencies across the whole of the health system. Through this collaboration we seek to ensure that services are well coordinated and cover the full continuum of care with the patient at the centre. These relationships also allow us to share resources, combine effort and reduce duplication and variation across the health system to achieve the best health outcomes for our population.

The Canterbury DHB:

- ***Plans*** the strategic direction for health and disability services in Canterbury, in consultation and partnership with clinical leaders, stakeholders and our community and in collaboration with other DHBs and service providers;
- ***Funds*** the majority of health and disability services provided in Canterbury, through relationship and service contracts with other 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 and public health and well-being through health promotion, health education and population health programmes.

In addition to these responsibilities the Canterbury DHB is the largest employer in the South Island with over 8,000 staff employed across our fourteen hospitals and numerous community bases, managed through our Hospital and Specialist Services Division. There are also a similar number of people employed in delivering health and disability services in Canterbury, which are funded either directly or indirectly by the Canterbury DHB with over 1,400 contacts managed by our Planning and Funding Division.

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.

1.2 Organisational Structure

Like all DHB's the Canterbury DHB has an established governance and organisational structure, based on the requirements of the NZPHD Act (the Act which established DHBs). We have three organisational 'arms' (divisions) through which we seek to improve the overall health and wellbeing of our population: a Governance-arm, a Funder-arm and a Provider-arm.

Governance and Corporate Division - the Role of the Board and Management of the DHB

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

The Board's core responsibilities are to set the strategic direction for the DHB and to develop policy that is consistent with Government objectives and improves health outcomes for our population. The Board appoints the Chief Executive and monitors their performance and that of the DHB. The Board also ensures compliance with legal requirements, DHB accountability requirements and Government expectations and maintains relationships with the Minister of Health, Parliament and the Canterbury community.

The Board has established three statutory (mandatory) advisory committees, and two additional sub-committees to assist it to meet its responsibilities. The membership of these committees is comprised of a mix of both Board members and community representatives who meet regularly throughout the year:

- *The Hospital Advisory Committee* - monitors the financial and operational performance of the DHB's hospital and specialist services, assessing strategic issues relating to those services and providing advice to the Board.
- *The Community and Public Health Advisory Committee* and the *Disability Support Advisory Committee* (delivered through the same body of membership) - provides the Board with advice on the health and disability needs of our population, how the services funded or provided by the DHB along with the policies we adopt will impact on our population, and promotes the inclusion, participation and independence of people with disabilities.
- *The Finance, Audit and Risk Committee* - enhances the Board's governance function by providing advice on the financial operation of the DHB and by monitoring quality and clinical risk issues.
- *The Remunerations and Appointments Committee* - deals with the employment of the Chief Executive and other specific industrial and employment matters.

While responsibility for the DHB's overall performance rests with the Board, it has a delegation policy assigning operational and management matters to the Chief Executive.

The Chief Executive is supported by an Executive Management Team which includes General Managers of Planning and Funding, Community and Public Health, Finance, Communications, Human Resources and Corporate Services. At this executive level support is also provided by the Executive Director of Māori and Pacific Health, the Chief Medical Officer and the Executive Director of Nursing, who provide cultural and clinical leadership and oversight of patient safety and quality (refer to Appendix 1 for an organisational chart of the Canterbury DHB).

>> Members of the public are welcome to attend, as observers, any Board or statutory committee meeting where decisions will be made. Meeting notices for these open meetings can be found on our website www.cdhb.govt.nz.

The Planning and Funding Division – Planning and Purchasing Health and Disability Services

The Planning and Funding Division of the DHB is responsible to the Chief Executive for planning and funding health and disability services in Canterbury and determining how best to use DHB funding to meet the health needs of our population. This involves assessing the population's current and future health needs and determining and prioritising the mix, range and volume of services to be purchased.

Using the funding available from Government, the DHB enters into service agreements/arrangements with the organisations or individuals who can best provide the health and disability services required to meet the needs of our population, achieve the objectives of the DHB and enhance efficiencies across the whole of the health system.

The core responsibilities of the Planning and Funding Division are:

- Assessing the health status of the population to determine the mix and range of services that should be offered;
- Building partnerships with service providers, Government agencies and other DHBs;
- Engaging with stakeholders and the Canterbury community through participation and consultation;
- Leading the development of new service plans and strategies in health priority areas;
- Prioritising and implementing national health and disability policies and strategies in relation to local need;
- Undertaking and managing contractual agreements with service providers; and
- Monitoring, auditing and evaluating service delivery.

While the Planning and Funding Division's responsibilities are primarily for the people living in the Canterbury district, it also has responsibility for specific regional or national contracts. The Division is also responsible for ensuring our 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.

In all of its work the Planning and Funding Division must comply with key Government policies including the National Service Framework and Service Coverage Schedule, which set out minimum requirements for service delivery.

>> Over 1,400 service contracts are held with individuals and organisations that provide services to our Canterbury population.

The Hospital and Specialist Services Division - Providing Health and Disability Services

As well as being responsible for planning and funding the health and disability services that will be delivered in Canterbury, the Canterbury DHB also provides a significant share of those services. The services provided directly by the DHB include inpatient and outpatient services, community services and day programmes. These services are provided through our Hospital and Specialist Services Division which consists of six service divisions: Medical and Surgical Services; Mental Health Services; Rural Health Services; Women's and Children's Services; Older Person's Health and Rehabilitation Services; and Hospital Support and Laboratory Services (refer to Appendix 2 for an overview of the services provided).

The DHB's fourteen hospitals are also managed by the Hospital and Specialist Services Division, and while the majority of hospital and specialist services are provided from these hospitals, some specialist services are delivered from community bases or through out-reach clinics. A significant proportion of the mental health services provided by the Canterbury DHB are provided in community settings.

Funding for the services provided is mostly via an internal service level agreement with the DHB Planning and Funding Division. However, the Hospital and Specialist Services Division also holds service delivery 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 hospital and specialist level services than others. Because of the size of the Canterbury DHB we provide an extensive range of higher level health and disability services, a number of which are also provided to people from outside the Canterbury district - coming from DHBs where more specialist or higher level services are not available.

Other DHBs who refer people to Canterbury services, are responsible for meeting the costs of the services provided to their population; referred to as 'inter-district' services or Inter-District Flows (IDFs). We closely monitor these IDFs to ensure that our ability to provide for our own population is not adversely affected by demand from other DHBs.

>> 65,000 people were discharged from a Canterbury DHB hospital last year (inpatient and day-case discharges).
>> 5,700 babies were born in Canterbury DHB hospitals.

1.3 Our Shared Decision Making Approach

While responsibility for the DHB's overall performance, operation and management rests with the Board and Chief Executive, both ensure that their strategic and operational decisions are fully informed through appropriate involvement and support at all levels of the decision making process. Clinical input into decision-making is facilitated by having a model of shared management and clinician leadership, at all levels within the DHB. This is led from the top through the involvement of the Chief Medical Officer and the Executive Director of Nursing as members of the Executive Management

Team providing support to the CEO and the Board in their decision-making processes and taking a whole of system view supported by formal and informal networks with primary and secondary care clinicians. Broader participation in decision-making is supported by the following mechanisms.

Māori Participation in Decision Making

The Board is committed to engaging with Māori to facilitate genuine participation in the planning and delivery of health and disability services, particularly as they affect Canterbury's Māori population. As such the DHB has informal relationships with a number of Māori groups and is engaged at many levels with Māori providers and Māori community groups. In 2008 the Board also signed a formal Memorandum of Understanding with Manawhenua Ki Waitaha as a further step to enabling the participation of Māori.[1] The Memorandum of Understanding commits the DHB to regular meetings and dialogue with Manawhenua Ki Waitaha, at an executive management level, as a pathway to shared decision making.

The DHB's Māori Health Plan, approved in 2008, also commits the DHB to establishing formal relationships with other Māori representative groups and Taura Here community groups.[2] We will look to continue to explore mechanisms to facilitate formal relationships and greater participation of Māori at a governance level over the coming year. Possibilities for such participation may include a Māori governance/advisory board providing Māori opportunities to engage more directly with the DHB Board.

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 provided, while meeting identified targets and budget objectives. The DHB's Clinical Board was established in 2003 to give a focus to clinical governance and to enable clinical champions to take a lead in developing clinical governance systems within the DHB.

The Clinical Board is a multi-disciplinary clinical forum whose membership includes clinical representatives from the primary, secondary and community sectors. There are 26 members on the Clinical Board, 17 of whom are elected. The Clinical Board is currently chaired by the DHB's Chief Medical Officer.

The Clinical Board has oversight of the DHB's clinical activity, provides advice to the Chief Executive on clinical issues and is charged with having a proactive role in setting clinical policy and standards and encouraging best practice and innovation. The Clinical Board also supports and influences the DHB's vision and values and provides an important clinical leadership role, leading by example to raise the standard of patient care. We will continue to look to the Clinical Board to provide clinical leadership over the coming year in terms of prioritising funding into improving patient outcomes, removing duplication, increasing standardisation and improving the delivery of quality patient services.

Consumer Council

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

In 2007, as part of the DHB's focus on long-term health services planning, a Consumer Council was established to provide input into decision making as part of the Health Services Planning Programme. The Consumer Council has now been adopted as a permanent advisory group for the Chief Executive and will support a 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 and advocacy groups and covers 10 key areas; family health, older persons' health, disabilities, Māori health, Pacific health, long-term conditions, mental health, rural communities, primary health care and refugees. Networks are being established to support each representative in their role and to facilitate communication with a wide range of individuals and groups within the Canterbury community.

Q "Participation in planning health services should be a partnership between the DHB and consumers at all levels. We are expecting our new Consumer Council to take an active role in influencing policy to better reflect consumer needs." *David Meates Chief Executive Canterbury DHB*

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

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

1.4 Clear Prioritisation and Decision Making Principles

The DHB is responsible for making decisions about which health and disability services or interventions to fund for the benefit of our population. Increasing demand, an ageing population, workforce shortages and recent business pressures have further highlighted the importance of prioritising where we commit our funding to ensure we are providing the best possible health outcomes for our investment.

Working closely with the Clinical Board, Consumer Council and Executive Management Team, the Planning and Funding Division recently reviewed the DHB's prioritisation framework and agreed an updated set of prioritisation principles. Based on best practice and consistent with our strategic direction, these principles will assist the DHB in making decisions about which competing services or interventions to fund with the limited resources available.

Because the health sector is continually changing, changes in health need, clinical practice or technology can mean that services currently being funding may not prove to be as effective as originally anticipated. The prioritisation principles will therefore also be applied as the DHB reviews all existing health investments in order to ensure funding is directed into the most effective and highest value patient services.

The prioritisation principles that guide DHB decision making are:

- *Effectiveness:* Publicly funded health and disability services should be effective. Effective services are those that produce more of the outcomes desired, such as a reduction in pain, maintenance of daily activity, greater independence and the prevention of premature death.
- *Equity:* Services should reduce significant inequalities in the health and independence of our population.
- *Value for Money:* Our population should receive the greatest possible value (in terms of effectiveness and equity) from public spending on health and disability services.
- *Whanau Ora:* Services should have a positive impact on the holistic health and wellbeing of the person and their family and whanau. This has particular significance for Māori, but relevance for all cultures.
- *Acceptability:* Services should be consistent with community values. Consideration will be given as to whether consumers or the community have had involvement in the development of the service.
- *Ability to implement:* Ability to implement the service should be carefully considered, including workforce considerations, impact on the whole of the health system and any risk and change management requirements.

The DHB does not see these prioritisation principles as the only criteria in the decision making process, however starting with a base of analysis against prioritisation principles will improve the quality of decision making. When making funding decisions we are also guided by the priorities and expectations set by the Minister of Health, by the Strategic Priorities established during the development of our District Strategic Plan, and by the specific health needs of our population. The DHB also takes national strategies into account when making funding decisions, particularly: the NZ Health Strategy 2000, Disability Strategy 2002 and the Māori Health Strategy 2002.[3]

Q "Prioritisation provides an opportunity to allocate or reallocate funding, on the basis of evidence, to services that are more effective in improving health outcomes and reducing inequalities." *Carolyn Gullery GM Planning and Funding Canterbury DHB*

1.5 Collaboration and Partnerships – Working as a Whole Health System

We recognise that our goals and objectives will not be achieved through the services we provide alone and our relationships with the organisations we fund need to more than contractual relationships. We have been building a shared vision with the whole of the Canterbury Health System through processes such as our Health Services Planning Programme and Vision 2020. Consistent with this we are developing more outcomes based contracting frameworks built on partnership and alliance models. Through collaboration and partnerships we seek to ensure that services are well coordinated and cover the full continuum of care with the patient at the centre. These partnerships also allow us to share resources, combine effort and reduce duplication and variation across the health system, to achieve the best health outcomes for our population.

[3] *All national health strategies referred to in this document can be found on the Ministry of Health's website ww.moh.govt.nz.*

Partnerships with other Health and Disability Service Providers

In addition to our own Hospital and Specialist Services Division, there are many other health and disability service providers with whom the DHB contracts to provide services across the Canterbury district. The services provided include: nursing services, pharmacy and laboratory services, mental health and addiction services, child and family health services, oral health and maternity services, services for older people (including residential support and rest home services), disability and rehabilitation services, specific Māori and Pacific health services and some hospital and specialist services not provided directly by the Canterbury DHB.

We work in a cooperative way with these providers for the benefit of our population and are committed to working as one health system and building the capacity and capability required to meet the increasing demands of our population. A number of existing partnerships already support patient centred models of care and the provision of services in the community and in people's own homes. We will seek to enhance these partnerships over the coming year in order to improve the patient journey through the health system and ensure a seamless transition between services.

Partnerships with Primary Health Organisations

The DHB also contracts with Primary Health Organisations (PHOs) for the provision of health services in Canterbury and sees joined up primary/secondary services as essential to achieving improvements in health outcomes, reducing health inequalities and assisting us to focus on continuums rather than 'silos' of care. PHOs provide the structure to implement the NZ Primary Care Strategy, a vision that sees people enrolled in local primary health care services that improve their health, keep them well, are easy to access and help to coordinate their care.[4]

Canterbury's five PHOs work in a collaborative model with each PHO taking a 'lead' role in the implementation of different projects and initiatives which ensures that major service developments are driven through a single infrastructure. This provides our population with collaborative primary health care services that a more competitive service model might not. The sharing of knowledge and resources also provides more equitable access to services across the Canterbury population and provides value for money by reducing the administrative costs and bureaucracy of completely separate PHOs.

We value our PHO and primary health care relationships and work closely on health system solutions for challenges such as acute demand management, reducing unnecessary or avoidable hospital admissions, building primary and community capacity and capability, after hours care, the management of long-term conditions and health promotion and population health initiatives. As the DHB seeks to build integrated pathways of care that begin with prevention, diagnosis and early intervention; partnerships with PHOs, general practice and other primary health care providers will be central to our success. We will continue to meet regularly to jointly address key issues and plan future initiatives and to ensure PHOs, general practice and primary health care representatives have input into DHB plans and strategies.

As part of our focus on the whole of the health system the DHB will seek to work with PHOs on establishing clear outcomes for our community and will work in partnerships to achieve those outcomes.

Public Health Partnerships – working with Other Organisations and Agencies

The social determinants of health (e.g. education, housing and income) have a major influence on health outcomes, but often influence over these determinants sits outside the health system. Our partnerships with other agencies, Mental Health Commission, Child, Youth and Family, Police, Housing NZ, the Ministries of Education and Social Development and ACC, are vital in helping to create policies and social and physical environments that reduce the risk of ill health.

The Canterbury DHB's Community and Public Health Division delivers population and public health services in partnership with a number of these agencies, local councils, our regional council and primary health care providers and leads collaboration on issues such as the prevention and control of communicable diseases and emergency planning to ensure preparedness for a natural or biological emergency.

The Community and Public Health Division also supports the development of healthy and safe physical environments, with a focus on safeguarding water quality, biosecurity (protecting people from disease carrying insects and other pests) and using resource management processes to achieve healthy outcomes. This includes an emphasis on promoting the importance of urban design in good health and making '*the healthy choice the easy choice*' through healthy housing, smokefree environments and environments that encourage physical activity.

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

Empowering our community to make healthy lifestyle changes relies heavily on a comprehensive cross-sector approach and support is actively given to a number of collaborative ventures and initiatives which endeavour to improve health outcomes for our population. The focus of these partnerships is on the reduction of behavioural and environmental risk factors to reduce long-term conditions and injury, including improving nutrition and physical activity to reduce obesity and reducing tobacco smoking, alcohol consumption and risk behaviours. Working collaboratively to provide 'safe' environments for our younger populations is also a key focus.

Strategies to reduce inequalities in health outcomes means Community and Public Health will prioritise work in settings and communities of high need such as education settings, workplaces and Māori and Pacific communities. The Division also identifies and shares information about our population's health status and what affects it, and will continue to provide training and support for community groups to improving their effectiveness in dealing with health issues.

Regional DHB Partnerships

The six South Island DHBs have jointly established the South Island Shared Services Agency Limited (SISSAL) which works with them providing services such as: contract and provider management, audit, analysis, service development and project management. This regional approach not only provides a forum for joint learning and collaboration but also reduces administrative costs and bureaucracy by not replicating these services in every South Island DHB.

Through SISSAL, the South Island DHBs are working on regional health services planning. The purpose of this collaborative approach is to provide a regional overview of health care and to challenge current service configurations to improve efficiency and effectiveness. It will allow the six DHBs to forward plan and align resources to meet the needs of our populations and the wider combined population of the South Island.

As the largest provider of hospital and specialist services in the South Island the Canterbury DHB provides services to people from DHBs who do not have the capacity or capability to provide these services. While those DHB's are responsible for meeting the cost of these services, we have a limited workforce and limited theatre and bed space and are mindful of the need to balance this regional service provision with the provision of services to our own population.

As other South Island DHBs consider alternative and innovative ways of delivering services to cope with future demand, we will all have input into planning that may impact directly on our collective ability to provide for our population. We are committed to regional collaboration having agreed to and commenced collaborative planning processes around elective services, health service planning, public health and mental health services and cancer services. Our work with the five other South Island DHBs will support strong clinical networks, provide clear long-term signals around service planning and enable better use of resources to improve and increase service capacity (refer to Appendix 4 for an outline of the agreed direction for a number of South Island collaborative plans).

National DHB Partnerships

The 21 DHBs also work in partnership to progress common issues and initiatives and have established District Health Boards New Zealand (DHBNZ), to provide coordination of activities at a national level. It is expected that in areas where DHBNZ is active, overall costs for DHBs collectively should be reduced by doing things once rather than 21 times. DHBNZ is supporting the 21 DHBs in a range of areas including: primary health, workforce development, industrial relations, pricing and prioritisation tools, procurement, value for money and information systems.

DHBs also collaborate with each other and with the Ministry on national issues such as workforce and employment issues and during 2004/05 a tripartite agreement between all DHBs, the Ministry and the Combined Trade Unions was put in place in respect of employment matters. National multi-employer collective agreements (MECA) are also in place for major occupational groups such as nurses and senior and junior medical staff. DHB collaboration also occurs at all levels and across most professional groupings such as Chief Executives, Medical Directors, Nursing Directors, Planning and Funding Managers, Finance Managers, Human Resource Management, Quality and Information Services.

Other DHB Partnerships

In addition to regional and national partnerships, we have formed partnerships with other DHBs for provision of common services and collaboration to reduce duplication including: hosting the payroll system for West Coast DHB, operating a financial management information system in partnership with the Bay of Plenty and Waikato DHBs and collaborating with six other DHBs to acquire and implement a new patient health management record system. We plan to expand our partnerships with other DHBs for mutual benefit especially around information sharing systems in finance, laboratory, payroll/human resources and rostering.

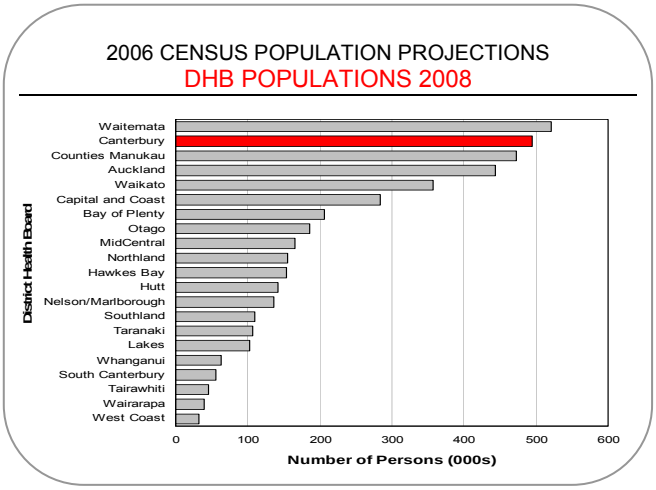
2 Our Environment - Identifying the Challenges

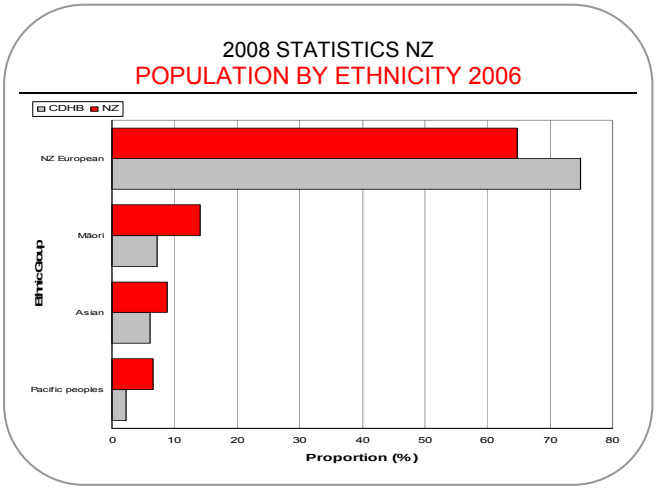
This Chapter provides background on the environment in which the Canterbury DHB operates. It outlines our population profile, identifies specific health issues faced by those in the Canterbury district and provides a summary of how operating pressures influence the choices the DHB makes.

2.1 Overview of the Canterbury Population

The DHB completed a health needs assessment in 2004, bringing together information describing the Canterbury population and the health status of Canterbury residents. Using this health needs assessment and a subsequent public consultation process we identified five Health Gain Priorities and four Disease Priorities where we believed there was the greatest opportunity for health gain or improvements in services delivery. These are identified in the following chapters.

The Canterbury District is the largest by geographic territory of all the DHBs, spanning from Kekerengu in the north to Rangitata in the south and Arthur's Pass in the West. It is home to 494,170 people, representing 12% of the population of New Zealand and making us the second largest DHB by population.





Age and Ethnicity

The age-ethnicity distribution in Canterbury is comparable to that of the rest of New Zealand. The Māori and Pacific population, both in Canterbury and nationally, are much younger than the 'Other' ethnicity population, which includes New Zealand European and Asian ethnicities. In 2008, 54% of the Canterbury's Māori and Pacific population was under 25 years of age, compared with 31% for the 'Other' ethnicity population. The national distribution was very similar, with 52% and 31% respectively.[5]

In contrast to these similarities in age-ethnicity distributions, the ethnic composition of the population in the Canterbury district differs considerably from that nationally. While Canterbury has a greater proportion of New Zealand Europeans (75% versus 65%), the proportions of Māori, Asian, and Pacific ethnic groups are considerably lower. Despite there being a smaller proportion of Māori in Canterbury than found nationally, they still represent a significantly sized population therefore, the DHB has a Māori Health Plan that recognises the disproportionate burden of poorer health outcomes suffered by this population group. We have identified *Māori Health* as a key Health Gain Priority for the DHB.

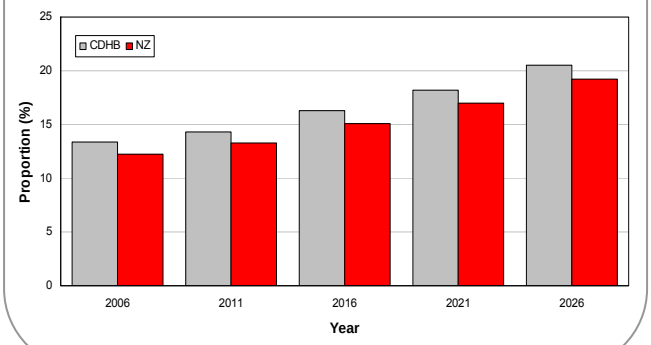
The population within the Canterbury district is ageing, with the proportion of the population over the age of 65 years expected to increase from 13% (64,500 people) in 2006 to 21% (115,450 people) by 2026. This increase is similar to that expected nationally over the same time period although the proportion of people over 65 years of age in Canterbury will remain approximately 1% higher the proportion nationally.

[5] *Projected ethnic population of New Zealand – by age and sex, Statistics New Zealand, 2008.*

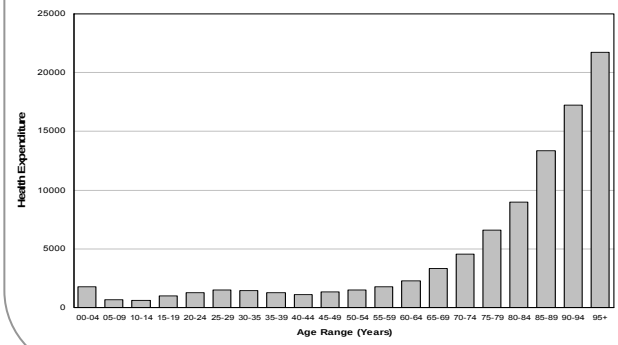
This demographic change has a number of significant implications for the provision of health care services, both in Canterbury and nationally. Age is a strong indicator of the need for health services, with older people being significantly higher users of health and disability support services. As a result, health expenditure by age group increases dramatically over the age of 65 years, from a mean annual per capita (per person) health expenditure in 2001 of $3,321 for the 65-69 age range to a peak of $21,738 in the same year, for those aged 95+.

As the proportion of those aged 65+ in Canterbury increases, so too will the demand for health care services and the funding required to care for this demographic. Any increase in demand requires increases in capacity, both in terms of funding and workforce; however, the current economic climate dictates that new health dollars are limited. Moreover, while the proportion of those over 65 is increasing, the proportion of Canterbury's population of working age is decreasing, raising concerns over the availability of sufficient workforce capacity to meet the predicted increase in demand for services. We have identified *Older Person's Health* as a Health Gain Priority for the DHB.

2006 STATISTICS NEW ZEALAND
PROJECTED POPULATION 65+



TREASURY 2002*
MEAN ANNUAL PER CAPITA HEALTH SPEND 2001



Social and Economic Environment

To a large extent, the environment within which we live, the social, economic, and physical, determines our health both as individuals and as a community. Social and economic factors, such as education, housing, and income, are now widely accepted as contributing greatly to a person's health. These determinants of health form the environment within which population health outcomes can be achieved.

In New Zealand, the relationship between socioeconomic status and health outcomes is estimated using the New Zealand Index of Deprivation (NZDep2006). This tool estimates population health using a measure other than disease status, and is constructed using nine Census 2006 social and economic variables including income, home ownership, family support, employment, qualifications and transport. It provides a summary deprivation score from 1 to 10 for small geographic areas, where a score of 1 represents the least deprived 10% of areas, and 10 represents the most deprived 10% of areas.

In contrast to the distribution of deprivation nationally, which is essentially uniform across the 10 deciles, Canterbury's distribution favours the lower decile scores, associated with better health outcomes. Both in Canterbury and nationally, the New Zealand European/Other ethnic group had the lowest deprivation scores across all NZDep2006 socioeconomic indicators with the exception of level of educational achievement, where the Asian ethnic group provided the lowest scores.[6] Across all ethnicities, Canterbury's rates of unemployment and household overcrowding were lower than the New Zealand average.

2.2 Key Health Trends in our Region

Measuring health status, behaviours and risk factors is important for setting health priorities and ensuring equitable provision of appropriate health services. Health is often defined in very broad terms, thus posing difficulties when

[6] *Canterbury DHB Health Needs Assessment, Ministry of Health's Health and Disability Intelligence Unit, September 2008.*

** Population Against Health Expenditure New Zealand 2002-2051, Scobie G, Creedy J, Treasury 2002.*

determining what is meant by health status and behaviours, and how they would be measured. This section provides a brief overview of a range of indicators of health status, behaviours and risk factors that describe aspects of health.

Mortality and Morbidity

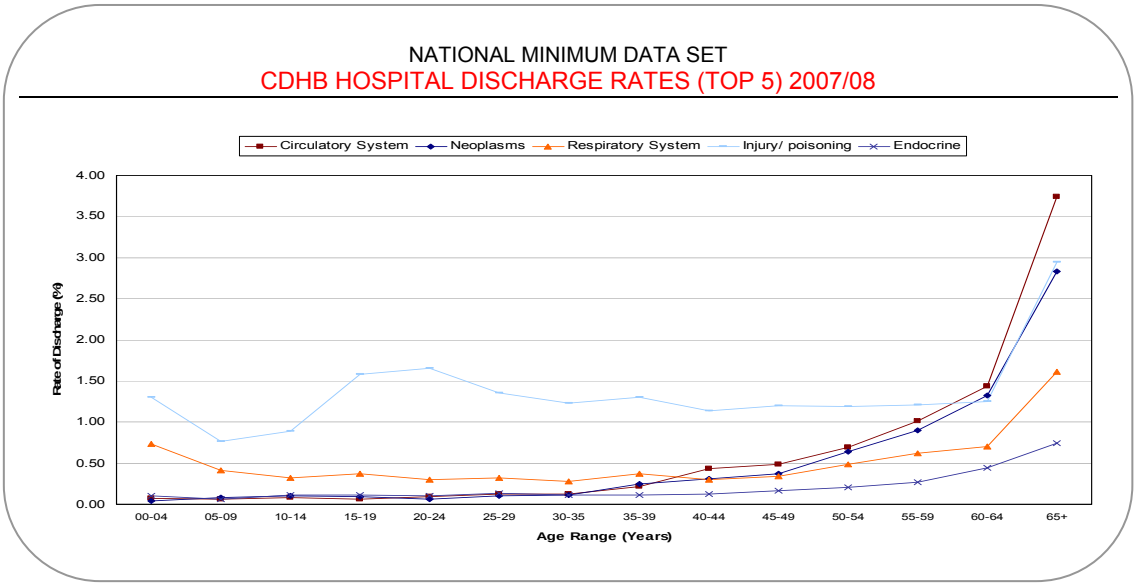
Approximately 3,307 people die in Canterbury each year and the top five causes of death are consistent with those at a national level.[7] Diseases of the circulatory system including ischaemic heart disease and cerebrovascular diseases (e.g. heart attack and stroke) account for the majority of deaths both in Canterbury (42%) and nationally (40%). The prevalence of these diseases is higher among people with disabilities.

Neoplasms (all cancers) are the second most common cause of death (28%), followed by diseases of the respiratory system, which include chronic obstructive pulmonary disease (COPD), injury and poisoning and endocrine disease including nutritional and metabolic diseases and immunity disorders (e.g. diabetes). It should be noted that diabetes is also an underlying causative factor in a significant proportion of people dying of circulatory diseases and therefore contributes significantly to the top five causes of death in Canterbury.

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

Compared to national averages, Canterbury's rates of discharge are lower across all ages for all conditions.[8] However, the morbidity associated with these causes still presents a significant burden on the health system. Many hospital admissions are considered 'avoidable hospitalisations' that could have been identified and treated earlier through primary or community intervention, thereby preventing the deterioration that resulted in hospital admission. Examples include angina, respiratory infections, asthma, complications of diabetes and vaccine preventable diseases.

