Statement of Intent 2009/2012

Canterbury District Health Board

About the Statement of Intent

DHBs were created on 1 January 2001 under the New Zealand Public Health and Disability Act 2000 (NZPHD Act) and are categorised as Crown Entities under the Crown Entities Act 2004. As such, all DHBs are required to produce a Statement of Intent to meet the requirements of both these Acts – the NZPHD Act (section 42 and section 39(8)) and the Crown Entities Act 2004 (section 139(1)).

The Statement of Intent sets out the DHB's objectives and goals for a three year period against established strategic priorities and national expectations. This Statement of Intent document describes to Parliament and to the general public what the Canterbury DHB intends to achieve during 2009/10 in terms of improving the health and well being of our community and also contains non-financial and financial forecast information for the two subsequent out-years 2010/11 and 2011/12.

Due to the wide range of services funded and provided by the DHB, this document provides an overview of those services and the performance targets we have set ourselves in priority areas.

The Statement of Intent, as a public accountability document, is used at the end of the year by auditors working on behalf of the Office of the Auditor-General to compare our planned performance with the actual performance delivered, described in the DHB's Annual Report.

EXECUTIVE SUMMARY

The Canterbury DHB's vision is to promote, enhance and facilitate the health and well being of the people of Canterbury. We will do this by meeting the objectives of the NZ Health Strategy, our District Strategic Plan and the expectations of the Minister of Health and by delivering on performance targets and service and financial commitments.

In past years we have successfully managed within our budget however it has become apparent, 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 will not be sustainable. To achieve our objectives and commitments we must transform the way we work and focus on the development of patient-centred models of care and the redesign of patient pathways to better manage acute demand and the burden of long-term (chronic) conditions. We must also look to improve organisational fitness and focus on doing the basics well and improving quality and patient safety to meet our responsibilities to our community.

We have been working in partnership across the sector with our clinicians and communities to build a vision of a sustainable future for the Canterbury Health System. We have embarked on a journey towards a system-wide transformation and have charted a course that will require the DHB to work collectively 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 with the intent of system transformation within three years.

We will look at all aspects of our business to determine how we can be more cost effective and efficient, while continuing to achieve our objectives and priorities and our way forward includes a range of efficiency and effectiveness solutions, regional and national alignment, service transformation and outcome focused investment. The development of joint pathways across primary and secondary services has been prioritised to improve the patient journey and reduce duplications and delays across the whole of the health sector.

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

This work is reflected in our Health Services Plan and Vision 2020 outputs, both of which are referred to in this document. This work will contribute significantly to the development of our next District Strategic Plan (2010-2020) which will commence in the coming year. We will seek to replace our current plan after a public consultation process and with the approval of the Minister of Health.

This year we have tried to make our Statement of Intent easier to follow. It has a simpler structure and is written in a narrative style to improve its readability. The document concentrates on demonstrating the longer-term outcomes we are seeking and setting out a summary of the associated outputs we will deliver to achieve those outcomes. Targets are set next to all the outputs in our forecast statement of service performance section to enable an evaluation of our delivery and performance over the coming year.

Further detail on specific actions and activity planned by the Canterbury DHB can be found in our District Annual Plan, which has been written alongside this document and in alignment with our current long-term District Strategic Plan. These documents can all be found on the Canterbury DHB website www.cdhb.govt.nz.

Signature
(Alister James – Chairman Canterbury DHB)

Signature
(David Morrell – Chairman Hospital Advisory Committee)

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1. INTRODUCING THE CANTERBURY DHB

The Canterbury DHB is the second largest DHB in New Zealand by population and the largest by geographical area. Our 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 Canterbury DHB is charged by Government with overall responsibility for working within the funding allocated to improve, promote and protect the health and independence of the whole of the population living in the Canterbury district. Our motivation is to do the very best we can to ensure our population gets the most efficient and effective services possible and that the services we provide or fund are delivering improved 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 best use the funding we receive and to improve the health of our population and enhance efficiencies across the whole of the health system. We have been building a shared vision with our community, partners and stakeholders through processes such as our Health Services Planning Programme and Vision 2020. 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.

In summary, the Canterbury DHB:

- ***Plans*** the strategic direction for health and disability services in Canterbury, in consultation and partnership with our stakeholders and community and in collaboration with other DHBs and health and disability service providers;
- ***Funds*** the majority of health and disability services provided in Canterbury, through relationship and service contracts with health and disability service providers;
- ***Provides*** health and disability services, encompassing women's and children's services, medical and surgical services, mental health, older person's health, and rural health services, laboratory and hospital support services and rehabilitation services; and
- ***Promotes*** community and public health and well-being through health promotion, health education and population health programmes.

The Canterbury DHB is also the largest employer in the South Island with over 8,000 staff employed across our fourteen hospitals and numerous community bases. A similar number of people are employed in delivering health and disability services in Canterbury, which are funded either directly or indirectly by the Canterbury DHB.

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.

1.1 Organisational Structure

Like all DHB's, the Canterbury DHB has an established governance and organisational structure based on the requirements of the NZPHD Act 2000 (the Act which established DHBs). We have three organisational divisions through which we seek to improve the overall health and wellbeing of our population: a Governance Division; a Funder Division; and a Provider Division.

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

The Board assumes the Governance role for the DHB and is responsible to the Minister of Health for our overall performance and management. Seven members are elected by the Canterbury community and four are appointed by the Minister of Health. There are currently two Māori members on the 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 the performance of the DHB, and has three statutory (mandatory) advisory committees and two additional sub-committees to assist it in meeting 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 our hospital and specialist services, assesses strategic issues relating to those services and provides 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 and how the services we fund or provide 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** *(non-statutory)* - 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** *(non-statutory)* - deals with the employment of the Chief Executive and other specific industrial and employment matters.

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.

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 who is supported by an Executive Management Team (*refer to Appendix 1 for an organisational chart of the Canterbury DHB*).

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

The Planning and Funding Division 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 working closely with our community, partner organisations and key stakeholders to assess the population's current and future health needs and determine and prioritise the mix, range and volume of services to be purchased.

The DHB works in partnership to achieve the objectives of the DHB and enhance efficiencies across the whole of the health system. These partnerships are supported by the service agreements/arrangements the DHB enters into with the organisations or individuals who can best provide the health and disability services required to meet the needs of our population.

The core responsibilities of the Planning and Funding Division are:

- Assessing the health status of the population to determine the mix/range of services that should be offered;
- Building essential 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.

The Canterbury DHB (through Planning and Funding) holds over 1,400 service contracts with the organisations and individuals who provide health and disability services to our population. These include approximately 117 pharmacies, 397 general practitioners, 105 dentists and 113 rest homes.

Our 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, the DHB also provides a significant share of those services. The services provided include inpatient and outpatient services, community services, support services and day programmes. These services are provided through the Hospital and Specialist Services Division, which consists of six service divisions: Medical and Surgical; Mental Health; Rural Health; Women's and Children's; Older Person's Health and Rehabilitation; and Hospital Support and Laboratory Services (*refer to Appendix 2 for an overview of the services provided by each division*).

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.

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, some 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 our ability to provide for our own population is not adversely affected by demand from other DHBs.

Over 65,000 people where discharged from the DHB's hospitals in the past year, over 5,700 babies were born and more than 70,000 presented at our Emergency Departments.

1.2 Our Shared Decision Making Approach

While responsibility for the DHB's overall performance, operations 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 model is replicated across the whole of the health system with a framework of primary/secondary clinical leadership seen as essential to drive the change and transformation needed to improve the delivery of health services. Clinical leaders provide support to the Chief Executive and the Board in their decision making processes and the model is supported by formal and informal clinical networks across the whole of the health system.

Broader participation in decision making is also 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. In 2008, the Board also signed a formal Memorandum of Understanding (MOU) with Manawhenua Ki Waitaha to enhance Māori participation in the planning and delivery of health

and disability services.[1] This MOU commits the DHB to regular meetings and dialogue with Manawhenua Ki Waitaha at an executive management level, as a pathway to shared decision making.

- **Clinical Board -** A commitment to quality and patient safety places responsibility on the DHB to have effective mechanisms in place for planning, monitoring and managing the quality of clinical care being provided. The Board was established in 2003 and is a multi-disciplinary clinical forum, whose membership includes clinical representatives from the primary, secondary and community sectors. The Clinical Board has oversight of DHB 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. Members support and influence the DHB's vision and values, and provide an important clinical leadership role, leading by example to raise the standard of patient care.

- **Consumer Council -** In 2007, a Consumer Council was established to 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 the Council's advice and input assists in developing DHB plans and strategies, and improving the delivery of health and disability services.

1.4 Clear Prioritisation and Decision Making Principles

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

The DHB recently reviewed its 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. The prioritisation principles will be applied as the DHB reviews all existing health investments 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 services is carefully considered, including workforce capacity, 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 our 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 supported by our partnerships and clinical leadership and guided by the expectations of the Minister of Health and by the Strategic Priorities established during the development of our Strategic Plan and the specific health needs of our population.

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

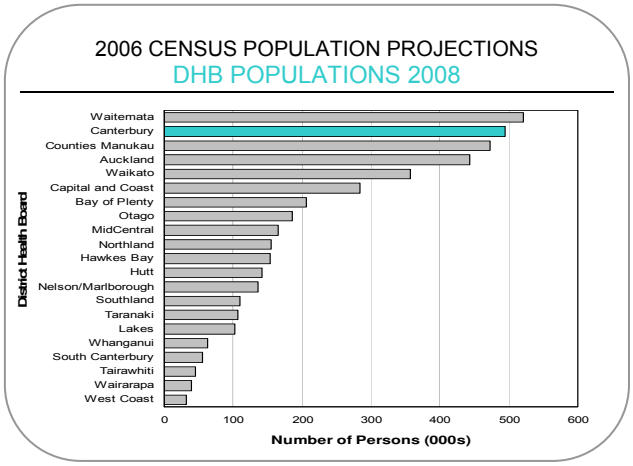
2. OUR ENVIRONMENT – IDENTIFYING THE CHALLENGES

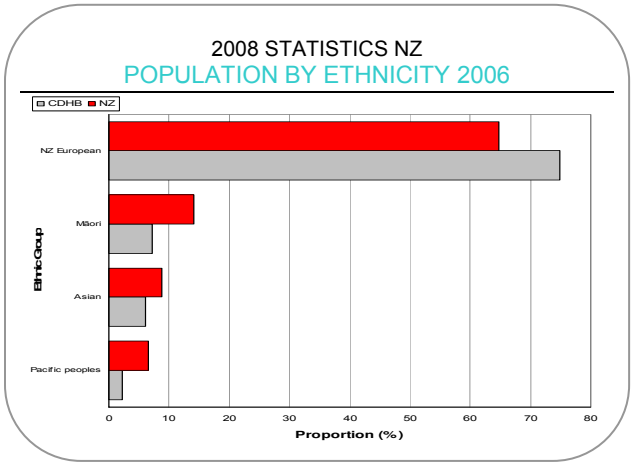
This section provides background on the environment in which the Canterbury DHB operates. It outlines our population profile, identifies specific health issues faced by those in the Canterbury district, and describes how operating pressures influence the choices the DHB makes.

The DHB completed a health needs assessment in 2004, bringing together information describing our population and the health status of Canterbury residents. This health needs assessment helped to identify five Health Gain Priorities and four Disease Priorities where we believed there was the greatest opportunity for health gain or improvements in service delivery. These priorities were confirmed through a public consultation process, formed the basis of the DHB's District Strategic Plan 2005-2010 and are identified in the following chapters. Also highlighted in the following chapters are the key outcomes that the DHB is seeking to achieve in order to improve the health of our population.

2.1 Overview of the Canterbury Population

The Canterbury District is home to 494,170 people, representing 12% of the population of New Zealand and making us the second largest DHB by population.





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 ethnic ities. 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.[2]

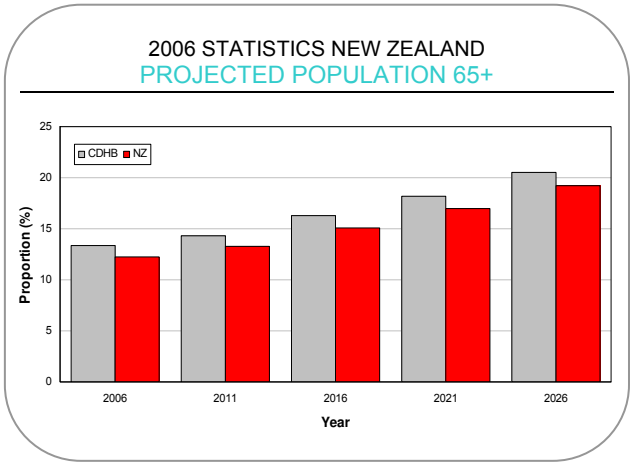
In contrast to these similarities in age-ethnicity distributions, the ethnic composition of the population in the Canterbury differs considerably from that observed nationally. While Canterbury has a greater proportion of New Zealand Europeans (75% versus 65%), the proportions of Māori, Asian, and Pacific 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, we also recognise the disproportionate burden of poorer health outcomes suffered by this population group. The DHB has identified *Māori Health* as one of our Health Gain Priorities.

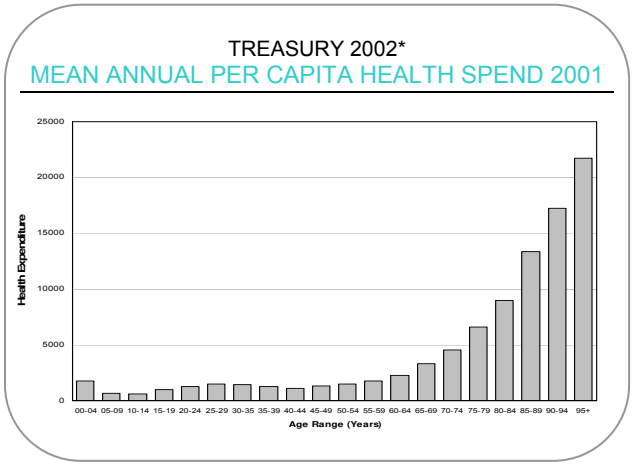
The population within the Canterbury district is ageing, with the proportion of the population over the age of 65 expected to increase from 13% (64,500 people) in 2006 to 21% (115,450 people) by 2026. This increase is similar to that expected nationally over the same time period although the proportion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

[2] *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 over 95.

As the proportion of those aged over 65 in Canterbury increases, so too will the demand for health care services and the funding required. 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 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 demand for services. In consideration of these issues, we have identified *Older Person's Health* as a Health Gain Priority for the DHB.





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 adequate and appropriate health services. Health is often defined in very broad terms, thus posing difficulties when determining what is meant by health status, and how this should be measured. This section provides a brief overview of a range of indicators of health status, behaviours and risk factors that describe different 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.[3] Diseases of the circulatory system, including ischaemic heart disease and cerebrovascular diseases (e.g. heart attack and stroke) account for the majority of deaths in Canterbury (42%) and nationally (40%).

Neoplasms (all cancers) are the second most common cause of death (28%), followed by diseases of the respiratory system including chronic obstructive pulmonary disease, injury and poisoning, and the endocrine disease including nutritional and metabolic diseases (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 on the top five causes of death in Canterbury.

Hospital discharge rates can also be used to estimate the presence or frequency of illness or disease (level of morbidity) within the population and analysis of this data identifies 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.

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

Compared to national averages, Canterbury's rates of discharge are lower across all ages for all conditions.[4] Despite this, the associated morbidity still presents a significant burden on the health system. Many admissions to hospital are considered 'avoidable hospitalisations' that could have been identified and treated earlier through primary or community intervention, thereby preventing the deterioration in health that resulted in the 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).[5] Although encouraging, this still represents a substantial and potentially avoidable burden on Canterbury's health system, while at the same time highlights opportunities to reduce the level of morbidity in the population. Reducing unnecessary or avoidable hospital admissions is one of the key outcomes the DHB is seeking to achieve in order to improve the health and wellbeing of our population. We have identified *Primary Health* as a service Health Gain Priority area in order to achieve this outcome, along with four Disease Priorities - *Cancer*, *Cardiovascular Disease*, *Diabetes* and *Respiratory Disease*.

Health Behaviours and Risk Factors

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, we exercise slightly less regularly than the national average and almost a quarter of our population over the age of 15 years (96,000+ people) are obese, with a body mass index of 30.0 kg/m2 or more.[6]

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.[7] 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. Obesity in children and adolescents has increased dramatically over recent years and has been associated with several important long-term conditions such as diabetes, asthma and sleep apnoea as well as social discrimination, poor self esteem and depression.[7]

It is tobacco smoking, however, that 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.[8] Smoking disproportionately impacts on Māori and Pacific people, and is seen as a substantial contributor to the 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 in Canterbury 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, they also represent an opportunity for prioritising health services and interventions that have the potential to significantly reduce this burden. Reducing obesity and tobacco smoking levels will greatly improve the health and wellbeing of our population and are a key outcome goals for the DHB.

We have identified *Disease Prevention and the Management of Long-term Conditions* as a Health Gain Priority for the DHB with a focus on reducing obesity and tobacco smoking and also on reducing the impact and complications of long-term conditions. We have also indentified *Child and Youth Health* as a Health Gain Priority, focused 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.

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

[5] *Health & Disability Intelligence Unit, 2008. Canterbury DHB Health Needs Assessment: September 2008. Wellington: Ministry of Health.*

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

[7] *Barness LA, Opitz JM, Gilbert-Barness E, 2007. Obesity: Genetic, molecular, and environmental aspects. J Med Genet Part A 143A:3016-3034.*

[8] *Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization, 2008.*

2.3 Operating Pressures

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 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 predominantly by older population groups. Between 2001 and 2006, our total population grew by 10% while the number of those aged over 65 increased 11% and those over 85 increased by 21%.

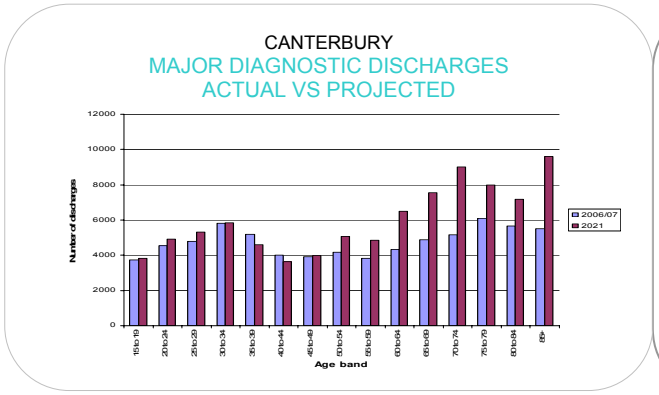
In 2006/07, there were approximately 65,900 inpatient and day-case discharges from DHB hospitals in Canterbury. This represents a 14% increase over the five years since 2001. Assuming that we continue to provide services at the same levels, and in the same way, population forecasts indicate a 22% increase 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.

