2018/19-2021/2022

Canterbury District Health Board

Statement of Intent

Incorporating the 2018/19 Statement of Performance Expectations

Statement of Joint Responsibility

The Canterbury District Health Board (DHB) is one of 20 DHBs established under the New Zealand Public Health and Disability Act in 2001. Each DHB is categorised as a Crown Entity under the Crown Entities Act, and is accountable to the Minister of Health for the funding and provision of public health and disability services for their resident populations.

This document is our Statement of Intent which has been prepared to meet the requirements of the New Zealand Public Health and Disability Act, Crown Entities Act, Public Finance Act and the expectations of the Minister of Health.

The Statement of Intent sets out our strategic goals and objectives and describes what we aim to achieve in terms of improving the health of our population and in ensuring the sustainability of our health system. It also contains our Statement of Performance Expectations for the coming year.

The Statement of Performance Expectation is presented to Parliament and used at the end of the year to compare planned and actual performance. Audited results are presented in the DHB's Annual Report.

In line with the New Zealand Health Strategy, the Canterbury DHB has made a strong commitment to 'whole of system' service planning. We work in partnership with other service providers and actively engage with individuals, their families and our community, to design and deliver service solutions to meet changing needs.

Clinically-led alliances have been established as vehicles for implementing system change. Our alliance framework means we share a joint vision for the health system with our alliance partners and agree to work together to improve health outcomes for our shared population. This includes our large-scale Canterbury Clinical Network (CCN) District Alliance, with twelve local provider partners, the South Island Regional Alliance with our four partner South Island DHBs and our transalpine partnership with the West Coast DHB.

The DHB recognises its role in actively addressing disparities in health outcomes for Māori and is committed to making a difference. We work closely with Manawhenua Ki Waitaha, both directly and through the CCN Alliance, to improve outcomes for Māori in a spirit of communication and co-design that encompasses the principles of the Treaty of Waitangi.

In signing this document, we are satisfied that it fairly represents our joint commitment and intentions for the coming year, and is in line with Government expectations for 2018/19.

Dr John Wood
CHAIR | CANTERBURY DHB

Ta Mark Solomon
DEPUTY CHAIR | CANTERBURY DHB

David Meates
CHIEF EXECUTIVE | CANTERBURY DHB

November 2018

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Part I

Overview

Who are we and what do we do?

Foreword from the Chair and Chief Executive

For the last six years, the Canterbury DHB has been engaged in responding to the after-effects of the earthquakes and dealing with complex facilities repairs and redevelopment challenges across our hospital sites. This has absorbed considerable leadership and management focus and has presented significant challenges for the day-to-day delivery of services.

In a joint statement, issued in May, the Ministry acknowledged the exemplary response of our health system to New Zealand's largest natural disaster and the extreme nature of the challenges we have faced.

The Ministry has also acknowledged the ongoing impact of the earthquake on the health and wellbeing of our population and our organisation. We have agreed an approach for working together to establish a sustainable pathway forward, which will build on the proven strengths of our health system.

The DHB continues to review services and service models to ensure we are using our resources in the most effective way. While there will be some hard decisions to make and many challenges still ahead, we look at the coming year as one of opportunity, clarity and forward momentum.

Commitment to Wellbeing

In responding to our increased health need, the Government has made a considerable investment in children's mental wellbeing and enabled the launch of Canterbury's Mana Ake (Stronger for Tomorrow) mental health support in schools initiative.

Through the Mana Ake initiative we will provide earlier intervention for children and their families/Whānau, experiencing ongoing issues impacting on their wellbeing, and practical support for teachers. Working with our partners in education, Police, Oranga Tamariki and community support, Mana Ake is an opportunity to come together not just as a health system but as a health and social services system. Being progressively rolled out to all primary schools across our district, Mana Ake will enable us to make a real difference for our more vulnerable young people.

Commitment to Our People

Canterbury is rich through its people who remain passionate and committed to our health system and the people we serve. We recognise the contribution that everyone working in our health system has made in the face of extraordinary challenges and the additional challenges they face. Our People Strategy will gain momentum in the coming year, creating an environment where our people can thrive and making sure the wellbeing of our people is prioritised.

Facilities Direction

The Outpatients building is scheduled for completion in late 2018 and the Acute Services Building is scheduled for completion in late 2019. This will allow us to regain some of the capacity lost after the earthquakes, support the co-location of aligned services and more efficient models of care, and improve the environment for both patients and staff.

We also anticipate clear direction will be given around our other major facilities and the future of almost all of the buildings on the Christchurch Hospital Campus in the next 12-18 months. This will allow the DHB to move forward with certainty and purpose.

Sector Direction

Over the past six months there has been clear acknowledgement that the multitude of pressures facing the health sector mean health services cannot continue to be provided in the same way. A number of national reviews are underway to provide advice on what the future of the health sector could look like.

We believe it is healthy to be asking ourselves tough questions about what we do and how we do it. This is core to our alliancing approach and this reflection has supported some of the most effective and innovative transformation across our system. We will actively participate in the national sector reviews in 2018/19 and encourage input from across our system.

The Coming Year

It has been quite a journey. When we first came together with our health system partners in 2008, we wanted to own our challenges and establish a collective vision for the Canterbury health system. We didn't know how important our shared commitment would become.

While our challenges have been many, our vision and our strategic direction remains the same. People are at the centre of everything we do. Through all of our work plans there is a clear recognition of the needs of our population, a desire to provide safe, equitable and effective care, and a focus on supporting people to be well and healthy in their own homes and communities.

Our goals for the coming year are highlighted in this document, in our Annual Plan, and in the joint System Level Measures Improvement Plan developed with our health system partners for 2018/19.

Dr John Wood
Chair

David Meates
Chief Executive

Introducing the Canterbury DHB

1.1 Who are we

The Canterbury District Health Board (DHB) is one of twenty DHBs in New Zealand charged by the Crown with improving, promoting and protecting the health and independence of their resident populations.

Canterbury is the second largest DHB in the country, both geographically and by population size.

We are responsible for a population of 567,870 people, 11.5% of the total NZ population, and cover 26,881 square kilometres and six Territorial Local Authorities.

We provide the second largest number of elective surgeries in the country and deliver half of all the elective surgery provided in the South Island

The Canterbury DHB owns and operates six major hospital facilities: Christchurch, Christchurch Women's, Hillmorton, Burwood, Princess Margaret and Ashburton and many smaller rural facilities.