Consistent with hospital discharge rates, the estimated rate of avoidable mortality in Canterbury (157 per 100,000) is significantly lower than the national rate (177 per 100,000).[9] Although encouraging, this still represents a substantial and potentially avoidable burden on our health system and, at the same time, highlights opportunities to reduce the level of morbidity in the population. We have identified *Primary Health Care* as a Priority area for the DHB along with four Disease Priorities: *Cancer*, *Cardiovascular Disease*, *Diabetes* and *Respiratory Disease*.



[7] *Mortality by Ethnicity 1996-2003 (average of combined 1999-2003 total), New Zealand Health Information Service (NZHIS), 2006.*

[8] *The exception is neoplasms (cancers) in the 5-14 age range, where Canterbury rate is slightly higher than the national average.*

[9] *Canterbury DHB Health Needs Assessment, Ministry of Health's Health & Disability Intelligence Unit, September 2008.*

Health Behaviours and Risk Factors

Health behaviours and risk factors, such as a sedentary lifestyle, obesity, poor nutrition, drinking alcohol at hazardous levels and tobacco smoking, are known to be significant contributors to poor health outcomes. Compared to the national average, Cantabrians have lower obesity levels, eat more fruit and vegetables, and are less likely to be regular smokers. Despite this, they exercise slightly less regularly than the national average and almost a quarter of Canterbury's population over the age of 15 years (over 96,000 persons) are obese, with a body mass index (BMI) of 30.0 kg/m2 or more.[10]

The main adverse health consequences attributable to obesity are cardiovascular disease, type 2 diabetes, and several cancers. As a result, obesity is one of the world's leading preventable causes of death. Of even greater concern is the rate of obesity in children aged 0-14 years; more than 5,700 children in Canterbury were classified as obese in 2007/08. Child and adolescent obesity has increased dramatically over recent years and is associated with several important chronic diseases such as diabetes, asthma and sleep apnoea as well as social discrimination, poor self esteem and depression.[11]

When it comes to alcohol, Cantabrians are as likely as other New Zealanders to drink in a hazardous manner, with a proportion of 21% in both populations. This corresponds to over 103,000 Cantabrians, constituting a major public health concern. Hazardous drinking has a wide range of adverse effects on health, including cirrhosis of the liver, pancreatitis, high blood pressure, haemorrhagic stroke, and a range of cancers. It also contributes to death and injury on the roads, suicide, assaults and domestic violence and some mental health disorders and sexual health problems. If consumed in a hazardous manner during pregnancy, alcohol can also lead to birth defects in infants, including foetal alcohol syndrome.

Tobacco smoking however, is the single most preventable cause of death in the world today. It is a major risk factor for six of the eight leading causes of death in the world, including ischaemic heart disease, cerebrovascular diseases, lower respiratory diseases, tuberculosis, and a range of cancers.[12] Tobacco disproportionately impacts on Māori and Pacific people, and is seen as a substantial contributor to socioeconomically based inequalities in health. Despite the prevalence of smoking in Canterbury (18.3%) being lower than that nationally (19.9%), over 91,800 people were regular smokers in 2006.

The negative health outcomes associated with the above health behaviours and risk factors represent a significant burden on the health system. However, the health behaviours and risk factors also represent an opportunity for prioritising health services and interventions that have the potential to significantly reduce this burden. We have included *Disease Prevention and the Management of Long-term Conditions* in our mix of Health Gain Priorities and also *Child and Youth Health* with a focus on setting good foundations at an early age and promoting healthier lifestyles to young people to reduce the risk behaviours that adversely affect health outcomes.

2.3 Demand Pressures

A number of factors contribute to the increasing demand on health and disability services in Canterbury: the increase in long-term conditions including cancers, diabetes and respiratory conditions, advances in diagnostics and treatment technology and rising public expectations. However, it is the changing demographics of our population that is likely to cause the majority of the pressure on our health care services over the next decade.

Demand for many of our services is growing at a faster rate than the growth in our population; particularly for services used predominately by older population groups. Between 2001 and 2006 our total population grew by 10%, and over the same five years the number of people aged over 65 increased by 11% and those over 85 by 21%.

In 2006/07 there were approximately 65,900 inpatient and day-case discharges from DHB hospitals in Canterbury. This represents a 14% increase over the five years since 2001. Assuming that we continue to provide services at the same levels, and in the same way, population forecasts indicate a 22% increase in medical and surgical admissions by 2021. Forecast demand for rehabilitation services, which is more directly affected by the age of our population, indicates the need for rehabilitation beds will increase 47% by 2021.

Discharges for acute (emergency) services in Canterbury have increased 16% over the last five years. Acute demand is a key area driven by demographic changes and by the increase in long-term conditions and because acute services often

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[10] *Obesity in New Zealand: How obesity is measured, Ministry of Health, 2009.*

[11] *Obesity: Genetic, molecular and environmental aspects, Barness LA, Opitz JM, Gilbert-Barness E – A J of Med, Genet Part A 143A:3016-3034.*

12 Closing the gap in a generation: Health equity through action on the social determinants of health. Commission on Social Determinants of Health. Geneva, World Health Organization, 2008.

take priority and use the same staffing and resources it puts at risk our ability to deliver elective (planned) services. This is of particular relevance as we strive to meet the Minister's priorities for delivery of increased elective services volumes and compliance with national elective services indicators which measure timeliness and access levels. We need to achieve an increased level of elective volumes and compliance with electives indicators in order to maintain access to a number of significant funding streams that enable us to provide additional services for our population.

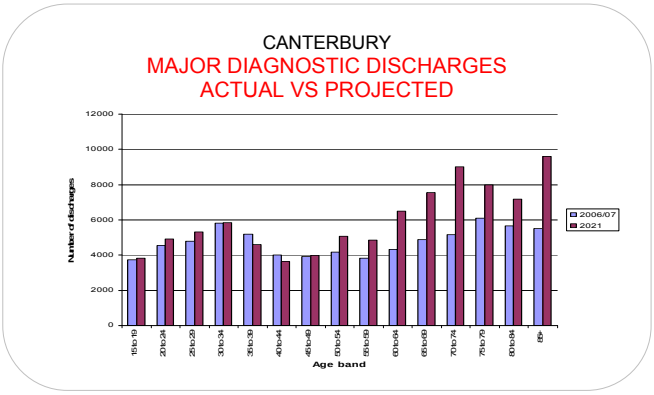
Increases in acute demand spill into increased attendances at the Emergency Department (ED), which have increased 15% in the past five years.[13] Growth has also occurred in the lower triage levels (where people presenting do not require hospital level care) and in the number of 'self' and ambulance referrals. Of all self referrals only 30% are admitted to hospital, suggesting that many could receive care in alternative setting, such as general practice or in their own homes. The Canterbury DHB funds a range of alternative services provided in the community and coordinated by primary care under the Acute Demand Management Strategy. Our urban population also continues to have access to a 24-hour primary care after hours facility.

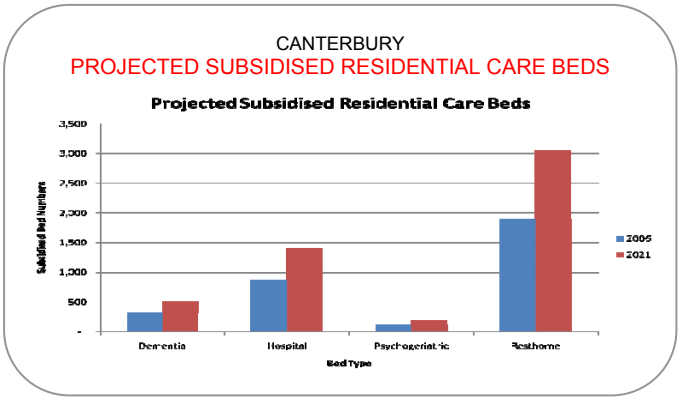
The Canterbury DHB also provides most of the tertiary level (highly specialised) services for the South Island and a significant volume of the higher level secondary care for residents of other South Island DHBs. Our capability to provide tertiary services to a growing number of people is a significant driver of demand, in particular the ability to intervene successfully at older ages. The capacity of other South Island DHBs to provide secondary care to their populations has been significantly challenged over recent years due to a combination of retention and recruitment issues around specialists and nursing. It is expected that demand for this inter-district service provision will continue to grow. This has to be carefully managed to avoid the potential to adversely affect service delivery to our local residents, in that other DHBs will refer their more complicated cases that will have a higher level of need – therefore taking priority over our residents in the standardised electives booking system. Our collective regional electives planning has focused particularly on this issue.

The changing demographics of our population also places similar demand pressure on primary and community services. Canterbury residents visit their GP on average 2.5 times a year, with those aged over 65 attending more regularly. There are 394 General Practitioners (GPs) in the Canterbury district; 1 GP for every 1,184 people (however the real ratio is less as many GPs do not work full-time and we are already experiencing access issues in some areas). Assuming current attendance patterns we would need an additional 68 FTE GPs by 2021 to meet the demands of population growth.[14]

Demand pressure is particularly evident in the aged residential care sector. In 2004/05 7% of people over 65 received a residential care subsidy in Canterbury (for rest home, long-stay hospital or dementia care). Assuming current admission practices and the projected growth of our population, forecasts indicate we would need to fund an additional 2,000 residential care beds in Canterbury by 2021.

The management of demand, particularly acute demand, will be a key priority for the DHB in 2009/10 along with a focus on the provision of elective services. The DHB's strategies are outlined in Chapters 6.4 and 8.1.





2.4 Workforce Pressures

National and international competition for scarce workforce resources in some clinical specialties and nursing areas and a decreasing working age population, are making it increasing challenging to recruit and retain health professionals. A

[13] *Christchurch Hospital ED data only.*

[14] *General practice workforce figures are sourced from PHO Performance Programme Provider Templates, April 2008.*

report prepared for the Ministry, predicts that if health and disability services were to retain their current share of the working-age population, demand for labour will outstrip supply as early as 2011.[15]

We are fortunate in that our staff turnover rates are relatively low; the average time spent working at the Canterbury DHB is 9.2 years, compared to an average of 7.3 years across all DHBs. However, the average age of our workforce is 44.7 years, slightly higher than the all DHB average of 44.4 years, and 10% of our workforce is over 60 compared to 7% three years ago. The workforce age poses an even more immediate challenge in rural areas where the average age is 50.5 years. As demand increases we will struggle to find the workforce needed to continue to deliver services as we currently do.[16]

Preferred working patterns will also be a factor in our inability to continue to deliver services using current service models. 41% of all our employees are now working in a permanent part time capacity. Senior Medical Officers (SMOs) have the highest percentage of part time positions with 56% of our SMOs employed on a permanent part time basis, an increase from 54% in 2007. Females are also more likely to work part-time than males and 81% of our workforce is female with 49% of our nursing workforce employed on a permanent part time basis.

Workforce pressures will have the biggest effect in terms of our current clinical working models, as clinical staff make up 79% of our workforce. While we strive to provide a rewarding and positive environment that supports the retention of our workforce, and will continue to identify areas of improvement. We also recognise that in order to cope with future demand we need to work smarter and ensure that we make the best use of our available clinical workforce.

As the largest health and disability provider in the South Island we must acknowledge that the workforce pressures currently being experienced, and forecast to continue, will pose a relatively greater challenge to smaller service providers. These providers are less likely to possess the surplus of skills required to withstand a shortage, and may struggle to provide wage and salary levels sufficiently high to retain existing staff and attract new people into the health care and support professions. We must also consider the workforce pressures on smaller DHBs in the South Island and prepare for the likely growth in inter-district referrals for tertiary and higher level secondary and specialist services.

To mitigate workforce pressures the DHB is activity involved in both regional and national health workforce initiatives, including extending the scope of practice of some health professionals to compensate for a shortage in other specialities. We support training for primary care teams and community support workers, train-the-trainer programmes, health scholarships for Māori and school road shows in efforts to extend the capability of Canterbury's health workforce and to ensure the quality of initiatives and services being delivered in the community. We also support clinical governance and clinical leadership.

Workforce predications give a sense of urgency to the need for transforming the way we work and developing alternative models of care and service delivery supported by an integrated electronic health record system to ensure we can continue to provide services in line with public need and expectations. We have already begun development of alternative service delivery models to ensure ongoing provision of specialist services in rural areas and 'Making Time for Caring' models in our hospital services which free up clinical staff to spend more contact time with patients. The continued development and delivery of alternative service delivery models will be a priority in 2009/10.

2.5 Financial Pressures

Over the past ten years an increasing share of Government expenditure has been going into health, however with the weaker economic outlook, the Minister of Health has given clear signals that the health sector cannot expect to receive funding increases at previous levels. The world-wide downturn in the economy will have significant implications for Government spending and will mean ongoing challenge for the health sector. New Zealand is experiencing weaker real growth and rising unemployment and is facing a period of sustained operational deficits. The economic downturn is also likely to increase demand for health services with the added risk of people cancelling private health insurance. The income of the population has an impact on the determinants of health and as such a downturn in the economy and rise in unemployment is likely to result in increased demand.

Government is looking to DHBs, and the whole of the health system, to re-think how we deliver improved health outcomes in more cost effective ways while managing within a more moderate growth platform now and through the medium to

[15] *Ageing NZ and Health and Disability Services: demand projections and workforce implications, 2001-2010 (NZIER 2004).*

[16] *Local DHB figures come from our Workforce Profile Report, as at 31 March 2008, with National figures from the DHBNZ Future Workforce Health Workforce Information Base Data Report as at June 2008.*

long-term. The Canterbury DHB is committed to planning and funding services that best meet the needs of our population and to meeting the expectations set by the Minister of Health – we are aware that this must be achieved within the limits of current funding.

Numerous factors contribute to the financial pressure on DHBs: the cost of demand growth; wage and salary increases; increased diagnostics and laboratory services; increasing costs of residential care services; lower New Zealand currency affecting prices of treatment related costs such as pharmaceuticals, clinical supplies; new technology; and compliance costs. Many of these costs are growing faster than our funding levels. In several areas the Canterbury DHB also spends relatively more than other DHBs, such as pharmaceuticals and residential care services. Our current levels of expenditure and delivery are not sustainable.

If an increasing share of our funding continues to be directed into meeting volume and cost growth, our deficit position will worsen. Not only will our ability to invest in capital and new initiatives be at risk, but also our ability to continue to maintain current service delivery to our population. We must make efficiencies and savings in order to maintain financial viability in the short-term and to enable the kind of investment in transformation that is essential to the long-term sustainability of the DHB and the wider Canterbury health system.

There is a clear urgency to achieving savings or efficiency gains:

- We must deliver against our responsibilities to Government in terms of a breakeven position by 2010/11;
- We must assure our population that we are providing the best value for money in terms of investing the funding we have available in efficient, effective and high value quality services that improve health outcomes; and
- We must free up funding in order to invest in transformational change that will enable us to meet the health needs of our growing population by 2020.

All areas of the organisation will be expected to make changes to ensure service delivery can be sustained. They will also be required to build into their plans efficiency targets that are ongoing, and represent significant gains, while also being realistic and achievable. A key focus will be on '*doing the basics well*' including collaborative production planning, improving productivity, maximising revenue streams and ensuring we receive adequate funding for the services delivered.

The DHB will also focus on containing cost and volume growth, both within our hospital and specialist services and across the primary and community services we fund. Containing growth in demand for services and related costs presents us with a challenge, but we have no choice if we are to reduce our budgeted deficit and invest in initiatives to transform our services in order to meet future demand pressures without a significant increase in our workforce.

The DHB already supports a number of mechanisms and strategies to minimise cost growth and achieve financial sustainability including: lean thinking processes, clinically-led service transformations and investment in clinical governance, collective collaboration with regional and other DHB's to share resources and reduce duplication and ongoing review of funding and expenditure in line with the DHB Prioritisation Principles to ensure value for money. We will also maintain a close focus on wage negotiations and employee management, given that salary and wage costs make up a major share of our total budget, and will work to achieve the Government's objective of redirecting resources towards front line patient care.

>> Key Principles for Managing Financial Pressures:

- Constrain expenditure to within the funding received.
- Reduce waste and duplication and improve the quality of patient care by adopting a standardised approach.
- Prioritise resources to meet increasing demand and to deliver the maximum health benefits.
- Take a whole health system approach to reduce unnecessary hospital admissions and manage acute demand.
- Manage the business of IDFs and ensure that the DHB receives the right funding for the services delivered.
- Re-allocate funding between discretionary and non-discretionary services to manage demand driven growth.

3 Our Strategic Vision - Meeting the Challenges

This Chapter looks to 2020 and considers the transformation required to meet the needs of our population in the future, outlining the planning principles and model of care developed over the past year and identifies the key focus for the DHB in terms of building the foundations needed for sustainable and lasting change. This chapter also summarises the DHBs current health gain priorities and provides an outline of the DHB's vision in action.

3.1 What will the Future Be Like - Looking to 2020

With a decreasing workforce capacity, financial constraints, and with our ageing population living longer with long-term conditions leading to ever-increasing demand for health service, there is a clear mandate for a significant change in the way health services are prioritised, planned for and provided.

Current population and demand needs would indicate that by 2020 Canterbury would need an additional hospital the size of Christchurch Hospital, 2,000 additional rest home beds and a 20% increase in the number of FTE GPs. In order to meet future demand and the needs of our growing population we will need to make significant changes to our models of care, the range and type of services provided, the location in which services are provided and potentially, recognising the limited resources available, access to some services.

The Canterbury DHB has acknowledged the challenge ahead and has begun a number of processes to identify the changes needed to equip the health system for the future. In the coming year the DHB combine its health needs assessment with regional health services planning in order to identify the needs of the wider South Island population.

This planning work, along with the identification of a clear vision and pathway forward to 2020 will be combined into an updated District Strategic Plan for Canterbury 2010-2020. The DHB will formally consult with stakeholders, its community and with clinical leaders on this Plan towards the end of 2009.

In the meantime our internal planning process and identification of the challenges we face have allowed the DHB to begin to put in place the foundations needed to improve service delivery and be in a position to undertake the transformational change that will be needed over the next three-five years.

>> Projecting out the increase in the total population and the age of that population, we will need another Christchurch hospital to cope with future demand if we don't change the way services are delivered.

3.2 Health Services Planning Principles

In the past two years the DHB has undertaken a Health Services Planning Programme to identify the challenges we face and to inform the future development of health services provided in the Canterbury district. The programme involved an extensive participatory engagement process with key stakeholders and consumers from across the Canterbury health system, designed to model a collaborative way of working and to facilitate a consensus on the way forward. The focus was on the re-orientation of the health system around the needs of the person, working across traditional boundaries to achieve the best possible health outcomes.

This Programme produced a Health Services Plan document providing a detailed account of directions and principles that will help ensure health services are developed to sustainably meet future health need and will also inform future physical infrastructure and workforce needs. The Health Services Plan direction and principles were presented to a wide audience of stakeholders and consumers and were endorsed by our Board in October 2008.

The principles recommended in the development of future health services are:

- A person/whanau centred approach, based on individual, whanau and community enablement;
- A point of continuity based in the community/primary care, with a trusted relationship;
- Consideration of the wider determinants of health;
- An individually tailored approach, with a holistic focus;
- Evidence based practice;

- Clinical responsiveness; and
- Management of the interaction between episodic intervention and the ongoing care of long-term conditions.

The resulting future direction will require a fundamental reorientation of our health system around a primary point of continuity based in the community, usually with general practice, and will require a range of community services and community based specialist support.[17] The shift of services from a secondary to a primary care focus is a direction that has been designed to meet our local health need and is based on international research, evidence and experience. It also meets the clear expectations of the Minister of Health of providing better, sooner and more convenient health care.

The key implications that will influence future service development are:

- An increased focus on supporting people/whanau to take greater responsibility for their health (both individually and in partnership with their health practitioner);
- The development of primary health care and community services to support people/whanau in a community based setting and provide a point of ongoing continuity; and
- The release of secondary care based specialist resources to be responsive to episodic events and support the provision of primary health care.

>> The Health Services Planning document is available on the DHB's website www.cdhb.govt.nz.

3.3 Developing a Vision for 2020

To supplement the work being undertaken through the Health Services Planning Programme, the DHB also began a process in 2007 named Vision 2020. Vision 2020 involved identifying and addressing the need for change and highlighted the impact that the demographic changes in our population will have on future service requirements, and the workforce capacity we would require to provide services in the future. The practical application of systems designed to address the need for change and the experience of other organisations in driving change were then considered, providing a basis for participants to understand the vision of the future in its entirety and the pathway and key steps to getting there.

A number of workshops have been held involving key stakeholders and local participants with the aim of establishing shared ownership of the direction of health service development in Canterbury. Vision 2020 will continue throughout 2009 and its outputs will link directly into the development of the DHB's new District Strategic Plan for 2010-2020.

Central to Vision 2020 is the development of a holistic system of health, within which there is a flow of seamless care for an individual rather than a series of episodic events. Key to achieving this is the development of partnerships in the patient journey and a system whereby a person will not need to be aware of which organisation will provide any particular aspect of their service, as it will be completely integrated.

3.4 Progressing that Vision – Sustainable Transformation

In the coming year the DHB will look to address the challenges we face that would otherwise hamper long-term progress. Much of our activity is planned to assist with addressing barriers to success and work has already begun which will provide the foundations to enable a change in culture and practice and allow us to create opportunities to change the way we deliver and fund health services in Canterbury.

Improving the pathway or the 'journey' for people through the health system is already a focus, and there is a clear recognition of the importance of a continuum of care between primary, community and hospital based settings. A successful continuum of care requires clinical pathways to be developed and agreed upon by all clinical groups and the pathways to be delivered in a patient-centric manner. The challenge for Canterbury is to develop a health system which safely supports care in the community and enables rapid diagnosis and transfer of care between settings. Primary and community services will require support from specialists and access to services for conditions previously regarded as requiring hospital admission.

[17] *This planning process and the subsequent redesign of services, has necessarily preceded the process of reviewing physical infrastructure (facilities). The future form of facilities will follow the understanding of service function.*

Achieving this type of transformation is reliant on breaking down the traditional boundaries between providers, types of care and service delivery models. In the Canterbury context it is expected that these changes will be clinician-led and supported by collaborative partnerships between organisations and health professionals. Clinicians will need to play an active role in budgeting for sustainable transformation.

Early developments include: consideration being given to the patient journey from a much broader perspective than simply a hospital event; improving the range of acute response services provided in a community setting; and implementing an electronic health record system to support and enable new model of care which will enhance general practice access to diagnostics and responsive secondary specialist advice. New arrangements that support collaboration across these boundaries are already staring to occur in work completed as part of the DHB's Referrals Project (now the Canterbury Initiative) and in specific priority service areas such as respiratory. Collaborative partnerships and clinical leadership has been critical to the developments to date and will continue to be a focus.

There are also significant issues for the DHB regarding the number of hospital sites currently in use and that some buildings do not meet seismic standards. The health services planning process has provided a basis for development of a Facilities Master Plan covering the DHB's major sites and buildings. This is also necessary to ensure that the new way of working envisaged by Vision 2020 is used to establish physical facilities that support the efficient and effective provision of health services as part of a continuum of care.

3.5 The DHB's Health Gain Priorities

In 2005 the DHB adopted a set of Health Gain Priorities and Disease Priorities during the development of our 2005-2010 District Strategic Plan. These Priorities took into consideration the health needs of our population, feedback from the community and stakeholders and the revenue available to the DHB at the time. We also considered national health trends and national expectations when establishing these local Health Gain and Disease Priorities.

We are currently in the process of reviewing our District Strategic Plan. However, our focus is still on improving the health of our population and on initial scan our identified Health Gain and Disease Priorities still fit well with national emphasis and with the challenges identified through our Health Services Planning and Vision 2020 work.

Until we complete the formal review of our District Strategic Plan we will continue to seek to achieve the goals we committed to in 2005. Activity in line with our priority areas will focus on improving health outcomes for our population, reducing inequalities in health status and improving the delivery and effectiveness of the services provided. Added to this will be the imperative that any initiatives or programmes developed under these priority areas will enable the DHB to build the foundations essential to drive transformational change and improvements in our challenging environment.

>> Health Gain Priorities:	>> Disease Priorities:
▪ Child and Youth Health ▪ Older People's Health ▪ Māori Health ▪ Primary Health Care ▪ Disease Prevention and the Management of Long-term Conditions	▪ Cancer ▪ Cardiovascular Disease ▪ Diabetes ▪ Respiratory Disease

3.6 Our Vision in Action – The Canterbury Initiative

The Canterbury Initiative began in July 2007 as a joint initiative between the Partnership Health PHO and the DHB. This programme has developed a range of new clinical pathways over the past 12 months and a new organisation structure has been established to support implementation and operational management of the new pathways.

The overall objective is to provide better outcomes for patients, develop effective and constructive relationships between general practice and hospital specialists and establish effective integration of services across the primary/secondary sectors. To achieve this objective the Canterbury Initiative has in general two key areas of work, namely Pathway Development and Pathway Implementation.

Pathway Development

Pathway development involves bringing together a range of representatives from general practice, hospital specialities, planning, funding and the community with the aim of designing consistent pathways across the primary/secondary sectors to inform alternative patient-centred models of care and provide service access in line with best practice.

The approach removes traditional boundaries by ensuring services are delivered in the most appropriate and convenient settings. GPs and hospital specialists provide clinical input and leadership in the design and implementation of new pathways and models of care and five clinical work-streams were initially established: child health, gynaecology, orthopaedics and musculoskeletal, plastics and respiratory. Further work-streams address common issues such as GP liaison, referrals between GPs and E-referrals; all aimed at improving the patient journey through the system.

We seek to offer a wider range of services provided by a wider range of people and to provide alternative care pathways in convenient, community-based locations. The approach is based on shared care and structured around the patient journey and is supported by clinical governance and evidence based best practice. It will help to minimise waits and unnecessary hospital visits and improve the continuum of care, leading to better health outcomes.

The pathways are tested through clinical review and pilots/trials and once finalised and signed off by the clinically-led teams, the focus moves to implementation and operational 'business as usual'. Implementation is likely to take different forms ranging from the establishment of new pathways within the existing infrastructure and ways of doing things, to the establishment of completely new approaches to service planning, management and delivery.

Pathway Implementation

To support the operational implementation of the new pathways the DHB has established the community-based Canterbury Initiative Support Organisation (CISO). The CISO will operationalise the work-streams and is responsible for the day to day operation of the integrated service on behalf of the DHB and Canterbury PHOs. This provides one infrastructural investment rather than separate set-ups through each of the five Canterbury PHOs and reduces the back-office and administration functions in favour of front line services. Having one point for implementing the pathways also allows for a standardised and consistent approach, clear interface between the primary/secondary sectors and equity of access and service quality for the Canterbury population.

The CISO provides financial management and facilitates payments for GP delivered services, establishes mechanisms to allow seamless health care delivery, provides continuous quality improvement and education and collects and collates information across the continuum of care. It also promotes active engagement with hospital specialists and general practices to increase the standard and proportion of care provided in the community. Services are delivered on a district-wide basis that builds capacity and capability within primary care and increases the delivery of specialist services in more convenient community settings. The increased primary capacity and capability will also free resources at the specialist level and increase our ability to provide more high level services to our population, with less waiting time for patients.

The CISO is governed by the Canterbury Initiative Governance Group comprising of GPs, hospital specialists, PHO and DHB hospital managers and DHB funders and chaired by the Chief Executive. The role of the Governance Group is to ensure the effective implementation of the newly developed clinical pathways, monitor the uptake of services in primary care and the impact on demand in secondary care, and to ensure collective decision making and accountability for outcomes.

Over the next year the CISO will implement the Respiratory Pathway to operationalise the integration of respiratory services. As initiatives are transitioned to the CISO, the Canterbury Initiative development group replaces them with new initiatives which are progressed through the same clinically-led process. This work has already resulted in the roll-out of a range of new subsidies for general practice delivered care including: excision of skin lesions, Mirena Insertion, pipelle biopsy, musculoskeletal steroid injections, spirometry and sleep assessments. The Canterbury Initiative will continue to progress new initiatives through 2009/10 and beyond including clinically-led treatment pathways for diabetes.

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

4 Achieving National Priorities

This Chapter summarises the Minister of Health's expectations of DHBs in the coming year, highlights the national Health Targets set for DHBs and outlines how we will monitor and report on our performance over the coming year.

4.1 The Minister of Health's Expectations

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

In setting expectations for the coming year there is a clear signal being given to all DHBs that it is a Government priority to deliver through existing resources and within existing DHB budgets. The Minister of Health wants the public health system to delivery better, sooner and more convenient health care by focusing on enhancing performance, increasing outputs, improving quality and managing resources effectively.

Improving hospital services, in particular their quality and availability, has been emphasised by the Minister in his expectations for the coming year. The Minister has also signalled an ongoing commitment to the NZ Primary Health Care Strategy and expects that DHBs will lay sufficient foundations for shifting appropriate secondary services to more convenient primary care settings.

The Minister has also demonstrated clear support for clinical governance and constructive engagement, signalling the need for strategic partnerships between clinicians and management and between DHBs, with regional cooperation as an essential part of the future direction. National collaboration will also be required with PHARMAC to implement the increase in community pharmaceutical funding by $180 million, nationally over three years, to expand the availability of subsidised community pharmaceuticals and cancer treatments.

The Minister's specific priorities for 2009/10 are to:

- Improve service delivery and reduce waiting times - increased elective and first specialist assessments and reduced emergency department and cancer treatment waiting times.
- Improve workforce retention - improved clinical staff retention and fostering of clinical leadership.
- Improve productivity and value for money with no deterioration of financial positions.
- Maintain a cap on management and administrative staff numbers at December 2008 levels.
- Implement the five Government commitments:
  - *Boost funding for medicines to expand the availability of subsidised medicines;*
  - *Kick-start the devolution of services to primary care;*
  - *Improve the quality of supervision in nursing and rest homes;*
  - *Increase respite-care beds so elderly can stay in their home for longer; and*
  - *Focus on post-natal stays to provide mothers with the choice to stay in birthing facilities longer.*

4.2 Achieving National Health Targets

To measure progress against national priorities and the Minister's expectations the Ministry have established a set of national 'Health Targets' with the anticipation that collaborative DHB focus will drive performance improvement across the sector. The Health Targets cover improvements across a range of areas, from 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 well the health system is impacting on the lives of New Zealanders.[18]

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

We are committed to making progress towards achieving the national Health Targets and the Minister of Health's expectations as set out in the table below. If factors beyond the control of the DHB prevent anticipated gains we will take appropriate corrective action to achieve the next best outcome. The activity planned to deliver on these Health Targets is outlined in Chapters 6-8 of this document.