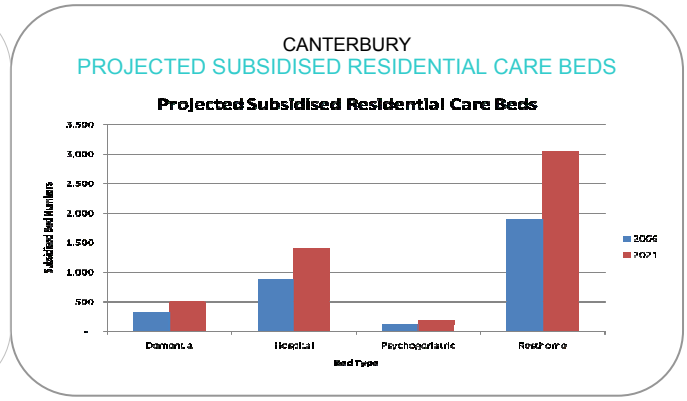
Discharges for acute (emergency) services in Canterbury have increased 16% over the last five years. Acute demand is a key area driven by demographic changes and by the increase in long-term conditions and because acute services frequently take priority and use the same staffing and resources, it puts at risk our ability to deliver elective (planned) services. This is of particularly relevance as we strive to meet the Minister of Health's priority for delivery of increased elective services volumes and compliance with national elective services indicators, which measure timeliness and access levels.

Increases in acute demand spill into the Christchurch Hospital Emergency Department (ED), where attendances have increased 15% in the past five years. 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 settings, such as general practice or in their own homes.

The changing demographics of our population also places similar demand pressures on primary and community services. This is particularly evident in the aged residential care sector. In 2004/05, 7% of people aged 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 priority for the DHB in 2009/10 in order to ensure we have the capability and capacity to provide services in line with the growth in our population. Two further outcomes the DHB seeks to achieve in order to improve the wellbeing our population are an increase in the proportion of our population able to remain in their own homes as they age and a reduction in the impact of the complications of mental illness and addictions on our population. Managing demand and providing timely and flexible access to services, ensuring the right people are able to access the right services at the right time, will help to reduce acute admissions and adverse complications and ensure the safety and wellbeing of our population.





Workforce Pressures

National and international competition for workforce resources in some specialties and nursing areas and a decreasing working age population are making it increasingly challenging to recruit and retain health professionals. A report prepared for the Ministry of Health predicts that, if health and disability services retain their current share of the working-age population, demand for labour will outstrip supply as early as 2011.[9]

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 national DHB average of 44.4 years, and 10% of our workforce is over 60 compared to 7% three years ago. The age of our workforce poses an even more immediate challenge in rural areas, where the average age is 50.5 years. As demand for health and disability services increases, we will struggle to find the workforce needed to continue to deliver services as do currently.[10]

As the largest health and disability service 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.

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 to ensure we can continue to provide high quality services in line with public need and expectations. We have already begun development of alternative service delivery models that will ensure ongoing provision of specialist services in rural areas and free up clinical staff in our hospital services to spend more contact time with patients. The continued development and delivery of alternative service delivery models will be a priority in 2009/10 with clinical leadership and engagement key to ensuring the DHB continues to provide a high quality of patient care.

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 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 costs of demand growth; wage and salary increases; diagnostics and laboratory services; increasing costs of residential care services; and lower New Zealand currency affecting prices of related 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.

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

[10] *All local DHB figures in this chapter come from the Canterbury DHB Workforce Profile Report, March 2008, and all National figures come from the DHBNZ Future Workforce Health Workforce Information Base Data Report June 2008.*

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 the current level and quality of service delivery to our population. We must make efficiencies and savings 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 by investing the funding we have available in efficient, effective and high value quality services that improve health outcomes; and
- We must free up funding to invest in transformational change that will enable us to meet the needs of our growing population by 2020.

All areas of the organisation will be expected to change 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 we deliver.

We will also focus on containing cost and volume growth, both within our hospital and specialist services and across the primary community sectors 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.

3. STRATEGIC OBJECTIVES AND PRIORITIES – MEETING THE CHALLENGES

This section outlines what the Canterbury DHB aims to achieve over the next three years in order to meet our long-term vision to '*Promote, enhance and facilitate the health and wellbeing of the people of Canterbury*'. Our local direction and objectives were established through a health needs assessment and public prioritisation process undertaken to develop our District Strategic Plan in 2005/06 and have been built on by recent health services planning and Vision 2020 work which considered the transformation required to meet the needs of our population in the future. The DHB's outcomes and objectives also reflect the expectations of the Minister of Health and Government policy and are consistent with the function and objectives of DHB's as set out in the New Zealand Health and Disability Strategy (Appendix 2).

Details on the specific actions, activity and outputs planned to make progress towards achieving our outcomes and objectives, both nationally and locally, are provided in our District Annual Plan for the 2008/09 year.[11]

3.1 Canterbury DHB Health Gain Priorities

In 2005, the DHB developed a five year strategy in consultation with our community and the Ministry of Health - 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 to improve the delivery or effectiveness of services provided. When deciding on these Priorities, we took into consideration the health needs of our population, feedback from our community and stakeholders and the revenue available to the DHB at the time. We also considered national expectations and priorities and our responsibilities under the New Zealand Public Health and Disability Act 2000.

>> 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.

We are currently in the process of reviewing our District Strategic Plan. However, until we complete the formal review 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 in line with our health service planning and Vision 2020 work.

Our approach to making progress against all of our Health Gain and Disease Priorities will be consistent - we will:

- Promote messages related to improved lifestyle choices, physical activity and nutrition and the reduction of risk behaviours, including 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 develop continuums of care and patient pathways 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 and improve productivity, efficiency and effectiveness.

[11] *All Canterbury DHB Plans referred to in this document are available on our website www.cdhb.govt.nz.*

- 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 and to improve wellbeing and the quality of life.

3.2 Government Priorities for 2009/10

When planning the actions and activity for any given year, the DHB must consider the Minister of Health's expectations, which are highlighted in the annual 'Planning Package' (between the Ministry and DHBs). The Package provides clear expectations, priorities and parameters for DHB planning and helps to maintain national consistency across the sector. Alongside national health and disability strategies and our own local health gain priorities and strategies, the Minister's expectations enable us to plan and prioritise activity for the coming years.

In setting expectations for the coming year, a clear signal has been 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 deliver better, sooner and more convenient health care expectations 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 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's specific priorities for 2009/10 are to:

- Improve service delivery and reduce waiting times - increased elective services delivery and first specialist assessments and improved 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 to:
  - *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 ensure mothers have the choice to stay in birthing facilities longer.*

A set of national DHB Health Targets have also been identified to focus DHB efforts and make faster progress on government priorities. These are aligned to the Minister's expectations and have been included in our selected set of performance measures in this document and clearly identified in our District Annual Plan for 2009/10.

The Health Targets cover improvements across a whole 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 positively impacting on the lives of New Zealanders.[12]

The DHB is committed to 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 the DHB's District Annual Plan for 2009/10.

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

National Health Targets and Performance Indicator		Canterbury DHB Target[13]	Output Class
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.	Hospital and Specialist Services
Improved access to surgery.	The volume of elective surgery will be increased by an average 4,000 discharges per year nationally (compared with the previous average increase of 1,400 per year).	Deliver 14,000 elective discharges in 2009/10.[14]	Hospital and Specialist Services
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. [15]	Improvement to 100% by 30 July 2010. [16]	Hospital and Specialist Services
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.	Primary and Community Services
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 target 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.	Hospital and Specialist Services
Better diabetes and cardiovascular services.	An increased percentage of the eligible adult population will have had their CVD risk assessed in the last five years.	>57.1% Māori >55.1% Pacific >68.9% Other >468.0% Total	Primary and Community Services
	An increased percentage of people with diabetes attend free annual checks.	>33% Māori >26% Pacific >44% Other >43% Total	Primary and Community Services
	An increased percentage of people with diabetes have satisfactory or better diabetes management.	>70% Māori >56% Pacific >78% Other >77% Total	Primary and Community Services

3.3 Our Longer Term Vision

With a decreasing workforce capacity, financial constraints, and our ageing population living longer with long-term conditions leading to an 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. To meet future demand and the needs of our growing population, we will have to make significant changes to our models of care, the range and type of services provided, the location at 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 already begun a number of processes to identify the transformation needed to equip the health system for the future. In the coming year we will combine

[13] *Unless otherwise indicated the DHB aims to achieve these targets by 30 June 2010.*

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

[15] *This target excludes Category D patients who have scheduled treatment dates.*

[16] *The DHB is committed to achieving the national Health 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 upgrading and replacing the DHB's older linear accelerators.*

our health needs assessment for the Canterbury district 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 a new District Strategic Plan for Canterbury 2010-2020. The DHB will formally consult with stakeholders, its community and with clinical leaders on the updating of our Strategic Plan towards the end of 2009.

3.3.1 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 inform the future development of health service provided in the Canterbury district. The programme involved an extensive participatory engagement process with key stakeholders and consumers from across the Canterbury health system, which was designed to model a collaborative way of working and facilitate a consensus as to the way forward. The focus was on the re-orientation of the health system around the needs of the person and working across traditional boundaries to achieve the best possible health outcomes.

The 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 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 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.
- 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 a range of community services and community based specialist support. The shift of services from a secondary care focus to a primary care focus is a direction that has been designed to meet our local health needs 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.

3.3.2 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 change in our populations will have on future service requirements and the workforce capacity we would require to provide them. 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 DHB's 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 our 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 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.

3.3.3 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 that will provide the foundations to enable a change in culture and practice and allow us to create opportunities to transform 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 that 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.

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 lead 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 models 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 beginning 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 to date has been critical in gaining and maintaining momentum 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 will provide a basis for development of a Facilities Master Plan covering the 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.

3.4 Bringing It All Together – Our Model of Care

Over the past two years, as part of its Health Services Planning work, the DHB has developed a patient centred model of care to manage long-term conditions irrespective of the specific diagnosis.

The model identifies different groupings of services, such as prevention, early intervention, treatment and support that will be delivered by a range of service providers on an individual or population-wide basis. These services can be for a specific group of people (older people) or a particular disease or condition (diabetes or mental illness) and the model ensures continuums of care across the whole of the health system and supports a strengthening of workforce capacity and capability and the best use of available resources.

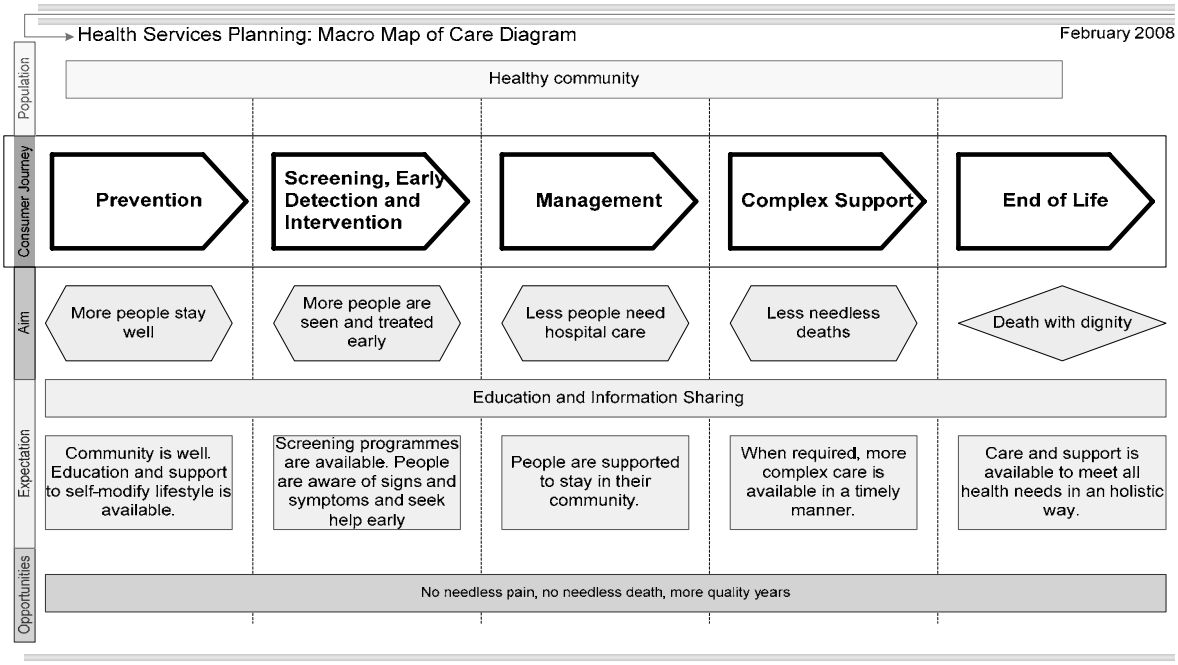
The model explicitly acknowledges the roles of other organisations, groups or individuals who have a key part to play in helping people to be healthy and describes how health services are linked together and how people can receive the care they need. It also presents a flexible approach so that people of differing cultures, ages and needs can get equitable and appropriate levels of help and support.

Viewed from the perspective of a DHB or Primary Health Organisation (PHO) this model underpins a way of coordinating, connecting and organising all different parts of the health system to meet the health needs of the community. The model considers the patient journey, starting with health promotion and prevention, and prompts a series of questions:

- What do we need to do to keep people well in the community?

- What do we need to do to ensure early detection and early intervention?
- How can we better manage people in the community and primary care to avoid unnecessary hospital admissions and improve the quality of life?
- How do we ensure that when people do require specific interventions such as hospital care, specialist advice or diagnostics that they are available in the right place, at the right time and are provided by the right people?
- How do we provide appropriate and restorative support services so people can quickly return to their normal lifestyles and avoid further complications?
- Does our health system respect people dying with dignity; do we listen to and meet their needs?

The key focus is on ensuring patients receive the right treatment, at the right time and in the most appropriate setting. The model 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.

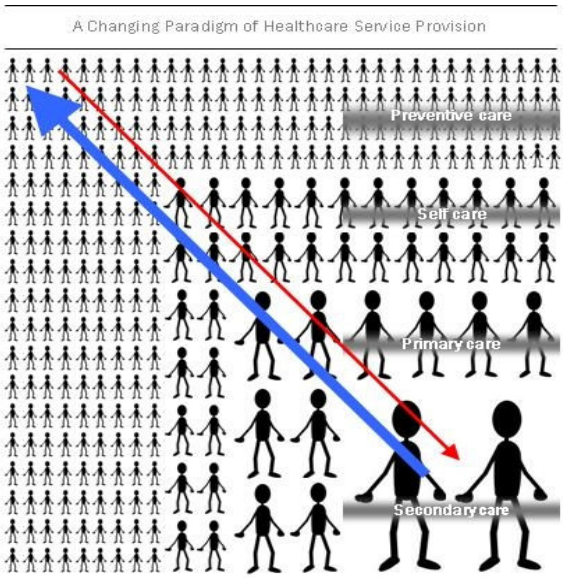


Over the next few years the DHB will begin to implement the transformation needed to ensure we are able to meet the needs of our growing and aging population and to support an improved journey through the health system. The drivers for change, service design principles and the model of care all suggest reorientation of the system to support a more community based/whanau centred approach.

The following diagram illustrates groupings of our population getting progressively smaller in number as more intensive services are required. The upper left groupings represent the whole population in a given time period, including those who are healthy. The next layer represents those who have some health issues but tend to provide care for themselves occasionally supported by health professionals. The next grouping is those who seek assistance from GPs, nurses and other primary and community providers to manage their health, while those who require hospital and specialist services are represented by the final bottom right grouping.

The diagram illustrates that only a small proportion of those who seek care require the more complex level care. The size of the people also illustrates the relative cost of the treatment at those levels.

The smaller red arrow represents forces such as recent trends towards increased specialisation or over-reliance of people on professional help rather than self care. The DHB's direction for service development is represented by the larger blue arrow which runs counter to this with the aim of moving care (where appropriate) away from hospital and specialist level to primary and community level, from primary and community level to self care (by empowering people) and lastly into no care requirements – through illness prevention and health promotion.



We believe we will be able to achieve our vision of improving the health and wellbeing of the people of Canterbury by providing more appropriate support to the individual and their family in community settings and freeing up high-level care resources for more complex cases. The associated shifts in service configuration to support this logic and the model of care are substantial, with three general shifts associated with this change:

- An increased focus on supporting people/whanau to take greater responsibility for their health;
- 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 and community services.

4. IMPROVING OUTCOMES FOR OUR POPULATION

This chapter and our forecast statement of service performance have been grouped into four output classes. These 'output classes' or groupings enable us to provide an overview of the services that the DHB is responsible or accountable for. Against each output class the DHB has the identified the longer and medium term outcomes we seek to achieve and against which we will measure our progress over time. In the forecast Statement of Services Performance (Chapter 5) we present a summary of the outputs we will fund in 2009/10 in order to realise those longer-term outcomes.[17]

The four output classes chosen by the DHB are:

- Public health services (disease prevention);
- Personal health services - with the subsets of primary and community services (early intervention and the management of long-term conditions) and hospital level and specialist services (complex care and support);
- Mental Health Services (focused across the whole continuum or patient journey); and
- Older Person's Health Services (also focused across the whole patient journey).

When determining the performance measures we will use as indicators for providing an overview of performance across the DHB, we have focused on our identified health gain priorities, the transformation we are seeking to achieve in line with our Health Services Planning Principles, Vision 2020 and the expectations of the Minister of Health. The indicators presented in the following chapters, under each output class, are an attempt to provide a picture of improved access to services, timeliness of service provision and the quality of care being provided to enable a robust evaluation of performance over time.

Where possible we have included past performance (baseline data) and national averages to give context to the reader both in terms of what we are trying to achieve and our current performance levels.

Programme logic is an evidence-based and systematic method of setting out the connections and hierarchies between the well defined long-term and medium term (intermediate) outcomes and the outputs that are required to achieve these. The development of programme logic is reliant on the engagement and participation of the clinical workforce in a participatory model to identify desired outcomes and appropriate measures to determine whether or not these outcomes are being achieved. The Canterbury DHB has already begun developing outcome hierarchies for a number of service areas and we plan to expand this approach across the service area spectrum. This will enable us to improve identification of the most appropriate outcome and output measures and better present a picture of progress and achievement.

Over the next few years the DHB will place greater emphasis on realising outcomes. Measuring progress is recognised as being critical to the provision of more efficient services that provide better value for money. There is a need to transition from 'inputs-based' to 'outcomes-based' contracting to support this emphasis across the whole of the health system. Our work on developing programme logic in partnership with clinicians is fundamental to providing rationale for the changes to the funding mechanisms necessary for achieving improved health outcomes for our population. This work will continue over the coming year and will feed into the review and development of our District Strategic Plan 2010-2020.

[17] *Unless otherwise indicated the data sources for the information contained in the following two Chapters are DHB internal collection systems. Where data is supplied from external sources this has been footnoted.*

4.1 Public Health Services

Our Long-term Objective - What are we trying to achieve?

We seek to keep our population well in the community by improving the health status of those at risk of developing long-term conditions and reducing the risk behaviours that increase the prevalence and impact of those conditions; by:

- Improving protective behaviours and reducing risk behaviours and risk factors;
- Targeting high needs groups and settings;
- Creating a supportive environment to ensure good health outcomes for all population groups; and
- Supporting continuums of care to ensure good health outcomes for all population groups.