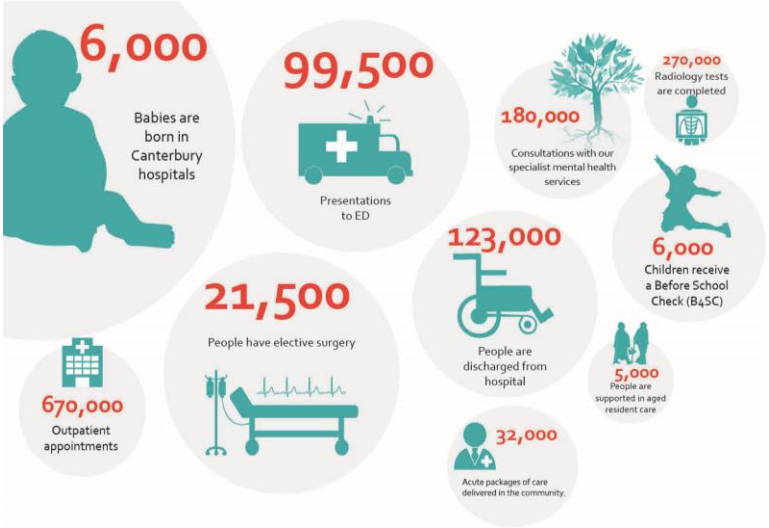
We employ more than 9,500 people across the DHB, making us the largest employer in the South Island.

We also hold and monitor over 1,000 service contracts and agreements with other organisations and individuals who provide health services for our population. This includes the three Primary Health Organisations in Canterbury, as well as general practice and private hospital, laboratory, pharmacy, mental health, home based support, district nursing, residential and aged care service providers.

Inclusion of the Chatham Islands

Since June 2015, Canterbury has also been responsible for the Chatham Islands population. The islands are located 840km east of Christchurch with a population of 610 people.

In an Average Canterbury Year



1.2 What do we do

Like all DHBs, we receive funding from Government with which to purchase and provide the services required to meet the needs of our population and we are expected to operate within allocated funding.

In accordance with legislation and government objectives, we use that funding to:

Plan the strategic direction of our health system and, in collaboration with clinical leaders and alliance partners, determine the services required to meet the needs of our population.

Fund the health services required to meet the needs of our population and, through collaborative partnerships and performance monitoring, ensure these services are safe, equitable, integrated and effective.

Provide a significant share of the specialist health and disability services delivered to our population, and to the population of other DHBs, where more specialised or higher-level services are not available.

Promote and protect our population's health and wellbeing through investment in health protection, promotion and education services and delivery of evidence-based public health initiatives.

1.3 Our regional role

Canterbury provides an extensive range of highly specialised services to people from other DHBs where the service or treatment is not available. We also deliver specialist clinics and surgery in other regions to support people throughout the South Island to receive care as close to home as possible.

In 2016/17, almost 7,000 people from other regions were discharged from one of our hospitals and over 14,000 people had an outpatient appointment.

This regional demand is complex in nature and growing steadily. In the five years to June 2017, there was a 19% increase in hospital admissions and a 31% increase in demand for outpatient appointments for people referred by other DHBs.

The services we provide on a regional basis include: eating disorder services, brain injury rehabilitation, child and youth inpatient mental health services, and neonatal, cardiothoracic, neurosurgery, paediatric oncology, endocrinology, mental health forensic and spinal services.

Our laboratory service (Canterbury Health Laboratories) is one of only two tertiary level diagnostic and reference laboratories in the country. In a typical year the service completes over four million diagnostic tests, which inform 60-70% of the critical clinical decisions made across out health system.

1.4 Our population profile

The Canterbury region has undergone rapid population changes post-quake. Despite an initial dip in our population, the population has returned and we are now experiencing a greater growth rate than predicted prior to the earthquakes.

There has been a 13.6% increase in our population over the past ten years. We had not anticipated reaching current population levels until 2025/26.

There has also been a steady increase in the average age of our population—one of the biggest ongoing challenges for our health system. Canterbury has the largest total population aged over 65 in the country.

The latest DHB population figures show 15.9% of our population are aged over 65, a total of 90,120 people.

Many conditions become more common with age, including heart disease, cancer, stroke and dementia. As people age they develop more complicated health needs and are more likely to need specialist services. Our ageing population will put significant pressure on our workforce and infrastructure.

Like age, ethnicity is also a strong indicator of need for health services and some populations are more vulnerable to poor health outcomes than others.

Canterbury has the second fastest growing Māori population in the country and the sixth largest by total population of all 20 DHBs. There are currently 51,840 Māori living in Canterbury and by 2026 they will represent 10% of our population.

Our Māori population has a considerably younger age structure, with 42% of our total Māori population aged under 20 compared to 24% of the total Canterbury population.

1.5 Our population's health

Canterbury's population continues to have a slightly higher life expectancy. However, like the rest of New Zealand, more Cantabrians are living longer with long-term conditions such as cancer, heart disease, respiratory disease and depression leading to an increasing demand for health services.

While gains have been made, Māori continue to have poorer overall health status than non-Māori in Canterbury.

A reduction in known risk factors, such as poor diet, smoking, hazardous drinking and lack of physical activity, could dramatically reduce the impact of these conditions on our population, and reduce the burden on our health system.

All four major risk factors have clear socio-economic gradients. Taking a strong population health focus is an essential component of our strategy to address the determinants of health and achieve better health equity and wellbeing across our population. This also presents an opportunity for our health system to work collaboratively to improve health outcomes.

The most recent results from the 2014-2017 New Zealand Health Survey found:

- 28% of our adult population are classified as obese and rates amongst our Māori (46%) and Pacific (59%) populations are significantly higher.
- 20% of our adult population identified as likely to drink in a hazardous manner (one in five).
- 15% of our total population are current smokers with smoking rates for our Māori (40%) and Pacific (37%) populations significantly higher.
- 11% of our total population identified as inactive (having little or no physical activity). Rates amongst Māori (12%) and Pacific (15%) are slightly higher.