Ministry Health Target and Performance Indicator		**DHB Target 2009/10**[19]	**DHB Priority**
Shorter stays in Emergency Departments.	95% of patients will be admitted, discharged or transferred from an Emergency Department within six hours.	Improvement to 95% by 30 June 2010.	Chapter 6.4
Improved access to surgery.	The volume of elective surgery will be increased by an average 4,000 discharges nationally per year (compared with the previous average increase of 1,400 per year).	Deliver 14,000 elective discharges in 2009/10.[20]	Chapter 8.1
Shorter waits for cancer treatment.	Everyone needing radiation treatment will have this within six weeks by the end of July 2010; and within four weeks by December 2010.[21]	Improvement to 100% by 30 July 2010.[22]	Chapter 7.5
Increased Immunisation rates.	85 percent of two year olds will be fully immunised by July 2010; 90 percent by July 2011; and 95% by July 2012.	Improvement to 85% for all population groups by July 2010.	Chapter 7.1
Better help for smokers to quit.	80% of hospitalised smokers will be provided with advice and help to quit by July 2010; 90 percent by July 2011; and 95% by July 2012. Similar targets for primary care will be introduced from July 2010 or earlier through the PHO Performance Programme (PPP).	Establish systems which will allow collection of baseline data and the provision of smoking cessation advice.	Chapter 7.4
Better diabetes and cardiovascular services.	(a) An increased percentage of the eligible adult population have had their CVD risk assessed in the last five years.	57.1% Māori 55.1% Pacific 68.9% Other 68.0% Total	Chapter 7.6
	(b) An increased percentage of people with diabetes attend free annual checks.	>33% Māori >26% Pacific >44% Other >43% Total	Chapter 6.7
	(c) An increased percentage of people with diabetes have satisfactory or better diabetes management.	>70% Māori >56% Pacific >78% Other >77% Total	

4.3 Monitoring and Reporting Performance

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

- Monitoring against a mix of financial and non-financial performance indicators, performance goals and targets set in the District Annual Plan and the Statement of Intent and reporting on those to our Board and its statutory committees. Yearly publishing of an Annual Report.
- Monitoring and assessing the quality of services provided by our hospital and specialist services and by external providers; via service agreements. Monitoring includes reporting adverse incidents, routine quality audits, consumer surveys, service reviews and issues-based audits.

[19] *Unless otherwise indicated the DHB aims to achieved these targets by 30 June 2010.*
[20] *Elective surgical discharges exclude elective cardiology and dental procedures.*
[21] *This target excludes Category D patients who have scheduled treatment start dates.*
[22] *The DHB is committed to achieving the target of 100% of patients waiting less than six weeks. In order to meet this target, significant effort will be required in 2009/10 to maintain current performance while building DHB capacity and replacing the DHB's older linear accelerators.*

- Reporting to the Ministry against service contract requirements 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 quality benchmark indicators and national performance indicators.

Alongside the Health Targets the Ministry has also established a number of '*Indicators of DHB Performance*' to focus DHBs on priority health areas, monitor activity and compare DHB performance. The Indicators of Performance for 2009/10 are attached to this document (refer to Appendix 3).

Like the Health Targets, these indicators reflect the accountability that the DHB has for improving service performance and the health status of its population. There are a number of indicators in this mix where our ability to improve outcomes is not through direct service provision but through funding and influencing other providers and in some cases influencing our community. Where the DHB is funding the service but is contacting a third party to deliver improved outcomes, there is more of a risk around meeting Ministry expectations. We are reliant on contracting methods, facilitation and the development of partnerships to achieve the goals for each performance indicator.

Local targets have been set for the 2009/10 year based on expectations expressed by the Ministry, the latest national data and the latest Canterbury DHB specific data. The results are published on a quarterly basis on the Ministry website, www.moh.govt.nz.

The DHB will also look to compare our performance against that of other DHBs to ensure we are providing our population with value for investment and returning improved health outcomes. Quality benchmark reporting and standardised intervention rates are indications of performance and the DHB will also monitor achievement against national health targets to provide a basis for evaluation of performance.

Our planned actions will only be successful if they lead to a discernible improvement in the health of our population and a reduction in health inequalities. It is important therefore that we identify measurable indicators and targets by which we can then determine our success. We have identified a number of these indicators and targets throughout this document and in more detail in our Statement of Intent 2009-2012.

5 Key Risks and Assumptions for 2009/10

This chapter outlines the key risks for the DHB in the coming year, identifies major service changes and summarises where the DHB's funding will be allocated over the coming year. This chapter also outlines the assumptions the DHB has made in preparing the District Annual Plan and forecasting its financial position.

5.1 Key Risks

All DHBs face ongoing challenges and risks as they try to balance the growing need and demand for services against the requirements to improve the health of their populations, support clinical quality and ensure ongoing financial viability.

Continuing to deliver health and disability services to meet growing demand is going to be the most significant challenge for the DHB, particularly when considered alongside the workforce and financial pressures being faced by the health sector. In the coming year the management of these pressures will require constant restraint and a sharpened focus on doing core business well and delivering the best patient outcomes within available resources.

When considering the achievement of our goals and objectives the biggest risks facing the DHB in 2009/10 are:

Pandemic - H1N1

A H1N1 pandemic in New Zealand is likely to cause considerable disruption to current services and planned activity with potential additional costs for the DHB. The effect of this is very difficult to estimate and as such, our District Annual Plan has been prepared without allowing for a H1N1 pandemic occurring.

Addressing the Needs of Our Ageing Population

There are significant risks around future viability and sustainability in terms of all services provided to our older population, and particularly around the provision of aged residential care and home support services where the growth in service demand has outstripped the growth in funding and the availability of workforce. Compared to other DHBs we have the fifth highest aged standardised per capita utilisation of aged residential care and a higher than national average utilisation of home support services.

Workforce issues are significant in the aged care and home support sectors where the average age of the workforce is higher. Workforce shortages and a reliance on part-time, locum and agency staff also places pressure on quality and patient safety. We are managing these risks by working locally with service providers to find and implement effective local solutions and regionally with other DHBs to address wider aspect of demand related to our aging populations and the cost of residential care services. We have identified Older People's Health as a key priority for the DHB in 2009/10, where transformational change is needed in order to meet future demand for services.

Managing Growing Demand for Acute Services

The number of acute discharges has increased 16% over the past five years. This is a faster rate of increase than the growth in our population and in our funding. Acute demand has now risen to a point where it is above financially sustainable levels and is a significant risk for the DHB. Even if funding, bed space and resources were not limited, the DHB could not find the workforce numbers required to cope if demand levels continue to increase at current rates.

The impact of the current financial crisis on demand for acute services is as yet unknown. However, it is reasonable to assume that health status of vulnerable groups will be negatively impacted potentially increasing demand. In addition, it is likely that financial concerns will result in an increased proportion of our population bypassing fee-for-service acute demand facilities in the community such as general practice and after hours services, in favour of free Emergency Department services.

We need to reduce acute admissions in order to minimise the drain on resources and expenditure, bring hospital costs back to budgeted levels and ensure that we can meet Government expectations to increase the volume of elective services provided to our population. Reducing acute admissions will also improve health outcomes as people are supported to stay well, better manage long-term conditions and seek appropriate intervention early. This is key challenge for 2009/10 and several projects are in place to reduce acute pressure on hospital services.

Acute Demand Impact on Delivering Electives Capacity

The DHB needs to deliver additional elective services volumes to keep pace with the demand driven by our growing population and to improve service access to levels similar to those of residents of other DHBs. We must also ensure that we provide clarity, timeliness and fairness for those accessing elective services, which is reflected in our compliance with the eight national Elective Services Patient Flow Indicators (ESPIs).

Our ability to deliver elective services is dependant on maintaining the clinical staff and resources required and on our organisational fitness to deliver services effectively and productively. It is directly affected by increased acute demand growth which pulls on these resources. We will focus on reducing acute demand pull on elective service capacity and have a number of projects in place to reduce acute demand pressure.

The DHB has established a robust electives services process to oversee elective services achievement and to closely monitor ESPIs compliance. We will place additional emphasis on production planning in 2009/10 and will look to plan the delivery of elective services with a regional focus and to enhance public/private partnerships to ensure the delivery of increased elective services volumes to our population.

Recruiting, Retaining and Maintaining the Engagement of Our Clinical Workforce

The ability to meet demand for services is heavily reliant on having the right people, with the right skills, in the right place, at the right time. Difficulties are being experienced in recruiting and retaining health professionals in some specialities and these issues are not unique to Canterbury; being experienced both nationally and internationally. The impact is more significant in rural areas where isolation makes recruitment more difficult and where the average age of our workforce is higher.

As the fiscal situation tightens the DHB will not be able to sustain investment in new technologies and services. An associated risk is that clinicians will become disengaged from leading/supporting the changes required to ensure the DHB's sustainability. To mitigate against this risk the DHB will invest in clinical leadership frameworks and continue with initiatives such as the Improving the Patient Journey Programme and Xcelr8.[23]

We manage workforce risks through active involvement in local, regional and national health workforce initiatives, through strengthening of clinical governance and clinical leadership models and through effective human resource management. However as the workforce continues to age and change its patterns of employment, this risk will increase. To further mitigate longer-term risk we are working on more adaptable models of service delivery for rural services to ensure provision of specialist service to rural populations. We are also working on transforming the models of care in our hospital and specialist services, seeking to reduce duplication and waste to allow clinical staff to spend more direct time treating patients. The continued development of primary/secondary pathways of care will also help to build capacity and capability across the Canterbury health system.

Maintaining Patient Safety and Clinical Quality

Patient safety is a significant issue for all modern health services. Adverse events occur at an unacceptable level which as well as causing avoidable harm to patients, drives unnecessary costs.

To meet this challenge and manage the risk we will continue our commitment to patient safety improvement. This will include active participation in national Quality Improvement Committee (QIC) programmes. Including, in particular, active participation programmes including: adverse event (and near miss) reporting and engagement with other DHBs to learn and improve from these events and a programme to improve patient flow and to release time to care through more effective and efficient services design. This risk is managed through our Clinical Board and Quality and Patient Safety Council. In 2009/10 we will give increased focus to further development and strengthening of clinical governance and implementation of the DHB's Quality Strategic Plan 2007-2010.[24]

Managing the Costs of Wages and Salaries

The cost of implementing wage and salary settlements are a significant challenge to be managed by the DHB sector. Existing settlements are projected to outstrip funding within the next three years. In addition there are a number of wage negotiations to be completed in 2009 and 2010 which could increase this challenge significantly.

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

[24] *Appendix 7 provides an overview of the goals of the DHB's Quality Strategic Plan 2007-2010.*

Over the past three years we have been successful in realising efficiencies in the delivery of services and have disposed of some surplus DHB land which has helped to partially offset the cost of wages and salaries. However, alongside increasing acute demand pressures, finding further large efficiencies as we go forward is becoming increasingly difficult. The flow-on effect of DHB wage and salary agreements into the primary and community sector is also a risk in terms of price increase expectations and longer-term sustainability of smaller providers.

Wage and salary expectations and preferred working patterns are a factor in our inability to continue to deliver services using current service models. We will need to work smarter and ensure we are making the best use of our available clinical workforce. The DHB will continue to work collectively on this issue through sector-wide negotiations with different workforce groups and through close communication with sector and clinical leaders.

Continuing to Achieve Momentum for Efficiencies and Change

Over the past several years the DHB has been successful in realising efficiencies in the delivery of our hospital and specialist services. In the past year particularly, there have been increases in productivity and improvements in outcomes as new models of care became operational. However, finding ongoing efficiencies as we go forward relies on maintaining the buy-in and commitment of our staff.

Ongoing active management of resources and a continuing passion for improving outcomes are essential to ensure that the DHB continues to deliver services effectively and efficiently. Our objectives cannot be achieved unless there are continuing changes in organisational culture, behaviour and capability. We will manage this risk through our ongoing focus on organisational fitness and "doing the basics well", value for money, patient safety and quality, strong clinical leadership, ongoing review and performance monitoring and ongoing staff training and engagement in the future vision. We have a strong and positive commitment to using lean systems for process improvements and this is embedded in our internal training programmes and project methodologies.

Treatment Related Cost Pressures

A number of our treatment costs are demand driven, uncapped or provided on a fee-for-service basis. The greatest risk sits with pharmaceuticals (including pharmaceutical cancer treatments) laboratory services and diagnostic services where it is likely that expenditure will exceed budget and significant pressure will be placed on the DHB to meet these costs.

There are several drivers increasing expenditure on pharmaceuticals, laboratory and diagnostic services including our ageing population an increasing focus on population health screening, with diabetes and cardiovascular risk assessment programmes gaining momentum. We will manage this risk by working closely with other DHBs, pharmacy groups, laboratories and referred services providers to develop new agreements for services and manage the growth in fees for services. We will also work collaboratively to plan and better manage expenditure. Strategies will include alignment of clinical and financial accountability through a range of mechanisms including shared decision making processes with the clinician groups that refer to these services.

Increased demand for services, increasing expenditure on new technologies and changing clinical practice also drives up internal treatment costs and as hospital and specialist services activity increases so does the consumption of items such as: implants, instrument consumables, blood products, catheters and patient food. There are initiatives underway to better manage these cost and purchasing risks around the weakening NZ dollar, focused on contracting to achieve maximise cost benefits and favourable supply contracts and item and utilisation standardisation in line with best practice.

Inter-District Flows (IDFs) and Regional Service Viability

The Canterbury DHB provides IDFs in the form of specialist services to people from other DHBs where these services are not provided and we carefully balance this regional service provision with the provision of services to our own population. While other DHBs meet the costs in terms of IDF prices, a lag in the pricing of IDFs and using sector wide average costs means that prices do not always match the actual cost of providing IDF services.

The viability of services in neighbouring DHBs also has a direct impact on IDFs. In the event of a service failure in another DHB more people would be referred to our services. This is particularly relevant in terms of acute demand for services which not only impacts on our ability to provide for our population, but also on our ability to maintain elective service delivery. The risk will be managed through active engagement and dialogue with neighbouring DHBs around regional health services planning and through sector-wide negotiations around IDF pricing.

Compliance Costs and Achieving Fair Prices

There are a number of national specifications and programmes that the DHB is expected to implement where the funding allocated is not seen as adequate for that implementation. This includes new specifications for the Baby Friendly Hospital Initiative (around breastfeeding), the national Violence Intervention Programme and the B4 School Checks Programme. We are working with the Ministry to highlight these risks and to resolve disputes around prices and funding and will continue to work with other DHBs and the Ministry to address these issues.

Integrating Primary and Secondary Services

A partnership approach to managing future demand, workforce shortages and funding expectations is seen as key to achieving ongoing service sustainability and will create a number of opportunities to improve health outcomes for our population. The DHB has begun to invest in the development of primary/secondary pathways and to kick start the devolution of appropriate services to primary care. However, while the capacity and infrastructure of the primary care sector has been increased with the implementation of the NZ Primary Care Strategy there is some risk that this growth may not be enduring and workforce issues continue to emerge. The Board has committed to a specific strategy of building primary and community capacity and capability to support the long term sustainability of service delivery.

To minimise risk the integrated pathways being developed will be focused on the patient and not the provider and will be based on a clinically driven consistent approach with as little duplication and variation as possible. The DHB will also support the development of a single shared patient register as a base for primary/secondary activity which will identify unmet need in the Canterbury region as a means of more accurately identifying the capacity needed in the future.

5.2 Assumptions behind this Plan

Given the significant challenges faced by the DHB a number of assumptions have been made in developing this District Annual Plan. If these assumptions do not hold true this will limit the DHB's ability to implement planned initiatives and strategies or may lead to adverse financial outcomes.

Assumptions – *it is assumed that …*	
Baseline Funding	▪ The DHB's funding allocations will increase as per funding advice from the Ministry. ▪ Early payment is retained. ▪ We will receive fair prices (including from the Ministry) for services delivered.
Operating Environment	▪ The rate for capital charge will remain at 8%. ▪ No industrial action will occur over the coming year. ▪ There will be no revaluation of land and buildings (last revaluation in June 2006).
Price Increases	▪ External providers will operate within the available funding received after allowance made for committed and uncontrollable funding commitments. ▪ Price increases agreed collaboratively by DHBs for national contracts and any regional collaborative initiatives will be affordable and sustainable. ▪ Any increase in treatment related expenditure and supplies is maintained at affordable and sustainable levels and the introduction of new drugs or technology will be funded by efficiencies within the service. ▪ The budget transferred to PHARMAC for cancer drugs will be based on historical DHB funding. ▪ The PHARMAC budget for community referred spending is as agreed at sustainable and affordable levels and forecast savings are achieved.
Efficiency Realisation	▪ A DHB wide integrated production planning approach will be developed and used, allowing the DHB to generate further efficiencies. ▪ We are able to align our service and access criteria with that of other DHBs.

Demand for Services	▪ The DHB can establish joint primary/secondary pathways to reduce hospital and specialist service demand and overall service costs. ▪ The DHB can recruit the staff numbers to meet service demands or can make changes to service delivery models to align the available clinical workforce with demand. ▪ 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.
Workforce Costs	▪ Employee cost increases are based on terms agreed in current wage agreements. Expired wage agreements are assumed to be settled on affordable and sustainable terms. Efficiencies will be generated under the partnership programmes and tripartite agreements. ▪ Staff vacancies (existing and as they occur in future) will be reassessed to ensure the positions are still required, affordable and alternatives explored before vacancies are filled. ▪ Improved employee management can be achieved with emphasis in areas such as sick leave, discretionary leave, staff training and staff recruitment/turnover.
Costs of New Initiatives and Compliance	▪ The cost of any new initiatives or programmes and the financial impact associated with any new legislative, regulatory or compliance policies, required by Government, will be fully funded through specific additional funding allocations to the DHB. Any financial impact associated with changes to DSS boundaries between age related and non-age related services and any contracts or services devolved will be cost neutral.
Operating Costs	▪ Cost to deliver additional elective surgery volumes will be within the funding received and will be delivered by the provider arm in the main. Some outsourcing may be required but it would be only for a short term, within the funding received and assurance that productivity in the provider arm is at the same level for the outsourced service. ▪ The DHB assumes normal operations will occur and there will be no additional costs for dealing with H1N1 or disruptions associated with H1N1 or any other pandemic. ▪ All other expense increases including volume growth will be managed within uncommitted funds available or deferred.

5.3 Identified Service Coverage Issues

The Ministry's Service Coverage Schedule specifies the minimum access, scope and eligibility to publicly funded services that the population can expect. The Canterbury DHB is committed to meeting the national service coverage requirements and does not expect any exceptions to this to occur for residents of Canterbury during 2009/10.

In a small number of cases some highly specialised services are not provided in Canterbury and are only available on a regional or national basis. For those services we have funding arrangements with other DHBs so that services provided to our residents are funded appropriately by us. Likewise when residents of other DHBs come to us for specialist services (IDFs), those DHBs are responsible for meeting the cost of the services provided to their residents.

While we expect to meet national service coverage requirements, there are a number of services which are considered to be 'vulnerable', where challenges such as workforce shortages, profit margins or quality and safety issues may put the services at risk. We have worked with other South Island DHBs to identify these services and put a management plan in place to mitigate the risk of service failure. The identification of services identified as most vulnerable will be further developed as part of the South Island Health Services Plan (see Appendix 4).

5.4 Anticipated Service Changes

Over the past several years a number of major initiatives, reviews and quality programmes have been implemented to increase our capacity to deliver services and to improve the quality and effectiveness of the services being delivered. A number of these initiatives will continue over the coming year, with the DHB building on earlier success to further improve outcomes for our population. Service change may occur as a result of this continued implementation.

These include:

- Implementing the Improving the Patient Journey Programme and subsequent Patient Flow Projects;
- Implementing the Acute Demand Project in collaboration with primary health care providers and PHOs;

- Implementation of primary/secondary pathways identified as work streams of the Canterbury Initiative;
- Implementation of new service models in line with the Health Services Planning Programme and Principles;
- Implementation of local health strategies including: the Māori Health Plan, Mental Health Plans, Information Services Strategic Plan and Quality Strategic Plan; and
- Continued implementation of the recommendations of the Ashburton and Rural Health Services Reviews.

We recognise that continuing to deliver health and disability services to meet the growing demands of our population will be a significant challenge. To be in a position to be able to provide for our population's needs by 2020 we need to significantly transform the way in which we currently deliver services. We will need to work as one health system in order to provide a continuum of care that keeps people well, reduces acute demand and unnecessary hospital admissions and provides a restorative focus to get people back into their own homes and into the community.

In line with our Health Services Plan a number of key areas of opportunity have been identified where change and transformation is already occurring in order to enable the Canterbury health system to meet the challenges of 2020. Service change is likely to occur as a result of this transformation in areas identified in this document including: Improving Organisational Fitness – Doing the Basics Well; Older Person's Health Services; Mental Health Services; Managing Access and the Delivery of Urgent Care; Pharmaceuticals, Diagnostics and Laboratory Services; Long-Term Conditions (respiratory disease and diabetes); and Improving Quality and Patient Safety.

Alongside this transformation, the DHB will continue to seek efficiency gains by delivering the same service in more productive ways and by reducing duplication between services and providers. Quality improvements will assist in standardising processes and reducing variation and will focus on improving patient outcomes by freeing clinical staff for more direct patient contact time. Production planning will also assist in the reduction of duplication and variation as well as improving our use of staff and resources and reducing costs in our hospital and specialist services.

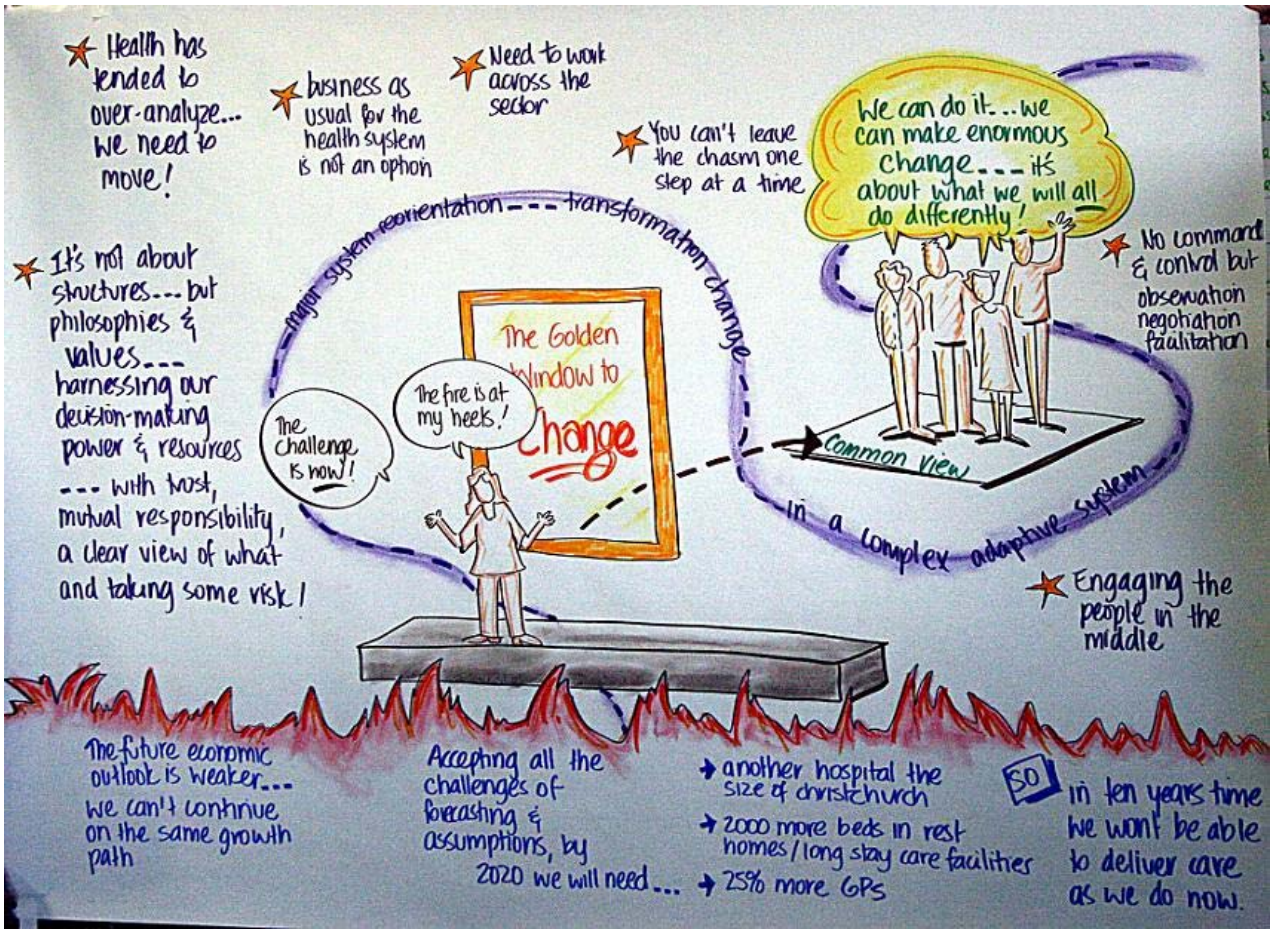
We will continue to ensure value for our investment through the regular review and evaluation of services and by using our prioritisation principles to question whether services are providing value for money and whether we can improve outcomes by delivering services in different ways. Regional collaboration and partnerships across the health system will support this work and allow a sharing of resources that will better support outcomes not only for our population but for the wider South Island. The DHB will also continue to implement Government policy and national strategies and will seek to meet the expectations of the Minister of Health.

It is anticipated that proposals for new models of care and new patterns of service delivery will emerge as this work progresses and it is possible that this will result in proposed service changes or changes to service arrangements. In this event advice to the Minister and consultation will occur as appropriate. Any service reconfigurations will also involve consultation with hospital or community based service providers and clinical leaders to determine appropriate solutions that best meet the needs of our community. Significant changes to services will involve consultation with the above groups and our resident population about the proposed change.

Service change or changes to service arrangements anticipated over the coming year fit into three categories:

- Implementation of internal reviews, initiatives or re-configurations to reduce bureaucracy, improve productivity, efficiency, value for money and quality and direct funding into front line services to improve health outcomes;
- Changes to service and delivery models to ensure continuation of service delivery, build capacity to meet future demand and reduce inequalities in health status; and
- Implementation of external national policy, reviews or strategy to ensure consistency across the sector, provide equity of access to service and improve health outcomes.

Action Planned Over the Coming Year …



Pictorial representation of Vision 2020 Workshop (November 2008)

The Canterbury District Health Board resolved the following directions to the Chief Executive for developing the new District Strategic Plan (2010-2020):

- to develop the District Strategic Plan to lead towards the Vision 2020 models of care within the budgets provided so as to enable a demonstrable positive impact on health outcomes across Canterbury's population groups;
- to progressively shift resources to support the Vision 2020 models of care;
- to encourage clinicians to take responsibility for meeting their budgets;
- to give consideration to ensuring the transformation is led and supported by clinicians; and
- to extend the quarterly Strategic Activity Report to incorporate the 2020 Vision.

6 Immediate Priorities to Enable Transformation - Key Focus 2009/10

Transformational Change

This District Annual Plan outlines the activity the DHB has planned to progress our strategic priorities and to meet national expectations. Without reducing the importance of these priorities and expectations we have also identified a number of key programmes or service areas for particular focus in 2009/10. These key areas will provide the DHB with the best opportunity to improve service delivery and health outcomes and to meet the challenges we face in terms of increasing demand, cost pressures and expectations.

The key focus areas for the DHB in 2009/10 are:

- Organisational Fitness – Doing the Basics Well;
- Older Person's Health Services;
- Mental Health Services;
- Managing Access and the Delivery of Urgent Care;
- Pharmaceuticals, Diagnostics and Laboratory Services;
- Long-Term Conditions – Respiratory Disease and Diabetes; and
- Patient Safety and Quality.

All seven areas are inter-related and focus on building the foundations needed to enable change and empower the DHB to make improvements in strategic priority areas and meet national expectations.

Improving organisation fitness, patient safety and quality and building pathways of care across primary/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). A concentrated focus on these areas will also allow the DHB to identify efficiencies and opportunities to improve productivity and effectiveness and allow the DHB to move funding and resources into patient services and investment to improve health outcomes for our population.

As the DHB moves forward in a tighter fiscal environment, and predicted workforce shortages develop, local and regional planning will be integral in meeting the growing demand for health and disability services. The focus that will be placed on service improvement is reflective of the Minister's emphasis on better, sooner and more convenient health care and much of the activity planned will involve primary, secondary and community service providers taking a wider patient-centred approach to improving the health status of the Canterbury population.

Much needs to happen to transform the direction of health care delivery and the challenge for the Canterbury DHB is to 'keep everything running and at the same time change everything'. Transformational change will focus on two key elements: alignment and adaptability - alignment through understanding and successfully operating our existing business and adaptability through exploring new, and often uncertain, opportunities.

6.1 Improving Organisational Fitness - Doing the Basics Well

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

The DHB aims to improve service quality and timeliness and to reduce waste, duplication and variation.

Why is this important?

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 we must ensure that the investments we make are returning benefits, that operations are effective and efficient and that the DHB is as productive as possible and is making best use of funding. Clinical leadership is seen as key to making improvements in quality and safety and in the effective use of resources with clinical decisions being made close to the point of contact leading to better patient outcomes. 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.

How will we seek to improve outcomes for our population?

The DHB has developed strong clinical leadership processes and will continue to identify and develop opportunities for clinical leadership. The Clinical Board comprises representatives from hospital specialties, general practice, nursing, allied health and consumers and provides advice to the Chief Executive and via the Chief Executive to the Board. The Clinical Board is seen as the keepers of practice standards, patient outcomes and patient safety. Clinical input is also viewed as essential to inform priority initiatives such as the Canterbury Initiative and the Improving the Patient Journey programme.

Improving the Patient Journey is a continuous quality improvement programme that is ongoing and ever evolving – a journey in change and not a destination. The core focus is improving the flow of patients through the hospital setting by removing delays and wastes to patient and clinical staff time. The programme is underpinned by the DHB's Quality Strategic Plan and lean thinking processes and until now has primarily been focused on DHB hospital and specialist services. The DHB will look to extend this programme in 2009/10.

The DHB has actively taken on the tools, techniques and philosophies of 'lean thinking' to engage the organisation in identifying improvement opportunities which will reduce variation and improve the patient journey. Lean thinking is increasingly being used in the health system as a means to improve patient flow and patient safety and most importantly as a means of empowering our health workforce to make continuous workplace improvements. Combining this approach with the DHB's proven production planning tools will enable us to balance hospital and specialist services activity in a resource constrained environment.[25]

Over the coming year the DHB will look to better understand its business, prioritise resources to meet increasing demand and deliver maximum health benefits within our available budget. This will likely mean a re-allocation of funding between discretionary and non-discretionary services to manage demand driven growth, taking a whole health system approach to reduce unnecessary hospital admissions and letting go and saying no to non-core services or services that do not provide the best value for money in terms of patient outcomes.

Eight key hospital and specialist service areas have been identified for internal focus over the coming year: child health, oncology/haematology, general medicine, general surgery, orthopaedics, cardiology, mental health acute inpatients and aged care services. We will also look to maximise health outcomes from improved management of follow-ups and outpatient services, intra-specialist referrals and inter-district flows between other DHBs.

The DHB also recognises that being an effective leader in health services, particularly in an environment of change, requires more than tools and techniques. A key challenge 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 the past year we have invested in two significant pieces of work, Vision 2020 and Xcelr8,

[25] *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.*

targeted at alignment, enablement and empowerment. Both initiatives are part of a longer-term programme for supporting leadership development throughout the Canterbury health system.