To a large extent, the environment within which we live determines our health both as individuals and as a community. Social and economic determinants such as education, housing, and income, are now widely accepted as contributing greatly to a person's health.

Alongside the determinants of health, long-term conditions are a major cause of poor health and morbidity in New Zealand and account for a significant number of potentially preventable presentations at hospital emergency departments and admissions to primary and hospital and specialist services. With an ageing population, the burden of long-term conditions will increase. The World Health Organisation (WHO) estimated that more than 70% of health care funds are spent on long-term conditions.

How will we improve outcomes for our population?

A number of long-term conditions share common risk factors and are preventable. Tackling lifestyle risk factors such as tobacco smoking, lack of physical exercise and poor nutrition are a key focus for the Canterbury DHB. Reducing risk factors and improving the effective management of long-term conditions can make a real difference by helping to prevent crises and deterioration and enabling people to attain highest possible quality of life.

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 spent on tobacco, resulting in less money being available for basic items such as food, education and health. Tobacco control remains the foremost opportunity to target improvements in the health of population with high need and to improve Māori health.

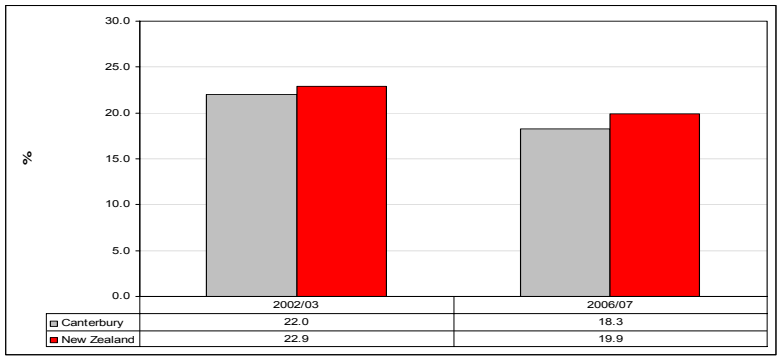
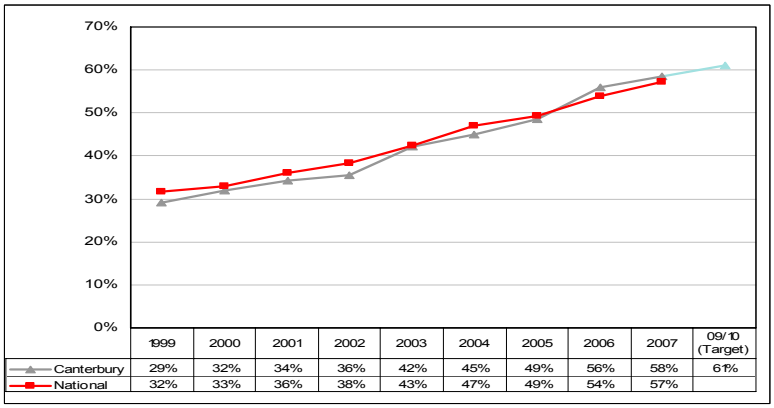
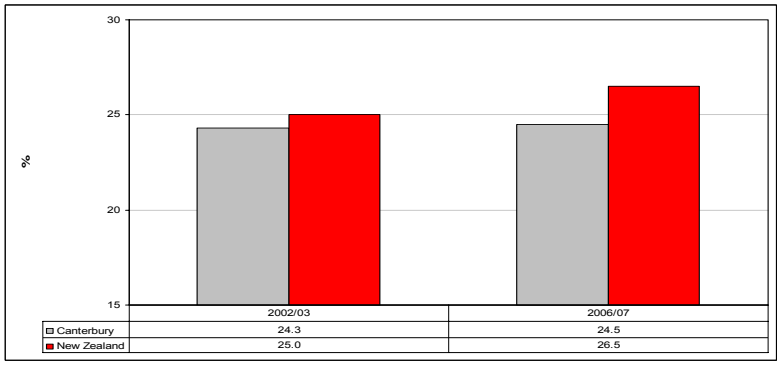
Inactivity, poor nutrition and rising obesity rates are also major contributors to an increase in the burden of long-term conditions.[18] The DHBs Healthy Eating Healthy Activity (HEHA) Plan is our approach to reducing these risk factors and is focused on population and personal health programmes that target improved nutrition and physical activity. The DHB is committed to its leadership role in HEHA and the partnerships that have been established and will continue to ensure a collaborative approach to improving health and lifestyles.

How will we know if we have been successful?

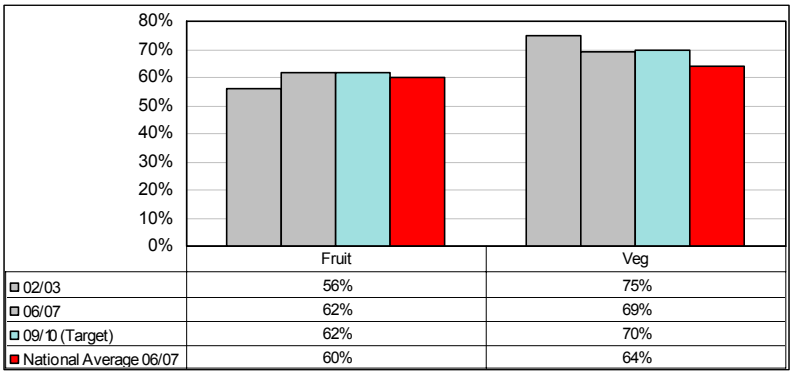
The DHB aims to work collaboratively to reduce risk behaviours, raise self awareness and support healthy choices. We have identified a number of longer and medium-term outcome measures as a means of providing an indication of the effectiveness of that collaboration and the consistency of public health messages and education in respect of tobacco smoking and obesity.

These measures are also indicative of access to services that promote change and good health and provide a measure of the quality of the outputs provided by the DHB, by measuring our effectiveness in promoting change and influencing healthier behaviour in our community.

[18] *Obese is defined as having a Body Mass Index (BMI) of >30.0 or >32.0 for Māori or Pacific.*

What is the DHB trying to achieve?	Associated Measures of Performance.[19]
A reduction in Smoking Rates amongst the Canterbury population (15years+). Smoking kills an estimated 5000 people in New Zealand every year, including deaths due to second-hand smoke exposure. Smoking is also a major contributor to long-term illness amongst populations with high need and is a major cause of lung and a variety of other cancers and chronic obstructive pulmonary disease, heart disease and strokes. The highest prevalence of smoking is amongst young people, with approximately one in every four Canterbury teenagers 15-19 currently smoking.	**Long-term Measure** - The proportion of the population who smoke (15 years+).  **Intermediate Measure** - The percentage of 'never smokers' among Year 10 students. 2007: 58% | 2009/10: 61% | 2010/11: >61% | 2011/12: >61% 
A reduction in Obesity Levels amongst the Canterbury population (15years+). Current trends indicate that by 2011, 29% of New Zealand's adult population will be obese. This has significant implications for rates of cardiovascular disease, diabetes, respiratory disease and some cancers, all identified as health gain priority areas for the DHB, as well as poor psychosocial outcomes and reduced life expectancy. Supporting our population to maintain healthier body weights, through an improvement in nutrition and physical activity levels, is fundamental to improving the health and wellbeing of our population and to the prevention of chronic conditions and disability at all ages.	**Long-term Measure** - The proportion of the population who are obese (15+). 

[19] *With the exception of the Year 10 smoking indicator the data for the measures in this section comes from the national NZ Health Survey collected by the Ministry every three years. The Survey was undertaken in 2003/04 and in 2006/07 and will not be repeated until 2009/10.*

<table>
<tr><th>What is the DHB trying to achieve?</th><th colspan="5">Associated Measures of Performance.[20]</th></tr>
<tr><td rowspan="5">A reduction in Obesity Levels amongst the Canterbury population (15years+) – continued…</td><td rowspan="5">Intermediate Measure - The percentage of the population having two+ servings of fruit and three+ servings of vegetables a day (15+).</td><td>2006/07</td><td>2009/10</td><td>2010/11</td><td>2011/12</td></tr>
<tr><td colspan="4">Fruit</td></tr>
<tr><td>62%</td><td>62%</td><td>>62%</td><td>>62%</td></tr>
<tr><td colspan="4">Vegetables</td></tr>
<tr><td>69%</td><td>70%</td><td>>70%</td><td>>70%</td></tr>
<tr><td colspan="5"> 
</td></tr>
</table>

[20] *With the exception of the Year 10 smoking indicator the data for the measures in this section comes from the national NZ Health Survey collected by the Ministry every three years. The Survey was undertaken in 2003/04 and in 2006/07 and will not be repeated until 2009/10.*

4.2 Personal Health Services

4.2.1 PRIMARY AND COMMUNITY SERVICES

Our Long-term Objective - What are we trying to achieve?

We seek to improve the health and wellbeing of our population and better manage people in primary care and in the community to reduce acute demand and avoid unnecessary hospital admissions by:

- Increasing protective behaviours and reducing risk behaviours and risk factors;
- Improving access and utilisation of primary and community care services;
- Improving the management of long-term conditions through early detection and intervention; and
- Supporting continuums of care to ensure good health outcomes for all population groups.

New Zealand is experiencing a growing prevalence of long-term conditions such as diabetes, respiratory and cardiovascular disease, which are major causes of poor health and morbidity in New Zealand and account for a significant number of potentially preventable presentations and admissions to primary and secondary services. Long-term conditions require an increased focus across the primary/secondary interface to ensure that they are recognised early and managed effectively; thereby preventing crises and deterioration. Primary care the point of continuity for patients in the health sector and reducing access barriers to primary care especially for some population groups including Māori, Pacific and high risk groups is important to achieving health for the population.

Canterbury is also experiencing a growth in demand for acute (emergency) services that is faster than the growth in our population. More than 70,000 people present at the Christchurch Hospital Emergency Department (ED) each year with an equivalent number of people being seen at Christchurch's 24 hour general practice service. A significant portion of this growth is in the number of self and ambulance referrals to the ED.

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

We value our primary and community provider relationships and we work closely on health system solutions for challenges such as acute demand management, reducing unnecessary or avoidable hospital admissions, 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 our partnerships with general practice, PHOs and other primary and community 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 our primary and community-based partners have input into DHB plans and strategies.

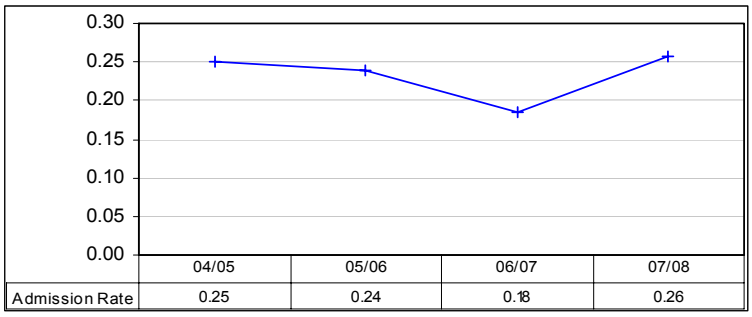
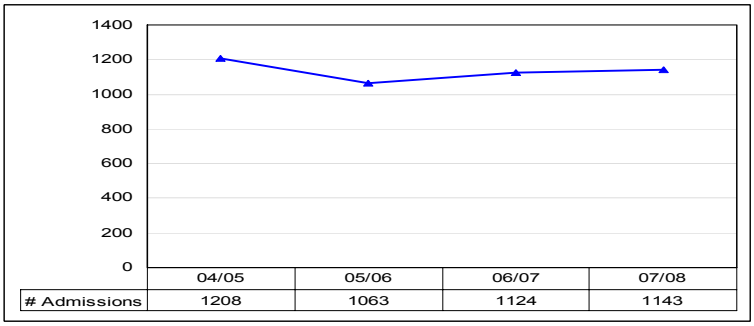
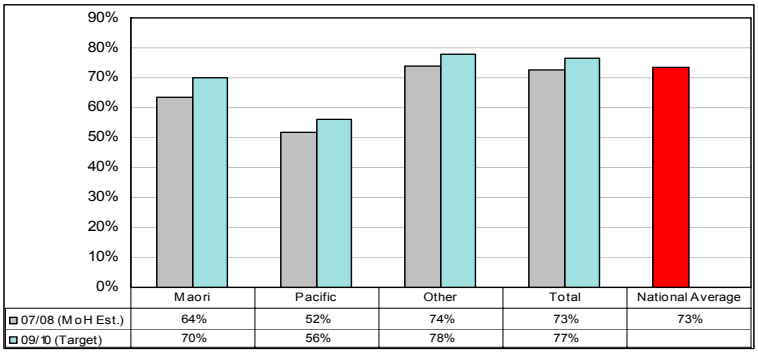
The DHB will support enhanced services to manage long-term conditions and the development of integrated pathways of care in priority areas including Child Health, Older People's Health, Māori Health, Mental Health, Diabetes and Respiratory Disease to improve the foundations to support better health outcomes for our population. This will also help to reduce the rate of unnecessary hospital admissions that will provide the potential to free up health resources allowing them to be directed to other priority areas.

The shift of services from a secondary to a primary care focus is 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. This shift will require reorienting our health system around a primary point of continuity based in the community, usually with general practice, supplemented by a range of community services and community based specialist support.

The DHB will also work with general practice, PHOs and other health care providers to implement the Acute Demand Management Programme to ensure people receive the most appropriate level of care in the most appropriate place. It is believed that 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. By ensuring the right people are presented at our Emergency Departments will we be able to better manage the future increased demand for services.

How will we know if we have been successful?

The long and medium-term outcome measures below provide a measure of the quality of outputs funded by the DHB, by measuring the effectiveness of collaboration in terms of reducing unnecessary hospital admissions and the complications of long-term conditions. The measures are also indicative of access to services and a measure of increased capability and capacity in terms of managing people in primary care and in the community rather than in hospital level and specialist services.

What is the DHB trying to achieve?	Associated Measures of Performance.
A reduction in the impact and complications of long-term conditions. 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 and the prevalence of diabetes is increasing at an estimated 4-5% a year. Respiratory Disease is recognised as one of the key developing long-term disease burdens associated with an aging population. Up to 100,000 people in Canterbury may be affected by respiratory issues including chronic obstructive pulmonary disease (COPD), asthma and sleep disorders. The impact of diabetes and respiratory disease in terms of illness and the cost to the health sector is significant, particularly for Māori and Pacific people who are disproportionately represented in diabetes and respiratory statistics with higher rates of both chronic conditions than other New Zealanders. Early diagnosis, intervention and disease management provide a major opportunity for improving health outcomes.	**Long-term Measure** – The rate of acute hospital admissions due to short term complications of diabetes (19years+).  04/05 | 05/06 | 06/07 | 07/08 Admission Rate: 0.25 | 0.24 | 0.18 | 0.26 **Long-term Measure** – The number of acute hospital admissions due to COPD.  04/05 | 05/06 | 06/07 | 07/08 # Admissions: 1208 | 1063 | 1124 | 1143 **Intermediate Measure** – The percentage of people with diabetes who have satisfactory or better diabetes management (HbA1c>=8%).[21] 2007/08 | 2009/10 | 2010/11 | 2011/12 Māori 64% | >70% | >70% | >70% Pacific 52% | >56% | >56% | >56% All 73% | >77% | >77% | >77%  Maori | Pacific | Other | Total | National Average 07/08 (MoH Est.): 64% | 52% | 74% | 73% | 73% 09/10 (Target): 70% | 56% | 78% | 77%

[21] *Previous year's diabetes data has been collected on calendar years and has been changed to financial years the 2007/08 baseline is an estimate of the financial year performance provided by the Ministry of Health.*

What is the DHB trying to achieve?	Associated Measures of Performance.

A reduction in unnecessary or 'avoidable' hospital admissions.

The estimated rate of avoidable hospitalisations in Canterbury is lower than the national rate. 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.

There are a number of admissions to hospital for conditions which are seen as preventable through access to appropriate primary and community health care. As such these avoidable hospital admissions provide an indication of access to and the effectiveness of, health promotion, early intervention and the continuum of care across the whole health system.

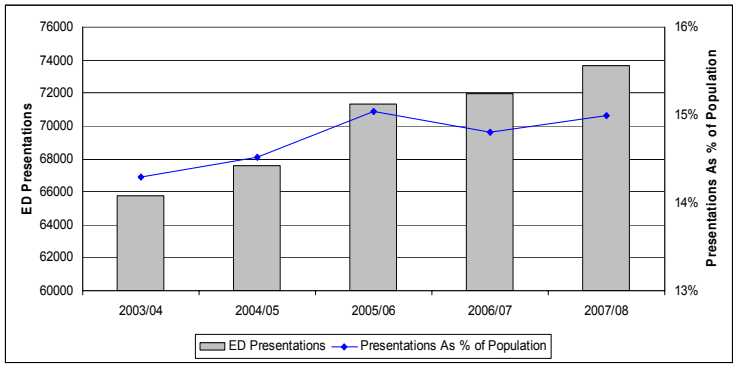
Alongside this a significant proportion of those people presenting at our Emergency Departments (particularly 'self' referrals) do not need hospital or specialist level intervention and as such could be better managed in more appropriate locations such as general practice or in their own homes.

We will expect to see a reduction in acute or unnecessary admissions as people are supported to stay well, better manage long-term conditions and seek appropriate intervention early. A reduction in these admissions will also minimise the drain on hospital resources and expenditure and enable the DHB to redirect resources to other priority areas.

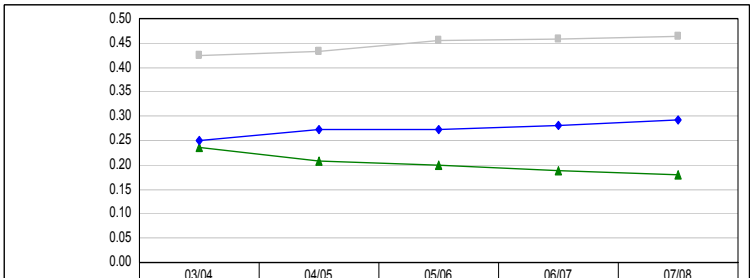
NOTE: Avoidable or 'Ambulatory Sensitive' hospital admissions are based on admissions for 26 conditions including: asthma, diabetes, angina and chest pain, vaccine preventable diseases, dental conditions, and gastroenteritis.

NOTE2: The expected ambulatory sensitive admission rate is the age-group specific national average admission rate and a ratio greater than 100 indicates performance worse than the national average.

Long-Term Measure – The ratio of ED presentations as a % of the population.