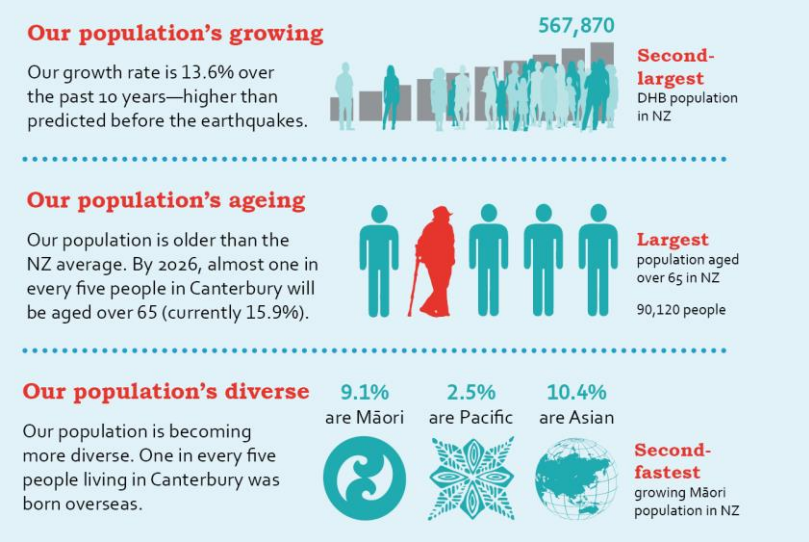
Community and Public Health is the division of the DHB that delivers public health services and takes the lead in the development of public health strategies and initiatives to make healthier choices easier.

EARTHQUAKE IMPACTS

The NZ Health Survey also reported that 23% of our population have been diagnosed with a mood or anxiety disorder, compared to just 19% of the population nationally.

While new research indicates some sections of our population are coping with the psychological impact of the earthquakes and thriving in their lives, there is increasing divergence in our community with a marked increase in demand for mental health support.

International disaster research suggests we can expect to see continued mental health service demand from some population groups for upwards of a decade. The long-term health impacts for children are particularly worrying. Supporting young people's wellbeing is a major focus for our health system.



Our Operating Challenges

Like health systems world-wide, the shared challenges DHBs are facing are well understood. Populations are ageing, service demand is increasing, treatment costs are rising, and workforce shortages are ever-present. Increasing pressure on government funding also means we are having to do more with less.

While Canterbury has made real inroads in achieving a truly integrated health system, meeting the health needs of a large population is complex. Progress is hampered by the unique operational challenges we have faced following the earthquakes.

1.6 A post-earthquake environment

POPULATION PRESSURES

Following the earthquakes, our population growth has been rapid, with a 13.6% increase over the past ten years. Only three years ago, predictions showed our population not reaching current levels until 2025/26.

While this population growth is a positive for our economic recovery and confidence in the region, it is a major challenge for our health system. We are working hard to find a balance between the increasing needs of our growing population, and the workforce, infrastructure, and funding resources at our disposal.

DEMAND PRESSURES

Seven years on from the first major earthquakes, service demand patterns have changed.

Prolonged levels of stress and anxiety are exacerbating chronic illness and negatively impacting on the health and wellbeing of our population. Increased demand is evident across our system, particularly in mental health services.

As a major tertiary (specialist) provider, we are also dealing with an increasing level of demand for highly complex and resource-intensive services coming from neighbouring DHBs. Our theatres, intensive care, radiology and oncology services are under particular pressure.

We have implemented a number of intervention strategies to reduce this growing demand, but it remains a significant issue. Our health system is at full capacity and resources are stretched.

FACILITIES PRESSURES

The earthquake damage to our infrastructure was extensive and repair strategies are not simple. Ongoing delays with delivering major redevelopment projects mean it will be November before Outpatients is complete and another year before construction of the Acute Services Building is finished.

In the meantime, the DHB is having to cope with fewer hospital beds and a shortage of theatres. We are hiring theatres for our staff to work in and outsourcing more surgeries, to ensure we can meet service demand and delivery expectations. The increased service costs are not sustainable and construction delays are placing additional pressure on staff and budgets.

Our growing population and increased service demands are compounding this pressure. The DHB is already having to look for solutions to increase capacity beyond what will be restored once the redevelopment programmes are complete.

At the same time, we are trying to deliver a substantial earthquake repair and seismic remediation programme. The future use of our major facilities needs to be determined and aligned with the repair programme to avoid wasteful investment in short-term solutions and ensure the safety or our staff and patients.

WORKFORCE PRESSURES

The DHB is working hard to maintain a safe environment and ensure the wellbeing of our staff as we shift people, patients, and services to make repairs and complete construction. We have implemented a number of initiatives to mitigate disruptions, however construction noise, service relocation and parking issues are causing increasing stress for staff and patients alike.

The age of our population, their mental wellbeing and the increase in specialist referrals from other DHBs means the health issues people are presenting with are increasingly complex. These factors place additional pressure on our workforce.

Our Staff and Family Wellbeing Survey results show that people are engaged and believe they are making a difference, but they are weary and staff commitment is being tested. This view is reiterated by providers from across our health system, equally concerned about the wellbeing and resilience of their workforce.

FISCAL PRESSURES

Meeting growing service demand, increasing treatment and infrastructure costs and heightened expectations around wage and salary increases is an ongoing challenge for all DHBs. The fiscal pressures are compounded in Canterbury by the extraordinary impacts of the earthquakes.

Significant earthquake-related operational costs are evident in a number of areas. These include increased health need and service demand, outsourcing costs to cover insufficient theatre capacity, lost bed capacity and multi-year delays in facilities construction and substantial depreciation and capital related charges related to the repair of damaged buildings.

It is apparent that a considerable portion of our earthquake repair work will not be covered by our insurance proceeds. The DHB's normal capital expenditure and maintenance budgets will not be enough to cover repair costs and to address capacity constraints as our population continues to grow.

Part II

Long-Term Outlook

What are we trying to achieve?

Our Strategic Direction

2.2 Nationally consistent

The long-term vision for New Zealand's health sector is articulated through the NZ Health Strategy. The overarching intent is to support New Zealanders to 'live well, stay well, get well'. The Strategy identifies five key themes to give a focus for change:

- People powered
- Closer to home
- One team
- Smart system
- High value and performance.

Our direction is further guided by a range of condition specific or population strategies, including: the Māori Health Strategy (He Korowai Oranga), the Pacific Health Strategy ('Ala Mo'ui), the Healthy Ageing Strategy, Disability Strategy and the United Nations convention on the Rights of People with Disabilities.

DHBs are also expected to commit to government priorities. The Minister of Health's Letter of Expectations signals annual priorities and expectations for DHBs. The 2018/19 expectations signal a strong focus on improving the delivery of public health services and improving equity in health outcomes. [1]

There is increased emphasis on:

- Population health services
- Mental health services
- Primary care health services
- Utilisation of the wider health workforce
- The health and wellbeing of infants, children and young people
- A reduction in the burden of long-term conditions
- Accountability for improved performance
- A stronger response to climate change.

The Canterbury DHB's Annual Plan outlines how we will meet these expectations in 2018/19.

2.3 Regionally responsive

There are five DHBs in the South Island (Nelson Marlborough, Canterbury, West Coast, South Canterbury and Southern) and together we provide services for over one million people, almost a quarter (23%) of the total NZ population.