NEXT STEPS IN 2009/10			
	OBJECTIVE	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is the DHB trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
6.1.1 - Enable and empower Clinical Leadership.	To ensure quality and safety and effective use of resources.	Devolve decision making to clinician/ management teams with local accountability. Develop clinician-led pathways through the system. Identify clinical outcomes and report performance against these at Board meetings.	Continue involvement of clinical staff at all levels of the organisation. Decisions made with clinical input result in safer patient outcomes.
6.1.2 - Engage our workforce and community in improvement priorities.	To ensure our workforce is constructively engaged with the emerging challenges.	Communicate Vision 2020 messages to our workforce and the wider community. Provide front line leaders with the tools and skills to operating in a changing environment.	A shared vision and sense of urgency for change and transformation.
6.1.3 - Implement clear production planning processes and improve the capture and recording of activity.	To provide optimal surgical delivery and service provision within available resources in order to maximise patient outcomes.	Implement production planning processes that provide intent for electives/planned procedures that allows for an increase in production and in certainty of delivery. Improve the capture and recording of activity to ensure appropriate funding is received for services delivered. Manage the business of Inter-District Flows and ensure appropriate levels of IDF outflow occurs. Establish alternative pathways for specialist advice.	Improved access to elective procedures for our population. Value for money is demonstrated. Cost of IDF services match revenue. Duplication of services is reduced. More cost effective delivery of care.
6.1.4 - Continue to implement the Improve the Patient Journey programme.	To reduce waste and variation in service delivery and improve the quality of patient care by adopting a standardised approach.	Implement key programme streams: ▪ Surgical Programme; ▪ Making Time for Caring; and ▪ Improving the Radiology Journey. Increase the proportion of direct care time and improve wait times for acute surgery.	Provision of safe and effective services that improve outcomes for patients. Efficient use of resources and improvements in the ward environment. Improved staff engagement/morale.
6.1.5 - Re-allocate funding between discretionary and non-discretionary services.	To ensure value for money in terms of patient outcomes and investment.	Review all funding and expenditure against the DHB's prioritisation principles. Disinvest in non-aligned services or those with lower value for money.	Resources prioritised to meet increasing demand and to deliver the maximum health benefits.
6.1.6 - Progress Supply Chain Initiatives.	To identify opportunities to centralise, consolidate or improve business processes.	Agree savings, stock reduction and efficiencies. Standardise supply department and DHB-wide processes, using recognised benchmarks.	Clear rules and process established with users and suppliers. Improved processes generate savings.
6.1.7 - Optimise the contribution of management and administration resources.	To ensure that all management and administration positions are adding value to the delivery of health services.	Undertake ongoing review and justification of management and administrative positions. Report the level of management and administrative FTEs against the established 'cap' on a monthly basis. Where required, take corrective action to ensure the DHB's management and administration FTEs remain within the cap. Redirect released resources to frontline services.	Management and administration FTE remains within the cap established by Government. Any released or new resources are able to be directed to frontline services.

OUTCOMES
How we will measure our success (associated measures of performance).
A reduction in adverse events and maintenance of high patient satisfaction levels.
An increased in the volume of elective services delivered within current resources and compliance with Elective Services Patient Flow Indicators (ESPIs).
A decrease in the DHB's deficit financial position.

6.2 Older Person's Health Services

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

We aim to support people to stay well in their own home, for as long as possible and establish a sustainable level of service provision for the future by:

- Providing appropriate access to a range of support services in the community;
- Improving the quality of home based support services;
- Consolidating assessment processes; and
- Supporting and maximising the recovery of older people on discharge from hospital.

Why is this important?

Canterbury's population, like that of New Zealand, is ageing. Older people experience more illness and disability that any other population group and while their health issues are likely to be more complicated, older people can be supported to rebuild and even improve their functioning, for example, after illness. The number of older Māori and Pacific people in our population is also increasing and these population groups are over-represented in terms of the long-term conditions experienced by older people including diabetes, cardiovascular disease and respiratory disease.

Our ageing population is driving an increasing demand for health and disability services and aged residential care services. Compared to other DHBs we have the fifth highest age standardised per capita utilisation of aged residential care services and a higher than national average utilisation of home based support services. Demand forecasts demonstrate that at current utilisation levels we will need over 2000 residential care beds in Canterbury by 2021. Higher utilisation of residential care in the future will mean fewer resources available for other services including those which may better support older people to stay well in their own homes. An innovative and cost effective range of community based services focussed on keeping people well in their own homes will be required to sustainably meet the needs of older people going forward. We would not expect to see a drop in the number of residential care beds in the future but the increase needs to occur at a more sustainable level. [26]

How will we seek to improve outcomes for our population in the year ahead?

In developing our local Aged Care Strategy, *Healthy Ageing, Integrated Support*, it was clear that many older people have a strong desire to age in place, i.e. in their own homes or in retirement villages. Providing people have the adequate supports and have a manageable level of need, ageing in place will likely result in much higher quality of life and people may remain healthier for longer as a result of staying active and positively connected to their communities.

Our local Strategy is aligned with the national Health of Older People Strategy and with our vision of integrated continuums of care and clinical pathways that reach across the whole of health system to enable better management of long-term conditions. The emphasis is on flexible, responsive, needs-based care provided in the community to assist older people to stay well and to remain in their own homes.

The DHB will focus on effective health promotion and disease prevention to support people to maintain good health for longer. Effective primary health care services are important in keeping people well and reducing unnecessary hospital admissions - including effective screening, CarePlus and long-term conditions management programmes and medication management. We will continue to support ongoing work in these areas.

It is aged residential care services that are the greatest challenge for the DHB. If our utilisation was consistent with the national average 570 fewer beds would be required. The approximate cost of these extra beds is $17m annually and this level of additional expenditure is not sustainable. The net result is that we are not fully supporting the potential for older people to age in place in their own homes, while at the same time incurring additional expenditure. Supporting more older people in their own homes in the future will also place pressure on community based resources and this will need to be addressed through innovative recovery focussed services prioritised to those most in need.

In considering the Canterbury health system's capacity to meet the increasing demand for services, the DHB will focus on making the best use of aged residential care, home based support and hospital and specialist services. We will review the

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

model of care for older people with a focus on improving referrals pathways, ensuring coordinated and consistent needs assessment, building a strong community base and increasing stand-alone day support and respite care services. Coordination and assessment services will be augmented to improve integration of access for different service areas and to ensure people receive appropriate and timely review of their care. We will work in partnership with primary and community providers to provide a smooth transition between services and to emphasise a restorative/rehabilitation approach by better supporting hospital discharge. There will be a clear focus on ensuring thresholds for access to aged residential care facilities, home based support services and district nursing services are being applied appropriately and in line with national access levels.

Home based support services will be focused on supporting those people assessed as having a range of priority needs. As part of this process the DHB will no longer provide service to those people who only have cleaning needs and are otherwise independent, socially active and well. This will help ensure that service provision levels going forward can be sustainably provided and targeted to supporting people with a range of needs to age in place. Appropriate service provision and any changes to service provision will be determined for individuals only after comprehensive evidence based assessment, using InterRAI tools.[27] Services users will have their needs reviewed annually or more frequently as required.

The focus of specialist health services for older people is expected to shift from inpatient assessment, treatment and rehabilitation beds to a community-based focus that integrates with primary health care. The facility configuration for specialist services should match this focus and some re-orientation may be required. The DHB will also continue to focus on improving the quality of care for older people and will work collaboratively with providers particularly around improving capacity, quality, consumer satisfaction and workforce development. Our quality focus on residential care will be around ensuring the safety and wellbeing of older people and building the capacity of residential care to support residents in episodes of acute or end of life care.

Meeting the Minister's Expectations

The Minister has indicated an expectation that DHBs will be required to increase respite-care beds so older people can stay in their home for longer. In Canterbury, in the first year, this will result in five dedicated respite beds of mixed levels to meet a range of patient needs.

The second expectation related to older person's health is to improve the quality of supervision in nursing and rest homes. This will be achieved by supporting the national processes, providing the additional funding as agreed and by increasing our focus on quality improvement process in aged residential care services. In addition to the tagged funding for supervision, our approach will incorporate the systematic implementation of InterRAI to ensure that people receive the most appropriate services and to assist us to measure service quality.

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

NEXT STEPS IN 2009/10			
	OBJECTIVE	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is the DHB trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
6.2.1 - Implement tagged funding for respite care.	To enable older people to remain safe and well in their own homes and reduce acute demand.	Create predictable capacity for respite. Provide five dedicated respite beds of mixed levels to meet a range of patient needs.	Reduced acute admissions for older people. Less stress for caregivers. Fewer people enter aged residential care reducing residential care spend per capita.
6.2.2 - Engage across the system/Pan DHB to support older person's health service development.	To ensure the transformation of older people's health services is appropriately led by clinicians and consumers.	Align a shared direction for services with the DHB's Health Services Planning Direction. Establish a more transparent planning and review processes. Complete a review of assessment and service coordination pathways and identify service improvement opportunities.	Improved informed investment, disinvestment and system realignment. Improved integration and service provision - better and more convenient access to services. Appropriate location of services identified to provide improved outcomes for older people.
6.2.3 - Consolidate assessment processes to improve the quality of home based support services.	To improve assessment processes and provide flexible, responsive services to support older people to stay in their own homes and maximise their independence.	Improve consistency of assessment alignment between need and service access. Align access levels for short and long-term community-based services and residential care to national levels. Include client directed goal orientation to assessment and service provision. Develop responsive models of community support and establish the best approach to implementing the restorative model of support.	More effective community-based support services enable people to regain and/or maintain their health and independence. Older people benefit from the restorative home support services approach and remain functional at home. Reduced acute admissions. Fewer people enter aged residential care therefore reducing spend per capita.
6.2.4 - Improve referral services and services on discharge from hospital for older people and simplify referral pathways.	To provide more timely and targeted responses to the needs of older people and enable, people to return home with the necessary treatment and supports to restore functioning and maintain independence.	Develop/establish appropriate services to support discharge. Establish a single pathway into aged residential care with consistent eligibility criteria. Separate complex and non-complex assessment functions with clearly aligned accountabilities. Improve the identification and management of frail elderly and those with complex needs. Improve the assessment and review of people with non-complex needs and a targeting of home support to those with a range of needs, to support aging in place.	Consistent assessment processes and reliable access to services in line with national access. Home based support services, including cleaning services, focus on people with a range of needs and service requirements and are no longer provided to people who are otherwise independent, socially active and well. Improved service coordination for people with non-complex and complex conditions and improved use of clinical resources. Older people experience more timely recovery from illness and/or injury and are supported to remain in their own homes. Supported discharge reduces length of stay and improves outcomes for frail elderly.
6.2.5 - Focus on quality improvement in aged residential care.	To ensure residents receive consistently high quality health services.	Complete the InterRAI Tool Pilot and implement improved audit and audit tools for residential care services – focused on patient care services. Implement tagged funding for improving the quality of supervision and nursing in rest homes.	An understanding of the value of the InterRAI residential care tool and decision about the wider investment in the InterRAI. Reduced acute admissions from rest homes. Improved consumer satisfaction.

OUTCOMES
How we will measure our success (associated measures of performance).
Reduced waiting times for complex and non-complex assessment.
Reduced length of stay in secondary care or long-stay facilities.
Reduced ambulatory sensitive (unnecessary) hospital admissions for people over 65 years old.
Reduced acute admissions for people over 65.
Over time an increased ratio of people over 65 receiving home based care compared to the number of people in residential care.

6.3 Mental Health Services

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

We seek to provide a system of care that is integrated and responsive and provides faster access to services for people with mental illness and alcohol and other drug problems.

Why is this important?

It is estimated that at any one time 20% of the New Zealand population have a mental illness or addiction and 3% are severely affected by mental illness. While suicide rates are reducing overall, certain groups within our population continue to be a high risk. Research forecasts that depression will be the second leading cause of disability by 2020.[28]

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

How will we seek to improve outcomes for our population in the year ahead?

The DHB's system of care is based on advancing a recovery approach for people with serious mental illness. This marks a shift away from specialist hospital services towards community-based care with increased collaboration between providers, service users and their families/whanau.

This way of working supports three key principles which align with the DHB's Health Services Planning direction: community-based care backed up by specialist services, realignment of secondary services to be specialist and regional and support for a greater role and more responsibility for community and primary care services. Over the past several years the majority of additional mental health funding has been directed into primary and community-based services and investment has greatly expanded the range of mental health services available to our population.

Simplifying access pathways and improving access to specialist support and advice to enable more flexible service options continues to be a major focus. We have implemented a Single Point of Entry for Adult and Child and Youth Services and have increased consult liaison services for primary and community providers to support assessment and treatment for people who do not require case management within specialist services. These initiatives will support a continuum of care that enables people to access lower-level mental health services at a primary or community service level, with specialist support and intervention available when needed. We are making good progress with the introduction of a cross-sector referral form and shared triage process for access to residential rehabilitation services. The driver for this work is to reduce variation and duplication and ensure sector resources (residential services) are prioritised for those most in need.

As a means of ensuring quality across the continuum and reducing avoidable acute or unplanned hospital admissions, we will ensure long-term service user have crisis/relapse prevention plans in place to support self management and to support primary and community providers to better manage people affected by mental illness. We will also continue to facilitate sector forums and initiatives that will build capacity and capability across the mental health sector and support the development of consumer-led and peer-support programmes that provide more flexible options and build capacity.

Information databases are an essential resource when examining the mix of mental health services in our district. The information improvements we have made over the past year have lead to quite dramatic changes in service behaviour, and have greatly enhanced planning and funding decisions by building the 'big picture' of sector activity using equivalent sets of information across the health system. We will continue to expand this mental health database and see it as fundamental for informing planning and funding decision making. As part of our commitment to improving information we are participating in the national mental health KPI benchmarking project being led by Counties-Manukau DHB.

In the coming year we will continue to examine the range and mix of mental health services in Canterbury and critically evaluate whether this reflects the needs of service users and will enable us to meet future demands. Our activity will concentrate on the rehabilitation sector, alcohol and other drug services and developing a 'whole of sector' approach to planning and clinical leadership.

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

NEXT STEPS IN 2009/10			
	OBJECTIVE	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is the DHB trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
6.3.1 - Establish a cross System/Pan DHB Leadership process to support service development within Mental Health and Addiction Services.	To ensure the transformation of mental health services is appropriately led by clinicians and consumers.	Develop a shared direction for mental health services, aligned with the DHB's Health Services Planning Direction. Establish more transparent planning and review processes. Complete the review of assessment and service coordination pathways and identify service improvement opportunities.	Informed investment, disinvestment and system realignment improve efficiency of resource allocation and outcomes. Integration and service provision improvements provide better and more convenient access to services. Improved assessment and coordination services. Appropriate location of services identified to provide improved health and wellbeing outcomes.
6.3.2 - Re-orient the psychiatric rehabilitation system to reflect current best practice models.	To improve access pathways for people with mental illness and to enable the DHB to meet future needs within available resources.	Implement a clinician and consumer led response. Increase the range of community rehabilitation services available. Increase the number of people able to access rehabilitation services.	Access to support services is not conditional on residing in specific facilities. Information collected builds a picture of outcomes and assists in determining value for investment. Increased flexibility and responsiveness of services and a decrease in unplanned readmissions.
6.3.3 - Re-orientate the Alcohol and Other Drug (AOD) system and services.		Implement a clinician and consumer led response. Provide a broader range of flexible AOD community support options.	Improved efficiency of resource allocation and improved value for money. Reduction in unplanned residential treatment admissions. People are better supported to self manage their addiction issues.
6.3.4 - Ensure long-term clients have up-to-date relapse prevention plans.	To improve identification of early relapse warning signs and to reduce acute admissions.	Ensure at least 90% of all long-term mental health clients have current relapse prevention or recovery plans in place.	People are supported to self manage conditions and to be better managed in the community. Reduction in acute unplanned admissions.
6.3.5 - Implement the Canterbury NGO Mental Health Workforce Development Plan.	To support the development of a sustainable skilled and flexible mental health workforce.	Establish a Mental Health Workforce Development Advisory Group. Support the delivery of training programmes targeted to the needs of the Canterbury NGO mental health sector workforce.	The quality of mental health care is improved through consistency of training standards across the sector. The capacity and capability of the NGO Mental Health workforce is enhanced and strengthened.

OUTCOMES
How we will measure our success (associated measures of performance).
An increase in the number of people accessing mental health and rehabilitation services in the community.
An increase in the number of people accessing hospital and specialist service level mental health services.
Over time a decrease in the number of unplanned/acute admissions of long-term clients.
Over time a decrease in unplanned re-admission rates to inpatient specialist mental health and AOD residential treatment services.

6.4 Managing Access and the Delivery of Urgent Care

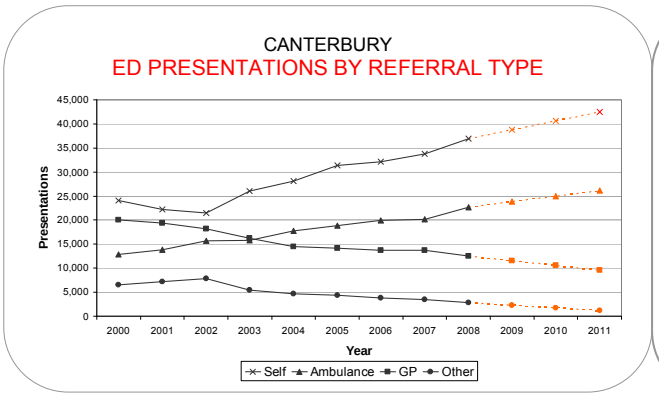
Long-Term Objectives – What do we want to achieve?

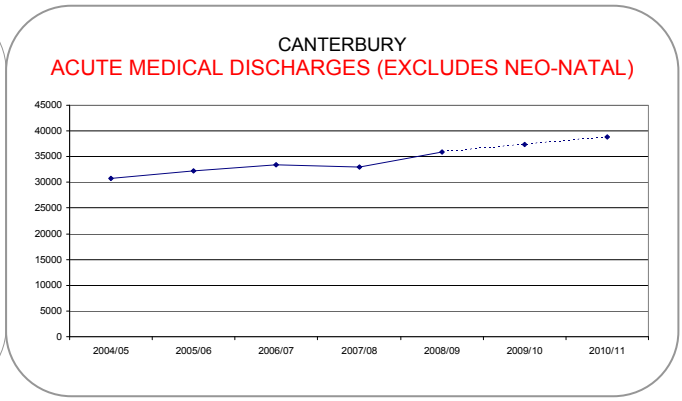
The DHB aims to reduce the growth in acute inpatient activity by ensuring that the right service is provided to the right patient, at the right time, in the right place and by the right provider.

Why is this important?

More than 75,000 people present at Canterbury DHB Emergency Departments (ED) each year with the vast majority attending Christchurch Hospital ED. Christchurch also has a 24 hour general practice service which sees an equivalent number of people every year. While we recognise that on a per capita basis our ED presentation levels are lower than most equivalent urban EDs, attendance numbers have grown at an average level of 3% or 1,900 attendances a year. A significant portion of this growth is in the number of self and ambulance referrals to the ED.

We need to reduce acute demand – both in terms of ED presentations and acute admissions to enable our hospitals to provide appropriate services within the capacity available. Excessive growth in acute demand places pressure on clinical care and reduces the effectiveness of hospital activity by consuming resources and expenditure. Reducing the need for acute admissions by supporting people to stay well, to better manage their long-term conditions and to seek appropriate intervention early will also improve health outcomes for our population.





How will we seek to improve outcomes for our population?

The growth in acute demand can be minimised through initiatives focused in areas such as public education, effective and affordable access to urgent care, rapid access to advice and diagnostics and alternative models of care for ambulance call-outs. The provision of effective and well targeted primary and community based services will also improve the rate of early detection and intervention and will help to decrease unnecessary hospital admissions.

The opportunity for improved management of patients with acute needs, in particular those with acute exacerbations of underlying long term conditions, is well accepted. Drivers for improvement in this area reflect the unsustainable nature of current patterns of service utilisation, with an ageing population and increased burden of chronic disease. Recent analysis has identified that almost half of our acute admissions are attributable to the group of patients who self-refer to ED.

The DHB is currently funding an extensive acute demand management service to assist with addressing acute demand but recent analysis suggests that this service is not well targeted. Discussions with key stakeholders and analysis of utilisation patterns indicate significantly more value could be obtained from this service, particularly by ensuring appropriate referrals to services and the DHB will work to refocus this service over the coming year.

The key issues relate to:

- Lack of clarity about how the service is targeted;
- Confusion amongst key stakeholders about the objectives and role of the service;
- The focus on general practice referral and management of patients while the growth in ED presentations and acute admissions is being driven by self and ambulance referrals, so the service is having less impact than originally planned;
- Fragmentation in care delivery and coverage between services; and

- Multiple coordination centres within the health system, adding to an already complex mix.

There are clear incentives and opportunities for improving the sustainability and effectiveness of after-hours services in Canterbury to support improved acute demand management. General practice after-hours care is designed to meet the needs of people who do not need acute hospital services but cannot be safety deferred until regular general practice services are next available. The DHB is investigating the assumption that access to urgent primary care during and after hours is less than it has been previously and that this is contributing to the increase in self and ambulance referrals.

Meeting the Ministers Expectations

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

Current achievement demonstrates that over the first few months of 2009 approximately 90% of those presenting at the Christchurch Hospital ED have had a wait time of less than six hours. The DHB aims to consolidate and improve this performance over the coming year and understands that this measure can best be affected by adopting a multi-stranded, clinically-led and 'whole of system' approach which improves patient flow and reduces ED length of stay by:

- Reducing ED attendances through the existing acute demand management service;
- Improving access to urgent primary care during normal hours and after hours with a budgeted investment of $2 million in after hours care;
- Increasing flow through ED by using the DHB's Acute Medical Assessment Unit (AMAU) and Surgical Assessment Review Area (SARA) to facilitate urgent access to relevant senior medical assessment;
- Implementing pathway, redistribution, capacity and admission initiatives;
- Developing innovative solutions for frequent attendees;
- Implementing a supported discharge service for people over the age of 65; and
- Facilitating discharge from ED utilising the community based Acute Nursing Service established as part of the acute demand management service.

DHB also recognises the importance of clinical leadership in improving acute care and, consistent with other activity, we will identify joint clinical champions from the primary and secondary sectors to provide clinical leadership and enhanced the focus on our 'whole of system' approach to improving access and delivery of urgent care.

NEXT STEPS IN 2009/10			
	OBJECTIVE	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is the DHB trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
6.4.1 - Progress the Acute Demand Programme.	To reduce acute demand growth and ED presentations especially in self and ambulance referrals which may be better treated elsewhere and support the DHB to reduce waiting times in ED by ensuring appropriate referrals and supporting discharge.	Re-orientate existing acute demand services to focus on patients with the greatest capacity to benefit. Develop a clinically-led response to specifically target self referrals to ED and collaborate with ambulance services to develop a response on alternatives to ED presentations. Reduce the number of coordination points, with a clear pathway for referrals. Provide support to people in the community, where appropriate, to facilitate alternatives to acute admission and to support discharge.	Increased appropriate admissions to ED with less self and ambulance referrals. The right people arrive in the right place at the right time improving patient outcomes and the likelihood of patients being able to stay at home is increased. Reduced iatrogenic morbidity from inappropriate hospital admissions. Reduced outpatient follow-ups. Reduced fragmentation of services. Reduced per capita utilisation of acute medical services.
6.4.2 - Work with PHOs to improve after hours services and service provision in the Canterbury district.	To improve the clinical sustainability of after hour's services and improve support for addressing acute demand growth.	Raise public awareness of when to seek health care and where and how to access the most appropriate assistance. Support specific after hours service approaches for urban and rural areas including: ▪ Telephone triage; ▪ Single overnight urban roster and subsidised access; ▪ Locum services district wide (with support of rural general practice); and ▪ Improved communication capability for remote locations.	Increased appropriate admissions to ED with less GP, self and ambulance referrals. Improved patient outcomes through the right people arriving in the right place at the right time with the right equipment. General practice (particularly rural) has access to timely and affordable locum services. Access to community-based after hours services is maintained across Canterbury. Improved personal safety for general practice teams members working in isolated locations.
6.4.3 - Work to deliver shorter stays in emergency departments.	To deliver ED services to patients in a timely manner that respects the patient's needs and values their time.	Complete the implementation of the Project RED stream of the DHB's Improving the Patient Journey programme to improve the flow of patients through the ED. Continue to improve information systems to track the patient journey time in ED and monitor time milestones for each patient. Establish joint primary/secondary Clinical Champions to provide leadership in the improvement of acute care across the whole of the Canterbury health system.	Reduced waiting and journey time for patients presenting to ED. Appropriate flow through AMAU and SARA. Improved ability to measure and report patient journey times for ED. Clinical engagement and focus on a whole of system approach to improving acute care.

OUTCOMES
How we will measure our success (associated measures of performance).
A reduction in ED self presentations, ambulance referrals and GP referrals.
An increase in the percentage of patients who wait no more than 6 hours in the Emergency Department to 95% by the end of 2009/10.
A reduction in the total number of people acutely admitted from ED/AMAU/SARA but an increase in the conversion rate from ED/AMAU/SARA to acute admission, as a measure of appropriate presentations/referrals.
A reduction in total case weights but an increase in the average case weight, as a measure of the complexity of acute admissions.
A reduction in total bed days but an increase in average length of stay, as a measure of the complexity of acute admissions.

6.5 Pharmaceuticals, Diagnostics and Laboratory Services

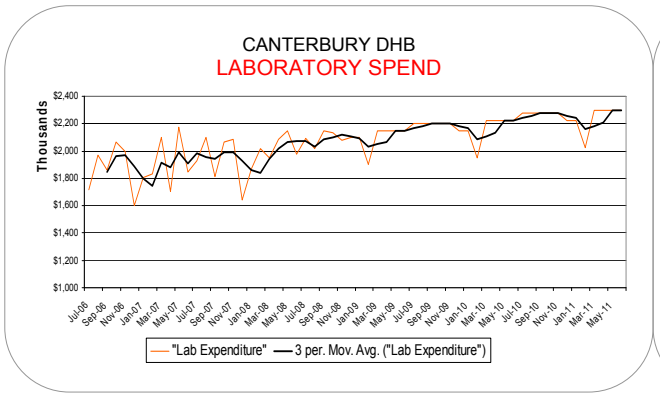
Long-Term Objectives – What do we want to achieve?

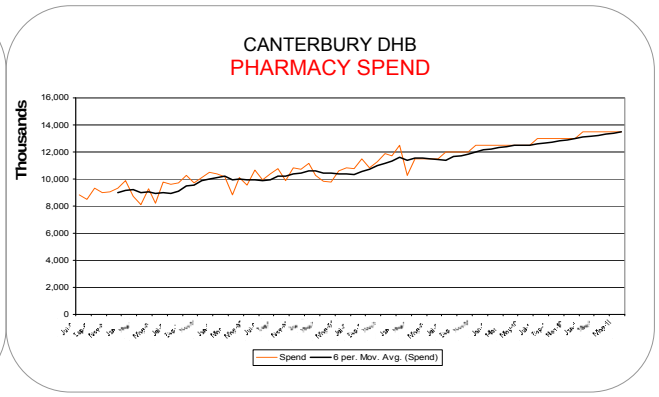
The DHB aims to achieve optimal utilisation of referred services across the Canterbury health system.

Why is this important?

Expenditure on pharmaceuticals, laboratory tests and diagnostics has been increasing significantly. Over a three year period from 2004 community pharmaceutical costs have grown on average $7.26m per annum and laboratory tests by $2.4m per annum (6.9% and 14.7% per annum respectively). Growth is primarily as a result of volume increase, change in mix and co-payment changes in the case of pharmaceuticals, noting the effective impact of PHARMAC on expenditure.[29]

The growth in laboratory costs is of significant concern and has occurred after a relatively stable period of utilisation when budget holding arrangements and associated education, peer review and utilisation feedback, were in place. This serves to further demonstrate the potential impact and opportunity around the presence of these types of initiatives. In terms of diagnostics, community radiology utilisation has also increased significantly as a result of increased access but the pattern of high utilisation of plain film Xrays is not suggestive of best practice.





How will we seek to improve outcomes for our population?

Supply-side management alone is not sustainable over the long term and may not in isolation align well with clinical best practice. However, demand-side interventions coupled with supportive supply-side interventions are considered to be more sustainable, can support clinical best practice and enhance the alignment of clinical and financial accountability. Previous local experience supports the implementation of devolved management for pharmaceuticals and diagnostics provided there is clear agreement as to how funds released from this process are prioritised for use.

There is likely to be an appropriate and unique opportunity arising from the success of the Canterbury Initiative to consider devolved management of resources across hospital and community settings. This would enable both hospital specialist and general practitioner determinants of utilisation to be addressed and support the development of best practice across the continuum of service delivery.

These initiatives are consistent with Government policy and provide an opportunity to engage clinicians across the system in the management of limited resources. It is consistent with other activity planned and can be implemented in a way which is supportive of the Canterbury Initiative, the DHB's Health Services Planning Principles and Vision 2020. Resources released through improved management can be utilised to hump fund the changes to long-term conditions management pathways and the building of community capacity and capability.

Meeting the Minister's Expectations

A Boost to funding for medicines to expand the availability of subsidised medicines has been identified as an expectation for 2009/10. We have set our pharmaceutical budget on the assumption that PHARMAC will ensure greater availability of identified medicines.

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[29] *PHARMAC is the Government's Pharmaceutical Management Agency.*

NEXT STEPS IN 2009/10			
	OBJECTIVE	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is the DHB trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
6.5.1 - Invest in reviewing and realigning the management of referred services: pharmaceuticals, laboratory services and diagnostics.	To establish clinician-led mechanisms to support optimal use of referred services across the system.	Further explore management mechanisms and, where appropriate, establish demand-side mechanisms for pharmaceuticals management. Further explore management mechanisms and, where appropriate, established demand and supply-side mechanisms for other referred services. Establish best practice pathways for key conditions through the Canterbury Initiative. Establish funding models to support change and appropriate utilisation. Engage clinicians across the system in the management of limited resources.	Improved continuity between secondary and primary care and greater confidence in treatment regimes. Improved health outcomes from reduced side effects, interactions and a shift to appropriate treatment mix. Appropriate, timely and consistent access to diagnostics. A reduction in unnecessary medicine use and diagnostic tests providing value for money and freeing resources for prioritised reinvestment.

OUTCOMES
How we will measure our success (associated measures of performance).
A reduction in variation in laboratory test utilisation amongst general practice.
A reduction in variation in prescribing amongst general practice.
A reduction in variation in utilisation of diagnostic imaging amongst general practice.
A reduction in the number of people on 14 or more medications.

6.6 Respiratory Disease

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

We aim to reduce the onset and impact of respiratory disease in our population by:

- Reducing risk factors through inter-sector collaboration;
- Improving quality and access through an integrated respiratory services; and
- Consistent access to best practice treatments for our population.

Why is this important?

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

The impact of respiratory disease in terms of illness and the cost to the health sector is significant and Māori are disproportionately represented in respiratory statistics with higher rates of respiratory disease than that of non-Māori. Very closely linked to the prevalence of smoking, improvements in early diagnosis and disease management provide a major opportunity for the DHB to improve Māori health outcomes and health status.

How will we seek to improve outcomes for our population in the year ahead?

The DHB is committed to supporting lifestyle change to reduce the prevalence of respiratory disease amongst our population. We will continue to promote increased physical activity and smoking cessation to decrease the risk factors that contribute to respiratory disease. There are also a number of external determinants that adversely affect respiratory health. While the DHB does not have direct control over these determinants (i.e. housing, heating and air quality), we will continue to work in collaboration with Territorial Local Authorities and the Regional Council in Canterbury to support environmental improvements that will improve respiratory health.

The major challenge over the next few years is the development of joined up respiratory services across the full continuum of care, with services centred around the patient. Improvements in intervention, quality of care, respiratory disease awareness and patient education will assist in the effective management of respiratory conditions. We are committed to improving respiratory services and making services available in the community so that people are quickly identified and have management plans in place to avoid unnecessary hospital admissions and adverse longer-term health outcomes.

There are significant opportunities for developing the respective roles of primary and secondary services to support people with respiratory conditions. The early diagnosis of conditions such as COPD and sleep-disordered breathing and the management of these conditions in primary care settings can be improved through partnership and collaboration with primary and community providers. COPD has a substantial impact on health and affects an estimated 15% of the adult population, with Māori rates of COPD more than twice that of non-Māori.