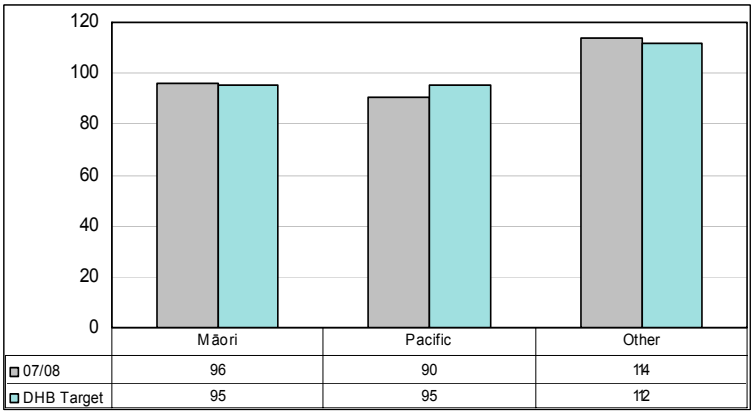
Long Term Measure – The ratio of self, GP and Ambulance referrals to ED.



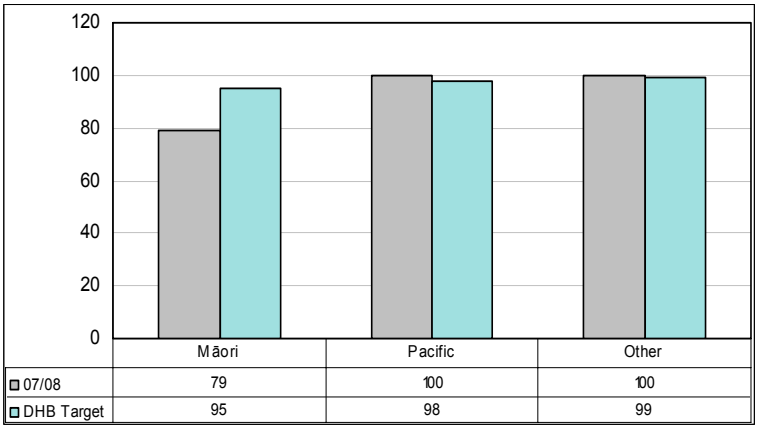
	03/04	04/05	05/06	06/07	07/08
Self to Total	0.42	0.43	0.45	0.46	0.46
GP to Total	0.24	0.21	0.20	0.19	0.18
Ambulance to Total	0.25	0.27	0.27	0.28	0.29

Intermediate Measure - The ratio of actual to expected ambulatory sensitive (avoidable) hospital admissions for those aged 0-4.

2007/08	2009/10	2010/11	2011/12
Māori			
95.8	≤95	≤95	≤95
Pacific			
90.3	≤95	≤95	≤95
Other			
113.8	≤112	≤108	≤104



What is the DHB trying to achieve?	Associated Measures of Performance.				
A reduction in unnecessary or 'avoidable' hospital admissions – continued...	**Intermediate Measure** - The ratio of actual to expected ambulatory sensitive (avoidable) hospital admissions for those aged 0-74.	2007/08	2009/10	2010/11	2011/12
		Māori			
		79.4	≤95	≤95	≤95
		Pacific			
		100	≤98	≤95	≤95
		Other			
		99.6	≤99	≤95	≤95



4.2.2 HOSPITAL LEVEL AND SPECIALIST SERVICES

Our Long-term Objective - What are we trying to achieve?

We seek to decrease the morbidity and mortality of Canterbury's residents (while living within our means) by:

- Providing quality services in line with best practice and clinical guidelines;
- Reducing duplication, variation and waste in the provision of hospital and specialist services; and
- Improving access to hospital care, specialist advice or diagnostic services for those with the greatest level of need, in a timely manner and in the most appropriate setting.

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

To remain clinically and financially sustainable the DHB must ensure that the investments it makes are returning benefits, that operations are effective and efficient, that we are as productive as possible and are making best use of funding. 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?

Clinical leadership leads to improved quality and safety, and effective use of resources with clinical decisions being made close to the point of contact resulting in better patient outcomes. The Canterbury DHB has developed strong clinical leadership processes and will continue to identify and develop opportunities for clinical leadership. Clinical input is viewed as essential to inform priority initiatives such as the devolution of services from the secondary to primary sector through the Canterbury Initiative.

Alongside this approach the DHB introduced a major new programme to improve the patient journey through the health system. The 'Improving the Patient Journey' programme is a continuous quality improvement programme that is ongoing and ever evolving – a journey in change and not a destination. The programme has primarily been focused on DHB hospital and specialist services and is underpinned by the DHB's Quality Strategic Plan and Lean Thinking processes. The core focus is improving the flow of patients through the hospital setting by removing delays and wastes to patient and clinical staff time and 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.[22]

The DHB will also look to better understand its business and prioritise resources to meet need and 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 or could be better provided in alternative locations or by other providers.

There are two types of hospital admissions: acute (or emergency) services for patients who are very ill and require immediate treatment and elective services (or booked surgery) for patients who have conditions that do not require immediate hospital treatment. The DHB has specific approaches to maximising capacity and outcomes for each type of admission.

[22] *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.*

The DHB is working collaboratively with primary health care providers to minimise the growth in acute demand by reducing unnecessary attendance at ED, but also has a clear focus on improving patient flow and systems within hospital and specialist services to reduce wait-times in ED and to improve the management and provision of acute services.

Freeing-up resources by reducing acute demand will enable the DHB to better meet its commitments around elective services and meet the Minister's expectations to provide an increased volume of electives services and to provide our population with the same level of services as the population of other DHBs. We have worked with the other five 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 the region's population. In delivering our objectives we take a structured, consistent and sustainable approach to managing elective surgery and will:

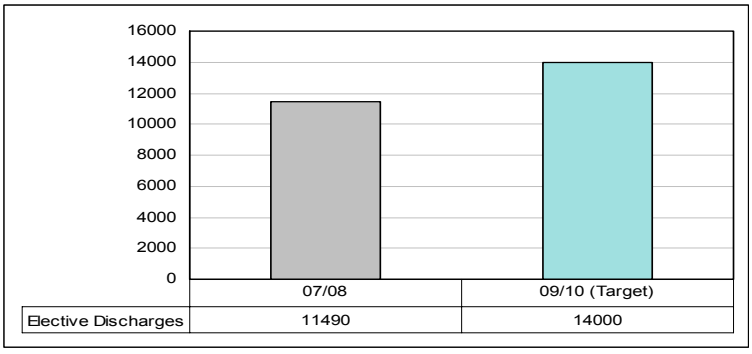
- Ensure delivery of agreed levels of service, increased elective services volumes and equitable access across the South Island;
- Use acceptable prioritisation processes to determine need and ability to benefit, ensure patients are assessed and prioritised for surgery on a consistent basis, and are receiving surgery in a timely manner and according to their priority (certainty of access and minimised waiting time);
- Streamline and improve patient flow management and increase capacity while maintaining ESPI compliance by delivering services in a way that is responsive to patient need and appropriately reflective of clinical best practice;
- Support joint initiatives with regional DHBs and primary health care providers to meet agreed levels of service, improve patient flow and measure unmet need in our community; and
- Improve partnership and referral management between clinicians and between districts to ensure efficient use of workforce and physical resources across South Island regions.

How will we know if we have been successful?

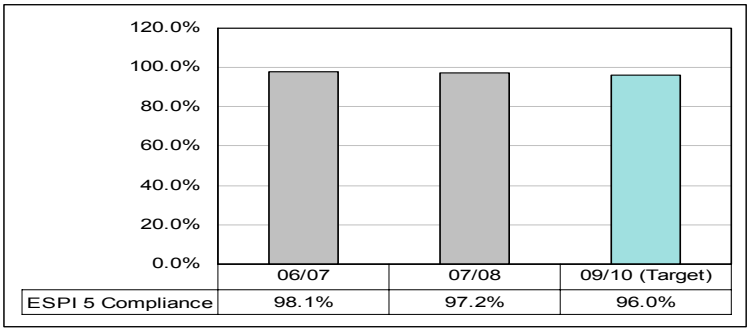
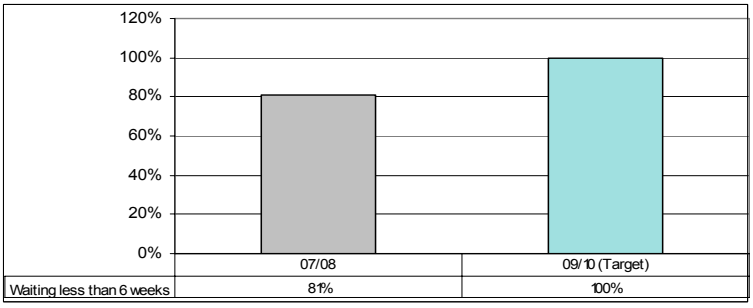
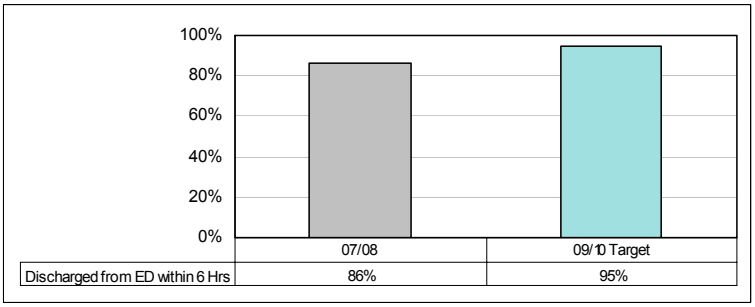
The DHB aims to improve our capacity and capability to provide for the needs of the Canterbury population. The following medium-term outcome measures are an indication of our improved capacity and capability in terms of the timely provision of services in order to provide the best possible outcomes for our population.

The measures are also indicative of internal process improvements in terms of improving the flow of patients through the system and reducing waiting-times and provide a measure of the quality of the services delivered by the DHB by measuring quality improvement and patient satisfaction with services being provided.

<table>
<tr><th>What is the DHB trying to achieve?</th><th colspan="5">Associated Measures of Performance.</th></tr>
<tr><td rowspan="3">An increase in capability and capacity to provide services in line with the growth in our population.

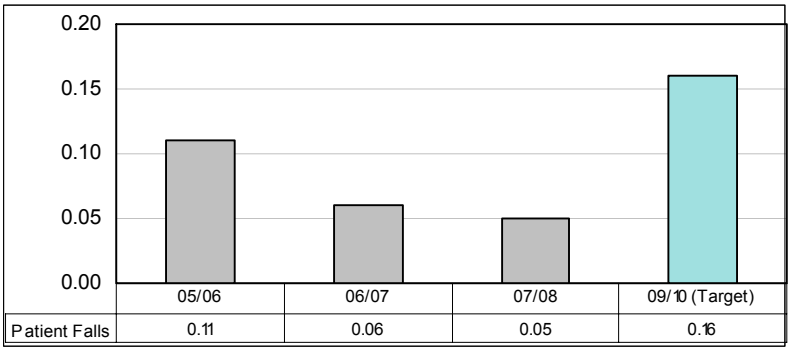
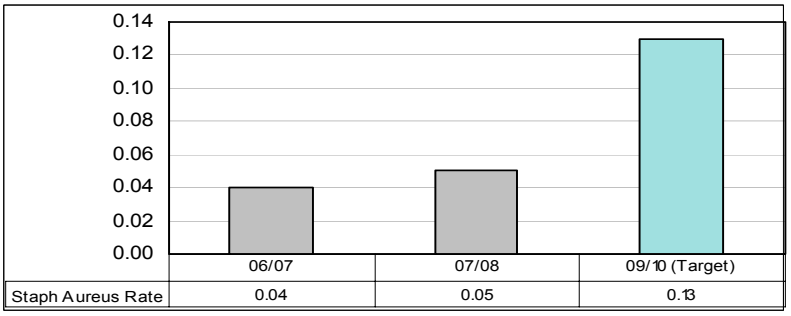
Canterbury DHBs population is growing and ageing which has resulted in increased demand for elective surgical procedures. The DHB will need to increase its capacity to deliver increased services.</td><td rowspan="2">Intermediate Measure – The volume of elective services delivered by the Canterbury DHB. [23]</td><td>2007/08</td><td>2009/10</td><td>2010/11</td><td>2011/12</td></tr>
<tr><td>11,490</td><td>14,000</td><td>14,627</td><td>15,254</td></tr>
<tr><td colspan="5"> 
</td></tr>
</table>

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

What is the DHB trying to achieve?	Associated Measures of Performance.				
An increase in capability and capacity to provide services in line with the growth in our population – continued… The DHB needs to ensure that those people in need of elective or acute services receive the right service, in the right place, provided by the right provider and that they receive that service in a timely manner that respects their needs and values their time. Timely access to treatment improves health outcomes and is indicative of increased capacity and improvement in the flow of patients through our services.	**Intermediate Measure** – The percentage of patients given a commitment to treatment and treated within six months (ESPI 5).[24]	2007/08	2009/10	2010/11	2011/12
		97.2%	>96%	>96%	>96%
					
	Intermediate Measure - The percentage of people receiving radiation (cancer) treatment within 6 weeks of the decision to treat.[25]	2007/08	2009/10	2010/11	2011/12
		81%	100%	100%	100%
					
	Intermediate Measure - The percentage of people presenting to ED who are discharged or transferred to an inpatient bed within 6hrs.	2007/08	2009/10	2010/11	2011/12
		86%	95%	95%	95%
					

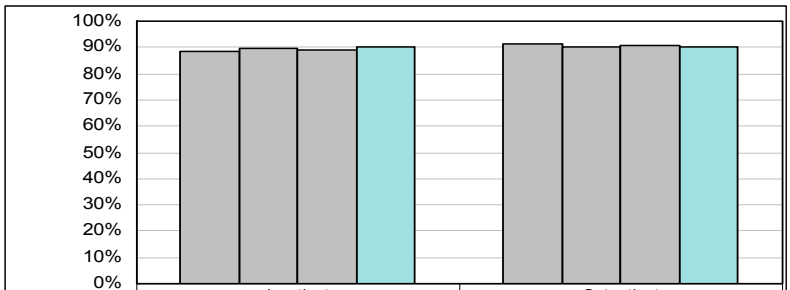
[24] *Elective Service Patient Flow Indicators (ESPIs) are measures of system performance at eight critical points. A full explanation can be found on the Ministry of Health website www.moh.govt.nz.*

[25] *The wait time is defined as the time between the decision to commence radiation treatment and the start of treatment. The measure reflects groups A, B and C. Group D patients have planned treatment (either as part of a trial or because of given protocols) and are therefore not included in targets. Previously data had been collected against an eight week target.*

What is the DHB trying to achieve?	Associated Measures of Performance.				
An improvement in the quality of patient care. 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 for the DHB. Quality improvements in service delivery, systems and processes will improve patient safety and reduce the number of adverse events; providing a better outcome for patients in our services. Patient satisfaction is a well accepted measure with high satisfaction indicative of high quality health care.	**Intermediate Measure** – The rate of patient falls (causing serious injury) per 1000 inpatient day equivalents.[26]	2007/08	2009/10	2010/11	2011/12
		0.05	0.16	<0.16	<0.16
					
	Intermediate Measure – The rate of staphylococcus aureus bloodstream infections per 1000 inpatient bed days.[27]	2007/08	2009/10	2010/11	2011/12
		0.05	0.13	<0.13	<0.13
					
	Intermediate Measure - Overall patient satisfaction in both inpatient and outpatient hospital services.	2007/08	2009/10	2010/11	2011/12
		Inpatient Satisfaction			
		89%	90%	≥90%	≥90%
		Outpatient Satisfaction			
		91%	90%	≥90%	≥90%

[26] *Total falls includes only those falls associated with serious injury to provide a direct measure of injury caused. Inpatient Day Equivalents reflect the total inpatient bed-days in the period plus half the total day patients.*

[27] *Staphylococcus Aureus Bloodstream Infections is a new Hospital Benchmarking Indicator and replaces the previously reported Hospital Acquired bacteraemia Indicator. Data reported excludes HSS Mental Health Services.*



	Inpatient	Outpatient
05/06	88.5%	91.1%
06/07	89.4%	90.1%
07/08	89.2%	91.0%
09/10 (Target)	90.0%	90.0%

4.3 Mental Health Services

Our Long-term Objective - What are we trying to achieve?

We seek to provide a system of care that is integrated across the whole health system, is responsive and provides faster access to services to improve outcomes for people with mental illness and alcohol and other drug problems.

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) also increases with age and older people have different patterns of mental illness, often accompanied by loneliness, depression, 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 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.

The model supported three key principles which align with the DHB's Health Services Planning Principles: community-based care backed up by specialist services; realigning secondary services to be specialist and regional; and supporting a greater role and more responsibility for community and primary care services. Over the past four years the majority of additional mental health funding has been directed into community-based services and has greatly expanded the range of community-based mental health services available to our population.

Simplifying access pathways and providing improved 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.

How will we know if we have been successful?

The DHB aims to work collaboratively to reduce risk behaviours common to mental illness and addictions, strengthen resiliency and protective factors, provide earlier intervention and identification of mental illness, raise awareness around mental illness and support access to treatment and rehabilitation.

The following outcome measures provide an indication of improved access to services that provide support and promote rehabilitation and provide a measure of the quality of service provided by measuring our effectiveness in providing appropriate and timely support to reduce adverse and more serious impacts for people with mental illness and alcohol and other drug issues.

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

What is the DHB trying to achieve?	Associated Measures of Performance.

A reduction in the impact of the complications of mental health conditions and addictions on our population.

Improved access pathways, and flexibility for planned admission, where clinical appropriate, will enable people with mental health conditions and addictions and their families and caregivers to establish more stable lives.

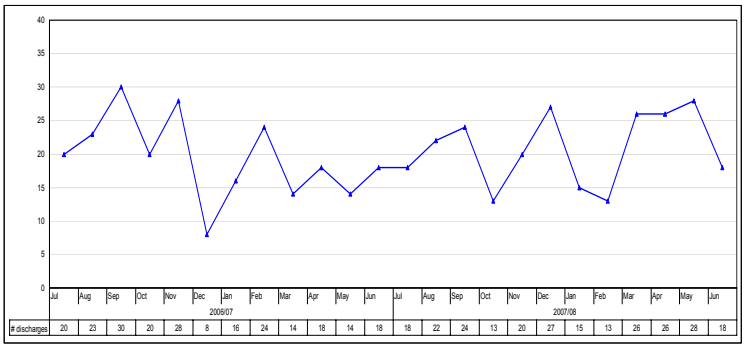
Timely and responsive intervention will also decrease the number of people requiring higher-level mental health intervention and as such a reduction in acute or unplanned re-admissions can be used to indicate whether people are being appropriately supported by mental health and addiction services.

A partnership approach and integrated 'patient focused and clinically driven' pathways are seen as key to improving access to services and in improving service flexibility and responsiveness and will create a number of opportunities to improve health outcomes for our population. Integrated pathways will also assist in managing future demand, workforce shortages and funding expectations by building future capacity and capability.