While each DHB is individually responsible for the provision of services to its own population, we work regionally through the South Island Regional Alliance to address our shared challenges and develop more responsive and effective health services.

Our jointly-developed Regional Health Services Plan outlines our agreed regional activity for 2018/19.[2] Canterbury has made a strong regional commitment and takes a clinical or executive lead in a number of priority areas including: cancer, child health, stroke, oral health, and palliative services.

Canterbury also takes a lead for Information Services regionally, including the development of HealthOne in partnership with Pegasus and Orion Health. This shared electronic health record system has been rolled out across the South Island, helping to avoid duplication of costs and simplifying access to patient information, no matter where the patient is treated.

The HealthOne system is now accessed over 3,000 times a day by health professionals across the South Island and won the award for Best Technology Solution for the Public Health Sector at the NZ Hi-Tech Awards in 2017.

2.4 Locally driven

Our vision is an integrated health system that keeps people healthy and well, in their own homes and communities. A connected health system centred around people, that aims not to waste their time.

Ten years ago, health professionals, providers, consumers and key stakeholders came together to rethink the future of the Canterbury health system.

We realised that our ageing population and the increasing prevalence of long-term conditions were placing significant pressure on our ability to meet the needs of our population, and that future funding and workforce constraints would further limit our capacity. We also recognised that people's needs were often met in hospital settings when they could be happier, and better managed, in their own homes.

We knew we needed to do things differently. Together, we developed a vision that recognised our future was not just about hospitals, but about everyone working together as one team to do the right thing for both the patient and the system.

In achieving our vision, we are focused on the delivery of three clear strategic objectives:

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

[1] *The 2018/19 Letter of Expectations is attached as Appendix 2.*

[2] *Refer to www.sialliance.health.nz for the Regional Plan.*

Our Immediate Focus

2.5 Our performance story so far

In working to deliver on our vision, we started to do things differently. We re-evaluated our relationships with each other, and with the people we cared for. We've become more integrated, more connected and we've reduced waste and duplication.

By integrating service delivery models and expanding the role of primary and community providers, we have been able to moderate the growth rate in acute demand for hospital services.

We have been able to significantly reduce the proportion of people living in aged residential care, and we have reduced their length of stay, creating savings which have been used to better support people in their own homes and communities.

Like some of the more innovative health systems around the world, a cornerstone of our success has been the redesign of shared clinical pathways and service delivery models, to address service gaps and improve access to the right services at the right time.

Connecting information systems and sharing data has also been a key enabler of change. Access to real-time information, at the point of care, is helping us to improve the quality and safety of the care we provide and is reducing the time people waste waiting.

Engagement with health services is positive. At the end of 2016/17, 94% of our population were enrolled with primary care, 95% of eight months olds were fully immunised and fewer people were admitted acutely to our hospitals (13,000 fewer than the national average).

Despite capacity constraints, access to services has increased. We delivered 400 more elective surgeries than the previous year, exceeding our national target. The average length of stay in our hospitals remained lower than the national result, and more people aged over 65 in Canterbury were living in their own homes.

2.6 Critical success factors

While we have achieved significant momentum, progress has been hampered by the unique operational challenges we have faced following the earthquakes. Our planning forecasts show our health system is at full capacity. Just sustaining current service levels will be a significant challenge.

To keep our system operating and meet immediate service demand within current resources, we need to manage our business well, identify opportunities to reduce duplication and waste and integrate and connect people and services - not only across our health system, but across all public services.

To ensure the long-term sustainability of our health system and continue our transformation, we need to rebuild our capacity and find solutions to enable investment in the infrastructure and workforce needed to meet the growing and evolving demand for services.

Because health resources are increasingly limited, we will need to ensure our investment and effort is directed into activity and services that will provide the greatest impact. Our Board has identified three Strategic Themes that highlight the factors seen as critical to both our immediate and long-term success.

Keeping Our Health System Operating:

- Maintaining our whole of system approach
- Improving the flow of patients across the system
- Supporting the commissioning of new facilities

Setting the DHB up for Future Success:

- Creating a sustainable pathway forward
- Investing in an effective People Strategy
- Delivering on our Digital and ICT Transformation
- Completing a masterplan for Christchurch Hospital

Contributing to the Regional and National Picture:

- Supporting industrial negotiations
- Delivering on new service expectations and policies
- Responding to vulnerable service challenges

The DHB's annual operating intentions to support progress in these areas are highlighted in our Statement of Performance Expectations and in our Annual Plan for 2018/19, available on our website: www.cdhb.health.nz.

Part III

Medium-Term Outlook

How are we going to get there?

Managing Our Business

We aim to be a responsive organisation, respected for the quality of the services we deliver, and successfully delivering against strategic goals and national targets.

This section highlights how we will organise and manage our business to support that aim, enable the transformation of our health system, and better meet the health needs of our population.

3.1 A patient-focused culture

The values of our organisation, the way in which we work, and the manner in which we interact with others are all key factors in our success.

ORGANISATIONAL VALUES

- Care and Respect for Others
- Integrity in All We Do
- Responsibility for Outcomes.

The DHB is committed to the development of a culture that focuses on the patient. Over the past eight years we have invested in leadership programmes that encourage staff to ask what is best for the patient and empower them to redesign the way they deliver services to improve the effectiveness of our system.

We will further encourage this focus through our annual Quality Improvement and Innovation Awards. These awards recognise excellence and quality improvement not only in our hospitals but across the whole of the Canterbury health system.

3.2 Effective leadership

We are fortunate to have Board members who contribute a wide range of expertise to their role. To support good governance, we have an outcomes-based decision-making and accountability framework that enables our Board to monitor service performance and provide direction.

Clinical leadership and consumer engagement is intrinsic to our ongoing success. Clinical and consumer input into decision making is embedded at all levels of our organisation, across primary and secondary services and across our local and regional alliances.

Strategic and operational decisions are further informed through the following formal mechanisms:

Our Clinical Board: where members support and influence the DHB's vision and play an important role in raising the standard of patient care.

Our Consumer Council: where members ensure a strong and viable voice for consumers in health service planning and service redesign.