In line with our Health Services Planning Principles and Vision 2020, opportunities involve exploring the management of both acute and long-term issues within a primary care setting; supported by flexible and responsive secondary services. This model will enable secondary services to support primary care and will both reduce the need for hospital admissions and free up capacity in secondary services for focusing on specialised interventions and complex cases.

Implementing this respiratory services model is a first step towards enabling Vision 2020 and the transformation of the health system to better meet the future needs of our population. A series of initiatives have been identified that will build the capacity of primary care to respond to acute and long-term 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 in primary care, particularly those for acute demand and long-term disease management, will be further developed to ensure we have the capability and capacity to manage people with respiratory conditions.

The respiratory services model will be implemented through the newly established Canterbury Initiative Service Organisation and the model will be evaluated based on reduced unnecessary hospital admissions for respiratory conditions, improved access for high-risk groups and increased patient satisfaction. A degree of additional funding will be required for an initial period to build capacity and capability in both primary and secondary services prior to achieving the

anticipated health outcomes and financial gains associated with lowering avoidable hospital admissions, shortening the length of hospital stays and making better use of specialist services time.

NEXT STEPS IN 2009/10			
	OBJECTIVE	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is the DHB trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
6.6.1 - Invest in the implementation of the Respiratory Pathway to improve the consistent management of people with Respiratory Disease; with a particular focus on COPD.	To ensure people with respiratory disease and those at risk of respiratory disease have the resources, information, support and care to enable them to self manage their condition and to stay well.	Provide access to specialist advice without requiring an outpatient visit. Continue to improve access to community-based diagnostics. Continue to increase access to community delivered spirometry to improve the diagnosis and management of COPD.[30] Provide access to community delivered pulmonary rehabilitation in the community. Improve the capacity of the acute demand service to respond to people with respiratory conditions. Establish advanced acute management plans as part of the COPD pathway. Increase the number of post-acute admission follow-ups in primary care.	The respiratory services pathway provides improved access to community based respiratory services. Every person with COPD has consistent access to the COPD pathway and care is person focused, prioritising self management. Primary care is the point of continuity supported by specialist care when necessary. COPD management is established as example of good practice including the response across the full continuum of secondary, community and primary services. There is a reduction in inter-departmental referrals within Hospital and Specialist Services (HSS) and follow-ups in respiratory outpatients, releasing scarce specialist resource. A reduced per capita hospital utilisation for people with COPD.

OUTCOMES
How we will measure our success (associated measures of performance).
Improved lung function at the point of diagnosis as a measure of early diagnosis of COPD.
A reduction in the proportion of HSS respiratory out-patient appointments that are follow-ups.
Over time a reduction in the number of readmissions for COPD for all population groups.
Over time a reduction in the number of acute admissions to hospital as a result of COPD for all population groups.

[30] *Spirometry is a tool for measuring lung function, following the volume and flow of inhaled and exhaled air assists in assessing a range of respiratory conditions.*

6.7 Diabetes

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

We aim to reduce the onset and impact of diabetes in our population by:

- Reducing risk factors through inter-sector collaboration;
- Improving quality and access through an integrated diabetes services; and
- Consistent access to best practice treatments for our population.

Why is this important?

Diabetes is estimated to cause around 1,200 deaths per year in New Zealand and can lead to blindness, amputation, heart disease and kidney failure. The impact of diabetes in terms of illness and the cost to the health sector is significant and the prevalence of diabetes is increasing at an estimated 4-5% a year, 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, and now being diagnosed in Canterbury's children and young people, is strongly linked to poor nutrition and is therefore seen as substantially preventable.

How will we seek to improve outcomes for our population in the year ahead?

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

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

We will continue to focus on partnerships with primary and community providers and Māori and Pacific communities to support population health promotion and diabetes education, and to enable early intervention and an increase in the uptake of diabetes services including annual diabetes reviews (checks), podiatry, and regular retinal (eye) screening.

An increase in the number of people, diagnosed with diabetes, who are having an annual review of their condition can be used to indicate access to care and an increase in the proportion of those people who have good diabetes control indicates the quality or effectiveness of that care. In Canterbury, while the proportion of people with good diabetes control is relatively high we are below the national average in terms of the number of free annual diabetes checks being delivered.

Diabetes is a priority area for the DHB and this is acknowledged in our focus on diabetes as a key transformational area for 2009/10. In collaboration with the Local Diabetes Team (LDT) we have undertaken consultative research to examine the perceptions and factors involved in consumer uptake or lack of uptake of funded diabetes annual reviews in Canterbury.[31] The objective of this research is to gain an actionable understanding of how people with diabetes view and experience the annual review process so that the DHB can work with the LDT, general practitioners, hospital specialists and the consumers themselves; to most effectively improve the process and address current barriers to diabetes management.

We aim to work collaboratively over the coming year to improve the identification of people with diabetes early in the disease's onset, and ensure people have a plan produced in partnership with their general practitioner to manage their condition and ensure routine assessments and reviews. Because diabetes affects eyesight and blood circulation (increasing feet problems) the DHB aims to improve access to community-based diabetes services including retinal screening and podiatry services.

In considering capacity and increasing demand for diabetes services we recognise that some prioritisation will be needed and preventative interventions and initiatives will firstly be targeted at populations with the highest risk and where the long-term benefit is greatest including Māori and Pacific population and during childhood, adolescence and pregnancy. We will also continue our focus on making improvements in data collection and ensuring robust data is available, to enable targeted service provision, monitor improvements in diabetes management and to improve the longer-term planning and funding of diabetes services.

[31] *Opinions Market Research Ltd, Diabetes Annual Review Consultation, May 2009.*

The DHB is currently completing a local Diabetes Vision where we will use our patient centred model of care and Health Services Planning Principles to establish clinically-led treatment pathways for people with diabetes and to determine where service investment will be made in order to maximise outcomes. The emphasis will be on establishing a continuum of care across the health system, and like our respiratory services model (already begun through the Canterbury Initiative) we will look to build capability in primary care to reduce unnecessary admissions to hospital and to improve the management of diabetes in primary or community settings by redirecting secondary care activity to support primary care. This will be supported by empowering people to self-mange their conditions through providing health education and access to newly developed pathways that will, where appropriate, include the provision of specialist advice without having to involve a hospital admission. The consultative research recently undertaken was also designed to explore how people with diabetes view their condition as patient perceptions and understanding of diabetes is likely to have a significant impact on self management.

A participatory model involving general practitioners, clinicians, PHOs, diabetes service providers and consumer representatives will facilitate opportunities to improve diabetes outcomes in Canterbury, and we will use our joined up respiratory services model as a lead for transformation and re-design of our diabetes services. The DHB has a dedicated resource within its Planning and Funding division who will support the Canterbury Initiative Development Team to re-design the diabetes pathways and prioritise resources to the areas of greatest gain. General practice has committed to work with us on ensuring that data collection processes are stream-lined to support best practice delivery of care.

NEXT STEPS IN 2009/10

	OBJECTIVE	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is the DHB trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
6.7.1 - Invest in a shared approach between self management, clinical management and support services to plan diabetes care pathways.	To ensure people with diabetes and those people at risk of diabetes have the resources, information, support and care to enable them to self manage their condition and to stay well.	Develop a clear direction for diabetes services in Canterbury. With confirmation from the Canterbury Initiative Governance Groups of diabetes as a priority by July 2009. Plan for finalising pathways and identifying implementation requirement provided for sign-off October 2009. Use the recently completed diabetes annual review research to inform understanding and action around reducing the barriers to improving diabetes management. Begin in August 2009 to develop consistent clinical treatment pathways that will improve diabetes management, based in primary settings and supported by specialists, using the same clinically-led process established through the Canterbury Initiative. Complete initial pathways for implementation by December 2009. Develop or adopt consistent education and awareness programmes for people newly diagnosed with diabetes. Provide improved access to appropriate diabetes services i.e. retinal screening or podiatry programmes, in more convenient community-based settings.	Every person with diabetes has consistent access to the diabetes care pathway and diabetes care is person-focused prioritising self management. Primary care is the point of continuity supported by specialist care when necessary. People identified with diabetes have diabetes care plans in place that ensure regular review of their diabetes management and an improvement in health outcomes. The diabetes services pathway provides more convenient and flexible diabetes services options based in the community. Information collected builds a picture of outcomes by monitoring the uptake of services and improvement in diabetes management and assists in determining value for investment. Service redesign/realignment enables reinvestment in new diabetes initiatives to improve health outcomes.

OUTCOMES

How we will measure our success (associated measures of performance).
An improvement in the number of people receiving annual diabetes reviews across all population groups to above 43% in 2009/10.
An improvement in diabetes case management (% of people with HbA1c >=8%) across all population groups to 77% in 2009/10.
An improvement in access to community based diabetes services i.e. retinal screening and podiatry services.
Over time a reduction in the number of acute admissions to hospital as a result of diabetes complications.
Over time a reduction in avoidable adverse outcomes as a result of diabetes.

6.8 Improving Quality and Patient Safety

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

We seek to continuously improve quality and patient safety in our health and disability services to improve health outcomes for our population.

Why is this important?

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

Improvements in quality will also provide a means for reducing variation in practice, duplication of effort and waste in the patient journey. Focusing on best practice and clinical pathways will enable the DHB to make savings in terms of efficiencies and to make better use of our clinical workforce and limited resources.

How will we seek to improve outcomes for our population in the year ahead?

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 and patient outcomes. The opportunity exists to build on this momentum, to provide clinical leadership and to engage our workforce in these processes and initiatives.

The DHB has a Quality Strategic Plan to promote quality and patient safety throughout the health system and provides Quality and Innovation Awards to recognise and publically acknowledge excellent quality, innovation and improvement initiatives. We have also established the position of Medical Director of Patient Safety to 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.

The DHB's Quality Strategic Plan (2007-2010) has five clear goals all focused on improving patient safety and providing effective quality services. The five Quality goals are:

- Continuously improve the safety of our services;
- Continuously improve our systems and processes;
- Continuously improve our practices;
- Continuously improve our relationships and partnerships; and
- Continuously improve the health of our community.

The goals and the priorities that sit beneath them clearly demonstrate the importance of quality improvement across the whole of the system. There are clear links between organisational fitness, clinical leadership, partnerships, workforce satisfaction and the improved management of long-term conditions (refer to Appendix 5 for the five goals and 25 priorities of our Quality Strategy Plan).

A safe patient journey through the health system 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. Improvements in the journey are covered by all of the DHBs quality goals and this will be a key focus for the DHB in the coming year. This safe patient journey will be backed by recognition and support for innovation and quality improvement across the system.

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. We will work in collaboration with other DHBs on these projects and will share the innovation and quality initiatives already being development and implemented locally in order to make the best use of joint resources.

NEXT STEPS IN 2009/10			
	OBJECTIVE	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is the DHB trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
6.8.1 - Implement the Safe Patient Journey Programme.	To improve the safety of our services to reduce adverse events and provide better patient outcomes and to improve our systems and processes to enhance integration and patient flow through the system.	Put in place improved processes for the review of patient care, harm and death. Introduce additional initiatives for reducing the number of patient falls resulting in serious harm. Define patient identification processes to reduce adverse incidents. Establish baseline data on hospital acquired infections. Establish and evaluate two quality and patient safety education programmes.	A reduction in the number of adverse events including: serious harm injuries resulting from patient falls, incidents relating to incorrect patient identification, hospital acquired infections and medication related incidents. A demonstrated improvement in patient outcomes based on audit review processes. A demonstrated increase in the knowledge and understanding of patient safety by staff groups.
6.8.2 - Implement national QIC Quality Improvement Programme Projects.		Implement national QIC initiatives in accordance with national timeframes including: ▪ Optimise the patient journey - national pilot for wards and making time for caring; ▪ Improve the management of health care incidents - national RCA training; ▪ Improve the prevention and control of infections - hand hygiene focus; and ▪ Improve medication safety and management.	A focused and coordinated national approach to quality improvement is supported. A demonstrated improvement in patient outcomes based on audit review processes.
6.8.3 - Recognise and support innovation and quality improvement across the system.	To improve our processes and systems to foster innovation and improvement in service quality.	Work with the Canterbury Development Corporation (CDC) to establish a quality improvement and innovation 'Hub' model. Undertake an Intellectual Property Audit identifying potential innovative opportunities. Develop a business case to support commercialisation and ongoing activities. Deliver the Canterbury DHB Quality Innovation Awards Programme. Channel Quality Award applications into external award programmes. Increase the number of services involved in innovation initiatives.	Patient safety and quality innovations and initiatives that improve patient care are implemented and are shared across the health system, where appropriate. Quality projects recognised and supported to assist in encouraging involvement and leadership. Improved service delivery models deliver improvements in patient care. Increased staff satisfaction and engagement is evident.

OUTCOMES
How we will measure our success (associated measures of performance).
A reduction in the number of adverse events – rates of: patient falls causing serious injury and staphylococcus aureus bloodstream infections.
An increase in patient satisfaction levels.

7 Health Gain Priorities to Improve the Health of Our Population

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

In 2005 the Board agreed on the vision for health services in Canterbury and developed a ten year strategy as to how this vision would be achieved. We developed this Strategy in consultation with our community and the (then) Minister of Health, and the strategy is documented as our District Strategic Plan 2005-2010.

This Plan identified five Health Gain Priorities and four Disease Priorities where we believed there was potential to make improvements in the health and wellbeing of our population, reduce inequalities in health status and improve the delivery or the effectiveness of the services provided.

Health Gain Priorities:

- Child and Youth Health;
- Older Peoples Health;
- Māori Health;
- Primary Health Care; and
- Disease Prevention and the Management of Long-term Conditions.

Disease Priorities:

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

The focus for the coming year continues to be improving the overall health and wellbeing of our population, reducing inequalities for those people who have the poorest health status and improving the delivery and effectiveness of the services we provide or fund. Our approach will be to harness and build upon the skills, knowledge and capability within the Canterbury health system and to seek advice from clinical leaders, stakeholders and our community about what initiatives will make a long-term difference in the health of the Canterbury population. Our ongoing commitment to partnerships and collaboration is outlined throughout 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 to provide an integrated and patient centred approach to service delivery and to ensure the development of continuums of care that help to better manage long-term conditions and reduce acute demand and unnecessary hospital admissions;
- Work with our hospital and specialist services to provide timely and appropriate quality services to our population, support the development of continuums of care and improve productivity, efficiency and effectiveness; and
- Implement a more restorative focus through improved access to home and community-based support, rehabilitation services and respite care to support people to better manage their conditions or illness and to improve their wellbeing and quality of life.

One of the DHB's Health Gain Priorities (Older Person Health) and two of our Disease Priorities (Respiratory Disease and Diabetes) have been identified as key transformation areas for 2009/10 and have been covered in the earlier Chapter.

7.1 Child and Youth Health

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

We aim to promote and improve the health of children and young people to enable them to become healthier adults by:

- Improving protective behaviours and reducing risk behaviours;
- Improving the access and utilisation of health and disability service;
- Reducing the number of unnecessary hospital admission; and
- Creating a supportive environment to ensure good health outcomes for all population groups.

Why is this important?

A focus on child and youth health is seen as an investment in the future health and wellbeing of the population of Canterbury. Poor health in childhood can lead to poorer health in adult years and behaviour patterns established in adolescence have a significant impact on long-term health outcomes. Preventable hospital admission rates for 0-4 year olds are also higher in Canterbury than the national average.[32]

How will we seek to improve outcomes for our population in the year ahead?

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

Continued support for the Baby Friendly Hospital Initiative, smokefree pregnancy services, a robust maternity strategy and commitment to breastfeeding action will all assist in promoting a healthy start in life. Breastfeeding contributes positively to both baby and maternal health and wellbeing and decreases the likelihood of obesity later in life, increasing immunisation rates is also a cost-effective means of avoiding preventable disease and long-term illness.

Improving the utilisation of effective primary health services is an important factor in reducing preventable hospital admissions for our youngest population groups. A national 'zero fees for under 6's' funding stream has been introduced to reduce the barriers to accessing primary care services for those families with children under six years of age. The DHB will continue to support this initiative and other programmes such as B4 Schools Checks which strengthen the relationship between families and their GP and improves wellbeing through earlier diagnosis and intervention.

Diseases of the gums and teeth are amongst the most common health problems experienced by New Zealanders and poor oral health can lead to poor overall health 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 addition, building on existing services, the DHB will introduce a targeted intensive preventive care program to preschool children most at risk of tooth decay. This will involve DHB, Well Child and Primary Care Services.

The DHB will continue to seek to provide a safer and more supportive environment for our youth population, and to promote improvements in mental and physical health and wellbeing. We aim to assist young people to maintain good health throughout their lifetime and support them to make informed decisions about risk behaviours. Christchurch students have high smoking rates and smoking amongst Pacific youth aged 15-24 is a particular concern. We will continue to support smoking cessation programmes and will work collaboratively to prevent the uptake of smoking and to reduce youth smoking rates.

In conjunction with Child, Youth and Family Services, the DHB will continue to deliver and develop integrated health services for children and youth in residential care. These children are often those with greatest need for coordinated multidisciplinary health services and their residential period is an opportunity to maximise health gains and to introduce healthy lifestyle changes that may aid these children and young people to attain better health in the future. The service model will be developed with Child, Youth and Family Services to provide a stable and consistent service, thus providing opportunities for building trusting relationships between residential staff, the children and young people and health

[32] *Ambulatory Sensitive Hospital Admissions (or 'unnecessary' admissions) are based on admissions for conditions which are seen as preventable by early intervention including: asthma, dehydration, diabetes, ruptured appendix, gastroenteritis and 'failure to thrive'.*

practitioners. A key focus will be placed on developing long term health plans for these children and young people that can be delivered by their local health services when they either return home or to a more permanent residence.

The DHB will also seek to minimise barriers to services and deliver care in appropriate environments, to increase the uptake of service by young people. We will continue to work to improve the utilisation of oral health services by adolescents, improve access to mental health services through continued implementation and enhancement of a single-point-of-entry for child and youth services and work with general practice to implement the national Human Papillomavirus (HPV) Vaccination Programme and provide young women with protection against cervical cancer.

NEXT STEPS IN 2009/10			
	OBJECTIVE	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is the DHB trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
7.1.1 - Focus on improving health promotion, injury prevention and early intervention.	To identify early any health concerns that may adversely affect future health and well-being and to provide good foundations for improved health and a reduction in any inequalities that might carry into adulthood.	Implement the DHB Breastfeeding Action Plan. Increase services available to support mothers to breastfeed, particularly in rural areas including peer support and lactation consultants	Increased Canterbury Breastfeeding rates to >68.5% at 6 weeks, >57% at 3 months and >27% at 6 months.
		Improve coordination between immunisation services and identify opportunities to focus on early vaccination of 'at risk' children. Support the provision of additional vaccinations through general practice and outreach immunisation services.	An increased in the number of two year olds fully immunised to 85% across all population groups. A reduction in acute admissions from vaccine preventable diseases.
		Implement the B4 Schools Checks programme through primary care and public health nurse services.	Earlier intervention and timely referrals for children with behavioural, developmental and other health issues.
7.1.2 - Provide tailored physical and mental health services to children and young people in Child, Youth and Family (CYF) Residences.	To improve access to primary health care services for children and young people in Canterbury's CYF residences improving health and well-being and reducing unnecessary hospital admissions.	Review health records and previous assessments for new residential children and youth to identify health needs and any additional assessments required. Support multidisciplinary service delivery to identified needs including personal health, health education, mental health etc in integrated packages for each child or youth. Put in place medium and/or long term health plans and discharge summaries for children and young people to accompany them to future health service providers and CYFS field social workers when they leave residential care.	Service is commenced by 1 July 2009. Equitable access is provided to primary health services for children and young people residing in CYF residences. The physical and mental health of children and young people residing in CYF residences is improved.
7.1.3 - Implement the DHB's Oral Health Business Case to upgrade and realign school and community oral health services.	To improve access to, and utilisation of, oral health services and improve over-all health and well-being.	Commission 10 Level One mobile dental clinics, with associated infrastructure, at 72 schools. Open four community dental clinics and close 43 school dental clinics. Deliver an intensive preventive care program to at-risk preschoolers.	Improved oral health for those children currently experiencing the worst oral health. Access to improved oral health services across the Canterbury region.
7.1.4 - Explore the feasibility of developing a dedicated child health facility.	To improve access to specialist child health facilities.	Complete a report describing the feasibility of developing a dedicated child health facility.	A decision is made regarding future health facility development.

OUTCOMES
How we will measure our success (associated measures of performance).
An increase in Canterbury Immunisation rates.
An increase in Canterbury Breastfeeding rates.
A reduction in unnecessary hospital admissions for 0-4 year olds.
A reduction in the number of five year olds with decayed, missing or filled teeth.

7.2 Māori Health - He Korowai Oranga

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

We seek to improve health outcomes for Māori and ensure that Māori and their whānau are supported to achieve their maximum health and wellbeing 'Whānau Ora' by:

- Targeting high needs areas;
- Reducing barrier to access; and
- Using our prioritisation framework to ensure services do not undermine outcomes for Māori.

Why is this important?

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

How will we seek to improve outcomes for our population in the year ahead?

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

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

Māori are also over-represented in terms of long-term conditions, particularly diabetes and respiratory disease, and while Māori will benefit from the DHBs investment in improving services in these areas, we recognise the need to target programmes and initiatives in key areas to reduce inequalities. The DHB will focus on increasing Māori utilisation of services to enable improvements in overall health outcomes, including reducing barriers to access, improving the cultural awareness and responsiveness of mainstream services, supporting community based services, Māori for Māori services and peer support services and establishing clear clinical pathways and continuums of care that stretch across the Canterbury health system.

The DHB plans to complete a Māori Health Profile in the coming year to establish a clear picture of the real gaps and inequalities in health outcomes and services at a local level which will enable us to more effectively target programmes and initiatives to improve access and utilisation. The importance of establishing this information has been recognised in our Māori Health Plan, where effective ethnicity data collection, health status monitoring and identification of areas of inequality are a focus. Insufficient quality data 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*'.

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

In the coming year the DHB will complete an updated Health Needs Assessment for the Canterbury district. The Māori Health Profile will provide valuable information feeding into this document. We will seek to engage Canterbury's Māori community in the district strategic planning process to identify key areas of inequality and prioritise areas of need.

NEXT STEPS IN 2009/10			
	OBJECTIVE	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is the DHB trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
7.2.1 - Establish a Māori Health Advisory Group.	To support Māori participation in the development of services.	Establish a DHB Māori Health Advisory Group. Establish clear pathway for participation. Identify key target areas for Māori health improvement.	A clear understanding of areas of opportunity to improve health outcomes for Māori.
7.2.2 - Focus on health promotion, early intervention and a reduction in risk behaviours.	To provide good foundations for improved health and a reduction in any health inequalities that might carry into adulthood.	Implement the DHB Breastfeeding Action Plan and increase services available to support Māori mothers to breastfeed.	Increased Māori Breastfeeding rates to >61.2% at 6 weeks.
		Improve the coordination of immunisation services and the provision of vaccinations to provide an increase in the number of Māori children fully vaccinated at age two.	An increased in the number of two year olds fully immunised to 85%. A reduction in acute admissions from vaccine preventable diseases.
		Implement the DHB's smoking programme that identifies the smoking status of Māori DHB patients and provides smokers with brief advice to quit and resources to support cessation.	An increase in the number of quit attempts amongst Māori. Māori who smoke are aware of, and utilise, Māori based cessation service.
7.2.3 - Improve the access and utilisation of health services.	To improve health outcomes for Māori and reduce inequalities in health status.	Provide ethnicity data against wait-times for radiation oncology treatment.	Ethnicity data collection enables identification of opportunities to reduce inequalities.
		Develop consistent diabetes clinical treatment and referral pathways, based in primary settings and supported by specialists, to improve health outcomes for Māori identified with diabetes.	A greater proportion of Māori identified with diabetes have a regular review of their diabetes and improved diabetes health management can be demonstrated.
7.2.4 - Implement the Māori Health Careers Service.	To improve Māori provider capacity to meet future demand.	Support road-shows in Canterbury schools encouraging a career in health. Provide scholarships for study in primary health to 10 students in 2009/10.	An increased numbers of Māori choose health as career. The cultural awareness and responsiveness of mainstream health services is improved.
7.2.5 - Implement the Māori Mental Health Strengthening Governance and Management Project.	Support Māori provider and workforce development and broaden the range, quality and choice of Mental Health and Addiction services for Māori.	Enable four providers to participate in the Project in 2009/10. Support providers to develop annual organisational workforce development plans.	The effectiveness of the governance and management of Māori providers is improved. Services are sustainable.
7.2.6 - Develop a Māori Health Profile for Canterbury.	To provide a clear picture of local mortality, morbidity and risk factor prevalence.	Complete a Māori Health Profile. Establish clear areas of priority and inequality. Provide a picture of Māori utilisation of hospital and specialist services in Canterbury.	Opportunities for improvements in Māori health status are identified. Information collected builds a picture of Māori health outcomes in Canterbury and assists in improving the planning and funding of health and disability services.

OUTCOMES
How we will measure our success (associated measures of performance).
A reduction in the number of unnecessary hospital admissions for Māori across all age groups.
An improvement in the number of Māori receiving annual diabetes reviews to above 33%.
An improvement in diabetes case management (% of Māori with HbA1c >=8%) to above 70%.
Over time a reduction in the number of acute admissions for Māori.

7.3 Primary Health Services

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

We seek to improve the overall health and wellbeing of our population and to reduce acute demand and unnecessary hospital admissions by:

- Improving protective behaviours and reducing risk behaviours;
- Improving the access and utilisation of primary care service;
- Reducing the number of unnecessary hospital admission; and
- Creating a supportive continuum to ensure good health outcomes for all population groups.

Why is this important?

Primary care is often the first point of contact with health services and reducing barriers to access helps people stay well. It is also the point of continuity for patients in the health sector; providing services from preventive and disease management through to palliative care. Reducing access barriers to primary care especially for some population groups including Māori, Pacific and high risk groups is important to achieving improvement in health outcomes for our population.

How will we seek to improve outcomes for our population in the year ahead?

The Canterbury Initiative is central to achieving positive outcomes in primary care and comprises two key components. Pathway development engages representatives from general practice and hospital specialities to design consistent pathways across the primary/secondary care interface. Clinical review and pilots/trials are used to validate the pathways which once finalised are signed off by the clinically-led teams.

The second component is implementation of the new pathways via the newly established community-based Canterbury Initiative Support Organisation (CISO). The CISO will operationalise the work-streams and is responsible for the day to day operation of the integrated service on behalf of the DHB and Canterbury PHOs. This provides one infrastructural investment rather than separate set-ups through each PHO and reduces the back-office and administration functions in favour of front line services. Having one point for implementing the pathways also allows for a standardised and consistent approach, a clear interface between the primary and secondary sectors and equity of access and service quality for the Canterbury population.

Devolving the management of funding for diagnostics and pharmaceuticals in a notional manner may better support clinical best practice, be more sustainable and enhance the alignment of clinical and financial accountability. Previous supply-side management has not been sustainable over the long term. The collaborative primary/secondary interface offered by the Canterbury Initiative provides an opportunity to slow the growth in expenditure on pharmaceuticals, laboratory tests and diagnostics.

Meeting the Minister's Expectations

The devolution of appropriate secondary services to primary care commenced in Canterbury in December 2009, with a range of services now funded in primary care. The DHB has allocated $2 million in the 2009/10 financial year to supporting the pathway development process, the underlying CISO infrastructure and services where additional funding is required. We also anticipate that some of the transitioned services will be funded from existing funding streams. Rather than destabilising secondary services we see an opportunity to free up constrained secondary care capacity to focus on patients that need specialist input; which will contribute to improved patient flow, reduced waiting times and improved inpatient discharge. The DHB does recognise that in some cases we will need to fund additional activity through the transition.

The following clinical areas will be focused on in 2009/2010 which will drive new pathway development including the shifting of activity from secondary care to primary care as determined by the clinical teams. It is planned that the new pathways will be identified by August 2009 and implementation will phased from that point dependant on the changes that need to be made to existing processes and funding mechanisms. In addition streamlined referral processes using a web-based system will be piloted with Gynaecology Services from August 2009.

New Clinical Project Areas 2008/10:

- Dermatology Services;
- Diabetes Services;

- Ear Nose and Throat Services;
- General Surgery Services;
- Haematology Services;
- Neurology Services;
- Rheumatology Services;
- Community-referred Radiology; and
- Continued implementation of the Integrated Respiratory Services Pathway.

The respiratory and diabetes outcome frameworks (Chapters 6.6 and 6.7) have been linked to activity to be undertaken in collaboration and through the Canterbury Initiative. The following outlined steps reflect the activity that will be taken to achieve the goals identified by the clinical teams in the clinical project areas listed above.

NEXT STEPS IN 2009/100			
	OBJECTIVE	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is the DHB trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
7.3.1 - Support the provision of accessible primary care services.	To establish effective integration of services across the primary/secondary sectors to ensure patients receive best practice care, at the right time, in the right place.	Establish a single community-based gateway for referral management. Increase the delivery of procedures in general practice supported by secondary care.	Transparency and certainty for patients. Increased number of procedures available in primary care settings. Patients with long-term conditions are better managed in the community and supported in their own homes.
7.3.2 - Support the development of primary/secondary pathways of care and the devolution of appropriate services from secondary to primary care.	To engage representatives from general practice and hospital specialities to design consistent pathways across the primary/secondary sectors.	Support GPs and Hospital Clinicians to provide clinical input and leadership into the development of new pathways. Develop new pathways for community based referrals.	New pathways developed and associated information utilised by primary/secondary sectors (via Healthpathways website). Patients receive best practice care, at the right time and in the right place. Secondary care capacity and resources are released to focus on higher-level interventions. Patient flow is improved through the system and waiting times are reduced.
OUTCOMES			
How we will measure our success (associated measures of performance).			
A reduction in ambulatory sensitive (avoidable or unnecessary) hospital admissions across all population groups 0-4 years 45-64 years and 0-74 years.			
An improvement in the early diagnosis of long term conditions - measured by associated improved function at the point of diagnosis.			
Over time a reduction in the number of acute admissions to hospital as a result of complications of long term conditions.			

7.4 Disease Prevention and the Management of Long-Term Conditions

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

We seek to improve the health status of Canterbury residents at risk of developing long-term (chronic) conditions and reduce risk behaviours to reduce the prevalence of these conditions by:

- Improving protective behaviours and reducing risk behaviours;
- Targeting high needs groups and settings;
- Creating a supportive environment to ensure good health outcomes for all population groups;
- Implementing the DHB's Patient Centred Model of Care; and
- Creating supportive continuums to ensure good health outcomes for all population groups.

We also seek to reduce the impact of long-term conditions and to improve quality of life by ensuring a continuum of care that creates a supportive environment, promotes good health and early intervention and establishes evidence based clinical care pathways that provide people with the right care at the right time. In developing this continuum we will also look to support improved communication across the health system and support opportunities to improve workforce capacity and to empower people to self-manage their long-term conditions.

Why is this important?

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

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

How will we seek to improve outcomes for our population in the year ahead?

Tobacco smoking contributes to a number of preventable illnesses and long-term conditions, resulting in a large burden of disease. In addition to the high public cost of treating tobacco related disease, tobacco and poverty are inextricably linked. In some communities, a sizeable portion of household income is 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's Tobacco Control Action Plan sets priority populations and environments where the DHB will focus its efforts to reduce the harm caused by tobacco smoking: Māori (especially young women), primary health care practitioner involvement in cessation advice, pregnant women and women of child bearing age, patients receiving secondary and specialist health services, children and young people (especially those with parents who smoke), mental health consumers; and smoking in homes and in cars. Our Plan for the coming year is very similar to that for 2008/09 but with more emphasis on implementation and over the coming year we will support programmes that reduce the uptake of smoking and increase quit levels, particularly amongst identified high risk groups.