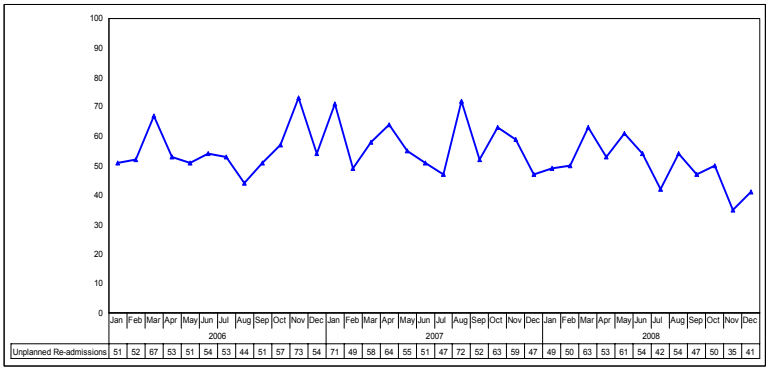
While the DHB puts emphasis and focus on building convenient and flexible primary and community-based services we must still maintain access levels to hospital and specialist services for those with higher level mental health needs (approximately 3% of the population).

NOTE: The DHB is building capability to measure access levels in primary and community-based services and will look to measure these levels alongside those for our hospital and specialist services.

Long-term Measure – The number of acute inpatient admissions with depression as the primary diagnosis.

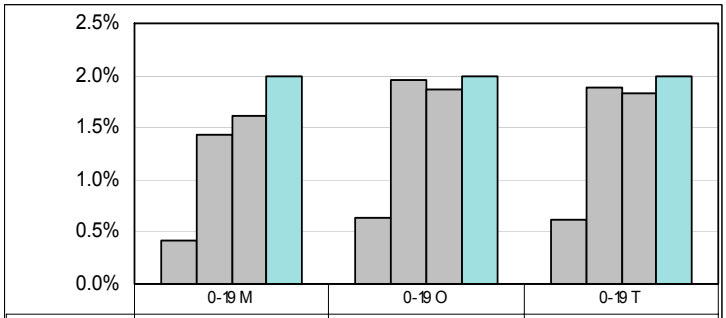


Long-term Measure - The number of un-planned inpatient specialist mental health re-admissions.



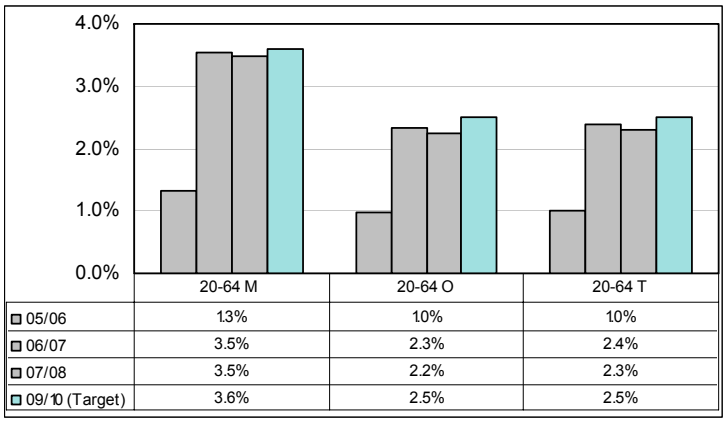
Intermediate Measure - Access rates to hospital and specialist service for young people (aged 0-19years) with severe mental illness.

2007/08	2009/10	2010/11	2011/12
Māori			
1.6	2.0	2.0	2.0
Other			
1.9	2.0	2.0	2.0
All			
1.8	2.0	2.0	2.0



	0-19 M	0-19 O	0-19 T
05/06	0.4%	0.6%	0.6%
06/07	1.4%	2.0%	1.9%
07/08	1.6%	1.9%	1.8%
09/10 (Target)	2.0%	2.0%	2.0%

What is the DHB trying to achieve?	Associated Measures of Performance.				
A reduction in the impact of the complications of mental health conditions and addictions on our population – continued…	**Intermediate Measure** - Access rates to hospital and specialist service for adults (20-64 years) with severe mental illness.	2007/08	2009/10	2010/11	2011/12
		Māori			
		3.5	3.6	2.5	2.5
		Other			
		2.2	2.5	2.5	2.5
		All			
		2.3	2.5	2.5	2.5



	20-64 M	20-64 O	20-64 T
05/06	1.3%	1.0%	1.0%
06/07	3.5%	2.3%	2.4%
07/08	3.5%	2.2%	2.3%
09/10 (Target)	3.6%	2.5%	2.5%

4.4 Older Persons Health Services

Our Long-term Objective - What are we trying to achieve?

We aim to support older people (65+) to stay well in their own home for as long as possible, and provide timely access to appropriate services so that people can quickly return to their normal lifestyles and avoid further complications; by:

- Realigning home based support services to ensure appropriate and timely access for those most in need;
- Supporting a restorative focus for home based and complex support services; and
- Aligning and re-orientating assessment processes and providing improved supported hospital discharge services.

Canterbury's population, like that of New Zealand, is ageing and this is driving an increasing demand for health and disability services and aged residential care services. We have the fifth highest age standardised per capita utilisation of aged residential care services and a higher than national average utilisation of home support services. Demand forecasts demonstrate that at current levels we will need an additional 2,000 residential care beds in Canterbury. With this higher utilisation and spend on aged residential care services we will need to concentrate on innovative and cost-effective initiatives to meet the needs of our older population and to align assessment process to ensure that we are allocating all services on the basis of need and affordability.

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. The local Strategy 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. While older people experience more illness and disability that any other population group and their health issues are likely to be more complicated, they can be supported to rebuild and even improve their functioning, for example, after illness. Our 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 the long-term conditions experienced by older people including diabetes, cardiovascular disease and respiratory disease.

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 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 ensure appropriate and timely review for service users. 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 and by re-orientating home based support services.

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. There will also 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 not longer provide services to those people who only have clearing needs and are otherwise independent, socially active and well. This will help ensure that service provision levels can be sustainably provided and targeted to supporting people with a range of needs to age in place.

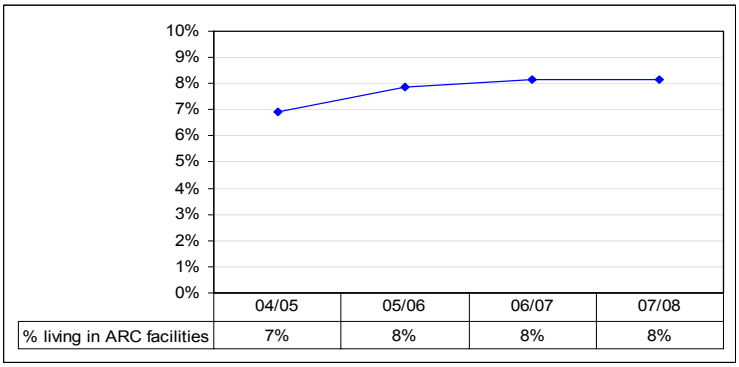
The DHB will also continue to focus on improving the quality of care for older people and will work collaboratively with providers particularly around improving capacity, quality, consumer satisfaction and workforce development. Our focus on residential care will be around ensuring the safety and wellbeing of older people and building the capacity of residential care to support residents in episodes of acute or end of life care.

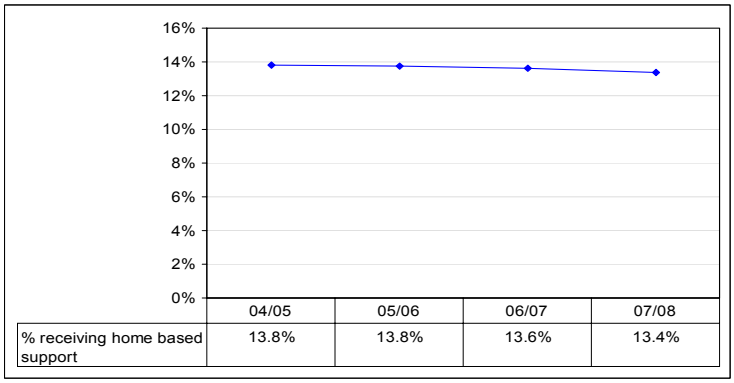
How will we know if we have been successful?

The following outcome measures are an indication of access to services that support people to return home and remain well after illness and provide a measure of the quality of services provided by measuring our effectiveness in keeping people well and enabling them to stay in their own homes rather in hospital level care or in aged residential care facilities. The measures also indicate the effectiveness of continuums of care and clinical pathways in managing long-term conditions.

<table>
<tr><th>What is the DHB trying to achieve?</th><th>Associated Measures of Performance.</th></tr>
<tr><td rowspan="2">An increase in the proportion of the population ageing in place.

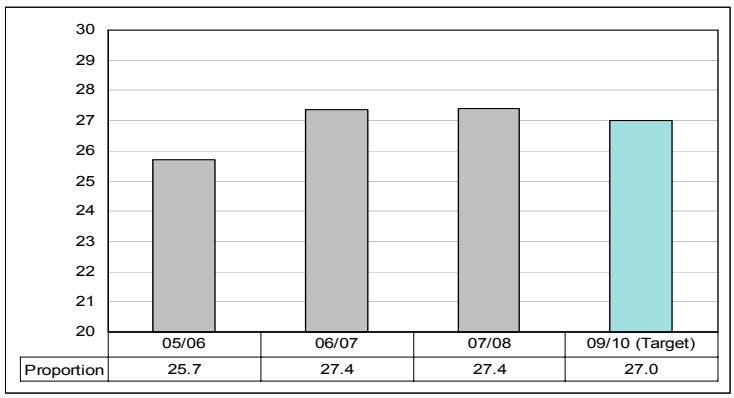
Providing people have the adequate supports and have a manageable level of need, ageing in place is considered to result in much higher quality of life, with people remaining healthier for longer as a result of staying active and positively connected to their communities.

While living in aged residential care is appropriate for a small group of our population Canterbury rates are above national averages. Living in aged residential care may be associated with a more rapid functional decline than those ageing in place. Receiving appropriate levels of support will ensure people are able to remain in their homes and communities for longer.</td><td>Long-term Measure – The percentage of people 65+ living in subsidised aged residential care (ARC) facilities.
 

<table>
<tr><td></td><td>04/05</td><td>05/06</td><td>06/07</td><td>07/08</td></tr>
<tr><td>% living in ARC facilities</td><td>7%</td><td>8%</td><td>8%</td><td>8%</td></tr>
</table></td></tr>
<tr><td>Long-term Measure – The percentage of people 65+ receiving home based support services.
 

<table>
<tr><td></td><td>04/05</td><td>05/06</td><td>06/07</td><td>07/08</td></tr>
<tr><td>% receiving home based support</td><td>13.8%</td><td>13.8%</td><td>13.6%</td><td>13.4%</td></tr>
</table></td></tr>
<tr><td>A reduction in unnecessary or avoidable hospital admissions.

Improved access pathways, needs assessment and earlier and more responsive intervention will help to reduce the number of people requiring higher-level services or hospitalisation – improving health outcomes and reducing pressure on higher-level clinical care and resources.

The number of acute admissions can be used to indicate whether people are being appropriately supported by good quality and effective services and are safe and well in their homes and communities. Maintaining current ratios will be a challenge as our population ages and demand increases.</td><td>Intermediate Measure - The proportion of acute admissions to hospital for people 65+.[29]
<table>
<tr><td>2007/08</td><td>2009/10</td><td>2010/11</td><td>2011/12</td></tr>
<tr><td>27.4%</td><td>27%</td><td><27%</td><td><27%</td></tr>
</table>


<table>
<tr><td></td><td>05/06</td><td>06/07</td><td>07/08</td><td>09/10 (Target)</td></tr>
<tr><td>Proportion</td><td>25.7</td><td>27.4</td><td>27.4</td><td>27.0</td></tr>
</table></td></tr>
</table>

[29] *Excluding ACC acute admissions.*

5. FORECAST STATEMENT OF SERVICE PERFORMANCE 2009/10

One of the functions of this Statement of Intent, and in particular this chapter, the Forecast Statement of Service Performance is to provide a summary of the outputs the DHB will deliver in order to achieve our objectives and outcomes. These measures and targets will be subject to an annual review by auditors appointed by the Office of the Auditor General.

The outputs and output measures we have chosen to include are not a comprehensive list and do not cover all of the activity of the DHB - but reflect a significant picture of activity under each of the output classes with a focus on the strategic priorities identified in our District Strategic Plan and the expectations of the Minister of Health. The output selected also reflect where the DHB's emphasis will be in terms of new investment or transformation to present a picture of the direction the Canterbury Health System is taking over the next few years.

The targets we have set against our outputs are based on the assumption that, notwithstanding funding and financial pressures, we will be able to maintain current levels of service provision. With limited funding available, the scope for service expansion is limited and therefore our performance targets tend to reflect the objective of maintaining current performance levels against increasing population growth. The targets also reflect our commitment to improving health status and reducing inequalities between population groups to meet our obligations under the New Zealand Public Health and Disability Act 2000.

Like the earlier chapter, where possible, we have included past performance (baseline data) to give context in terms of what we are trying to achieve and to enable evaluation of our performance at the end of the year.

Achievement of all of the targets set in this chapter requires the DHB to find better ways of working, to develop collaborative models of service delivery, support a sustainable health workforce and to provide leadership in the sector. The DHB is reliant on support from the Ministry, other DHBs, Government and non-Government agencies, community and primary providers and our community to meet the outcomes and objectives we have set, and we acknowledge the support and collaboration that allows us to achieve improved outcomes for our population.

More specific detail concerning the outputs of the DHB can be found in our District Annual Plan 2009/10.

5.1 Public Health Services

Key Priorities for 2009/10 – What action will we take to improve outcomes?

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 and we will support programmes that reduce the uptake of smoking and increase quit attempts, particularly amongst identified high need population groups.

In particular the DHB will work collaboratively with community groups, Māori and Pacific communities and primary care to reduce the uptake of smoking – the average age of smoking initiation in adolescents is 14.6 years. The DHB will also work within its hospital and specialist services identifying smokers and assisting people to stop smoking through the provision of advice and help to quit. Promoting clear and consistent messages across sectors is central to achieving a change in risk behaviours for our population.

We will work collaboratively with early childhood centres, schools and community groups to promote good nutrition and physical activity behavioural habits amongst children and young people in Canterbury. This work will be driven through our Health Eating, Healthy Action (HEHA) Ministry Approved Plan and will focus on providing access to education and nutritional advice and to physical activity programmes to support behavioural change.

In addition the DHB will also work collaboratively over the coming year with local councils, community groups and other government agencies to create environments that support healthy choices and lifestyles. The provision of environments, both physical and social, that support health enhancing behaviour is essential to protecting and promoting health. The reduction of harm from alcohol and improvement in healthy housing will involve collaboration with the Christchurch City Council and NZ Police.

What is the DHB trying to achieve?	What services will we provide to make this happen (outputs)?	What impact will this have?	Associated Measures of Performance.
To ensure that all smokers are identified and given advice and support to quit in order to reduce the harm caused by tobacco.	DHB patients will be asked about their smoking status, smokers will be given brief advice on quitting smoking and the resources to support cessation. Systems established to collect baseline data and record the provision of smoking cessation advice. Smokefree environments will be supported.	Patients regularly asked about smoking cessation by health professionals. Increased quit attempts supported by NRT by smokers in the Canterbury area in all population groups. Tobacco will be less available to adolescents.	**Measure** – The percentage of hospitalised smokers provided with advice and helped to quit. Baseline 2007/08 new programme Target 2009/10 establish baseline[30] **Measure** – The percentage of non-compliant tobacco retailers identified from controlled purchase operations. Baseline 2007/08 55 retailers (16% non-compliant) Target 2009/10 <10% non-compliant
To improve the health of children and young people through improved nutrition with priority on schools and Early Childhood Education (ECE) with high Māori or Pacific roles.	Increased services available to support mothers to breastfeed, particularly in rural areas including peer support and lactation. consultants Schools and ECE supported to adopt a range of health initiatives/plans/policies. Maori and Pacific communities supported to achieve HEHA goals.	Increased Canterbury Breastfeeding rates. Schools and ECE provide education and environments that support healthy food choices and physical activity. The local environment supports families to choose healthier options.	**Measure** – The proportion of infants exclusively and fully breastfed.[31] 6wks 3mths 6mths Baseline 2007/08 67% 55% 31% Target 2009/10 68.5% 57% 27% **Measure** – The percentage of schools supporting the Health Promoting Schools Framework. [32] Baseline 2007/08 41% Target 2009/10 >41%
To engage multiple sectors in action that will reduce risk factors for those most at risk of poor health and to share resources and capability across the region.	A health profile of Christchurch is complete. Home insulation programme developed and implemented. Community violence reduction project implemented to reduce alcohol-related harm. Host responsibility legislation is enforced.	Intersectoral agreement on Christchurch specific health issues that need addressing. Families most at risk from cold damp homes have improved health and wellbeing. Improving the health of those with chronic conditions such as asthma and helping to reduce unnecessary hospital admissions. The local environment supports less intoxication and alcohol-related harm is reduced.	**Measure** – The number of eligible households registered in the home insulation retrofitting programme. Baseline 2007/08 new programme Target 2009/10 400 homes

[30] *The national Health Target is for 80%. The DHB supports this target and aims to establish the systems to measure our baseline and performance over the coming year at the same time as we implement the programme.*

[31] *The DHB has set targets emphasising its aim to focus on increasing rates at 6 weeks and 3 months while seeking to maintain rates at 6 months where the DHB is already achieving higher than average rates.*

[32] *HPS is viewed as a framework to be used to address health issues with an approach based on activities within the school setting that can impact on health: the provision of health services, the inclusion of health education in curricula, and the creation of a healthy environment. As such, the definition also includes schools promoting Fruit in Schools and Active Schools.*

5.2 Personal Health Services

5.2.1 PRIMARY AND COMMUNITY SERVICES

Key Priorities for 2009/10 – What action will we take to improve outcomes?

Over the coming year the Canterbury DHB aims to demonstrate that the number of people accessing primary health services in Canterbury is increasing, particularly those people with high needs and those on lower incomes. The DHB will continue to support screening and targeted population health initiatives that will build the foundations to support improved health longer-term.

We will also support general practise and PHOs to enhance services to manage long-term conditions and to develop integrated pathways of care in priorities areas including Diabetes and Respiratory services. The DHB will also work closely with the primary care sector in the management of acute demand and the provision of urgent services to improve health outcomes for our population and to release secondary care resource to enable investment in other priority areas.

Many people experience episodes of illness which can be managed in a primary or community setting rather than a hospital setting. The DHB will work to encourage and enable innovative, appropriate and effective means of support the management of illness and chronic conditions in primary or community setting.

Part of this enablement will include a commitment to the devolution of clinically appropriate services and activity from secondary to primary settings. Devolution in Canterbury commenced in December 2008/09 with a range of services now based in primary and community settings and supported through the Canterbury Initiative. Rather than destabilising secondary services the DHB sees an opportunity to free up constrained secondary care capacity to focus on those patients that need specialist input. This will contribute to improved patient flow, reduced waiting times, improved inpatient discharge and better outcomes for our population.