3.3 Collective impact

Our vision is based on bringing to life a truly integrated health system where everyone is working together to do the right thing for the patient and the system. Working collaboratively has enabled us to respond to the changing needs of our population and is a key factor in achieving our goals and objectives. The DHB's major strategic partnerships include:

The District Alliance: The Canterbury Clinical Network (CCN) is where the DHB and its partner organisations come together to improve the delivery of health services and realise opportunities to improve health outcomes. This includes delivery of Canterbury's annual System Level Improvement Plan, which is incorporated into the DHB's Annual Plan.[3]

Our Realign Alliance: Realign is the name given to the way Christchurch campus clinical leaders are working together to improve care. A surgical services alliance is well established, focused on theatre utilisation, patient flow and workforce capacity. Audiology, cancer and medical services will be a focus for the coming year.

Manawhenua Ki Waitaha: Under a shared Memorandum of Understanding, the DHB actively engages Māori leaders in the planning and design of health services and strategies to improve Māori health outcomes. Members of Manawhenua Ki Waitaha also bring a Māori perspective to the redesign of services across a number of the CCN alliance work streams.

Transalpine Partnership: The initial priority of connecting up the Canterbury and West Coast health systems to reduce duplication has now shifted to helping formalise clinical pathways, and enabling sustainable access to specialist services for the West Coast population. The two DHBs share senior clinical positions as well as management expertise, corporate services teams and information systems.

Public Health Partnerships: All DHBs have a statutory responsibility to improve, promote and protect the health and wellbeing of their populations. Community and Public Health (CPH) is a division of the DHB and takes a lead in the delivery of public health strategies and services for our population. CPH also serves as the Public Health Unit for South Canterbury and West Coast DHBs. Our Public Health Action Plan for 2018/19 is available on our website.

Collective public health focused initiatives include: Healthy Christchurch, a DHB-led cross-sectoral partnership with over 200 signatories; and 'All Right?' a social marketing campaign to support people's wellbeing after the earthquakes in partnership with the Mental Health Foundation.

[3] The CCN is the broadest health alliance in the country with 12 system partners including: the DHB, three Primary Health Organisations, pharmacy, laboratory, radiology, ambulance, midwifery and home-based support service providers.

3.4 Commitment to quality

Our commitment to quality improvement is in line with the NZ Triple Aim: Improved quality, safety and experience of care; improved health and equity for all; and better value from public health resources.

As a partner in the regional Quality & Safety Alliance, we work with the other South Island DHBs to implement quality and safety improvements through a community of practice. We also support each other to meet commitments under the national Health Quality and Safety Commission (HQSC) programmes.

The regional implementation of the South Island Incident and Risk Management System (Safety 1st) is assisting in real time tracking of events, allowing us to examine incidents as they happen and take action to improve quality and patent safety. With a culture of reporting now well established, safety issues are becoming more transparent and empowering the organisation to respond to needed improvement.

The Canterbury DHB also has a focus on improving patient experience in our services. We have made a commitment to using our inpatient experience survey results to improve the way we communicate with patients and their families. Our focus for the coming year is reflected in our Annual Plan.

The national HQSC Quality and Safety Markers are used by our governance groups to monitor patient safety and track the effectiveness of improvement activity. We report quarterly to our Clinical Board and the Quality, Finance, Audit & Risk Committee. Our performance against the Markers is also reported annually to our community through our Quality Accounts which can be found on our website.

The delivery of externally contracted services is also aligned with national quality standards, and auditing of contracted providers includes quality audits.

3.5 Performance management

The DHB's Board is responsible to the Minister of Health for the overall performance of the DHB. The Board delivers against this responsibility by setting strategic direction and policy that is consistent with Government objectives, meets the needs of our population, and ensures sustainable service provision.

The Canterbury DHB has invested in the development of 'live data' systems where real-time information on the day-to-day operations within our hospitals enables more responsive decision making and planning.

Our service and financial performance is monitored by the Executive Team, the DHB Board, and its Quality, Finance, Audit and Risk Committee. The DHB's performance is presented in a public forum to the Board's Advisory Committees. The DHB also reports monthly and quarterly to the Ministry of Health against key service and financial reporting indicators outlined in our Annual Plan.

At a broader level, we monitor our performance against a core set of desired population outcomes, captured in the DHB's Outcome Framework. The Framework defines success from a population health perspective and is used as a means of evaluating the success of our health system and the effectiveness of our investment decisions.

Our performance is also audited annually against our Statement of Performance Expectations and the results are published in our Annual Report. Further detail on the DHB's outcome goals can be found in the Monitoring our Performance section (page 18).

3.6 Asset management

Having the right assets in the right places and managing them well is critical to the ongoing provision of high-quality and cost-effective health services.

As an owner of Crown assets, the DHB is accountable to the Government for the financial and operational management of those assets.

Since the earthquakes, our capital intentions have been updated annually to reflect known changes in our asset state and future intentions, in line with our earthquake repair programme and the Burwood and Christchurch Hospital campus redevelopments.

In response to Treasury requirements for monitoring investments across government, the DHB has developed a Long-term Investment Plan with a ten year outlook. This Plan reflects the anticipated impact of changing patterns of demand and new models of care on our future asset requirements and will support investment decisions going forward.

The DHB is freshening this Long-Term Plan alongside a review of its Asset Management Policy, Asset Plan and asset performance metrics to understand and evaluate whether we are investing wisely.

As at 30 June 2017, the total value of the DHB's asset portfolio (property, plant, equipment and ICT assets) was $685M. Refer to page 40 for a summary of the DHB's major capital investments to 2021.

3.7 Risk management

The Canterbury DHB manages and monitors risk to ensure we are meeting our obligations as a Crown Entity. Our risk management processes are aligned to the main elements of the International Standard for Risk Management AS/NZS ISO 31000:2009.

The DHB maintains Divisional Risk Registers. The top tier risks are reviewed by the Executive Management Team and the Board's Quality, Financial, Audit and Risk Committee every two months, providing assurance on the management of the most significant risks faced by the DHB. Twice a year, the full Risk Register is provided to the Board's Quality, Financial. Audit and Risk Committee for their attention.

3.8 Ownership interests

The Canterbury DHB has a number of ownership interests that support the delivery of health services including two operational subsidiaries, both of which are wholly owned by the DHB.

Canterbury Linen Services Limited: provides laundry services to DHB hospitals and external commercial clients. The Canterbury DHB owns all shares, as well as the land and buildings.

Brackenridge Estate Limited: provides residential care, respite services and day programmes for people with intellectual disability and high dependency needs. The primary source of funding is service contracts with the Ministry of Health. The DHB is the sole shareholder.

The South Island Shared Service Agency Limited: functions as the South Island Alliance Programme Office. It is jointly owned and funded by the five South Island DHBs and provides audit services and drives regional service development on our behalf.

The New Zealand Health Partnership Limited: is owned and funded by all 20 DHBs and aims to enable DHBs to collectively maximise and benefit from shared service opportunities. Canterbury participates in the Finance, Procurement and Supply Chain programme.