Inactivity, poor nutrition and rising obesity rates are also major contributors to an increase in long-term conditions. The DHBs Healthy Eating Healthy Activity (HEHA) Plan is our approach to reducing these risk factors and is focused on population and personal health programmes that target improved nutrition and physical activity. The DHB is committed to its leadership role in HEHA and the partnerships that have been established across a number of key settings and will continue to ensure a collaborative approach to improving health and lifestyles.

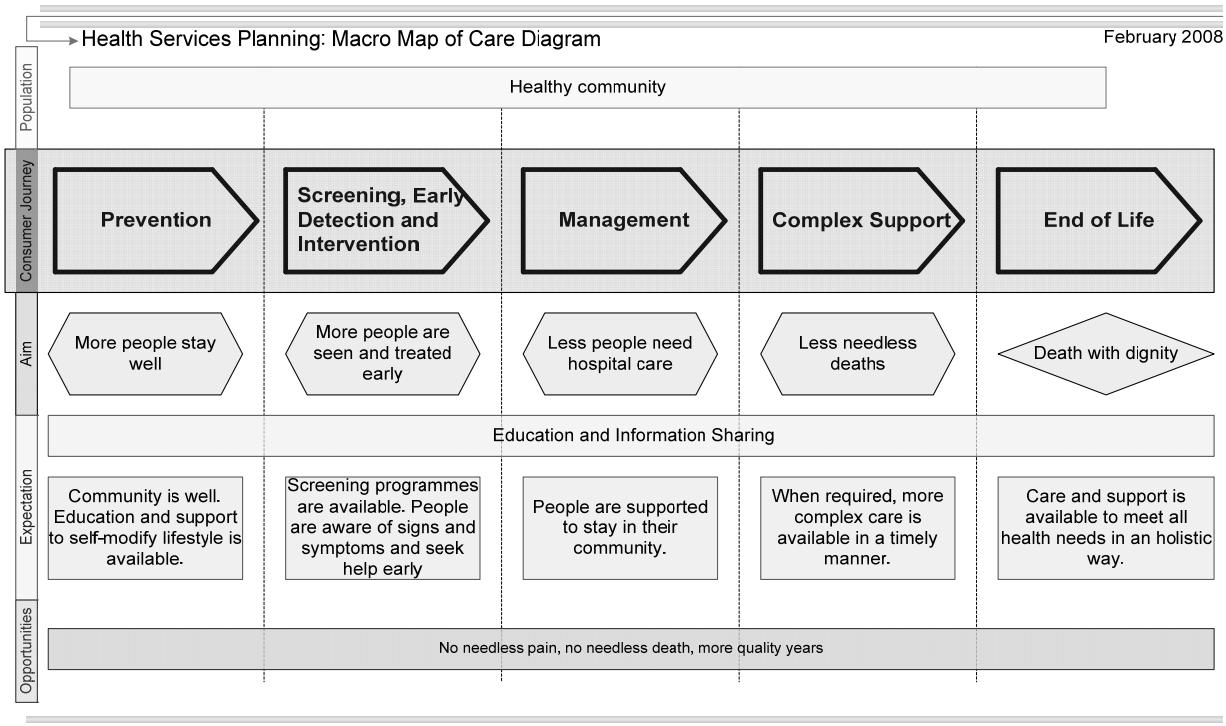
Over the past two years, as part of its Health Services Planning work, the DHB has developed a patient-centred model of care for managing long-term conditions, irrespective of the specific diagnosis. The model supports continuums of care across the whole spectrum of care, for all age and population groups and supports a strengthening of workforce capacity and capability and the best use of available resources.

The key focus is on ensuring patients receive the right treatment, at the right time and in the most appropriate setting. The framework supports the DHB vision of a joined-up health system, focused around patient services and clinical outcomes from 'end to end' where the patient journey through the health system will be timely, seamless between providers, provide consistent quality, and offer the best quality outcomes.

The DHB is identifying opportunities for implementing the model and we are working to ensure investment in resources will support this implementation. Investment in the coming year will seek to support patient centred models of care by:

- Ensuring services located in hospital settings complement community based services;
- Supporting a patient-centred focus and promoting the patient as leader in their own care;
- Minimising barriers in access to services, co-locating services where possible and undertaking service re/development in locations that are accessible; and
- Optimising health outcomes and encourage innovation while 'living within the DHB's means'.

The DHB's Health Services Planning programme, the Canterbury Initiative and Vision 2020 all support this joined-up focus on the patient journey and greater emphasis will be placed on improving the patient journey in 2009/10 with respiratory disease and diabetes as key priorities for the DHB.



NEXT STEPS IN 2009/10			
	OBJECTIVE	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is the DHB trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
7.4.1 - Support collaborative programmes and projects to improve the determinants which negatively affect health.	To engage multiple sectors in action that will reduce risk factors for those most at risk of poor health and share resources and capability across the region.	Support the completion of a joint health profile of Christchurch City. Agree on an intersectoral City Health Plan addressing important health outcomes.	Intersectoral agreement is reached on working at a health determinants level. Christchurch specific health issues that need addressing and jointly identified.
		Support the development and implementation of a home insulation programme through the Healthy Housing Programme. Identify and register eligible households.	400 families most at risk from cold damp homes have improved housing quality by having a warmer home.
		Implement the Community Violence Reduction Project in collaboration with the Christchurch City Council and NZ Police. Ensure licensed premises comply with host responsibility legislation.	The local environment supports less intoxication. Alcohol-related harm is reduced through the creation of a safer central city.
7.4.2 - Implement the ABC Strategy for smoking cessation.	To ensure that all smokers are identified by health professionals, given advice and support to quit smoking, and referred to cessation services in order to reduce the harm caused by tobacco.	Identify the smoking status of DHB and primary care patients and provide smokers with brief advice on quitting smoking and the resources to support cessation. Establish systems which will allow collection of baseline data and record the provision of smoking cessation advice. Ensure Māori who smoke are aware of and can utilise a Māori based cessation service. Provide smokefree environments to support those making cessation attempts.	DHB and primary care patients will be regularly asked about their smoking status. An increased percentage of hospitalised smokers will be provided with help and advice to quit smoking. Increased quit attempts will be supported by Nicotine Replacement Therapy, for all population groups.
7.4.3 - Implement the DHB's Healthy Eating Healthy Action (HEHA) Plan.	To improve the health of children and young people through improved nutrition with priority on Schools and Early Childhood Education (ECE) Centres with high Māori or Pacific roles.	Implement the DHB's Breastfeeding Action Plan and increase services available to support mothers to breastfeed, particularly in rural areas including peer support and lactation consultants	An increased percentage of children in Canterbury are fully or exclusively breast fed >68.5% at 6 weeks, >57% at 3 months and >27% at 6 months.
		Support Schools and ECE centres to adopt a range of sustainable initiatives, health promotion plans, policies and guidelines to improve nutrition and physical activity.	>41% of schools and ECE provide education and environments that support healthy food choices and physical activity.
		Support community action to empower and enable Māori and Pacific people to achieve HEHA goals and increase HEHA capability and capacity among Māori and Pacific communities.	Māori and Pacific communities create social and physical environments that support healthy food choices and physical activity.
		Implement the Eastgate Swap to Win project working with the Linwood Community to promote healthy cost effective food options.	Local environments support families to choose healthier options.
7.4.4 - Establish clear plans for the management of an emergency or pandemic.	To ensure comprehensive, robust emergency response plans and protocols are in place which minimise risk to the public and the DHB.	Review and update emergency and pandemic plans in conjunction with other national plans and protocols. Ensure key staff are appropriately trained.	Improved capacity to respond to an emergency or pandemic.

OUTCOMES
How we will measure our success (associated measures of performance).
An increase in Canterbury Breastfeeding rates.
A reduction the uptake of smoking by young people.
Over time a reduction in the proportion of the population who smoke across all population groups in Canterbury.
Over time an increased in the intake of fruit and vegetables.
Over time a reduction in the proportion of the Canterbury population who are obese.

7.5 Cancer

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

We aim to reduce the onset and impact of cancer in our population by:

- Reducing risk factors through inter-sector collaboration;
- Improving quality and access through an integrated cancer services; and
- Provide consistent access to best practice treatments for our population.

Why is this important?

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

How will we seek to improve outcomes for our population in the year ahead?

The DHB is finalising its local plan, for implementing the national Cancer Control Strategy and Action Plan. Our local direction of a patient-centred model of care supports the national Cancer Strategy and promotes 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 DHB is committed to supporting lifestyle change to reduce the risk factors for long-term conditions including the implementation of the Human Papillomavirus (HPV) Vaccination Programme to provide young women with protection against cervical cancer in primary care and implementation of the DHB's Tobacco Control Action Plan. However a signification reduction in risk behaviours will take some time to result in reduced cancer rates.

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

As home to one of New Zealand's six regional cancer treatment services it is in the diagnosis and treatment of cancer where the DHB has the most direct influence, and where our immediate challenges sit. 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.

In seeking to reduce wait times for cancer treatment we are working to find solutions to capacity issues including facilities, equipment, processes and workforce. Over the past year a commitment was made to upgrade treatment equipment and our cancer services are to get two replacement linear accelerators. Linear accelerators are used to give radiation treatment and the Canterbury DHB has three of these machines, the oldest of which are to be replaced.

The DHB is also committed to system improvements to clinical pathways that will improve the patient journey and make the best use of the capability and capacity we have in Canterbury. New cancer facilities and services are scheduled to be established in the private sector in Christchurch over the next 12 months. We will work collaboratively with the private sector through the development of guidelines and protocols to shape the public/private interface in order to maximise the use of local resources.

We will also look to ensure long-term sustainability of cancer services by working in partnership with regional DHBs to consider capability and capacity. The establishment of the Southern Cancer Network will assist in this regional collaboration and in making the most efficient use of the resources available across the wider South Island.

Workforce development and staff retention are key areas of concern in the delivery of cancer services. Current challenges in appointing appropriately qualified and experienced staff for existing services will be exacerbated by the need for additional staff to operate new equipment and technology. The DHB participates in national training programmes to support future workforce capacity and closely monitors its staffing levels.

Meeting the Minister's Expectations

DHBs are expected to ensure that everyone needing radiotherapy starts this within six weeks, from the decision to treat, by July 2010 and within four weeks by December 2010. The Canterbury DHB is conscious of this expectation and is committed to enhancing its capacity to deliver cancer treatment to its population and reduce waiting times.

Significant effort will be made by the DHB's oncology services over the coming year to maintain service levels while replacing our two oldest linear accelerators. Continuity of service provision will be maintained by building a fourth bunker to house the first replacement machine, thereby enabling the DHB to continuing using all three of its older machines until the new one is in place. The next oldest machine will then be taken out of service and replaced by the second new linear accelerator.

NEXT STEPS IN 2009/10			
	OBJECTIVE	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is the DHB trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
7.5.1 - Rollout of the national HPV Vaccination Programme through primary care.	To reduce the incidence of Cervical Cancer.	Support the implementation of the national HPV Vaccination Programme through primary care. Deliver a Whanau engagement service for hard to reach young women. Ensure eligible young women receive the HPV Vaccine by monitoring the implementation of the programme.	>50% of eligible young women in Canterbury are vaccinated against cervical cancer.
7.5.2 - Support Cancer screening programmes and early intervention.	To reduce the impact of cancers by identifying conditions early.	Support breast cancer and cervical cancer screening programmes through the PHO Performance Programme.	High needs populations are screened at equivalent or better than national rates.
7.5.3 - Build the infrastructure and capacity required to deliver timely cancer treatment.	To improve outcomes for people diagnosed with cancer by providing treatment within clinically appropriate timeframes. Reduce waiting times for Radiation Therapy in line with national Health Targets.	Develop tumour stream pathways. Improve utilisation of existing linear accelerators to reduce waiting times. Complete the construction of a new linear accelerator bunker by November 2009. Install the first replacement linear accelerator with service online by April 2010. Extend current operating hours as required during construction of the new bunker and replacement of the linear accelerators. Take-down the end-of-life machine and install the second replacement linear accelerator with service online October 2010. Investigate and support local and regional collaboration to increase capacity.	Improved co-ordination and integration of the oncology services. Maximum wait time for radiotherapy treatment reduced to six weeks by 30 July 2010. Two linear accelerators installed and operational by October 2010 extending the DHB capacity and capability and enabling the DHB to further reduce wait times.
7.5.4 - Improve Palliative Care Services.	To improve quality of life for cancer patients and their whanau.	Implement the Liverpool Care Pathway to transfer the hospice model of care into other care settings, including selected aged residential care settings.	Increased consistency and quality of service for end-of-life care.

OUTCOMES
How we will measure our success (associated measures of performance).
An increased percentage of people receive radiotherapy cancer treatment within six weeks of the decision to treat.
Over time a reduction in cervical cancer rates
Over time a reduction in cancer mortality rates.

7.6 Cardiovascular Disease

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

We aim to reduce the onset and impact of Cardiovascular Disease (CVD) in our population by:

- Reducing risk factors through inter-sector collaboration;
- Improving quality and access through an integrated CVD services; and
- Consistent access to best practice treatments for our population.

Why is this important?

CVD includes coronary heart disease, circulation, stroke and other disease of the heart and is the main cause of death in Canterbury and the leading cause of hospitalisation (excluding pregnancy and childbirth). Older people, Māori and Pacific people have higher rates of CVD, which will increase as our population ages. CVD is also strongly influenced by environmental and lifestyle influences and by risk behaviours such as lack of physical activity and tobacco smoking.

How will we seek to improve outcomes for our population in the year ahead?

Healthy lifestyles leads to a decrease in the risk factors for CVD as with all long-term conditions, and the DHB will promote physical activity, good nutrition, weight risk reduction and smoking cessation to improve cardiovascular health. We will also collaborate with primary care providers and support CVD risk assessment, risk management and early intervention for high-risk patients and support the development of effective population-based heart health programmes.

As our population ages, increasing rates of CVD will mean an increased demand for more specialised care and treatment for heart attack, stroke, heart failure, and other circulatory diseases. We will have to work collaboratively to ensure we have the capacity across the Canterbury health system to provide people with treatment within appropriate timeframes.

The DHB's plan for minimising the effects of CVD on our population highlights the importance of population-based strategies for reducing the impact and prevalence of CVD. It also highlights the importance of improving rehabilitation and access to community-based support after acute heart events in order to reduce the impact of that acute event on a person's life and to prevent readmission.

Our model of care for managing long-term conditions places emphasis on the continuum of care to improve service delivery and the patient journey for those with conditions such as CVD. Our approach will be to strengthen service capacity across that continuum and to look to ensure services are being provided in the most appropriate settings to maximise outcomes for our population. We will work to build capability in primary care by enabling specialist services to provide support and advice and to reduce unnecessary admissions to specialist services when people may be cared for in primary or community settings or in their own homes.

The DHB will also seek to reduce readmissions by empowering people to self-mange their conditions with clinical input and by identifying appropriate supports. We will focus on increasing the number of people accessing rehabilitation after acute events including cardiac rehabilitation courses and organised stroke rehabilitation services.

Strokes (where supply of blood to the brain is interrupted), can have a significant effect on a person's quality of life and make it difficult for them to do everyday things like bathing, feeding and dressing themselves. Our rehabilitation focus will be backed by support for increased access to home support services and respite care in order to allow people to return to their homes and to improve the quality of life for our population.

Meeting the Minister's Expectations

Better diabetes and cardiovascular services is a national Health Target with the aim to increase the percentage of the eligible adult population having their CVD risk assessed. In line with this focus, new initiatives in CVD risk assessment have been launched in the past year including support for decision software in primary care to assist with CVD risk assessment and the diagnosis and ongoing management of CVD. Risk assessment targets have been set as part of the PHO Performance Programme to increase the number of people receiving CVD risk assessments in primary care settings and the DHB will continue to support this focus.

NEXT STEPS IN 2009/10			
	OBJECTIVE	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is the DHB trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
7.6.1 - Support the implementation of the CVD Risk Assessment Programme in Primary Care.	To reduce the impact of CVD on our population by identifying those people 'at risk' of CVD and providing appropriate intervention and support.	Support an increase in the number of CVD risk assessments provided in primary care in line with the PHO Performance Programme. Monitor the increase in fasting lipid and glucose tests in line with the national Health Target and the DHB's commitment to a 2% increase in the number of tests across all population groups.	Cardiovascular risk is assessed and those at risk are identified early. Where appropriate, people are supported to self-manage their CVD conditions.
7.6.2 - Support the integration of CVD services across primary/secondary continuums.	To improve the management of people with CVD and ensure equitable access to services.	Support capacity and capability growth in primary care. Support the development of clinically-led pathways of care for CVD.	Primary care is the point of continuity supported by specialist advice and care when necessary. Reduced per capita hospital utilisation by people with CVD.
7.6.3 - Improve the access and uptake of rehabilitation programmes after acute events.	To reduce the likelihood of a subsequent CVD event and to optimise recovery.	Support access to stoke rehabilitation services. Support access to cardiac rehabilitation services.	People are supported to self-manage their CVD conditions after acute events.
OUTCOMES			
How we will measure our success (associated measures of performance).			
A two percent increase in the percentage of the eligible adult population who have had a fasting lipid/glucose test in the past five years.			
Over time a reduced number of people re-admitted for an acute CVD event.			
Over time a reduced number of people admitted for an acute CVD event.			

8 Ongoing Priorities to Achieve Government Expectations

Meeting Government Expectations

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

The following section addresses the specific expectations that fall outside of the DHB's identified Strategic and Health Gain Priorities, but reflect ongoing work which is of particular interest to the Minister, the Ministry and the Canterbury community.

For 2009/10 the areas of additional focus are:

- Value for Money;
- Elective Services Delivery;
- Infrastructure;
- Workforce; and
- Maternity Services.

Value for Money

A major focus of planning for 2009/10 is to ensure that all investments made are returning value for money. The current financial situation has brought increasing pressure on the DHB to ensure value for money both through our transformational work in moving the sector towards 2020 and in maximising effectiveness and efficiency in our operations.

The Canterbury DHB is committed to ensuring that the services funded are evidence based and to giving priority to interventions that provide the most benefit relative to the resources used. A variety of productivity measures and benchmarking processes are used to assess and promote service quality and efficiency (e.g. caseload and consultation evaluations, consumer satisfaction, complaints and timeliness) along with the DHB's Prioritisation Principles. We will also continue to collaborate on value for money initiatives with DHBNZ.

Working with the entire Canterbury Health system we are developing a process of combining routine data sets (particularly primary and secondary care) to allow us to identify opportunities for service improvement and to create a meta-database where we can test actual service delivery against best practice. This process will enhance our ability to reduce duplication, waste and variation and thereby optimise the use of existing resources.

Our Health Services Planning Principles and Vision 2020 approach will ensure value for money assurance is embedded within key work streams. The Canterbury DHB's Planning and Funding Division also works, from a neutral standpoint, to provide the best possible outcomes for our population, within the funding received.

8.1 Elective Services

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

We aim to increase elective discharges to improve our ability to meet the increasing demand for elective surgery resulting from our ageing population.

Why is this important?

The Canterbury DHB's population is growing and ageing which has resulted in increasing demand for elective surgical procedures. The DHB's ability to meet this increasing demand is often compromised by increasing demand for acute surgery and demand for our tertiary level service from other DHBs.

How will we seek to improve outcomes for our population in the year ahead?

To achieve our objective of increasing elective surgical discharges, we have worked with the other South Island DHBs to produce the South Island Regional Elective Services Plan as a first step on a pathway to improved delivery of elective services to our own population but also that of the wider South Island.

In developing this Plan we recognise that the capacity of the public health system to efficiently provide elective surgery to meet demand is governed by a number of often competing crucial factors which include:

- Demand for acute surgery;
- Demand for hospital beds;
- Availability of surgeons, anaesthetists and nursing staff;
- Theatre capacity;
- Scheduling and management practices;
- Effective planning of admission and discharge; and
- Systematic and agreed clinical pathways.

The focus of the Regional Electives Services Plan has been to achieve an end point that will deliver for the population of the South Island:

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

Initially Canterbury's current intervention rates appear low when compared to other DHBs, however detailed analysis of the intervention rates at a procedure level has raised questions in relation to the actual intervention rates for Canterbury residents. In particular, this analysis has highlighted that our approach to counting some services may explain a portion of the difference in intervention rates. The DHB therefore believes that our intervention rates may not be significantly different to those of other DHBs. Further work will be undertaken to better understand the current intervention rates and the levels of unmet need in our region to ensure an improved evidence base exists to support investment in the 2010/11 year and beyond.

In line with our Health Services Planning Principles and Vision 2020 the DHB believes, within the context of providing a regional approach to service delivery, that we must ensure patients receive care as close to their home as practical, this means:

- We must support the development of models that ensure local and regional service sustainability; and

- Capacity must be developed locally to meet the needs of Canterbury residents. However developing any additional capacity will explicitly recognise the need to provide complex services for residents of other DHBs and that other DHB facilities/staffing may be utilised to ensure equitable access for all of our resident populations.

In the short term (2009/10) the DHB is likely to continue to utilise private capacity in the areas of Ophthalmology, Orthopaedics and Cardiothoracic surgery in order to support delivery of appropriate levels of service to our population.

Meeting the Minister's Expectations

Elective services have been identified as a national Health Target for all DHBs and we are required to contribute to the national goal of increasing the volume of elective surgery discharges per annum from an average increase of 1,432 discharges to an average increase of 4,000 elective discharges per annum.

In line with the Minister's expectation the Canterbury DHB is committed to meeting the increasing demand for elective services from our population and ensuring the services are sustainable. During the 2009/10 year the DHB intends to deliver at least 14,000 elective surgical discharges. We then intend to increase our elective services delivery to at least 14,627 discharges in 2010/2011 and to 15,254 elective surgery discharges in 2011/2012. [33]

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

NEXT STEPS IN 2009/10			
	OBJECTIVE	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is the DHB trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
8.1.1 - Increase production capability	To deliver the planned increases in elective surgical discharges in 2009/10.	Establish 'real' whole of DHB production plans providing a clear operational basis for delivery to reduce the number of cancelled operating theatre sessions.	At least 14,000 elective surgical discharges are delivered in 2009/10. A reduction in the number of planned theatre sessions that are cancelled.
		Establish new mechanisms to enable the DHB to maintain a pool of low complexity patients to act as 'list fillers'.	An increase the number of procedures delivered per theatre session.
		Explore opportunities with other Sth Island DHBs to: ▪ Re-direct IDF Inflows to other South Island DHB, increasing the capacity available to Canterbury DHB residents in our facilities. ▪ Utilise other DHBs facilities to deliver care to Canterbury DHB residents ▪ Utilise other DHB human resources to deliver planned additional sessions at Canterbury DHB facilities.	An increase the percentage of elective surgery delivered by the Canterbury DHB to its resident population.
		Re-negotiate agreements with private providers to ensure service delivery occurs within the national pricing framework.	New agreements with private providers are settled within national pricing frameworks.
	To identify the areas of unmet need to determine the service increases required for 2010/11 and beyond.	Undertake further analysis of intervention rate data to better understand the areas of unmet need relative to other DHBs. Develop improved mechanisms for indentifying the unmet elective surgical need in our community.	Increases in elective surgical delivery will be better focused to meet unmet need on our community.
	To identify the additional capacity required to provide a sustainable increase in public capacity to meet service delivery targets in 20010/11 and beyond.	Undertake DHB wide production to identify and remove the bottle-necks in current capacity. Identify new facility requirements, including theatres.	The DHB's Facilities Master Plan includes facility requirements associated with increasing elective surgical discharges. Reliance on private capacity to deliver elective surgery services is reduced.
8.1.2 - Improve Service Quality	To reduce cancelled elective theatre sessions due to constrained ICU capacity and acute surgical demand.	Develop improved clinical frameworks for the management of ICU beds to enable greater flexibility to match the supply of ICU beds to demand. Continue to refine the acute theatre models of care to reduce the impact of variation in acute demand on the delivery of elective surgery.	The number of planned theatre sessions that are cancelled is reduced.
	To reduce time wastage in theatres.	Develop a benchmarking tool (using Lean Thinking principles) that enables surgical teams to establish performance benchmarks and monitor time wastage in theatre.	An increased number of procedures are delivered per theatre session.
	To increase day surgery and day of surgery admission rates.	Identify approaches that support a culture that ensures that, wherever clinically appropriate, day surgery and day of surgery admission are the norm.	Rates of day surgery and day of surgery admissions are increased.

OUTCOMES
How we will measure our success (associated measures of performance).
An increase in elective surgical delivery occurs in line with the principles of clarity, timeliness and fairness.
Public capacity is sustainably developed, and efficiently utilised to meet increasing elective surgical delivery.
Canterbury residents are provided with appropriate access to elective surgical procedures.
South Island residents are provided with equitable access to elective surgical procedures

8.2 Information Technology Infrastructure

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

To provide accurate and timely patient-focused information to better inform clinical decision-making.

Why is this important?

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, timely and available at the point of care, to allow the best decisions to be made about patient care.

How will we seek to improve outcomes for our population in the year ahead?

In order to deliver to clinical requirements and to ensure long-term sustainability, the DHB's information infrastructure requires continual updating. Information Management is a national priority, with DHBs taking a collective approach to implementing the Government's Health Information Strategy NZ (HIS-NZ) and ensuring quality standards are met. 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 our 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 the national strategy and involves working closely with clinicians and other 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 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 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 HIS-NZ) which will allow discharge summaries to be sent to GPs electronically and will significantly assist 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 legacy 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 part of a consortium of seven DHBs investigating the possibility of a single pan-DHB electronic health record and replacement patient administration system.

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 health care 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 and sustained quality improvement.

NEXT STEPS IN 2009/10			
	OBJECTIVE	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is the DHB trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
8.2.1 - Address the replacement of our hospital patient administration system.	To support the Canterbury DHB's Vision 2020 initiative and ensure sustainable provision of quality patient information to better inform clinical decision making.	Present options for the interim upgrade of HOMER patient administration system if necessary. Collaborate with other DHBs in the Health Management Systems Consortium to produce options around a patient centric clinical information system that can be utilised across the entire health sector.	In the short-term - an understanding of the financial and HR resource investment needed to establish a single Health Management System. In the medium to long-term - the potential to significantly improve the health of Cantabrians and all New Zealanders.
8.2.2 - Continue relevant upgrade and future proofing of IS systems.	To prevent IS core infrastructure failure that would have widespread impact on both clinical and business systems.	Produce options for potential implementation of a new Storage Area Network environment that will contribute towards maintaining clinical application uptime.	Pathways are identified for reduced risk of system failure.
		Evaluate options for reducing risks around the current Data Centre operations.	Short-term data centre options developed and medium and long-term solutions identified.
		Mirror the Canterbury Health Practitioner Index (HPI) in preparation for integration into Clinical and Patient Administration Systems. Produce an accurate HPI database with valid, up to date, information.	DHB has a file that will enable future HPI integration into clinical/patient systems. Ensured compliance with national strategic direction.
8.2.3 - Accelerate Clinical Information System (CIS) Implementation.	To provide improved clinical access to patient information, to lower clinical risk and to improve efficiency and patient outcomes.	Complete the CIS project rollout in Medical / Surgical services. Extend effort to the implementation of CIS to other divisions.	The CIS enables and supports changing clinical work flow and improves clinical efficiency. Improved clinical access to clinical information Lower clinical risk and improved patient care.
8.2.4 - Support the electronic signoff of laboratory results.		Change/configure the laboratory results repository to accommodate signoff by other departments. Increase the percentage of laboratory results being electronically signed off.	More consistent processes across the DHB. Improved and timelier results management.
8.2.5 - Support Electronic Referrals.	To improve the quality and efficiency of referrals to improve patient outcomes and meet national strategic requirements.	Support the Canterbury Initiative to enable GPs to create compliant e-referrals in a central database. Review options and present potential solutions for selection.	Improved referral processes across the health system. Improved clinical information for episodes of care and enriched information available in Clinical Information Systems.
8.2.6 - Implement TestSafe South.	To provide access to clinical laboratory results in the community lowering clinical risks and reducing duplication.	Provide access to community results as part of the Concerto Clinical Record. Provide GP with access to test results as part of Phase II of the Project.	Clinicians have faster access to clinical results. Reduction in repeat lab tests. Improved patient care.

OUTCOMES
How we will measure our success (associated measures of performance).
Clinical application up-time in excess of 99.5%.
An increase in number of electronic referrals.
An increase in percentage of laboratory tests signed-off electronically.

8.3 Workforce

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

We seek to access the best possible talent available and unlock its full potential to support the Canterbury health system's strategic direction.

Why is this important?

The Canterbury DHB like other DHB's is dependant on the quality of its people for delivery of its plans. To be successful we need to source, develop and retain a skilled and empowered workforce.

Business challenges including transformational changes to the way Canterbury and regional health services are delivered, including clinical networks; strong competition for skills in the marketplace; expectations of new employees; new technology; increasing governance and public reporting issues; and rapidly changing workplace demographics will make this a demanding task.

How will we seek to improve outcomes for our population in the year ahead?

The identification and development of people who can perform in a leadership role will be critical to achieving strategic and operational plans. The role of leaders in healthcare is complex. Often leadership roles at different levels in our organisation are forged by a hybrid mix of clinical and management responsibilities.

Developing leaders who can transform, innovate, adapt and prepare healthcare organisations for transformational change will require us to identify people who are capable of adapting to sustained and relentless change. These leaders will need to display an inclusive leadership style, whilst demonstrating the ability to lead with sensitivity to individual needs and at the same time maintaining a high level of moral and ethical integrity.

This type of leadership is different but aligned to clinical leadership where the capacity and credibility to engage colleagues and champion change in their respective areas of expertise is paramount.

Employee engagement describes the level of emotional and intellectual involvement and commitment an employee has to an organisation, and its success. Engaged employees are committed to making a difference in the business and believe that their efforts make a difference. Employee engagement goes beyond 'satisfaction' in that it describes a personal and real willingness to be involved, contribute, and to take responsibility for work results. Creating a work environment where our clinical workforce is engaged is a key workforce objective for the DHB.

As the global economy shifts we will build on existing recruitment efforts and adopt differing approaches to source candidates widely and effectively dependant on the profession and availability. As part of this the DHB will invest in a strategic approach to workforce planning including alignment with national health workforce planning initiatives.

NEXT STEPS IN 2009/10			
	OBJECTIVE	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is the DHB trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
8.3.1 - Establish a leadership development model.	To provide a clearly defined model to be used to benchmark across the DHB.	Establish a capability (behaviours and style) framework for the DHB. Complete the pilot assessment program. Provide desktop alignment of competencies and skill frameworks. Enhance partnerships between health services and education providers.	Baseline capability model established. Talent planning commenced. Development plans for pilot group in place.
8.3.2 - Maintain and improve clinical retention.	To ensure managers manage and leaders lead.	Design, develop and pilot a basic skills programme. Develop a safety leadership program and commence implementation. Establish a supportive learning environment for students transitioning to practitioners.	Improved retention rates. Improved employee engagement rates. Reduced industrial relations focus.
8.3.3 - Implement a systematic approach to clinical leadership.	To establish a systematic approach to identification and development.	Analyse data and identify characteristics. Consult clinical communities on preferred model. Finalise Model.	Engagement of clinical community.
8.3.4 - Improve organisation culture and employee engagement.	To engage employees rationally and emotionally.	Survey employees to assess culture, levels of employee engagement and attitudes. Analyse results and communicate these to business teams. Establish benchmarked results.	Organisation plan to address gaps developed.
8.3.5 - Develop a workforce plan.	To ensure enough people with the right skills are in the right places at the right time.	Develop demand forecasting models. Implement workforce analysis and supply forecasting. Develop EMT and GM succession plans. Develop a recruitment sourcing strategy.	Workforce planning risks identified and plans to address these developed.
8.3.6 - Implement workforce systems.	To provide managers with simple, relevant practices and tools.	Review and refine HR practices, policies, guidelines. Digitise 50% of HR processes. Develop shared services concept.	Consistency, quality, cost, service measures. Metrics for decision support established.
8.3.7 - Develop performance management tools.	To ensure employees understand what standard is required.	Develop a performance management process. Develop an education program and commence rollout.	Process established as key accountability tool. Top two organisation levels participate in program.