What is the DHB trying to achieve?	What services will we provide to make this happen (outputs)?	What impact will this have?	Associated Measures of Performance.
To identify early any health concerns that may adversely affect future health and well-being and to reduce unnecessary hospital admissions.	Support screening programmes and early intervention through the PHO Performance Programme. Improved coordination between immunisation services with opportunities identified to focus on 'at risk' children. B4 Schools Checks implemented by primary care and public health nurses. The national HPV Vaccination Programme implemented through primary care. Implement upgrades to school oral health services in line with the DHB's Business Case.	CVD risk is assessed and those at risk identified and supported to self manage their condition. Additional vaccinations provided by general practice and outreach immunisation services. Earlier intervention and timely referrals for children with behavioural, developmental and other health issues. A Whanau engagement service is delivered for hard to reach young women ensuring those eligible receive the HPV Vaccine. Improved access to oral health services across the Canterbury region.	**Measure** – The percentage of the eligible adult population having had a fasting-lipid/glucose test in the last five years. Baseline 2007/08 63.9% Target 2009/10 68.0% **Measure** – The percentage of two years olds fully immunised. Maori Pacific All Baseline 2007/08 81% 82% 84% Target 2009/10 85% 85% 85% **Measure** – The percentage of four year olds receiving B4 School Checks. Baseline 2007/08 new programme Target 2009/10 50% **Measure** – The percentage of girls completing HPV immunisation. Baseline 2007/08 new programme Target 2009/10 50% of eligible girls

What is the DHB trying to achieve?	What services will we provide to make this happen (outputs)?	What impact will this have?	Associated Measures of Performance.
To ensure people with long-term conditions and those at risk of developing chronic conditions have the resources, information, support and care to enable them to self manage their condition and to stay well.	Consistent treatment and referrals pathways developed in primary settings supported by specialist. Access to specialist services is enabled without requiring outpatient visits. Access to community based diagnostics is improved. Appropriate services are devolved to primary care with increased access to convenient community-based services.	Reduced impact of chronic conditions by identifying conditions early. People with chronic conditions have consistent access to treatment pathways. Primary care is the point of continuity supported by specialist care when necessary. Pathways provide improved access to community-based services. The impact and complications of chronic conditions is reduced. Secondary care resource and resources released for reinvestment in other priority areas and to better meet increased demand.	**Measure** – The percentage of people with diabetes attending free annual checks. Maori Pacific All Baseline 07/08 35% 68% 65% Target 09/10 - >33% >26% >43% **Measure** – The number of community-based spirometry delivered.[33] Baseline 2007/08 new programme Target 2009/10 1250 **Measure** – The number of level-4 sleep assessments delivered in the community. Baseline 2007/08 new programme Target 2009/10 500
To reduce acute demand growth and ED growth especially in self and ambulance referrals which may be better treated elsewhere and support the DHB to reduce waiting times in ED by improved patient flow and supporting discharge.	Acute demand services reoriented to focus on patients with the greatest capacity to benefit. Clinically-led response developed to target self referrals and ambulance presentations to ED. The number of coordination points is reduced with a clear pathway for referrals. Support provided to people in the community to facilitate alternatives to acute admission and to support discharge. Public awareness is raised of when and where and how to access the most appropriate assistance. Specific approaches developed to support after hours service sustainability for urban and rural areas.	Increased appropriate admissions to ED with less ambulance and self referrals. Reduced iatrogenic morbidity from inappropriate hospital admissions. Fragmentation of services is reduced. Access to community based after hours services is maintained. Reduced per capita utilisation of acute medical services.	**Measure** – The number of self referrals to ED. Baseline 2007/08 34,183 Target 2009/10 ≤34,183 **Measure** – The number of ambulance referrals to ED. Baseline 2007/08 21,495 Target 2009/10 ≤21,495

[33] *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.*

5.2.2 HOSPITAL LEVEL AND SPECIALIST SERVICES

Key Priorities for 2009/10 – What action will we take to improve outcomes?

Over the coming year the DHB will also look to better understand its business and 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.

We will continue with our 'Improving the Patient Journey' programme focusing on improving the flow of patients through the hospital setting by removing delays and wastes to patient and clinical staff time. Eight key hospital and specialist service areas have been identified for 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 maximise health outcomes from improved management of wait times, follow-ups and outpatient services, intra-specialist referrals and inter-district flows between other DHBs.

Being an effective leader in health services, particularly in an environment of change, requires more than tools and techniques. A key challenge for the DHB is the need to align, enable and empower both the leadership and the workforce to constructively engage with the emerging challenges. Alignment comes from having clarity of purpose and direction; enablement from skills and knowledge of business principles, and empowerment from permission giving and knowledge sharing and the DHB is committed to continuing the momentum it has already achieved in supporting leadership development.

<table>
<tr><th>What is the DHB trying to achieve?</th><th>What services will we provide to make this happen (outputs)?</th><th>What impact will this have?</th><th>Associated Measures of Performance.</th></tr>
<tr><td rowspan="3">To increase the DHB's capacity and capability to provide services in line with the growth in our population and within clinical appropriate timeframes.</td><td rowspan="3">Establish real production plans to reduce the number of cancelled operating theatre sessions.

Develop mechanisms to enable low complexity patients to increase the numbers of procedures delivered per session.

Improved understanding of unmet elective surgery need to enable better targeting of future capacity increases.

Identify new facility requirements.</td><td rowspan="3">Increase the number of procedures delivered per theatre session.

Increase percentage of elective surgery delivered by the DHB to its resident population.

Increases in elective surgical delivery will be better focused to meet unmet need in our community.</td><td>Measure – The volume of elective services discharges for Canterbury DHB residents'.[34]
Baseline 2007/08 11, 490
Target 2009/10 14,000</td></tr>
<tr><td>Measure – The percentage of patients waiting less than six months for their first specialist assessment (ESPI 2).
Baseline 2007/08 99.3%
Target 2009/10 >98.4%</td></tr>
<tr><td>Measure – The number of patients given a commitment of treatment and treated within six month (ESPI 5).
Baseline 2007/08 97.2%
Target 2009/10 >96%</td></tr>
<tr><td>Cancer tumour stream pathways developed.

Improve utilisation of existing Linear Accelerators.

Installation of two replacement linear accelerators.

Regional collaboration to increase capacity.</td><td>Improved co-ordination and integration of oncology services.

Maximum wait time for radiation (cancer) treatment reduced.

Two new linear accelerators operational October 2010.</td><td>Measure – The percentage of people receiving radiation treatment within 6 weeks of the decision to treat.
Baseline 2007/08 81%
Target 2009/10 100%[35]</td></tr>
</table>

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

[35] *In order to meet this target longer-term, significant effort will be required in 2009/10 to maintain current performance while building DHB capacity and upgrading and replacing the DHB's older linear accelerators.*

What is the DHB trying to achieve?	What services will we provide to make this happen (outputs)?	What impact will this have?	Associated Measures of Performance.
To deliver emergency department services to patients in a timely manner that respects the patient's needs and values their time.	Project RED implementation completed. The patient journey time in ED is tracked and time milestones are monitored for each patient. Joint primary/secondary clinical champions established to provide leadership across the whole system.	Reduced waiting and journey time for patients presenting to ED. Increased flow through the ED department. Ability to measure and report patient journey times for ED presentations. Clinical engagement and focus on whole of system approach to improving acute care.	**Measure** – The percentage of people presenting to ED who are discharged or transferred to an inpatient bed within 6 hours. Baseline 2007/08 86% Target 2009/10 95% **Measure** – The percentage of people presenting to ED who are discharged or transferred to an inpatient bed within 4 hours. Baseline 2007/08 68.4% Target 2009/10 90%
To reduce waste and variation in service delivery and improve the quality of patient care through a standardised approach.	Implementation of the Improve the Patient Journey Programme streams. Increase the proportion of direct care time to patients. Improved processes for the review of patient care, harm and death. Additional initiatives for reducing the number of patient falls resulting in serious harm introduced. Patient identification processes defined to reduce adverse incidents.	Efficient use of resources. Provision of safe and effective services that improve outcomes for patients. A reduction in the number of adverse events. A demonstrated increase in the knowledge and understanding of patient safety by staff groups. A demonstrated improvement in patient outcomes based on audit review processes. Improved staff engagement and satisfaction.	**Measure** – The rate of patient falls (causing serious injury) per 1000 inpatient day equivalents.[36] Baseline 2007/08 0.05 Target 2009/10 <0.16 **Measure** – The rate of staphylococcus aureus bloodstream infections per 1000 inpatient bed days.[37] Baseline 2007/08 0.05 Target 2009/10 <0.13

[36] *Total falls includes only those falls associated with serious injury to provide a direct measure of injury caused. Inpatient Day Equivalents reflect the total inpatient bed-days in the period plus half the total day patients.*

[37] *Staphylococcus Aureus Bloodstream Infections is a new Hospital Benchmarking Indicator and replaces the previously reported Hospital Acquired bacteraemia Indicator. Data reported excludes HSS Mental Health Services.*

5.3 Mental Health Services

Key Priorities for 2009/10 – What action will we take to improve outcomes?

As a means of ensuring quality across the continuum and reducing unplanned acute hospital admissions, we will ensure long-term service user have crisis/relapse prevention plans in place to support self management and to enable primary and community providers to better support 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 to cope with increased demand as our population ages.

In the coming year we will also examine the current range and mix of mental health services in Canterbury and critically reflect on 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.

What is the DHB trying to achieve?	What services will we provide to make this happen (outputs)?	What impact will this have?	Associated Measures of Performance.
To improve access pathways for people with mental illness to reduce unplanned hospital-level admissions and the ability to meet future needs within available resources.	A clinician and consumer led response is implemented across psychiatric rehabilitation and alcohol and other drug services. Service improvements are made through a review of assessment and service coordination pathways. An increased range of community rehabilitation services are made available. A broader range of flexible AOD community support options are made available.	Informed investment, disinvestment and system realignment. Access to support services will not be conditional on residing in specific facilities. Increased flexibility and responsiveness of services. Improved efficiency of resource allocation and improved value for money. People are better supported to self manage their addiction issues. A reduction in unplanned residential readmissions.	**Measure** – The number of people accessing Brief Intervention Counselling services in primary care. Baseline 2007/08 new programme Target 2009/10 1,536 people **Measure** – The number of people accessing community-based mental health and rehabilitation services. Baseline 2007/08 1,687 Target 2009/10 >1,687
To improve identification of early relapse warning signs to reduce acute admissions and improved self management.	All long-term clients have a current relapse prevention or recovery plan in place.	People are supported to self manage conditions and to be better managed in the community. A reduction in acute unplanned admissions of long term clients.	**Measure** – The percentage of long-term clients with current relapse or recovery plans in place. Baseline 2007/08 86% Target 2009/10 90**%**

5.4 Older Person's Health Services

Key Priorities for 2009/10 – What action will we take to improve outcomes?

The DHB aims to work collaboratively to support people to stay well and remain healthier for longer, to better manage long-term conditions and to support a restorative focus that helps people to rebuild and improve their functioning after illness so that they can return to their normal lives and avoid further complication.

In considering the Canterbury health system's capacity to meet the increasing demand for services, the DHB will also focus on making the best use of aged residential care, home based support and hospital and specialist services. We will review the 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. 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 targeted to those who have a range of needs to support aging in place. Services will not be provided to those people who only have cleaning needs and who are otherwise independent, socially active and well. Appropriate service provision will be determined only after comprehensive evidence based assessment using tools from InterRAI and service users will have their needs reviewed annually or more frequently if required.

What is the DHB trying to achieve?	What services will we provide to make this happen (outputs)?	What impact will this have?	Associated Measures of Performance.
To enable older people to remain safe and well in their own homes and reduce acute admissions.	Predictable capacity for respite is created. An increased number of dedicated respite beds of mixed levels is available to meet a range of patient needs.	Reduced acute admissions. Less stress for caregivers. Fewer people enter aged residential care therefore reducing spend per capita.	**Measure** – The number of dedicated respite beds available. Baseline 2007/08 flexible resource Target 2009/10 5 dedicated beds
To improve assessment processes and provide flexible, responsive services to support older people to stay in their own homes and maximise independence.	Consistency of assessment and better alignment between need and service access. Access levels for services aligned to national levels. Client directed goal orientation included in assessment and service provision. Responsive models of community support developed and implemented.	More effective community-based support services enable people to regain and/or maintain their health and independence. More older people remain functional at home. Reduced acute admissions. Fewer people enter aged residential care therefore reducing spend per capita.	**Measure** – The maximum wait-time for complex assessment. Baseline 2007/08 new process Target 2009/10 6 weeks

What is the DHB trying to achieve?	What services will we provide to make this happen (outputs)?	What impact will this have?	Associated Measures of Performance.
To provide more timely and targeted responses to enable older people to return home with the necessary treatment and supports to restore functioning and maintain independence.	Appropriate services are established to support hospital discharge. Single pathway into aged residential care established with consistent eligibility criteria. Separation of complex and non-complex assessment functions with clearly aligned accountabilities. Improved identification and management of frail elderly and those with complex needs. Improved assessment and review of people with non-complex needs.	Consistent assessment processes and reliable access to services in line with national access. Home based support services focus on people with a range of needs. Improved service coordination for people with non-complex and complex conditions. Improved use of clinical resources. More timely recovery from illness and/or injury. Reduced length of stay and improved outcomes for frail elderly through supported discharge processes.	**Measure** – The maximum wait-time for non-complex assessment. Baseline 2007/08 new process Target 2009/10 12 weeks
To ensure aged residential care residents receive consistently high quality health services.	InterRAI Tool Pilot completed. Improved audit and audit tools implemented for residential care services – focused on patient care services. Tagged funding for improving the quality of supervision and nursing in rest homes implemented.	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.	**Measure** – Proportion of people accessing residential services having been assessed using InterRAI assessment tool. Baseline 2007/08 new process Target 2009/10 80%

6. FINANCIAL PERFORMANCE - MANAGING OUR FINANCIAL RESOURCES

6.1 Financial Outlook

The Canterbury 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 obtain 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)

6.1.1 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. 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. 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.

6.1.2 ACTION PLAN

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 CDHB'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.

6.1.3 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 it will 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 achieve financial sustainability. We assume that our strategy and action plans will enable the DHB to further reduce its deficit and reach break-even in out-years.

6.1.5 FINANICAL ASSUMPTIONS AND RISKS

Included in the financial forecast are the following key assumptions:

- The DHB's funding allocations will increase as per funding advice from the Ministry and early payment is retained;
- The rate for capital charge will remain at 8%. No industrial action will occur over the coming year and there will be no revaluation of land and buildings will be required in 2009/10 (last revaluation in June 2006);
- 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;
- We will receive fair prices (including from the Ministry of Health) for services delivered;
- 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;
- 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;
- 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;
- We are able to align our service and access criteria with that of other DHBs;

- 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 can establish joint primary/secondary pathways to reduce hospital and specialist service demand and overall service costs;
- All other expenses increases including volume growth will be managed within uncommitted funds available or 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.

The assumptions underlying the Statement of Intent can be found in the Canterbury DHB's District Annual Plan 2009/2010. The over-riding risk to achieving the financial performance relates to the key assumptions above not holding true and the risks around wage increase expectations for the health sector, both internal staff and external providers, following the national employment collective settlements. Other risks include the inability to implement identified service reconfiguration and/or facility realignment or service reduction, according to planned timeframes and the inability to achieve efficiencies and address cost over-runs internally.

6.2 Asset Planning and Sustainable Investment

6.2.1 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.

6.2.2 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.

6.3 Debt and Equity

The DHB's estimated total term debt is expected to be $75M (as at June 2010). The debt level is based on key assumptions including Canterbury DHB achieving its 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 the DHB does not have any banking covenants required of its loans the forecast key financial ratios for the DHB would be as follows:

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

As the above ratios indicate, this 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.

6.3.1 Disposal of Land

Disposal of significant surplus assets over the next three years could possibly include the Canterbury DHB owned former Christchurch Women's Hospital site, however a formal decision has yet to be made as to whether or not this land is 'surplus'.

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

6.3.2 Activities for which Compensation is Sought

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

6.3.3 Acquisition of Shares

Before the Canterbury DHB or any associate or subsidiary subscribes for, purchases, or otherwise acquires shares in any company or other organisation, the Board will consult the responsible Minister/s and obtain their approval.

6.3.4 Accounting Policies

The accounting policies adopted are consistent with those in the prior year for a full statement of accounting policies refer to Appendix 4.

7. FORECAST STATEMENT OF FINANCIAL PERFORMANCE 2009/10-2011/12

7.1 Forecast Group Statement of 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)**	-	-

7.2 Forecast Group Statement of 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**

7.3 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**

7.4 Forecast Group Statement of 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**

7.5 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)**	-	-

8. OUR ORGANISATIONAL CAPABILITY

8.1 Building Capability

Capability is defined as "what an organisation needs in terms of access to leadership, people, culture, relationships, processes and technology, physical assets and structures to efficiently deliver the outputs required to achieve its goals".[38]

The Canterbury DHB is committed to building health sector and workforce capability by improving provider relationships, inter-sector collaboration, clinical governance and leadership. The DHB also has an ongoing commitment to quality and safety, improving knowledge and information management and increasing the participation of Māori and high needs groups in service planning.

Clinical capability is supported through the DHB's model of shared management and clinical leadership at all levels of the organisation which is led by the DHB's Chief Medical Officer and Executive Director of Nursing who provide clinical leadership and input into decision making process at the highest level of the organisation.

We are also fortunate to have a well functioning Board whose members contribute a wide range of skills and expertise to their governance role. Governance capability is maintained through regular forums and training and is backed by the selection of a mix of experts, professionals and consumers on the Board's advisory committees. The role of the DHB's advisory councils in shared decision making also contributes to governance capability including the Clinical Board, Consumer Council and (through our Memorandum of Understanding) Manawhenua Ki Waitaha.

However, with funding constraints and increasing demand the DHB's capability and capacity to deliver services is stretched. The need for alternative and innovative models of care, reconfiguration of traditional service models and the development of more robust prioritisation mechanisms is becoming increasingly evident. To achieve our long-term objectives and goals we need to determine the most appropriate and affordable mix of services to meet the needs of our population and to ensure that service investment is sustainable.

In building capability the DHB's aim is to create an organisation of joined up health services focused around the patient. The patient journey through the health system will be timely, seamless between providers and provide consistent quality to achieve the best possible outcomes. We will work to ensure that investment and workforce planning supports the delivery of patient centred models of care and makes the best use of our available resources.

Improving the patient journey and supporting patient pathways between primary and secondary services have a key 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 lower income groups). Longer-term planning for health services across all sectors is also critical in terms of future sustainability and in enabling the Canterbury DHB to ensure that the right services are provided at the right time, in the right place, and by the right provider.

The DHB has undertaken an extensive and participatory Health Services Planning Programme which will support the development of a Facilities Master Plan. This Plan will enable us to undertake any major facility re/development in an informed manner, to better prioritise capital expenditure and funding applications, and to reconfigure service delivery models to match the best location for the delivery of patient centred services.

As the DHB moves forward and predicted workforce shortages develop, regional and national planning will also be integral in meeting the growing demand for health and disability services. The national focus is reflective of an emphasis on a shared planning approach and much of our activity planned to achieve national priorities will involve community, primary and secondary service providers in a wider-DHB partnership to improve the health status of our population.

[38] *Guidance and Requirements for Crown Entities; preparing the 2005/06 Statement of Intent, www.crownentities.ssc.govt.nz.*

8.1.1 WORKFORCE DEVELOPMENT

Workforce development and strong organisational health is central to the DHB's ability to provide effective quality services and meet the ongoing and future challenges of improving our community's health.