The New Zealand Health Innovation Hub: is a joint partnership between Canterbury, Counties Manukau, Waitemata and Auckland DHBs. The Innovation Hub engages with clinicians and industry to develop, validate and commercialise health technologies and improvement initiatives that will deliver health and economic benefits to the system.

The DHB does not plan to acquire shares or interests in any other companies, trust or partnerships in 2018/19.

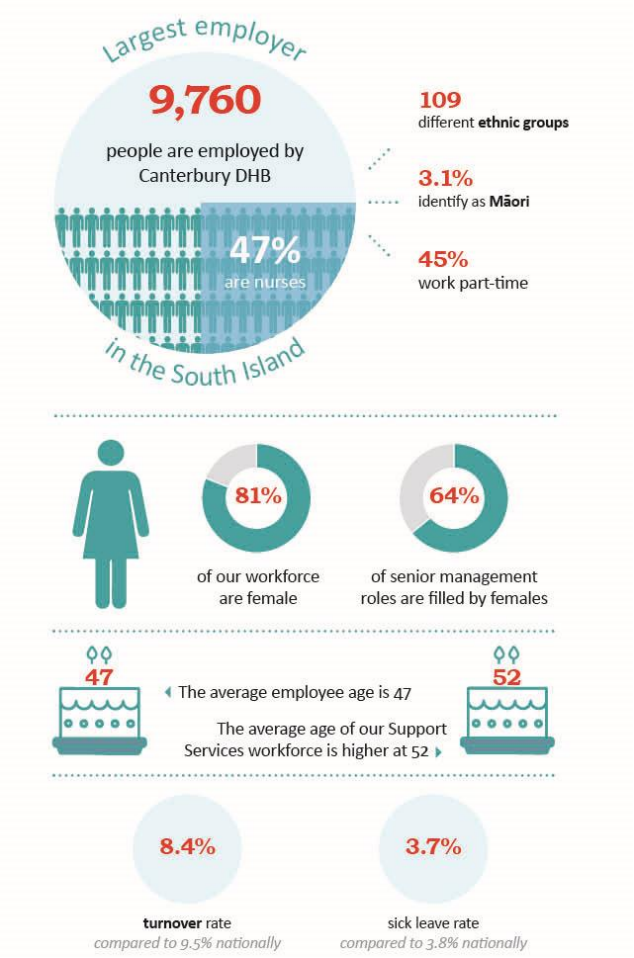
Setting the DHB Up for Future Success

3.9 Investing in our people

To meet the needs of our population and achieve our vision we need a motivated workforce of the right people doing their best for the patient and the system.

The DHB is committed to being a good employer and promotes equity, fairness and a safe and healthy workplace. We have a clear set of organisational values supported by our core operational policies, including a Code of Conduct, a Wellbeing Policy and an Equality, Diversity and Inclusion policy.

The DHB is committed to implementing the national Care Capacity Demand Management agreement by June 2021.



As part of our commitment to our workforce we are also reviewing our people processes and systems and engaging in conversations about how we can put our people at the heart of all that we do.

Many of our people are still facing unprecedented challenges, both at home and at work. They are in the middle of the country's biggest health facilities repair and redevelopment programme. Many have also had to struggle with housing and insurance issues caused by the earthquakes and most still deal with the reality of living in a rebuilding city.

There is a commitment to making things better. The DHB has adopted a People Strategy to ensure actions which will positively support the wellbeing of our people are prioritised and actioned.

In implementing our People Strategy, we will create a culture in which:

- Everyone understands their contribution
- Everyone can get stuff done
- Everyone is empowered to make it better
- Everyone is enabled to lead
- Everyone is supported to thrive.

A range of initiatives will be developed and rolled out over the next few years to deliver on the priorities in our People Strategy. We will be measuring the impact we make and using what we learn to inform our next steps. We will also involve our people every step of the way to ensure we are focused on what is important.

Other areas of workforce development and investment for the period of this Plan include:

MIDWIFERY WORKFORCE

The DHB is currently developing a forward thinking Maternity Strategy to improve care and outcomes for pregnant women and their babies. This will include consideration of the skill sets and availability of the whole team providing care and birthing services and options outside the tertiary hospital to sustain the Lead Maternity Carer service.

The Canterbury DHB continues to support graduate midwives with 10 places being offered at Christchurch Women's Hospital in 2019. With the opening of a new joint teaching block in the Health Precinct, the DHB will also have more opportunity to be involved (with Ara) in supporting education of student midwives.

In the coming year, the DHB will look to establish a development framework and career pathway for employed midwives. Working with the Colleges of Midwives we will also seek to re-establish an LMC Liaison role that was been vacant for some time.

The DHB aims to be meeting Midwifery Employee Representation & Advisory Service (MERAS) Staffing Standards 80% of the time by July 2020. Six monthly audits will track our progress towards this goal.

MĀORI HEALTH WORKFORCE

The DHB seeks to encourage increased participation of Māori in the health workforce, with Māori making up 9.1% of the total Canterbury population but just 3.1% of our workforce.

As part of this focus Canterbury participates in the national Kia Ora Hauora programme, aimed at increasing the number of Māori working in health, by supporting pathways into tertiary education, Māori and Pacific health scholarships and work placements.

In partnership with Pegasus Health and Canterbury's Māori & Pacific Provider Collective we have established a blended model for a Nursing Entry to Practice (NETP) Māori Initiative titled 'Korimako'. This includes annual funding for new graduate registered nurse positions as a sustainable pathway for building a primary care registered Māori nursing workforce.

In the coming year, as part of further collaboration with the Māori & Pacific Provider Collective, the DHB will invest in a five day workforce development symposium to build capacity in evaluation, supervision and cultural development. The aim is to inspire people, foster collaboration, grow collective leadership and deliver tangible outcomes by enabling improved practice.

The DHB will also undertake a review of internal recruitment with an emphasis on improving practices that may unintentionally limit job placement prospects for Māori and Pacific applicants. In collaboration with the West Coast DHB we will develop workshops for staff responsible for recruitment and an action plan to address issues identified as a result of applying the Health Equity Assessment Tool (HEAT).

HEALTHY AGEING WORKFORCE

Canterbury has the largest total population aged over 65 in the country, with 15.9% of our population aged over 65. The ageing of our population is one of our biggest challenges and will put significant pressure on our workforce.

We have established a Health of Older People Workstream and a Community Services Service Level Alliance, where together with our health system partners, we are part of ongoing planning to identify service and workforce gaps and determine the best models of care to support our ageing population.