OUTCOMES
How we will measure our success (associated measures of performance).
An improvement in retention rates among clinical staff.
An improvement in retention rates among non-clinical staff.
An improvement in employee engagement.

8.4 Maternity Services

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

We seek to provide the best possible maternity services to meet the needs of women, their babies and families/whanau.

Why is this important?

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

How will we seek to improve outcomes for our population in the year ahead?

Over the last few years the Canterbury DHB has experienced a significant growth in the number of births in our facilities increasing from 6,045 births in 2005 to 6,322 births in 2008 - representing a 4.6% increase. This places significant pressure on our maternity services. While the majority of our births (80%) occur at Christchurch Women's Hospital, primary maternity services are provided by a range of different level facilities across the Canterbury region including the St Georges Hospital.

Facility	Maternity Bed Numbers	Average Occupancy %
Christchurch Women's Hospital[34]	45	78%
St Georges Hospital	17	71%
Burwood Hospital	7	57%
Rangiora Hospital	7	38%
Lincoln Hospital	7	37%
Ashburton Hospital	4	46%
Kaikoura	3	2%
Waikari	3	0%
Akaroa	2	9%
Darfield	2	11%

The maternity facilities within the Canterbury region are in general well utilised and in Canterbury women, on average, have a postnatal stay of 2.2 days following a normal delivery and an average length of stay of 5.2 days for those women having a caesarean section. The Canterbury DHB currently operates mechanisms to ensure that those women who have a clinical need receive extended stays.

The 2007 Maternity Services Survey Report[35] highlights that 13% of women reported not feeling ready to leave hospital. This was due to a number of issues which included the need for more rest, feeling unwell and breastfeeding issues. These results highlight that in the case of Canterbury residents, approximately 900 women per annum may require additional support to ensure they can establish breast feeding and have the confidence to return home.

In recognition of the increasing demand for maternity services and the need to increased choice to new mothers, the DHB has developed a draft Maternity Strategy which sets the direction for maternity services in Canterbury. Finalisation of this Strategy has been put on hold pending the finalisation of the Ministry's national Maternity Action Plan 2008-2012 in order to ensure our local action and direction is in line with national emphasis and to make the best use of all resources.

Meeting the Minister's Expectations

Extending post-natal stays to increase confidence levels in new mothers and assist the establishment of breastfeeding is an expectation of the Minister for the coming year. In Canterbury we will look to meet this expectation by reviewing current mechanisms for identifying new mothers who may require extended stays to ensure this choice is offered. The additional $616,000 available to Canterbury DHB for ensuring longer post-natal stays will dedicated to increasing capacity both at Christchurch Women's hospital and in our primary birthing units, largely for increasing midwife and/or nurse numbers.

[34] *Antenatal and Post-natal beds only.*
[35] *Health Services Consumer Research: Maternity Services Consumer Satisfaction Survey Report: January 2008.*

NEXT STEPS IN 2009/10			
	OBJECTIVE	**OUTPUTS**	**IMPACTS**
Priority Projects	*What is the DHB trying to achieve?*	*What action will we take to make this happen?*	*What impacts will this have?*
8.4.1 - Support the implementation of a Canterbury Maternity Strategy in alignment with national strategy and within budget.	To provide efficient and equitable access to maternity services across Canterbury district.	Review the draft Maternity Strategy's alignment with the final Ministry Maternity Action Plan to ensure alignment. Complete consultation on the draft Maternity Strategy and establish a clear direction. Improve confidence in primary maternity units. Improve the utilisation of primary birthing units to support those new mothers who require an extended stay	Improved utilisation of maternity services across all Canterbury maternity facilities. Re-orientation of secondary and tertiary level maternity services in line with best practice and clinical need. Increased volume of births at local primary maternity units.
8.4.2 - Re-establish Rural Maternity Services in Kaikoura.	To provide improved access to primary maternity care for women domiciled in the area.	Work with midwives and general practice to re-establish primary maternity services in Kaikoura. Improve the utilisation of Kaikoura maternity services to support those new mothers who require an extended stay	Primary maternity services are established that provide Kaikoura women with a choice to receive locally delivered antenatal education, birthing services and postnatal services.
8.4.3 - Provide information, education and support throughout pregnancy and childbirth and postnatal periods.	To ensure new mothers can establish breast feeding and they have the confidence to return home.	Work with Lead Maternity Carers, maternity facility providers, consumers and key community groups and agencies to review information for new mothers to ensure it is relevant and easily accessible. Work with the Ministry, NZCOM and NZCGPs to ensure LMCs are providing the required level of care, including appropriate planning and information. Utilise consumer satisfaction surveys to measure the readiness of new mothers to return home and highlight areas for improvement. Explore opportunities to improve access to additional services such as lactation consultants and psychological support to increase support to new mothers at home.	An increased proportion of infants are exclusively and fully breastfed to >68.5% at 6 weeks, >57% at 3 months and >27% at 6 months. Increased access to support services in the community is provided. Post-natal care supports the establishment of breastfeeding in line with Minister's expectations.
	To provide the infrastructure to allow longer post-natal stays.	Develop and incorporate clinical criteria into care plans to identify high priority women for extended stays. Review and ensure increased capacity by increasing utilisation of primary birthing units (including rural), reorienting outpatient operative services to free up beds and maximising our partnership with the private sector. Develop and implement data systems to capture the offer and take-up of longer post-natal stays (including pathways, discharge, length of stay, separated for first-time mothers and repeat birth mothers. Ensure data collection systems are congruent between secondary, primary and rural birth units.	Increased number of women offered extended post-natal stays. Increased length of stay for women prioritised as meeting clinical criteria.[36]

OUTCOMES
How we will measure our success (associated measures of performance).
An increase in the average length of stay for new mothers.
An increase in Canterbury Breastfeeding rates.
An improvement in consumer satisfaction.
An increase in the proportion of women birthing in local primary birthing units.

[36] *Canterbury DHB is fully supportive of the Minister's expectation and will need to closely monitor operational spending and the potential for maternity services to impact on delivery of medical/surgical services.*

9 Meeting the Demands on Our Financial Resources

This Chapter outlines the DHB's financial forecast position for 2009/10 and the two out-years beyond this: 2010/11 and 2011/2012. It also summarises the DHB's key financial challenges and the action plans for dealing with these challenges and provides forecast financial statements for the Canterbury DHB.

9.1 Financial Outlook

The DHB is forecasting funding/revenue to increase by approximately $48M for 2009/10 with initial planned cost expected to increase by $83M. With the deficit from 2008/09 of $13M and the removal of the one-off gain from sale of surplus property of $10M in 2008/09, the forecast result for 2009/10 would be a deficit of $58M if no changes were made.

We have performed a line by line review of every contract and expenditure line in the DHB. The result of this exercise has identified areas where expenditure will be reduced, thus enabling the DHB to operate in a fiscally and clinically sustainable position. We have also identified savings initiatives that the DHB will implement to enable us to make the savings required in the coming year. The 2009/10 forecast is summarised as follows:

	$M (GST excl)
Net increase in funding/revenue (including non-base)	47.885
Less	
Increase in expenditure (external and CDHB provider service)	(80.571)
Increase in interest and depreciation	(2.000)
Shortfall carried forwards from 2008/09	(13.000)
Gain on sale of surplus property	(10.364)
Forecast net results without changes	(58.050)
Cost increases avoided	40.750
Savings initiatives	8.300
Forecast net result	(9.000)

Included in the DHB's financial forecasts are the following key assumptions:

- Employee cost increases will be based on terms agreed in current wage agreements and expired wage agreements will be settled on affordable and sustainable terms;
- Staff vacancies (existing and as they occur in future) will be reassessed to ensure the positions are still required, affordable and alternatives have been explored before vacancies are filled;
- Improved employee management is implemented with emphasis in areas such as sick leave, discretionary leave, staff training and staff recruitment/turnover;
- We will receive fair prices (including from the Ministry) for services delivered;
- A DHB wide integrated production planning approach will be developed and used, allowing the DHB to generate further efficiencies;
- External providers will operate within the available funding received, after allowance made for committed and uncontrollable funding commitments;
- We will align our service and access criteria with that of other DHBs;
- The cost to deliver additional elective surgery volumes will be within the funding received and will be delivered primarily by the DHB's hospital and specialist service division. Any outsourcing required will be short term, within the funding received and with assurance that productivity in our services is at the same level as the outsourced service;
- The DHB's funding allocation will increase as per funding advice from the Ministry and early payment is retained;
- All other expense increases, including volume growth, will be managed within uncommitted funds available or can be deferred; and

- Due to the uncertainty around the H1N1 situation the DHB assumes normal operations will occur and there will be no additional costs for dealing with H1N1 or disruptions associated with H1N1 or any other pandemic.

9.2 Key Financial Challenges

The DHB is facing significant financial challenges ahead and the financial forecast above assumes that these challenges will be managed by the DHB without further increasing the forecast deficit. The key financial challenges affecting the DHB include:

- The downturn in the New Zealand and world-wide economy has and will continue to have a significant effect on the DHB. Whilst the immediate impact has been on the Crown's ability to continue with the level of funding received in the last few years, the other potential impact of the downturn on the DHB is the likely increase in demand across all areas of health services. The income of the population has a high impact on most of the determinants of health and as such the downturn in the economy is likely to result in increased demand. This means that in the year ahead the DHB will have to meet higher demand with limited funds. To face this challenge, the DHB will have to be disciplined, remove waste and duplication, use technology to increase productivity, and ensure that funding decisions are based on our priorities, developed in partnership with clinicians and provide the best possible healthcare return.
- The DHB has annually improved health services and provided value for the funding it receives. However, this has not been reflected in reports from national systems due to incomplete capture of activities. In the coming year, we will seek to improve our capture and recording of activities so that we can provide a more accurate picture of services provided and are better able to demonstrate value for funding received. Improving the accuracy around recording of activities will also improve the DHB's financial position with funding received for services provided but not reported and therefore not funded in the past.
- The birth rate, while expected to slow down, will continue to increase. It is important therefore that the limited secondary maternity capacity is used effectively and efficiently. One of the government's key priorities is to increase post natal stays. We will work towards meeting this priority while ensuring that the limited secondary maternity capacity is used effectively and efficiently.
- The DHB competes in the international market for clinicians and workforce shortage is currently being experienced especially in some specialised clinical areas. With limited funds, it is not sustainable to recruit to these positions solely based on higher salaries. The DHB will adopt a number of strategies to meet our workforce requirements including providing a supportive learning environment for students undertaking undergraduate preparation and then transitioning from student into clinical practice as a practitioner, retaining clinical staff. We will also seek to collaborate with other tertiary DHBs in highly specialised clinical areas. In addition, future employment award settlements will have to be affordable and sustainable.
- The funding package included an increase of around 600 CWDs of inpatient services for other DHBs' residents before the impact of additional cardiac surgery volumes under the elective initiatives programme is taken into account. Complex tertiary procedure funding does not adequately compensate the providing DHB for the cost incurred and as more volumes are delivered, it increases the providing DHB's deficit. In addition, funding in some areas such as clinical training and disability services is currently at below cost. We plan to ensure that we receive fair funding for complex tertiary procedures for other DHBs and contracts currently operating at a loss or alternatively modify services provided to remove the loss.
- The Minister of Health has signalled a cap on management and administration staff numbers. The objective of this approach is to redirect resources towards the provision of frontline services. The DHB will implement an action plan designed to enable us to comply with this expectation as well as to achieve other DHB objectives. It will involve monthly review of Management and Administration FTE.

9.3 Action Plan for Dealing with Financial Challenges

The DHB has commenced implementing the action plan to achieve the forecast financial results and financial and clinically sustainability in the future. The action plan includes:

- Focus on cost containment – this will focus on ensuring expenditure relates to necessity instead of 'nice to have' and doing the basics well. The DHB's delegation policy has been revised requiring higher level of approval for certain types of expenditure and procurement of the 'right' supplies;

- Removing waste and duplication from the system – this will mean a realignment of services support functions within the DHB, across providers and across the collective DHBs;
- Clinical leadership – this is critical for the DHB to remove waste, prioritisation, transform key services, and to contain costs. We will seek to further build clinical input and leadership into this DHB's operational processes and decision making including the option to budget hold;
- Staff establishment - as part of the 2009/10 budget process, staff establishment was reviewed and adjusted where required. This has resulted in existing positions currently vacant in some areas being removed while establishment increased in other areas reflecting the additional staff currently being used to meet clinical demands. The budget review has also identified areas where savings opportunities from reconfiguration exist and this will be further investigated during the year.
- Workforce – we will develop and implement a workforce and leadership plan enabling the DHB to obtain greater benefits from its current staff training investments as well as to provide continuity of services at existing levels. In addition, we expect reduction in recruitment and staff turnover costs. The plan will also enable the DHB to improve its management of discretionary and sick leave.
- Salaries and wages increase – we have calculated the rate that is affordable and sustainable for the DHB. As agreements expire and are renewed, we will ensure that the agreements are settled within that rate so that the DHB is fiscally and clinically sustainable.
- Improve accuracy and completeness on recording of services delivered – we have developed exception reports to identify potential coding errors and have changed existing processes to ensure all important services delivered are captured and reported in a timely and accurate manner;
- Collaboration and partnerships – work in collaboration with other DHBs to share resources and reduce duplication across the sector. For example, we are currently sharing a FMIS system with Bay of Plenty DHB and Waikato DHB. We plan to engage other DHBs currently using the same FMIS software to collaborate and converge to one version hosted by one organisation;
- Transformation – we will seek to transform services that drive 80% of the DHB's expenditure and activities by focusing on flow and what is required to achieve the DHB's 2020 vision. Transformation projects that have started or are about to start include the Canterbury Initiative, Mental Health and Aged Care;
- Variation from national prices – the DHB has a number of funding contracts including some with the Ministry of Health where national prices and appropriate fair prices have not been used to fund the DHB. We have assumed that fair prices will be received in 2009/10 or services adjusted to match funding received;
- Moving to national average - in a number of areas the DHB provides services at a higher level than the national average. This is often associated with lower than average access thresholds and higher service allocations. Initiatives to reduce expenditure have been targeted at these areas to address this misalignment; and
- Discipline – the DHB will need to be disciplined to ensure that funding and investments are in accordance with approved priorities, provide the best value for money and are within available funds.

9.4 Out-years Scenario

The DHB expects funding increases for out-years to be around 2% (planning advice from the Ministry suggested 2.67% and, in light of recent economic conditions, we have planned for a lower rate) for both 2010/11 and 2011/12 with demographic funding continuing to be received at the same rate in the out-years as received in 2009/10. The DHB has also assumed that we will be able to contain expenditure increases to be, on average, below the rate of funding increase received.

We will continue implementing the strategies and actions developed to meet our financial challenges and to achieve financial sustainability indicated throughout this document. We assume that our strategies and action plans will enable us to further reduce our deficit and reach break-even in out-years.

9.5 Asset Planning and Sustainable Investment

Business Cases

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

- Facilities Business Case for any facilities redevelopment requirements arising from the Facilities Master Plan. An additional loan facility may be required from the Health Capital Envelope should some large facilities redevelopments be required and subsequently approved by the National Capital Committee, Ministry and the Minister.
- Health Management System Business Case. The DHB is participating in a DHB collaboration with seven other DHBs to replace the outdated legacy Patient Administration System with a patient centric Health Management System. The seven DHBs have agreed to work collaboratively on the replacement with the detailed planning work currently underway. It is expected that the value of the Health Management System will require approval from the National Capital Committee, Ministry and the Minister. It is also likely that an additional loan facility may be required from the Health Capital Envelope following completion of the detailed planning work and approval.

Capital Expenditure

The DHB has significant capital expenditure committed in the 2008/09 financial year where the expenditure will be incurred in the 2009/10 financial year including: boiler, electricity network infrastructure and replacement linear accelerators. In addition, the DHB has just approved the preparation of a Facilities Master Plan and is collaborating with six other DHBs to replace our outdated legacy Patient Administration System.

Based on the DHB's fiscal position, we estimate that we will be able to fund a total of $40M of capital expenditure in 2009/10, including committed capital expenditure from 2008/09 but excluding any potential impact arising from the Facilities Master Plan or replacement of our Patient Administration System. This means there is likely to be a reduction in the amount of capital expenditure available for approval in the 2009/10 financial year, compared to previous years. As capital expenditure funding will be tight, we plan to be disciplined and focus on the DHB's key priorities in determining our capital expenditure spending. Where possible, we will seek to collaborate with other DHBs to avoid duplication. For example, we plan to collaborate with other DHBs to converge towards one hosted Financial Management Information System for DHBs who are currently using the same software.

The DHB also notes that 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. The DHB's Health Services Planning Programme, Vision 2020 and the South Island Regional Health Services Planning Programme (currently underway) will guide the development of the DHB's Facilities Master Plan. It may be likely that building replacement as part of legislative compliance will take place in conjunction with other service redesign/reconfigurations arising from the development of the DHB's Facilities Master Plan. The funding for these significant projects will be discussed with the Ministry when the implications are known.

9.6 Debt and Equity

The DHB's estimated total term debt is expected to remain unchanged at $75M (as at June 2010). The debt level is based on key assumptions including achieving our budget operating result, and does not take into account any impact arising from the DHB's Facilities Master Plan or replacement of the legacy Patient Administration System.

While we do not have any banking covenants required of our loans the forecast key financial ratios for the DHB would be:

REQUIRED	FORECAST RATIO
Interest Cover Ratio:	Approx 7 times
Debt/Debt plus Equity Ratio:	Approx 25%
Shareholder Funds/Tangible Assets	Approx 45%

As the above ratios indicate, the DHB has a low debt/debt plus equity ratio. This low ratio results in a higher than average interest and capital charge expenditure compared to the sector and is out of alignment with the funding for interest and capital charge. We will explore in the coming year strategies for reducing our interest and capital charge expenditure or seek to have the funding better matching cost.

The DHB is repaying $1.861M of equity as part of the agreed FRS-3 funding.

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

The accounting policies adopted by the DHB are consistent with those in the prior year. A full statement of accounting policies is an appendix to the DHB's Statement of Intent 2009-2012.

9.8.1 Forecast Group Statement Financial Performance

	2007/08 Actual $'000	2008/09 Forecast $'000	2009/10 Forecast $'000	2010/11 Forecast $'000	2011/12 Forecast $'000
Operating Revenue					
MoH Revenue	1,116,673	1,194,014	1,259,702	1,289,896	1,315,694
Patient Related Revenue	36,545	37,607	39,517	40,307	41,113
Other Revenue	27,830	34,743	19,896	20,200	20,510
Total Operating Revenue	1,181,048	1,266,364	1,319,115	1,350,403	1,377,317
Operating Expenditure					
Employee Costs	472,445	501,093	529,390	540,126	551,276
Treatment Related Costs	105,008	111,843	115,660	118,993	121,373
External Providers & IDF	480,389	525,157	538,953	545,732	556,647
Non Treatment Related & Other Costs	65,963	71,182	72,023	73,463	74,932
Total Operating Expenditure	1,123,805	1,209,275	1,256,026	1,278,314	1,304,228
Result before Interest, Depn & Cap Chrge	57,243	57,089	63,089	72,089	73,089
Interest, Depreciation & Capital Charge					
Interest Expense	(5,584)	(4,786)	(5,786)	(5,786)	(5,786)
Depreciation	(47,808)	(45,303)	(46,303)	(46,303)	(47,303)
Capital Charge Expenditure	(20,617)	(20,000)	(20,000)	(20,000)	(20,000)
Total Interest, Depreciation & Capital Charge	(74,009)	(70,089)	(72,089)	(72,089)	(73,089)
Net Operating Results	(16,766)	(13,000)	(9,000)	-	-

9.8.2 Summary of Revenue and Expenses by Output Class

Funding Arm

	2007/08 $'000	2008/09 $'000	2009/10 $'000	2010/11 $'000	2011/12 $'000
Revenue					
MoH revenue	1,071,753	1,149,765	1,213,185	1,242,449	1,267,298
Total Revenue	1,071,753	1,149,765	1,213,185	1,242,449	1,267,298
Expenditure					
Other - Personal Health	761,090	820,162	872,565	895,017	912,917
Other - Mental Health	116,889	121,094	127,622	130,175	132,778
Other - Disability Support	188,237	205,046	207,820	211,976	216,216
Other - Public Health	1,518	1,822	3,521	3,591	3,663
Other - Maori Health	1,396	1,641	1,657	1,690	1,724
Other - Governance & Admin	3,588		-		
Total Expenditure	1,072,718	1,149,765	1,213,185	1,242,449	1,267,298
Net Surplus/(Deficit)	**(965)**	-	-	-	-

Governance & Funder Admin

	2007/08 $'000	2008/09 $'000	2009/10 $'000	2010/11 $'000	2010/11 $'000
Revenue					
MoH revenue	3,596	533			
Total Revenue	3,596	533	-	-	-
Expenditure					
Personnel	2,859	3,353	3,456	3,525	3,596
Other	632	(2,820)	(3,456)	(3,525)	(3,596)
Total Expenditure	3,491	533	-	-	-
Net Surplus/(Deficit)	**105**	-	-	-	-

Provider Arm

	2007/08 $'000	2008/09 $'000	2009/10 $'000	2010/11 $'000	2010/11 $'000
Revenue					
MoH revenue	632,746	668,324	720,749	744,164	759,047
Patient Related Revenue	36,545	37,607	39,517	40,307	41,113
Other	27,830	34,743	19,896	20,200	20,510
Total Revenue	697,121	740,674	780,162	804,671	820,670
Expenditure					
Personnel	469,586	497,740	525,934	536,601	547,680
Depreciation	47,808	45,303	46,303	46,303	47,303
Interest & Capital charge	26,201	24,786	25,786	25,786	25,786
Other	169,432	185,845	191,139	195,981	199,901
Total Expenditure	713,027	753,674	789,162	804,671	820,670
Net Surplus/(Deficit)	**(15,906)**	**(13,000)**	**(9,000)**	-	-

In House Elimination

	2007/08 $'000	2008/09 $'000	2009/10 $'000	2010/11 $'000	2010/11 $'000
Revenue					
MoH revenue	(591,422)	(624,608)	(674,232)	(696,717)	(710,651)
Total Revenue	(591,422)	(624,608)	(674,232)	(696,717)	(710,651)
Expenditure					
Other	(591,422)	(624,608)	(674,232)	(696,717)	(710,651)
Total Expenditure	(591,422)	(624,608)	(674,232)	(696,717)	(710,651)
Net Surplus/(Deficit)	-	-	-	-	-

Consolidated

	2007/08 $'000	2008/09 $'000	2009/10 $'000	2010/11 $'000	2010/11 $'000
Revenue					
MoH revenue	1,116,673	1,194,014	1,259,702	1,289,896	1,315,694
Patient Related Revenue	36,545	37,607	39,517	40,307	41,113
Other	27,830	34,743	19,896	20,200	20,510
Total Revenue	1,181,048	1,266,364	1,319,115	1,350,403	1,377,317
Expenditure					
Personnel	472,445	501,093	529,390	540,126	551,276
Depreciation	47,808	45,303	46,303	46,303	47,303
Interest & Capital charge	26,201	24,786	25,786	25,786	25,786
Other	651,360	708,182	726,636	738,188	752,952
Total Expenditure	1,197,814	1,279,364	1,328,115	1,350,403	1,377,317
Net Surplus/(Deficit)	**(16,766)**	**(13,000)**	**(9,000)**	-	-

9.8.3 Forecast Group Statement Financial Position

	30/06/08 Actual $'000	30/06/09 Forecast $'000	30/06/10 Forecast $'000	30/06/11 Forecast $'000	30/06/12 Forecast $'000
Public Equity					
Opening Equity	268,142	249,515	234,654	223,793	221,932
Equity Repayment	(1,861)	(1,861)	(1,861)	(1,861)	(1,861)
Net Result for the period	(16,766)	(13,000)	(9,000)	-	-
Total Public Equity	249,515	234,654	223,793	221,932	220,071
Current Assets					
Cash & Bank (OD)	42,339	37,571	25,429	24,871	30,313
MoH Debtor	15,372	12,000	12,000	12,000	12,000
Other Debtors & Other Receivables	19,765	17,000	17,000	17,000	17,000
Prepayments	872	800	800	800	800
Stocks	8,963	8,000	8,000	8,000	8,000
Total Current Assets	87,311	75,371	63,229	62,671	68,113
Current Liabilities					
Creditors & Accruals	80,096	70,000	66,000	66,000	66,000
Capital charge payable	7,229	5,000	5,000	5,000	5,000
GST	5,770	5,800	5,800	5,800	5,800
Interest Accrual	545	600	600	600	600
Staff Entitlement	109,932	107,000	105,000	100,000	100,000
Total Current Liabilities	203,572	188,400	182,400	177,400	177,400
Working Capital	(116,261)	(113,029)	(119,171)	(114,729)	(109,287)
Investments	9,170	9,170	9,170	9,170	9,170
Restricted Assets - Trust Fund	11,522	11,522	11,522	11,522	11,522
Fixed Assets	440,190	422,097	415,794	409,491	402,188
Total Non Current Assets	460,882	442,789	436,486	430,183	422,880
Term Staff Entitlement	(8,584)	(8,584)	(7,000)	(7,000)	(7,000)
Trust Funds Liabilities	(11,522)	(11,522)	(11,522)	(11,522)	(11,522)
Term Loans	(75,000)	(75,000)	(75,000)	(75,000)	(75,000)
Total Non Current Liabilities	(95,106)	(95,106)	(93,522)	(93,522)	(93,522)
Net Assets	249,515	234,654	223,793	221,932	220,071

9.8.4 Forecast Group Statement of Movement in Equity

	30/06/08 Forecast $'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	268,142	249,515	234,654	223,793	221,932
Add/(Less):					
Equity Injection / (Repayment)	(1,861)	(1,861)	(1,861)	(1,861)	(1,861)
Revaluation of Property					
Net Result for the period	(16,766)	(13,000)	(9,000)	-	-
Total Public Equity	249,515	234,654	223,793	221,932	220,071

9.8.5 Forecast Group Statement Cashflow

	2007/08 Actual $'000	2008/09 Forecast $'000	2009/10 Forecast $'000	2010/11 Forecast $'000	2011/12 Forecast $'000
Cashflows from Operating Activities					
Cash provided from:					
MOH Receipts	1,105,160	1,197,386	1,259,702	1,289,896	1,315,694
Other Receipts	55,691	58,495	54,697	55,791	56,907
	1,160,851	1,255,881	1,314,399	1,345,687	1,372,601
Cash applied to:					
Employee Costs	462,833	504,025	532,974	545,126	551,276
Supplies & Expenses	646,530	717,243	730,636	738,188	752,952
Capital Charge Payments	27,240	22,229	20,000	20,000	20,000
Finance Costs	5,602	4,731	5,786	5,786	5,786
Taxes Paid	(320)	(30)	-	-	-
	1,141,885	1,248,198	1,289,396	1,309,100	1,330,014
Net Cashflow from Operating Activities	**18,966**	**7,683**	**25,003**	**36,587**	**42,587**
Cashflows from Investing Activities					
Cash provided from:					
Sale of Assets	2,235	13,150		-	-
Interest Received	8,819	6,260	4,716	4,716	4,716
	11,054	19,410	4,716	4,716	4,716
Cash applied to:					
Advance to JV/Trust Investments		-	-	-	-
Purchase of Assets	23,803	30,000	40,000	40,000	40,000
	23,803	30,000	40,000	40,000	40,000
Net Cashflow from Investing Activities	**(12,749)**	**(10,590)**	**(35,284)**	**(35,284)**	**(35,284)**
Cashflows from Financing Activities					
Cash provide from:					
Equity Injection					
Loans Raised	-	-	-	-	-
	-	-	-	-	-
Cash applied to:					
Loan Repayment	12,650				
Equity Repayment re FRS-3	1,861	1,861	1,861	1,861	1,861
	14,511	1,861	1,861	1,861	1,861
Net Cashflow from Financing Activities	**(14,511)**	**(1,861)**	**(1,861)**	**(1,861)**	**(1,861)**
Overall Increase/(Decrease) in Cash Held	(8,294)	(4,768)	(12,142)	(558)	5,442
Add Opening Cash Balance	50,633	42,339	37,571	25,429	24,871
Closing Cash Balance	**42,339**	**37,571**	**25,429**	**24,871**	**30,313**

10 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.

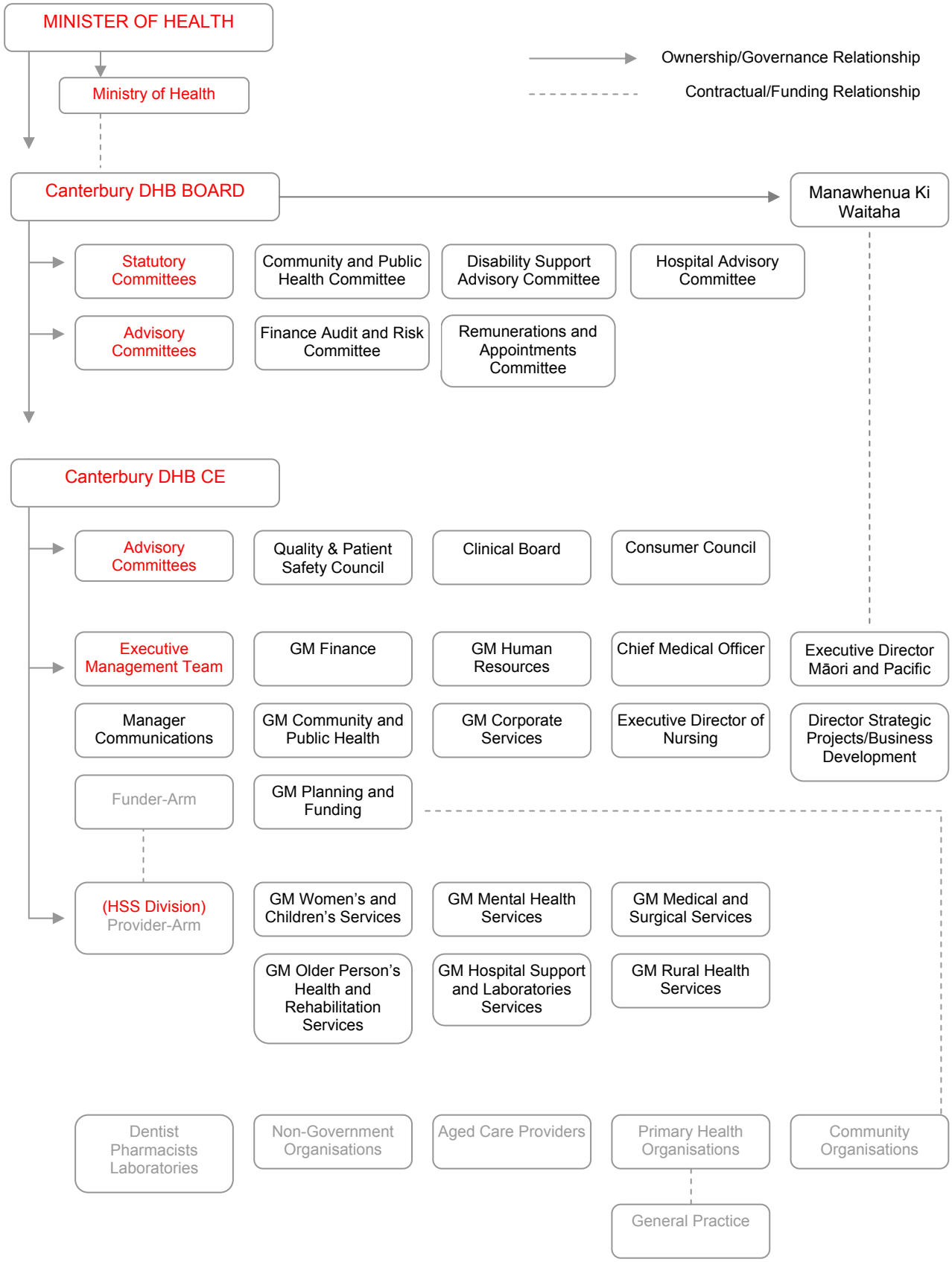
- District Strategic Plan: A Healthier Canterbury: Directions 2006.
- Canterbury DHB Health Services Plan 2008.
- Canterbury DHB Statement of Intent 2009-2012.
- Health Needs Assessment for Canterbury 2004.
- Canterbury DHB Quality Strategic Plan 2007-2010.
- Māori Health Plan, *Te Whakamahere Hauora Māori Ki Waitaha* 2007-2011.
- Canterbury DHB Aged Care Strategy: Healthy Ageing, Integrated Support 2005.
- Healthy Eating, Active Living (HEAL) Plan 2005-2010.
- Canterbury DHB Information Strategy Strategic Plan 2005.
- Mental Health and Addiction Strategy May 2004.