The DHB seeks to access the best possible talent available and unlock its full potential to support our strategic direction. We are committed to developing a Workforce Plan to ensure enough people with the right skills are in the right place at the right time. We are also committed to being a 'good employer' in terms of leadership opportunities, a positive culture for the organisation, engagement with staff, harassment and bullying prevention and the provision of a safe and healthy environment.

Workforce development activities over the next few years will include a number of key approaches to building and maintaining capability and capacity and engaging our workforce in the future direction including:

- Establishing a leadership development model;
- Maintaining and improving clinical retention;
- Implementing a systematic approach to clinical leadership;
- Improving organisation culture and employee engagement;
- Implementing workforce systems; and
- Developing performance management tools.

The statutory requirements of being a Good Employer are well implemented and require the DHB to provide:

- Good and safe working conditions;
- An equal employment opportunities programme;
- The impartial selection of suitably qualified persons for appointment;
- Recognition within the workforce of the aspirations and needs of Māori, other ethnic or minority groups, women and people with disabilities; and
- Training and skill enhancement of employees.

8.1.2 QUALITY AND SAFETY

The Canterbury DHB has a strong commitment to the provision of high quality health care services and seeks to continuously improve quality and patient safety in our health and disability services to improve health outcomes for our population. We strive to ensure provision of an integrated service that strongly encourages evidence based clinical care and is responsive to consumer needs.

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 quality improvement, innovation and clinical leadership.

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 engage our workforce in these processes and initiatives. 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.

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.

Our Quality Strategic Plan (2007-2010) has five clear goals all focused on improving patient safety and providing effective quality services. The goals, and the priorities that sit beneath them, clearly demonstrate the importance of quality improvement across the whole of the system (*refer to Appendix 7 for an overview of the five goals*).[39]

The five Quality Strategic Plan 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.

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 a key focus for the DHB in the coming year.

8.1.3 INFORMATION SYSTEMS AND SERVICES

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 needs to be accurate, timely and available at the point of care to better inform clinical decision-making and improve health outcomes.

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

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

For the Canterbury DHB this includes the development of a Clinical Information System which will assist in affecting changes in practice by providing integrated and timely information at the point of care. Clinically relevant information is currently stored in multiple systems, which are not integrated. Clinical staff move from patient to patient and need mobile 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 roll-out of our Clinical Information System has commenced and includes a focus on E-Discharges which will allow for electronic discharge summaries to be sent to GPs electronically and will significantly improve primary/secondary integration. The DHB is committed to ensuring that the benefits of improved primary/secondary communications are realised and will continue to promote the use of the Clinical Information System to clinicians.

Local priorities also include the implementation of a single patient administration system. The DHB currently supports three different patient administration systems and one of those systems the HOMER Patient Management System, used in acute hospital settings, is approaching 'end of life'. The DHB has begun a programme of work to replace this software and to move to one single system. Implementation will focus on 'best

[39] *The DHB's Quality Strategic Plan was developed within the context of the national document Improving Quality: A Systems Approach for the NZ Health and Disability Sector - the Plan is available online at www.cdhb.govt.nz.*

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 DHB's investigating the possibility of a single Pan-DHB electronic health record and the replacement of legacy Patient Administration Systems.

8.1.4 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 be more than contractual relationships. 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.

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 to over these determinants sits outside the health system. Our partnerships with agencies including the Mental Health Commission, Child, Youth and Family, Police, Housing NZ, the Ministries of Education and Social Development and the Accident Compensation Corporation (ACC) are vital in helping to create policies and social and physical environments that reduce the risk of ill health.

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.

Strategies to improve outcomes for those groups with the highest need means the DHB will prioritise work in settings and communities of high need such as education settings, workplaces and Māori and Pacific communities. The DHB also identifies and shares information about our population's health status and what affects it, and provides training and support for community groups to improving their effectiveness in dealing with health issues.

Partnerships with Primary and Community Health and Disability Service Providers

In addition to our own Hospital and Specialist Services Division, there are a many other health and disability service providers with whom the DHB contracts to provide services across the Canterbury district. The services provided include: general practice services, 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.

The DHB also contracts with PHO 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.

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

Regional DHB Partnerships

The six South Island DHBs have jointly established the South Island Shared Services Agency Limited (SISSAL) which works in partnership with them providing services such as: contract and provider management, audit and analysis, strategy and 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 own populations and the wider population of the South Island.

As other DHBs consider alternative and innovative ways of delivering services to cope with future demand, we all need to have input into planning that may impact directly on our ability to provide for our population. We are committed to regional collaboration to support strong clinical networks, provide clear long-term signals around service planning and enable better use of all DHB resources to improve and increase service delivery.

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 supports the 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 collaborate with each other and with the Ministry on national issues such as workforce and employment issues, procurement, information technology and long-term health services planning. DHB collaboration also occurs at all levels and across most professional groupings such as Chief Executives, Medical Directors, Nursing Directions, Planning and Funding General Managers, Finance Managers, Human Resource Management, Quality Management and Information Services.

8.1.5 ASSOCIATE AND SUBSIDIARY COMPANIES

The Canterbury DHB is a joint shareholder in SISSAL, which is wholly owned by the six South Island DHBs: Nelson Marlborough, West Coast, Southland, Otago, South Canterbury and the Canterbury DHB. SISSAL is funded by the DHBs to provide these services with an annual budget of around $2.8m and produces its own Statement of Intent.

The DHB also has two subsidiary companies, which as wholly owned subsidiaries, have their own Board of Directors and report on a regular basis to the DHB as their shareholder.

Brackenridge Estate Limited - Incorporated in 1998, Brackenridge Estate Limited provides residential care services and day programmes to people with intellectual disability and high dependency needs. Brackenridge operates twenty-three houses on the Brackenridge site and in the community.

Funding of Brackenridge comes from two sources; a contract directly with the Ministry and contracts with Child, Youth and Family Services. Brackenridge is currently working through a strategic planning process.

Canterbury Laundry Services - Canterbury Laundry Service Limited was incorporated as a company in February 1993. The Company acquired the laundry and linen supply operation from the former Canterbury Area Health Board - the shareholding was originally owned equally by the former Canterbury Health Limited and Healthlink South Limited. The Canterbury DHB now owns all shares. The Canterbury DHB appoints two directors to the Laundry Services Board.

The land and buildings used by the Company are located at Sylvan Street, Addington in Christchurch and are owned by the Canterbury DHB. Plant and equipment, motor vehicles and the rental linen pool are now the major fixed assets of the Company. A rental is paid for the use of the land and buildings to the Canterbury DHB.

The Canterbury DHB is continually assessing the role and efficiency of its subsidiaries to ensure efficiency for the DHB's core services.

8.2 Accountability - Reporting to the Minister of Health

As a Crown Entity, the DHB is responsible to the Minister of Health and is held accountable through a number of regular reporting streams including (but not limited to):

- 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;
- 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; and
- 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.

DHBs also produce an Annual Report which includes a Statement of Service Performance and financial statements outlining our performance during the year. The Annual Report is a public document and is tabled in Parliament. The Canterbury DHB's Annual Report is published on our website, www.cdhb.govt.nz.

We will 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 we will 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 District Annual Plan 2009/10.

Initiatives, such as reconfiguration of services, may warrant formal consultation with the Ministry. The DHB will identify any consultation needs and, in each instance, will meet our obligations, including consulting with the Minister of Health. The NZPHD Act specifies that consultation is required in relation to 1) the development of, and changes to, the District Strategic Plan; 2) changes to the District Annual Plan; and 3) the disposal of land.

9. APPENDICES

- Appendix 1: Glossary of Terms.
- Appendix 2: Objectives of a DHB – New Zealand Public Health and Disability Act 2000
- Appendix 3: Hospital and Specialist Services Overview
- Appendix 4: Canterbury DHB Organisational Chart
- Appendix 5: Canterbury DHB Quality Strategic Plan Goals 2007-2010
- Appendix 6: Statement of Accounting Policies.

References

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

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

The following two documents referenced in this Statement of Intent are available on the Treasury website (www.treasury.govt.nz):

- Crown Entities Act 2004; and
- Public Finance Act 1989.

APPENDIX 1: 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.

APPENDIX 2. OBJECTIVES OF A DHB – NEW ZEALAND PUBLIC HEALTH AND DISABILITY ACT 2000.

Part 3: Section 22:

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

APPENDIX 3. 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.

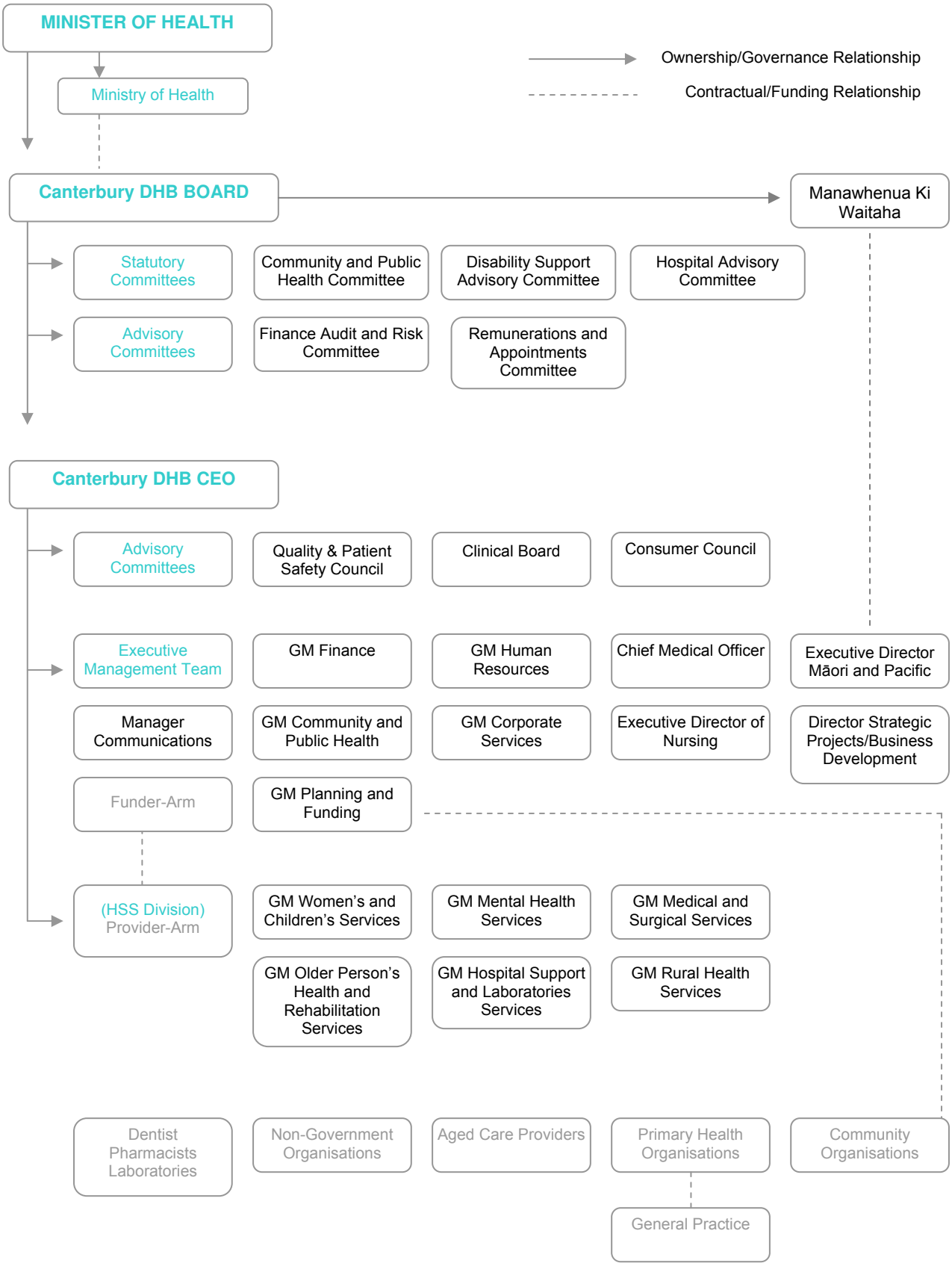
ASHBURTON AND RURAL HEALTH SERVICES

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.

APPENDIX 4. CANTERBURY DHB - ORGANISATIONAL CHART.



APPENDIX 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

APPENDIX 6. STATEMENT OF ACCOUNTING POLICIES.

The Canterbury DHB will adopt the following accounting policies consistently during the year and apply these policies for the Annual Accounts. In accordance with the NZ Institute of Chartered Accountants Financial Reporting Standard 42 *Prospective Financial Statements (issued 2005*), the following information is provided in respect of the Statement of Intent:

(i) Cautionary Note

The Statement of Intent's financial information is prospective. Actual results are likely to vary from the information presented, and the variations may be material.

(ii) Nature of Prospective Information

The financial information presented consists of forecasts that have been prepared on the basis of best estimates and assumptions on future events that the Canterbury DHB expects to take place.

(iii) Assumptions

The main assumptions underlying the forecast are noted in Section 6 of the SOI.

New Zealand Equivalents to International Financial Reporting Standards (NZIFRS)

FRS-42 states that the (prospective) forecast statements for an upcoming financial year should be prepared using the same standards as the statements at the end of that financial year.

The prospective (forecast) financial statements in this SOI have been prepared in accordance with the New Zealand Equivalents to International Financial Reporting Standards (NZIFRS).

REPORTING ENTITY AND STATUTORY BASE

Canterbury DHB ("Canterbury DHB") is a Health Board established by the New Zealand Public Health and Disability Act 2000. Canterbury DHB is a Crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand. Canterbury DHB is a Reporting Entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Financial Reporting Act 1993, Public Finance Act 1989, and the Crown Entities Act 2004.

Canterbury DHB has designated itself and its subsidiaries, as public benefit entities, as defined under New Zealand International Accounting Standard 1 (NZ IAS 1).

The consolidated financial statements of Canterbury DHB consists of Canterbury DHB, its subsidiaries Canterbury Laundry Service Ltd (100% owned) and Brackenridge Estate Ltd (100% owned), and associate entities, New Zealand Centre for Reproductive Medicine Ltd (50% owned) and South Island Shared Services Agency Ltd (47% owned).

In addition, funds administered on behalf of patients have been reported in the financial statements.

NATURE OF OPERATIONS

Canterbury DHB's primary objective is to deliver health and disability services and mental health services in a variety of ways to the Canterbury community.

STATEMENT OF COMPLIANCE

The consolidated financial statements have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000 and Section 154 of the Crown Entity Act 2004, which includes the requirement to comply with New Zealand generally accepted accounting practice (NZ GAAP). In accordance with NZ GAAP, the consolidated financial statements comply with New Zealand equivalents to International Financial Reporting Standards (NZ IFRS), and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

These are Canterbury DHB's first NZ IFRS financial statements. NZ IFRS 1 has been applied, and comparatives for the year ended 30 June 2008 have been restated to NZ IFRS accordingly.

SIGNIFICANT ACCOUNTING POLICIES

BASIS OF PREPARATION

The financial statements are presented in New Zealand dollars (NZD), rounded to the nearest thousand. The functional currency of Canterbury DHB is New Zealand dollars.

The accounting policies set out below have been applied consistently to all periods presented in these consolidated financial statements and in preparing an opening NZ IFRS statement of financial position at 1 July 2006 for the purposes of the transition to NZ IFRS.

The preparation of financial statements in conformity with NZ IFRS requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, income and expenses. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of making the judgements about carrying values of assets and liabilities that are not readily apparent from other sources. These estimates and assumptions may differ from the actual results. The estimates and underlying assumptions are reviewed on an ongoing basis.

The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amount of assets and liabilities within the next financial year are discussed below:

Property, plant and equipment useful lives and residual value

At each balance date Canterbury DHB reviews the useful lives and residual values of its property, plant and equipment. Assessing the appropriateness of useful life and residual value estimates of property, plant and equipment requires Canterbury DHB to consider a number of factors such as the physical condition of the asset, expected period of use of the asset by Canterbury DHB, and expected disposal proceeds from the future sale of the assets.

An incorrect estimate of the useful life or residual value will impact the depreciation expense recognised in the statement of financial performance, and carrying amount of the asset in the statement of financial position. Canterbury DHB minimises the risk of this estimation uncertainty by:

- Physical inspection of assets;
- Asset replacement programs;
- Review of second hand market prices for similar assets; and
- Analysis of prior asset sales.

Canterbury DHB has not made significant changes to past assumption concerning useful lives and residual values.

Retirement and long service leave

The present value of the retirement and long service leave obligations depend on a number of factors that are determined on an actuarial basis using a number of assumptions. Two key assumptions used in calculating this liability include the discount rate and the salary inflation factor. Any change in these assumptions will impact on the carrying amount of the liability.

Management has exercised the following critical judgements in applying Canterbury DHB's accounting policies for the period ended 30 June 2008:

Leases classification

Determining whether a lease agreement is a finance or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to Canterbury DHB.

Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased assets, whether or not to include renewal options in the lease term and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant and equipment, whereas for an operating lease no such asset is recognised.

Canterbury DHB has exercised its judgement on the appropriate classification of its leases and, has determined all leases arrangements are operating leases.

Non-government grants

Canterbury DHB must exercise judgement when recognising grant income to determine if conditions of the grant contract have been satisfied. This judgement will be based on the facts and circumstances that are evident for each grant contract.

MEASUREMENT BASIS

The financial statements are prepared on the historical cost basis except that the following assets and liabilities are stated at their fair value: derivative financial instruments (foreign exchange and interest rate swap contracts), financial instruments classified as available-for-sale, and land and buildings.

Non-current assets held for sale and disposal groups held for sale are stated at the lower of carrying amount and fair value.

SPECIFIC ACCOUNTING POLICIES

Subsidiaries

Subsidiaries are entities controlled by Canterbury DHB. Control exists when Canterbury DHB has the power, directly or indirectly, to govern the financial and operating policies of an entity so as to obtain benefits from its activities. In assessing control, potential voting rights that presently are exercisable or convertible are taken into account. The financial statements of subsidiaries are included in the consolidated financial statements from the date that control commences until the date that control ceases.

Canterbury DHB measures the cost of a business combination as the aggregate of the fair values, at the date of exchange, of assets given, liabilities incurred or assumed, in exchange for control of subsidiary plus any costs directly attributable to the business combination.

Basis for Consolidation

The purchase method is used to prepare the consolidated financial statements, which involves adding together like items of assets, liabilities, equity, income and expenses on a line-by-line basis. All significant intragroup balances, transactions, income and expenses are eliminated on consolidation.

Canterbury DHB's investments in its subsidiaries are carried at cost in the Canterbury DHB's own "parent entity" financial statements.

Associates

Associates are those entities in which Canterbury DHB has significant influence, but not control, over the financial and operating policies.