With oversight of the Alliance, we have invested in a home and community support model where registered nurses, allied health professionals and support workers are part of the same community provider teams. This model enables the transfer of knowledge and upskilling of support workers. This is a feature of our supported discharge model and workplace satisfaction is high, with lower support worker turn over in these teams.

The DHB has 2 FTE gerontology nurse specialists and 4.8 FTE palliative care nurse specialists in place to support our Aged Residential Care facilities. These roles have enabled considerable upskilling within ARC clinical teams and are part of our wider strategy to support and retain appropriately trained ARC staff in Canterbury. The DHB has identified the gerontology nursing workforce as a key priority within our Nursing Workforce Education Plan and prioritised establishment of a Nurse Coordinator ARC position to assist with further strengthening this workforce.

In the coming year we have prioritised a focus on supporting informal carers, as a vulnerable group, including more flexible options for carer support and education to encourage earlier uptake of support.

We will also develop training initiatives to assist our support care workforce trained overseas (anticipated to exceed 50% by 2025). These workers are trying to integrate into workplaces that may be very different than those in the country that they trained.

Our own workforce is ageing and this is an important consideration in the DHB's workforce planning. The average age is 47 and support services are our oldest workforce group with an average age of 52 years.

The DHB supports the work of the South Island Workforce Development Hub, to identify workforce gaps and support skill development and training for vulnerable workforces.

The South Island DHBs have established a Sustainable Nursing Workforce Group that is examining rostering practices, succession planning and ways to value older clinicians, sharing their knowledge in different roles as they near retirement. Canterbury is also part of a regional Nurse Practitioner Workforce Group focused on the development of this workforce to meet our ageing population needs.

Utilising our Dedicated Education Units, there is a well-developed pipeline of nursing students trained within the Canterbury health system, with over 900 nursing student placements each year. This student cohort feeds into the Canterbury NetP Programme and New Entry to Specialty Practice Mental Health & Addiction Programme that successfully employs over 260 new registered nurses annually.

Priority focus areas include older person's health, specialist mental health and primary and community nursing. Our joint approach to recruitment has almost doubled the number of graduates working in primary and community areas over the past four years.

With the complexity of health need increasing as our population ages, we also need to consider the preparation and qualifications of our unregulated workforce. We support our Health Care Assistants, Orderlies and Theatre Assistants to achieve the NZ Certificate in Health and Wellbeing. This is an employer-led training model that is embedded in everyday workplace activities and leads to the delivery of a higher standard of care and higher retention rates.

In the coming year, the DHB will continue to invest in HealthLearn, our online learning management system. This platform offers over 300 courses to health care staff working across the Canterbury health system including aged residential care and primary care staff.

The DHB will also focus on skill development for our older workers and will develop a workforce plan for administrators who routinely assist older patients. At present, 47% of this workforce group are over the age of 55. Heart First workshops will upskill and support administrators who are moving into new facilities and dealing with patient complaints.

3.10 Investing in health literacy

The Canterbury DHB takes a leadership role in improving healthy literacy, making it easier for people to make informed decisions about their health and wellbeing. Our commitment is inherent in our vision and the first of our three strategic objectives: '*The development of services that support people to stay well and enable them to take greater responsibility for their own health and wellbeing'*.

We have invested in HealthInfo, our local information website designed to give people access to up-to-date information about their health conditions. Translated into multiple languages, HealthInfo includes a video tutorial to help people navigate the site and find the information that they need, and has printable factsheets for people without web access.

We routinely invite individuals and Whānau to provide feedback on the services they use. Work with our Youth Advisory Council led to the development of new communication cards for use in our hospitals. The picture cards support interaction between staff and patients around three key areas: symptoms and acuity, what the person needs right now, and how they are feeling about treatment and plans.

We also support staff development in health literacy practice and communication through the HealthLearn e-learning platform. We offer online foundation courses in cultural competency and working with people with disabilities, which aim to improve communication, challenge assumptions and build people's confidence. Online videos, where patients share their experience in our service, support this learning.

Areas of investment for the period of this Plan include:

- Increased use of Patient Experience Surveys.
- Evaluation of the content of HealthInfo for two priority issues affecting older people.
- Review of the accessibility of Interpreter Services across our health system.
- Review of the drivers behind Did Not Attend (DNA) rates in our Diabetes Service.

3.10 Investing in information systems

Improved access to patient information enables more effective clinical decision-making, improves standards of care and reduces the time people spend waiting.

Connecting up health services electronically is central to our vision. By allowing us to realise opportunities to reduce duplication and wasted time, this is a key factor in the future sustainability of our health system.

Improving information management and capability is also a national priority. All DHBs are expected to align their direction with the national Digital Health Strategy.

The South Island DHBs have determined collective actions to deliver on the Strategy and we are committed to this approach. Canterbury is taking a lead in rolling out several of the information solutions that are streamlining the way health professionals across the South Island make requests, send referrals, and share patient information. This includes the award winning Health Connect South, HealthOne (where over 1 million people across the South Island now have a single shared electronic health record), and the South Island Patient Information Care System (PICS).

Our transalpine partnership with the West Coast DHB also makes shared information systems increasingly important. We are in the process of aligning IT systems to facilitate access for staff working across both DHBs.

Telehealth, videoconferencing and mobile technology that support staff working remotely are an important factor in improving service capacity. Investment to date has already saved clinical time by reducing the need to travel. We will also continue to connect up services and systems electronically with the digitalisation of our new hospital and adoption of national systems, to improve patient safety and the quality of services we deliver.

Areas of investment for the period of this Plan include:

- Increased development and use of digital forms to eliminate paper across our new hospitals and increased automation of HR and IT processes, including the automation of process between recruitment and IT systems access live in Q2.
- Increased focus on building test and infrastructure automation capability to deliver IT projects efficiently, including planning for a virtual desktop upgrade and Windows 10 rollout in 2018/19.
- Continued focus on improving ICT disaster recovery capability to allow normal operations to resume quickly after a disaster, including planning for moving to cloud technology in 2019/20.
- Continued rollout of the South Island PICS to reduce the number of duplicated systems across the South Island, with the Christchurch Campus and Ashburton rollouts planned for Q3 2018/19.
- Continued expansion of HealthOne into more private providers, hospitals and other DHBs throughout the year, including planning for improved Pharmacy integration in Q4 2018/19.
- Improved technical security maturity to further secure the information we hold on behalf of people in Canterbury and the South Island region, with CDHB Cyber security aligned to NZ Cyber security goals by the end of 2018/19.
- Planning and engagement for establishing unified communications for text messaging to improve clinical efficiency by replacing pagers, with a pilot underway by the end of 2018/19.
- Planning for the implementation of the National Maternity System in Q2 2018/19, pending further development of the national application and clinical endorsement.