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

Appendices

- Appendix 1. Canterbury DHB - Organisational Chart.
- Appendix 2. Hospital and Specialist Services Division - Overview of Services.
- Appendix 3. Indicators of DHB Performance.
- Appendix 4. South Island Collaborative Plans.
- Appendix 5. Canterbury DHB – Quality Strategic Plan Goals 2007-2010.
- Appendix 6. Glossary of Terms.

10.1 Canterbury DHB - Organisational Chart



10.2 Hospital and Specialist Services Division - Overview of Services

HOSPITAL SUPPORT AND LABORATORY SERVICES

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

MEDICAL AND SURGICAL SERVICES

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: general surgery, vascular, ENT, ophthalmology cardiothoracic, orthopaedics and neurosurgery, urology, plastic and cardiothoracic surgeries and the services of the day surgery unit. Medical and Surgical Services also covers: emergency investigations, outpatients, anaesthesia, intensive care, radiology, nuclear medicine, clinical pharmacology, pharmacy, medical physics and allied health services. The Christchurch Hospital has a busy Emergency Department treating around 72,000 patients per annum.

MENTAL HEALTH SERVICES

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

OLDER PERSON'S HEALTH AND REHABILITATION SERVICES

Covers assessment, treatment and rehabilitation services both inpatient and community based, psychiatric services for the elderly both inpatient and community, under 65 needs assessment service, generic geriatric outpatients, specialist osteoporosis clinics and specialist under 65 assessment and treatment services for disability funded clients. The Older Person's Health Specialist Service also operates a psychogeriatric day hospital and access to geriatric day facilities. Inpatient and community stroke services are also part of the services provided by this Service. Rehabilitation services (provided at Burwood Hospital) include rehabilitation health services through the spinal injuries unit, the brain injury unit, the orthopaedic rehabilitation unit and pain management services. A significant proportion of elective surgery is also performed at Burwood Hospital.

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

10.3 Indicators of DHB Performance

The Canterbury DHB's Indicators of DHB Performance for 2009/10 follow and are in addition to a wider set used by the Ministry within its accountability arrangements with DHBs.

Indicator Code	Measure and Canterbury DHB Targets	Reporting Expectations
HKO-01 Local Iwi/Māori are engaged and participate in DHB decision-making and the development of strategies and plans for Māori health gain.	1. Report the percentage of PHOs with Māori Health Plans agreed by the DHB **Target – 100%** 2. Report the percentage of DHB members having Treaty of Waitangi training **Target – 100%** 3. Report on achievements against the Memorandum of Understanding between 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 2009/10. For reporting in Q2, provide a progress report on the milestones, and for reporting in Q4, provide a report against achievement of those milestones.	Report six-monthly in the second and fourth quarter.
HKO-03 Improving mainstream effectiveness.	1. Provide a report describing the reviews of pathways of care (within the DHB provider-arm) that have been undertaken in the last 12 months, focused on improving Health outcomes and reducing health inequalities for Māori. 2. 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.	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 predicted expenditure for Māori health in the 2009/10 DAP in comparison to the actual expenditure with explanation of the variances.	Annual reports to the Ministry in quarter four (not part of the monthly financial reporting template).
PAC-01 Pacific provider service contracts.	Report the total number and type of service contract delivered by Pacific providers as a percentage of the total number and type of service contracts held by the DHB.	Annual report to the Ministry in quarter four.
POP-04 Oral health - Mean Decayed, Missing, Filled Teeth score at year eight.	Report 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 Community Oral Health Service against the total number of children, who have been examined in the Year eight group, in that year. Provide data by: ethnic group and fluoridation status (of school area the child attends) using the Ministry template provided. **Target to 2012 (end of current SOI period)** **Māori Pacific Other Total** **2.00 2.00 1.20 1.32**	Annually in quarter three for the period 1 January to 31 December 2008.
POP-05 Oral health - Percentage of children caries free at age five years.	Report 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 Community Oral Health 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 and fluoridation status (of school area the child attends) using the Ministry template provided. **Target to 2012 (end of current SOI period)** **Māori Pacific Other Total** **47 30 70 65**	Annually in quarter three for the period 1 January to 31 December 2008.

Indicator Code	Measure and Canterbury DHB Targets	Reporting Expectations
POP-06 Improving the health status of people with severe mental illness.	Report the average number of people domiciled in the DHB district, seen per year rolling every three months being reported (period lagged by three months) against the projected population of the DHB district. Provide data by age and ethnicity for the following groupings: child and youth aged 0-19, adults aged 20-64, people aged 65+. Where the rate has not been met provide commentary/resolution plans, using the Ministry templates provided. **Target Māori Other Total** **0-19 2 2 2** **20-64 3.6 2.5 2.5** **65+ - (no targets as service primarily funded by DSS)**	Six monthly in the second (rates to 30 September of the previous year) and fourth quarters (rates to 31 march of the previous year).
POP-07 Alcohol and other drug service waiting times.	Report the DHBs longest waiting time, in days, for each mental health service type for one month prior to the reporting period - by Māori and Other ethnicities. Waiting times are measured from the time of referral for treatment to the date the client is admitted to treatment, following assessment. Whilst assessment and motivational or pre-modality interventions may be therapeutic, they are not considered to be treatment. If a client is engaged in these processes, they are considered to be still waiting for treatment.	Measured, for one month, every six months. Reports due: in the second and fourth quarters.
POP-10 Chemotherapy treatment waiting times.	1. Provide Chemotherapy Templates that measure the interval between the first specialist assessment and the start of first chemotherapy treatment. Templates must be supplied on time and complete (emailed to Ministry within 2 weeks of the end of each calendar month). **2.** Provide qualitative reports commenting on reasons (and management plans) for people with chemotherapy waits longer than six weeks in quarterly reports.	Monthly supply of chemotherapy templates. Qualitative reports quarterly.
POP-11 Family Violence Prevention.	DHBs are expected to achieve an overall score of 70/100 in audits for child abuse and partner abuse responsiveness. Where an overall score below 70/100 is not the DHB is required to provide a progress report on specific actions taken since the audit to progress the recommendations of the audit. **Target - Overall score of 70/100 or above.**	Annual report in fourth quarter.
POP-14 Utilisation of DHB funded dental services by adolescents.	Report the proportion of adolescents utilising DHB oral health services (Year 9 to age 17 years) broken down by ethnicity. **Target – 70%.**	Annually in quarter three for the period 1 January to 31 December 2008.
POP-15 Ambulatory Sensitive (avoidable) Hospital Admissions.	1. Provide commentary on the DHB quarterly ASH data (provided by the MoH. The report may include additional district level data that's not captured in the national data collection and information about local initiatives that are intended to reduce ASH admissions. 2. Provide information about how health inequalities are being addressed with respect to this health target, with a particular focus on ASH admissions for Pacific and Māori 45-64 year olds. **Targets:** [37] **Other (0-74) at or below 99** **Māori (0-74) remain below 95** **Pacific (0-74) remain below 98** **Other (45-64) at or below 95** **Māori (45-64) remain below 95** **Pacific (45-64) remain below 95** **Other (0-4) at or below 112** **Māori (0-4) remain below 95** **Pacific (0-4) remain below 95**	Six monthly in the second and fourth quarters.

[37] *The DHB notes its concerns around the change in ASH definition and the lack of historical data against the new definitions. We are working on understanding the dynamics in terms of the new definitions and may have to refocus programmes to specifically influence a change in these rates. The DHB is also in the process of improving ethnicity coding - it is likely that as we improve our identification of Māori and Pacific people this will impact on ASH results.*

Indicator Code	Measure and Canterbury DHB Targets	Reporting Expectations
POP-17 Improving Mental Health Services.	1. Report the number of adults (20 years plus) with enduring serious mental illness who have been in treatment* for two years or more since the first contact with any mental health service (*at least one provider arm contact every three months for two years or more.) The subset of alcohol and other drug only clients will be reported for the 20 years plus. 2. Report the number of Child/Youth (0-19 years) who have been in secondary care treatment* for one or more years (*at least one provider arm contact every three months for one year or more). 3. Report the number and percentage of long-term clients with up to date crisis prevention/resiliency plans (NMHSS criteria 16.4), and describe how this is assured. 4. Where the DHB did not meet targets provide commentary/resolution plan on addressing performance using the Ministry template provided. 5. All reports must provide ethnicity breakdowns. Where DHBs have exceptionally high rates of Māori and Pacific Island acute bed use rates, the relevant DHBs will be notified and asked to review their treatment of these long term consumers. **Target – 90% of all long-term clients have up to date crisis prevention/resiliency plans across all age groups and ethnicities.**	Six monthly based on data for the six month period just completed.
POP-18 HEHA Improve Breastfeeding Rates.	Provide a quarterly report on progress towards DHB-specific breastfeeding targets with both quantitative and qualitative information on breastfeeding activity and achievement of the breastfeeding targets. DHBs that choose to collect data on breastfeeding rates from their Well Child providers to supplement Plunket data are encouraged to do so. Ministry will provide guidance on the information required for the collection of this data and will work to include this data in quarter four for a more complete analysis of breastfeeding rates within the DHBs who choose to collect the additional data. **Target: 6wks 3mths 6mths** **Māori 61.2%** **Pacific 65.7%** **Total 68.5% >57% >27%**	Quarterly.
QUA-03 Improving the quality of data provided to National Collections Systems.	Provide a report explaining the DHB's improvement plans for areas where the DHB's ratings fall into the 'not' or 'partially' achieved levels for the following measures (Ministry will provide data to the DHB) – DHBs are to provide a quarterly report where they are not achieving: 1. The number of NHI duplicates that require merging by NZHIS per DHB as a % of the total number of NHI records created per DHB per quarter. 2. The total number of NHI records created with ethnicity status of 'Not Stated' per DHB as a % of the total number of NHI records created per DHB per quarter. 3. The number of versions of text descriptor per code per DHB as a % of the total number of codes per DHB. 4. The total number of publically funded NMDS events loaded into the NMDS more than 21 days post month of discharge as a % or the total number of publically funded NMDS events in the NMDS per DHB per quarter.	Quarterly.
RIS-01 Service Coverage.	Provide a report with information on progress achieved during the quarter towards resolution of gaps in service coverage identified in the DAP, and not approved as long term exceptions, and any other gaps in service coverage identified by the DHB or Ministry through: analysis of explanatory indicators, media reporting, risk reporting, formal audit outcomes, complaints mechanisms and sector intelligence.	Quarterly.

Indicator Code	Measure and Canterbury DHB Targets	Reporting Expectations
SER-04 Continuous Quality Improvement and Improving Elective Services.	▪ For publicly funded casemix included elective discharges in a surgical DRG, a target intervention rate of at least 280 per 10,000 of population will be achieved. ▪ For major joint replacement procedures, a target intervention rate of 210 per 100,000 of population will be achieved. This should be comprised of the following rates: (105 per 100,000 of population for hip replacement and 105 per 100,000 of population for knee replacement). ▪ For cataract procedures, a target intervention rate of 270 per 100,000 of population will be achieved. ▪ For cardiac procedures a target intervention rate of at least 59 per 100,000 of population will be achieved. DHBs with rates of 59 per 100,000 or above in 2007/08 will be required to maintain this rate. DHBs with rates less than 59 per 100,000 will be required to increase the level of service to at least 59: 100,000. By 2011/12 all DHBs will be delivering at a rate of at least 65 per 100,000 of population. ▪ Cardiac surgery is defined as coronary artery bypass graft (CABG), valve replacement or repair, and CABG plus valve replacement or repair, for people aged 15 and over. ▪ The current national intervention rate for percutaneous revascularization is 108. It is expected that DHBs will maintain their current rates of this procedure in 2009/10. Provide a report for any procedure where the SDR is below the target level demonstrating what analysis the DHB has done to review the appropriateness of its rate and either - 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. Must include evidence of consultation with the primary sector as to the perceived level of access. Any recovery plans must have actions, timeframes and responsibilities included.	Six monthly Q1 (previous full year results) Q3 (Q1/Q2 combined)
SER-07 Low or reduced cost access to first level primary care services.	1. 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%.** 2. Report the number of PHO practices that ensure public access to local information on the fees PHO practices are charging patients. **Target - 100%.** 3. Report 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.

10.4 South Island DHB Collaborative Plans

South Island Health Services Planning - Agreed Direction (draft)

Background

The New Zealand Ministry of Health have recognised that the New Zealand health system will face significant challenges over the next 20 years, including:

- Population growth, redistribution and ageing;
- Increasing risk and prevalence of long term conditions;
- Reducing health inequalities;
- Managing within an affordable funding path;
- Effective utilisation of the available workforce;
- Effective application of technological advances; and
- Rising consumer expectations.

To support the health system in meeting these challenges the Ministry of Health and the DHB sector are developing a Health Futures Framework. The South Island DHBs agree that access to timely and accessible health and disability services, of a high quality, is a right that all New Zealanders have regardless of where they live. Services will only be accessible if they are sustainable. Services will only be sustainable in the medium to long term if they are of a high quality reflecting contemporary evidence based practice. These two issues create a counterbalancing effect when considering the configuration of health and disability services across the South Island, and indeed across New Zealand. This dichotomy ultimately results in a balancing between local provision of services and centralisation of services.

South Island Health Services Plan

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

The vision of the South Island Health Services Plan (SIHSP) is to:

- Reduce inequalities in access to health services across the South Island;
- Enhance the quality of health services across the South Island;
- Enhance the sustainability of all health services for the South Island population that are appropriately delivered in the South Island; and
- Engage with key stakeholders to ensure understanding and acceptability of South Island Health Services.

DHB Participation

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

The SIHSP provides a framework for regional and sub-regional, clinical and non-clinical developments, each of which forms part of the programme of work. Workstreams are based around clinical services, e.g. vulnerable services and chronic care, while others consider enablers that will support different of models of care and ways of delivering services. Each workstream includes participation from relevant stakeholders including DHB clinicians and managers.

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

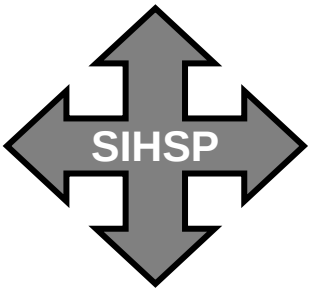
South Island Health Service Planning Principles

The following principles have been adopted by the DHBs as those that will support the development of a sustainable health service for the population of the South Island. These will be reflected in all regional and sub regional activity.

<table>
<tr><th>Equity of Access</th><th>Clinical Engagement</th><th>Quality & Safety</th><th>Clinical Sustainability</th></tr>
<tr>
<td>▪ Planning will be based on the health needs of our constituent communities.
▪ Historical demand and service provision will not determine future needs.
▪ Planning for health services relates to recognising and planning for changing demand and providing an equitable level of service for the population catchments with a continuing focus on reducing inequalities in health status.</td>
<td>▪ Clinician input, through active clinical leadership, into the planning and decision making process is recognised as a critical component of the success of the SIHSP.
Patient Centred Consumer Involvement
▪ Health care services will be co-designed with service users including the patient.
▪ This will be a collaborative process allowing a sharing of perspectives and experiences.</td>
<td>▪ The health consumer is the primary focus of any model of health care quality management
▪ Health treatment and care is based on the best available evidence with appropriate monitoring and evaluation.
▪ All health care providers have access to systems that enables outcomes of care to be assessed.
▪ Quality of care systems that focus on: safety, effectiveness, access, efficiency, acceptability, appropriateness, and consumer participation.</td>
<td>▪ The identification of future need and supply of clinical skills.
▪ Design of service delivery models that allow appropriate access, meet credentialing requirements, support evidence based practice, and are consistently delivered to a high standard of quality & safety.
▪ Clinical education and ongoing training for all health care providers must be considered to ensure quality service delivery.</td>
</tr>
<tr><th>Māori Health Service Needs</th><th>Community Acceptance</th><th>Continuum of Care</th><th>Fiscal Sustainability</th></tr>
<tr>
<td>▪ We recognise our commitment to partnership with Māori.
▪ We recognise that Māori in our communities do not have equal access to health care or equal health outcomes.
▪ We aim to reduce health disparities by planning for services to address these.</td>
<td>▪ The Community will be informed and involved so that they have an awareness of the SIHSP, the drivers of sustainable health services that may result in changes to health service configuration and can accept the outcomes as being in the long term best interest of the population.</td>
<td>▪ SIHSP will consider the full continuum of care.
▪ Continuum of care refers to services and integrating mechanisms that guide & track patients/clients over time through a comprehensive array of services spanning public health through to tertiary & including supports required to enable service delivery.</td>
<td>▪ Acknowledgement that efficient and effective use of resources will be required across the SI.
▪ Resources include workforce, facilities and infrastructure (including: information systems, clinical equipment, and transport) required to deliver the models of care within the allocated funding system.</td>
</tr>
</table>

SIHSP – Whole of Health Service Planning

Principles								
Equity of Access	Māori Health Service Needs	Clinical engagement	Patient centred consumer involvement	Community acceptance	Quality and safety	Continuum of care	Fiscal Sustainability	Clinical sustainability

Service Developments		Sub-Regional
Clinical service plans e.g. Neurosurgery, others TBA **Regional Services** e.g. Health South, Electives initiative, others TBA **Health Networks** E.g. SIRMHN, SCN, others TBA		**Clinical service developments** **Non-clinical service developments**

Enablers						
Ministry Tools e.g. role delineation	Funding Options	Demand forecasting	Technology	Human Resources	Transport and Accommodation	Communications Plan

2009 -2010 Priorities

Aim	Develop regional service plans for 'at risk' services to support viable health & disability services for the South Island population
Actions	Regional service planning of prioritised vulnerable services as identified in stocktake undertaken in 2008-09 Establish working groups of stakeholders from relevant SI DHBs and across the continuum. Where possible there will be clinical leadership of these groups.
Outputs	Business case development to support service delivery changes as appropriate Ongoing review and support of regional service developments Health networks established where appropriate to support ongoing service delivery.
Measure	A reduction in service failure across the South Island Regional collaboration to support equitable access to services
Aim	Develop a South Island Elective Services Plan that supports efficient, effective and sustainable management of elective surgical services for the future, in compliance with national policy and standards
Actions	Provide a framework for the development and implementation of a collective approach for the delivery of elective surgical services across the South Island to ensure equitable access for all population groups
Outputs	Elective service capacity and capability across the South Island meets funding thresholds and equity of access Strengthening of regional collaborations and support the increase in productivity across South Island District Health Boards (DHBs) through utilising all surgical service options including public and private
Measure	Elective service outputs delivered as required by Government From current agreed base numbers of discharges/case weights, move towards regional equity of access (e.g. SDR's, thresholds) DHB resources considered prior to contracting with private sector
Aim	Develop a plan from each enabler workstream that will support viable service delivery within the South Island
Actions	Develop workstreams to consider opportunities within technology, employment and transport & accommodation that will support alternative service delivery models across the continuum of care Involve stakeholders from across the SI DHBs
Outputs	Workstream plans Business case development to support recommendations as appropriate.
Measure	Implementation of changed models of service delivery supported by changes through enabler workstreams

Southern Cancer Network (Draft)

Background

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

The Southern Cancer Network brings together key stakeholders to plan and deliver a set of comprehensive and integrated cancer services, that are co-ordinated across patient care pathways through a multidisciplinary team approach, for their given population area (region). The Southern Cancer network can increase access to comprehensive cancer services by promoting a collaborative approach to care planning and delivery.

The SCN was formed in September 2007 and the present management infrastructure established in March 2008. A steering group was elected in March 09 to provide advice and direction to the Management Team and associated groups. The steering group is representative of the South Island cancer continuum with members selected from each region and professional grouping.
Each SI DHB is working towards achieving or has developed a Local Cancer Plan and the SCN Strategic planning process will build on the work achieved to date. SCN will work with its stakeholders to influence prepare and develop a South Island strategic plan. The SCN planning process will be conducted according to broad project management principles.

The Southern Cancer Network is collaborating with the South Island Health Services Planning Team to avoid duplication of effort and to share knowledge.

2009 - 2010 Priorities

Aim	Develop two service improvements for lung and bowel cancer
Actions	Collaborate with regional networks in development of national guidelines and patient management frameworks. Liaise with South Island Local Cancer Networks
Outputs	Development of National guidelines for lung cancer Development of Patient Management Framework for lung cancer (initially)
Measure	Guidelines and Patient Management Frameworks are adopted by cancer service providers
Aim	Determine South Island Inequalities for Cancer patients
Actions	Review of South Island's delivery of cancer services to its population Work with stakeholders to identify and address issues relating to inequalities Incorporate strategies for know inequalities with respect to cancer
Outputs	Inequalities are identified with recommendations.
Measure	Action plan developed for implementing recommendations.
Aim	SCN maintains an informed position with respect to cancer service provision across the region and works with stakeholders to address issues
Actions	Support SI DHBs to review and or establish multi-disciplinary meetings for the management of: major tumour streams Work with Local Cancer Networks Groups to monitor, co-ordinate and identify local issues and to oversee development and implementation of Local Cancer Plans. Develop data collection, monitoring systems and a range of indicators. Understand the South Island Cancer burden at a regional and district level
Outputs	South Island local Cancer Plans Data collection to enable the network to monitor progress against strategies over time South Island Health Needs Assessment for Cancer
Measure	Data and information ensures local, regional and national cancer strategies align
Aim	Develop a co-ordinated and seamless cancer journey for the patient.
Actions	Work with the MOH, other Cancer networks and all relevant groups to explore the national adoption of Patient Management Frameworks for common cancers Promote a consistent approach to mapping the patients journey, promote a sequencing of work to maximise resources and identify what work should be undertaken at a regional level
Outputs	The patient journey is 'mapped' for lung and bowel cancer in the South Island
Measure	Report with recommendations is produced

South Island Regional Mental Health (Draft)

The second South Island Regional Mental Health strategic plan (2009–2012) builds on key national policies and emulates Te Tahuhu: Improving Mental Health 2005–2015 and Te Kokiri: The Mental Health and Addiction Action Plan 2006–2015. Te Tahuhu and Te Kokiri set clear outcomes that the Government expects agencies to pursue. It also defines the priorities or challenges that must be tackled collaboratively and implemented collectively if they are to be achieved. It is these collaborative priorities that the South Island Regional Mental Health strategic plan addresses.

The South Island Regional Mental Health Network provides a mechanism for progressing regional collaboration and for achieving the overall purpose identified in the terms of reference:

- To provide effective regional mental health planning and funding advice and recommendations to the South Island Regional General Managers Network;
- To develop, prioritise, monitor and support the implementation of the regional mental health planning and funding work programme; and
- To promote effective and appropriate sharing of information that supports a regional perspective on Mental Health Planning and Funding, influences changes, and progresses the implementation of National Mental Health Strategy.

The strategic plan outlines the ten strategic challenges identified in Te Kokiri and provides the proposed South Island DHB's strategic activities to achieve these challenges. The South Island Regional Mental Health Network identified all actions within Te Kokiri with a DHB or regional lead responsibility; they considered DHBs Strategic Plans, District Annual Plans and District priorities. Strategic activities were then identified for which a regional approach is most appropriate.

The strategic activities will inform the development of the annual work plan for the next three years, identifying projects that will contribute towards achieving the expected outcomes. Within the context of a dynamic and evolving health environment, wider societal changes and expectations of Government, the strategic plan activities will be reviewed annually and an annual work plan developed to meet these changing demands.

Priorities 2009 – 2010

Aim	To promote effective and appropriate sharing of information that supports a regional perspective on Mental Health Planning and Funding, influences changes, and progresses the implementation of National Mental Health Strategy.
Actions	The South Island Regional Mental Health Network continues to share information and collaborate regionally.
Outcomes	A regional perspective on mental health planning and funding improves effectiveness and reduces duplication.
Measure	Regional collaboration occurs, influences change and progresses the implementation of National Mental Health Strategy.
Aim	To implement the regional activities as defined in Te Kokiri, that support the development of South Island mental health services.
Actions	An annual work plan is developed with key projects that meet the objectives defined in the ten Strategic Challenges in Te Kokiri.
Outcomes	There is an improvement in mental health outcomes for the South Island population.
Measure	Annual work plan activities are regularly monitored and reported and are achieved by the end of June 2010.
Aim	To support national workforce and service development initiatives and guidelines.
Actions	Regional plans are developed that support national guidelines.
Outcomes	There is an improvement in mental health outcomes for the South Island population.
Measure	South Island mental health services reflect national guidelines.

10.5 Canterbury DHB Quality Strategic Plan Goals 2007-2010

GOAL 1 **Continuously Improve the Safety of our Services**	GOAL 2 **Continuously Improve our Systems and Processes**	GOAL 3 **Continuously Improve our Practices**	GOAL 4 **Continuously Improve our Relationships and Partnerships**	GOAL 5 **Continuously Improve the Health of our Communities**
A Culture of 'No Blame' Reporting	Patient/Consumer Flow and Integration	Patient/Consumer and Family-Centred Approaches	Open Disclosure	Reduction Preventable Disease, Infection, Addiction, Impairment
Analysis, Action and Shared Lessons in Response to Error	Fostering Innovation and Improvement	Evidence-based Best Practice	Community Participation and Partnership	Responsible Patients/ Consumers and Communities
Improved Medication Safety	Good use of Resources	Successful Recruitment and Retention	Patient/Consumer Satisfaction	Equitable and Accessible Services
Prevention and Control of Infection	Good use of Technology	Professional Development	Workforce Satisfaction	Reduced Barriers for Patients/ Consumers who are disabled
Prevention of Patient/Consumer 'Handover' Errors	Performance Measurement and Evaluation	Credentialing processes	Collaboration with other Organisations	Chronic Disease Well Managed

10.6 Glossary of Terms

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

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

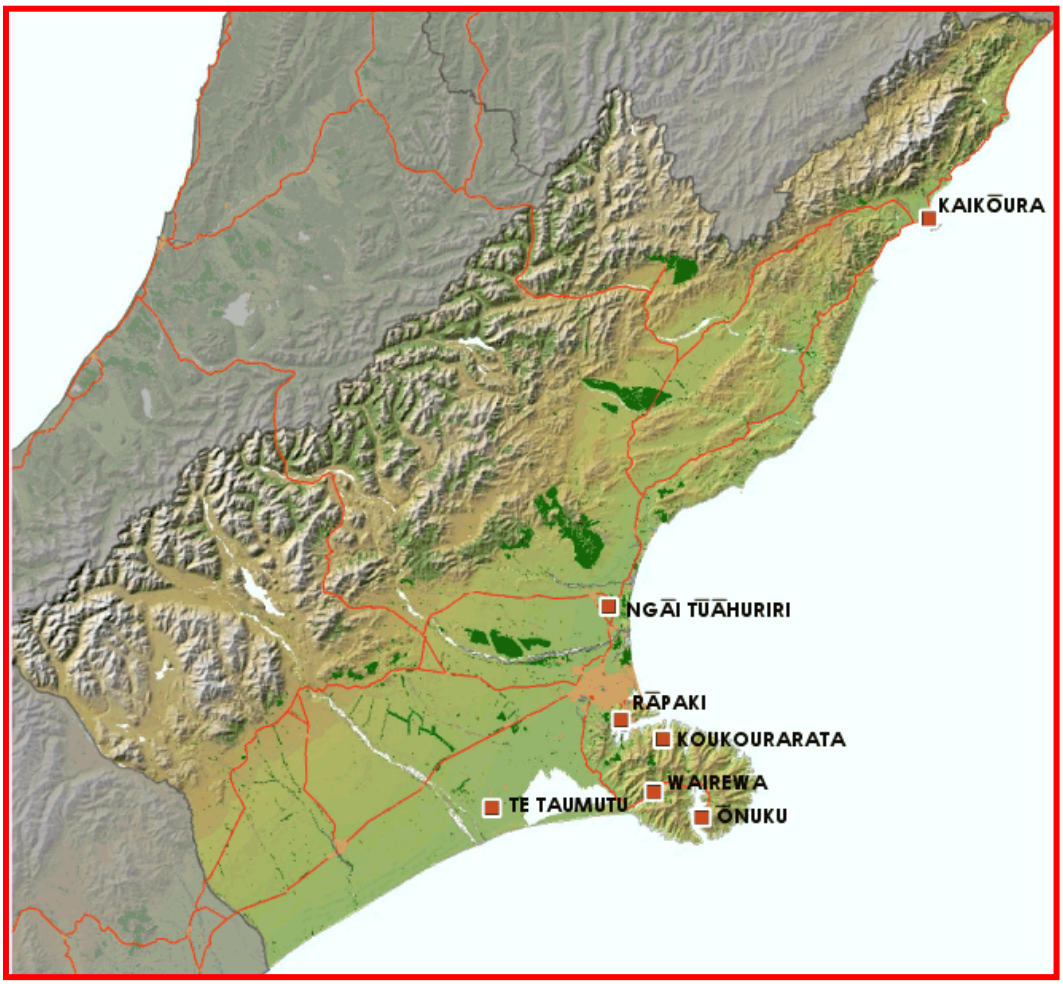
		person's demographic details. The NHI and associated NHI numbers are used to help with the planning, co-ordination and provision of health and disability support services across NZ.
NIR	National Immunisation Register	The NIR is a computerised information system that has been developed to hold immunisation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

DISTRICT ANNUAL PLAN
1 July 2009 – 30 June 2010

Produced in 2009 by the
Canterbury District Health Board
PO Box 1600, Christchurch
www.cdhb.govt.nz

ISSN: 1176-3124 (Print)
ISSN: 1177-9500 (Online)

Canterbury
District Health Board
Te Poari Hauora ō Waitaha



Picture illustrates the Canterbury DHB Region and the seven Ngāi Tahu Rununga within the region.