The consolidated financial statements include Canterbury DHB's share of the total recognised gains and losses of associates on an equity accounted basis, from the date that significant influence commences until the date that significant influence ceases. When Canterbury DHB's share of losses exceeds its interest in an associate, Canterbury DHB's carrying amount is reduced to nil and recognition of further losses is discontinued except to the extent that Canterbury DHB has incurred legal or constructive obligations or made payments on behalf of an associate.

Canterbury DHB's investments in associates are carried at cost in Canterbury DHB's own "parent entity" financial statements.

Transactions eliminated on consolidation

Intragroup balances and any unrealised gains and losses or income and expenses arising from intragroup transactions, are eliminated in preparing the consolidated financial statements. Unrealised gains arising from transactions with associates are eliminated to the extent of Canterbury DHB's interest in the entity. Unrealised losses are eliminated in the same way as unrealised gains, but only to the extent that there is no evidence of impairment.

Foreign currency

Transactions in foreign currencies are translated at the foreign exchange rate ruling at the date of the transaction.

Monetary assets and liabilities denominated in foreign currencies at the balance sheet date are translated to NZD at the foreign exchange rate ruling at that date. Foreign exchange differences arising on translation are recognised in the statement of financial performance.

Non-monetary assets and liabilities that are measured in terms of historical cost in a foreign currency are translated using the exchange rate at the date of the transaction. Non-monetary assets and liabilities denominated in foreign currencies that are stated at fair value are translated to NZD at foreign exchange rates ruling at the dates the fair value was determined.

Budget figures

The budget figures are those approved by the Canterbury DHB in its District Annual Plan and included in the Statement of Intent tabled in parliament. The budget figures have been prepared in accordance with NZ IFRS, using accounting policies that are consistent with those adopted by Canterbury DHB for the preparation of these financial statements.

Property, plant and equipment

Classes of property, plant and equipment

The major classes of property, plant and equipment are as follows:

- freehold land
- freehold buildings and building fitout
- leasehold building
- plant, equipment and vehicles
- work in progress

Owned assets

Except for land and buildings and the assets vested from the hospital and health service (see below), items of property, plant and equipment are stated at cost, less accumulated depreciation and impairment losses.

Land, buildings and building fitout are revalued to fair value as determined by an independent registered valuer, with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every five years. Any increase in value of a class of land and buildings is recognised directly to equity unless it offsets a previous decrease in value recognised in the statement of financial performance. Any decreases in value relating to a class of land and buildings are debited directly to the revaluation reserve,

to the extent that they reverse previous surpluses and are otherwise recognised as an expense in the statement of financial performance. Additions to land and buildings between valuations are recorded at cost.

Where material parts of an item of property, plant and equipment have different useful lives, they are accounted for as separate components of property, plant and equipment.

Fixed Assets Vested from the Hospital and Health Service

Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets and liabilities of Canterbury Health Ltd were vested in Canterbury DHB on 1 January 2001. Accordingly, assets were transferred to Canterbury DHB at their net book values as recorded in the books of Canterbury Health Ltd. In effecting this transfer, the DHB has recognised the cost/valuation and accumulated depreciation amounts from the records of Canterbury Health Ltd. The vested assets will continue to be depreciated over their remaining useful lives.

Additions

The cost of an item of property, plant and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to Canterbury DHB and the cost of the item can be measured reliably.

Where an asset is acquired at no cost, or for a nominal cost, it is recognised at fair value when control over the asset is obtained.

Subsequent costs

Subsequent costs are added to the carrying amount of an item of property, plant and equipment when that cost is incurred if it is probable that the service potential or future economic benefits embodied within the new item will flow to Canterbury DHB. All other costs are recognised in the statement of financial performance as an expense is incurred.

Disposal of Property, Plant and Equipment

Where an item of plant and equipment is disposed of, the gain or loss recognised in the statement of financial performance is calculated as the difference between the net sales price and the carrying amount of the asset.

When revalued assets are sold, the amounts included in revaluation reserves in respect of those assets are transferred to general funds.

Donated Assets

Donated assets are recorded at the best estimate of fair value and recognised as income. Donated assets are depreciated over their expected lives in accordance with rates established for other fixed assets.

Depreciation

Depreciation is charged to the statement of financial performance using the straight line method so as to write off the cost or valuation of fixed assets above $2,000 to their estimated residual value over their expected economic life. Assets below $2,000 are written off in the month of purchase. Land is not depreciated.

The estimated useful lives of major classes of assets and resulting rates are as follows:

Class of Asset	Years	Depreciation Rate
Freehold Buildings & Fitout	10 – 50	2-10%
Leasehold Building	3 – 20	5-33%
Plant, Equipment and Vehicles	3 – 12	8.3-33%

The residual value of assets is reassessed annually. Work in progress is not depreciated. The total cost of a project is transferred to the appropriate class of asset on its completion and then depreciated.

Intangible assets

Software development and acquisition

Expenditure on software development activities, whereby the new or substantially improved software and processes, is capitalised if the product or process is technically and operationally feasible and Canterbury DHB has sufficient resources to complete development. The expenditure capitalised includes the cost of materials, direct labour and an appropriate proportion of overheads. Other development expenditure is recognised in the statement of financial performance as an expense as incurred. Capitalised development expenditure is stated at cost less accumulated amortisation and impairment losses.

Acquired computer software licences are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

Amortisation

Amortisation is charged to the statement of financial performance on a straight-line basis over the estimated useful lives of intangible assets with finite lives. Such intangible assets are amortised from the date they are available for use. The estimated useful lives are as follows:

Type of asset	Estimated life	Amortisation rate
Software	2 years	50%

Investments

Financial instruments held for trading are classified as current assets and are stated at fair value, with any resultant gain or loss recognised in the statement of financial performance.

Other financial instruments held are classified as being available-for-sale and are stated at fair value, with any resultant gain or loss being recognised directly in equity, except for impairment losses and foreign exchange gains and losses. When these investments are derecognised, the cumulative gain or loss previously recognised directly in equity is recognised in the statement of financial performance. Where these investments are interest-bearing, interest calculated using the effective interest method is recognised in the statement of financial performance.

Financial assets classified as held for trading or available-for-sale are recognised / derecognised on the date the DHB commits to purchase / sell the investments.

Trade and other receivables

Trade and other receivables are initially recognised at fair value and subsequently stated at amortised cost less any provision for impairment. Bad debts are written off during the period in which they are identified.

Inventories

Inventories held for distribution, or consumption in the provision of services, that are not issued on a commercial basis are measured at the lower of cost (calculated using the weighted average cost method) and current replacement cost. Where inventories are acquired at no cost or for nominal consideration, the cost is the current replacement cost at the date of acquisition.

Other inventories are stated at the lower of cost (calculated using the weighted average method) and net realisable value. Net realisable value is the estimated selling price in the ordinary course of business, less the estimated costs of completion and selling expenses.

Cash and cash equivalents

Cash and cash equivalents comprises cash balances, call deposits and deposits with a maturity of no more than three months from the date of acquisition. Bank overdrafts that are repayable on demand and form an integral part of cash management are included as a component of cash and cash equivalents for the purpose of the statement of cash flows, but are shown within borrowings in current liabilities in the statement of financial position.

Impairment

The carrying amounts of Canterbury DHB's assets other than inventories are reviewed at each balance date to determine whether there is any indication of impairment. If any such indication exists, the assets' recoverable amounts are estimated.

If the estimated recoverable amount of an asset is less than its carrying amount, the asset is written down to its estimated recoverable amount and an impairment loss is recognised in the statement of financial performance.

For revalued assets the impairment loss is recognised directly against the revaluation reserve for that class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in the statement of financial performance.

An impairment loss on property, plant and equipment revalued on a class of asset basis is recognised directly against any revaluation reserve in respect of the same class of asset to the extent that the impairment loss does not exceed the amount in the revaluation reserve for the same class of asset, at which point it is recognised in the statement of financial performance.

When a decline in the fair value of an available-for-sale financial asset has been recognised directly in equity and there is objective evidence that the asset is impaired, the cumulative loss that had been recognised directly in equity is recognised in the statement of financial performance even though the financial asset has not been derecognised. The amount of the cumulative loss that is recognised in the statement of financial performance is the difference between the acquisition cost and current fair value, less any impairment loss on that financial asset previously recognised in the statement of financial performance.

The estimated recoverable amount of receivables carried at amortised cost is calculated as the present value of estimated future cash flows, discounted at their original effective interest rate. Receivables with a short duration are not discounted.

Estimated recoverable amount of other assets is the greater of their fair value less costs to sell and value in use. The value in use is the depreciated replacement cost for an asset where the future economic benefits or service potential of the asset are not primarily dependent on asset's liability to generate net cash inflows and where Canterbury DHB would, if deprived of the asset, replace its reminding future economic benefits or service potential.

The reversal of an impairment loss on a revalued asset is credited to the revaluation reserve. However, to the extent that an impairment loss for that class of asset was previously recognised in the statement of financial performance, a reversal of the impairment loss is also recognised in the statement of financial performance.

Impairment losses are reversed when there is a change in the estimates used to determine the recoverable amount.

An impairment loss on an equity instrument investment classified as available-for-sale or on items of property, plant and equipment carried at fair value is reversed through the relevant reserve. All other impairment losses are reversed through the statement of financial performance.

Borrowings

Borrowings are recognised initially at fair value. Subsequent to initial recognition, borrowings are stated at amortised cost with any difference between cost and redemption value being recognised in the statement of financial performance over the period of the borrowings on an effective interest basis.

Employee benefits

Defined contribution plans

Obligations for contributions to defined contribution plans are recognised as an expense in the statement of financial performance as incurred.

Defined benefit plans

Canterbury DHB makes contributions to the DBP Contributors Scheme (the scheme), which is a multi-employer defined benefit scheme.

Insufficient information is available to use defined benefit accounts, as it is not possible to determine from the terms of the scheme, the extent to which the surplus/deficit will affect future contributions by individual employers, as there is no prescribed basis for allocations. The scheme is therefore accounted for as a defined contribution scheme.

Long service leave, sabbatical leave, retirement gratuities and sick leave

Canterbury DHB's net obligation in respect of long service leave, sabbatical leave and retirement gratuities is the amount of future benefit that employees have earned in return for their service in the current and prior periods. The obligation is calculated using the projected unit credit method and is discounted to its present value. The discount rate is the market yield on relevant New Zealand government bonds at the year end date. Canterbury DHB accrues the obligation for paid absences when the obligation both relates to employees' past services and it accumulates. Sick leave amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date; to the extent Canterbury DHB anticipates it will be used by staff to cover those future absences.

Annual leave, conference leave and medical education leave

Annual leave, conference leave and medical education leave are short-term obligations and are measured at undiscounted nominal values based on accrued entitlements at current rates for pay.

Provisions

A provision is recognised when Canterbury DHB has a present legal or constructive obligation as a result of a past event, and it is probable that expenditures will be required to settle the obligation. If the effect is material, provisions are determined by discounting the expected future cash flows at a pre-tax rate that reflects current market rates and, where appropriate, the risks specific to the liability.

ACC Partnership Programme

Canterbury DHB belongs to the ACC Partnership Programme whereby the DHB accepts the management and financial responsibility for employee work related illnesses and accidents. Under the programme the DHB is liable for all its claims costs for a period of two years up to a specified maximum. At the end of the two year period, the DHB pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC.

The liability for the ACC Partnership Programme is measured using actuarial techniques at the present value of expected future payments to be made in respect of the employee injuries and claims up to the reporting date. Consideration is given to anticipated future wage and salary levels and experience of employee claims and injuries. Expected future payments are discounted using market yields on government bonds at balance date with terms to maturity that match, as closely to possible, the estimated future cash outflows.

Trade and other payables

Trade and other payables are initially measured at fair value and subsequently stated at amortised cost using the effective interest rate.

Derivative financial instruments

Canterbury DHB uses foreign exchange and interest rate swaps contracts to hedge its exposure to foreign exchange and interest rate risks arising from operational and financing activities. The DHB does not hold these financial instruments for trading purposes and has not adopted hedge accounting.

Derivative financial instruments are recognised initially at fair value. Subsequent to initial recognition, derivative financial instruments are remeasured to fair value at each balance date. The gain or loss on remeasured to fair value is recognised immediately in the statement of financial performance.

Income tax

DHB is a crown entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under section CB3 of the Income Tax Act 1994.

Goods and services tax

All amounts are shown exclusive of Goods and Services Tax (GST), except for receivables and payables that are stated inclusive of GST. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

Revenue

Revenue is measured at the fair value of consideration received or receivable.

Revenue relating to service contracts

Canterbury DHB is required to expend all monies appropriated within certain contracts during the year in which it is appropriated. Should this not be done, the contract may require repayment of the money or Canterbury DHB, with the agreement of the Ministry of Health, may be required to expend it on specific services in subsequent years. The amount unexpended is recognised as a liability

Services rendered

Revenue from services is recognised, to the proportion that a transaction is complete, when it is probable that the payment associated with the transaction will flow to Canterbury DHB and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by Canterbury DHB.

Interest income

Interest income is recognised using the effective interest method. Interest income on an impaired financial asset is recognised using the original effective interest rate.

Operating lease payments

Payments made under operating leases are recognised in the statement of financial performance on a straight-line basis over the term of the lease. Lease incentives received are recognised in the statement of financial performance over the lease term as an integral part of the total lease expense.

Non-current assets held for sale

Non-current assets held for sale are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. Non-current assets held for sale are measured at the lower of their carrying amount and fair value less costs to sell.

Any impairment losses for write-downs of non-current assets held for sale are recognised in the statement of financial performance.

Any increases in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised.

Non-current assets held for sale (including those that are part of disposal group) are not depreciated or amortised while they are classified as held for sale.

Borrowing costs

Borrowing costs are recognised as an expense in the period in which they are incurred.

Standards, amendments and interpretations issued that are not yet effective and have not been early adopted

Standards, amendments and interpretations issued but not yet effective that have not been early adopted and which are relevant to Canterbury DHD include:

- NZ IAS 1 *Presentation of Financial Statements (revised 2007)* relaces NZ IAS 1 *Presentation of Financial Statements (issued 2004)* and is effective for reporting periods beginning on or after 1 January 2009. The revised standard requires information in financial

statements to be aggregated on the basis of shared characteristics and introduces a statement of comprehensive income. The statement of comprehensive income will enable readers to analyse changes in equity resulting from non-owner changes separately from transactions with the Crown in its capacity as "owner". The revised standard gives Canterbury DHB the option of presenting items of income and expense and components of other comprehensive income either in a single statement of comprehensive income with subtotals, or in two separate statements (a separate income statement followed by a statement of comprehensive income). Canterbury DHB intends to adopt this standard for the year ending 30 June 2010, and is yet to decide whether it will prepare a single statement of comprehensive income or a separate income statement followed by a statement of comprehensive income.

- NZ IAS 23 *Borrowing Costs (revised 2007)* replaces NZ IAS 23 *Borrowing Costs (issued 2004)* and is effective for reporting periods commencing on or after 1 January 2009. The revised standard requires all borrowing costs to be capitalised if they are directly attributable to the acquisition, construction or production of a qualifying asset. Canterbury DHB intends to adopt this standard for the year ending 30 June 2010 and has not yet determined the potential impact of the new standard.
- NZ specific amendment to NZ IAS 2 *Inventories.* In November 2007 the New Zealand Accounting Standards Review Board approved an amendment to NZ IAS 2 *Inventories*, which requires public benefit entities to measure inventory held for distribution at cost, adjusted when applicable for any loss of service potential. Prior to the amendment, public benefit entities were required to measure inventories held for distribution at the lower of cost and current replacement cost. Application of the amendment is mandatory for reporting periods beginning on or after 1 January 2008. Canterbury DHB will adopt the amended standard for the year ending 30 June 2009 and expects the impact of adopting the new standard to be minimal.

STATEMENT OF INTENT
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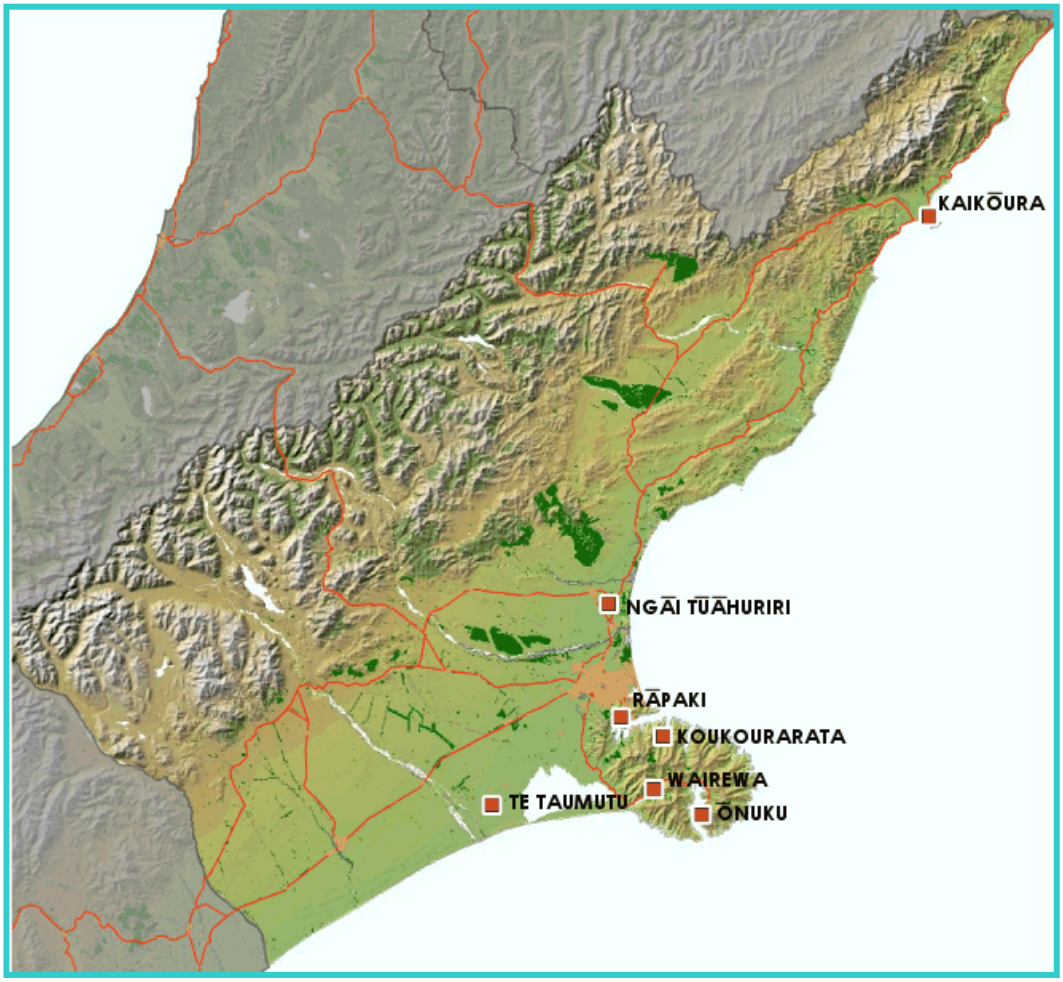

Picture highlights the Canterbury DHB region and the seven Ngāi Tahu Rununga within the region.