3.11 Investing in facilities

In the same way that workforce and information technology underpin our transformation, health facilities can both support and hamper our ability to meet the needs of our population.

Completion of the Outpatients and Acute Service Buildings on our Christchurch Hospital site will allow us to regain some of our capacity lost after the earthquakes. It will also allow us to make efficiency savings by co-locating and consolidating services and introducing new models of care.

Unfortunately ongoing delays with the redevelopment programme mean we are still operating with our capacity significantly reduced. Our growing population, increased service demands and the disruption from our ongoing earthquake repair and seismic remediation programme are compounding this pressure.

Seven years post-earthquakes there is still not a clear, agreed solution to deal with the substantive earthquake damage on the Christchurch Hospital campus.

To establish a sustainable pathway forward, it is critical that the Outpatients and Acute Services Buildings are completed without further delay. Solutions also need to be found to increase our capacity beyond what will be restored once the redevelopments are complete and to reduce the safety risks of our compromised facilities.

Areas of investment for the period of this Plan include:

Christchurch Hospital Redevelopment: Construction of the Outpatient Building is now scheduled for completion late 2018 and the Acute Services Building in the second half of 2019. Construction of the Energy Centre, Carpark and Tunnel are also anticipated in the period covered by this Plan.[4]

The Christchurch Health Precinct: The development of a Health Research and Education Facility is underway in collaboration with Ara Institute and the University of Canterbury. The building is under construction by a private developer, with expected occupation in 2018.

Akaroa: The development of an IFHC is planned for the Akaroa Hospital site. The DHB is working with the community to develop this facility with expected occupation in mid-late 2019.

Rangiora: Phase II of the Rangiora Community Hub development involves the relocation of the temporary Outpatients Building from Christchurch Hospital. Timing is expected to be confirmed on the completion of the new Outpatients Building.

The Princess Margaret Hospital: The DHB will deliver proposed facilities solutions for the relocation of mental health services stranded on this site. A detailed business case will be completed in 2018/19.

Canterbury Health Laboratories: The DHB has completed an initial strategic assessment in regards to a future facility for Canterbury's tertiary laboratory and pathology services and will look to progress with the development of an indicative business case in 2018/19.

Christchurch Hospital Campus: An indicative business case outlining future plans for the campus will be completed for consideration in 2018/19, following completion of the master-planning process for this site. The DHB will then look to progress with the development of a detailed business case.

Hillmorton Hospital Campus: Longer-term master-planning is also underway to determine the future use of existing buildings and facilities on the Hillmorton Hospital Campus. This will be completed following agreement on the relocation of services currently located on The Princess Margaret Hospital site.

Over the coming year the DHB will also consider the future use of all of our rural hospitals.

[4] *Note: Operational oversight for the Christchurch Campus redevelopments have been transitioned to the Ministry.*

3.12 Cross-sector investment

Recognising the wider influences that shape the health and wellbeing of our population, the DHB works in partnership with organisations from outside the health sector to improve health outcomes for our population.

Earthquake recovery continues to be an important focus of our cross-sectoral work. This involves support and advice into policy processes, community resilience initiatives, and psycho-social recovery—all of which contribute to our vision of a healthier Canterbury.

We are also working closely with ACC, Corrections and the Ministries of Social Development, Education and Justice, investing in a number of initiatives aimed at improving health outcomes for the most vulnerable in our community.

Areas of investment for the period of this Plan include:

The Mental Health Support in Schools (Mana Ake: Stronger for Tomorrow) Initiative: The DHB is taking the lead in implementing this significant national initiative. Driven through the CCN, we are working closely with the Ministry of Education to design a system that works for children, their families/whānau and teachers. The programme will boost the number and range of health professionals and support workers focused on the wellbeing of young children and will see those in need receive support sooner.

Canterbury Children's Team: The DHB will continue its commitment to work in a collaborative partnership with Oranga Tamariki, to better support vulnerable children and their families in the Canterbury District.

The Integrated Safety Response Pilot: The DHB will continue to participate in this Police-led social investment strategy to pilot rapid responses from government and social agencies to meet the needs of people affected by family violence.

Step Up: The DHB is working alongside the Ministry of Social Development and Pegasus Health to develop a new prototype primary care service to support people with health conditions on their journey back into employment.

The All Right? Social Marketing Campaign: The DHB will continue to work in partnership with the Mental Health Foundation to support people's mental health and wellbeing after the earthquakes.

Strength and Balance Programmes: The DHB is also working in collaboration with ACC to enhance our Falls Prevention Programme by providing increased access to community-based Strength and Balance Programmes alongside the in-home Falls Prevention Service and the Fracture Liaison Services.

3.13 Service redesign

SERVICE COVERAGE

All DHBs are required to deliver a minimum level of service to their population, in accordance with the national Service Coverage Schedule. This Schedule is incorporated as part of the Crown Funding Agreement between the Crown and DHBs, under Section 10 of the NZ Public Health and Disability (NZPHD) Act 2000, and is updated annually.

DHBs are responsible for ensuring that service coverage is maintained for their population. The Canterbury DHB works to identify service coverage risk through the monitoring of performance indicators, risk reporting, formal audits, complaint mechanisms and the ongoing review of patient pathways.

At this stage we are not seeking any formal exemptions to the Service Coverage Schedule for 2018/19. However, in our current circumstances, there are obvious service coverage risks related to resource and capacity constraints, infrastructure damage, rebuild delays, and evolving service demand.

SERVICE REDESIGN

We work in partnership with other service providers to redesign the way we deliver health services to meet the needs of our population and to ensure the future sustainability of our health system. We anticipate that new models of care and service delivery will continue to emerge through this collaborative work and as we seek to address our capacity and resource constraints.

Consistent with our shared decision-making principles, we look to our clinically-led alliance work streams and leadership groups for advice on the redesign of any service models. We also endeavour to keep a steady stream of information flowing across our system in regards to service change or transformation.

In the coming year, the DHB will review capacity and costs across all service areas, and look to prioritise resources onto areas of most immediate or greatest need. This includes aligning practice and intervention rates with national service specifications or accepted practice in other DHBs, and may impact on the configuration, scope and location of some services.

At times we may wish to negotiate, enter into, or amend service agreements or arrangements to assist in meeting our objectives and delivering against the vision and goals outlined in this document. In doing so (pursuant to Section 24(1) and Section 25 of the NZPHD Act 2000), we will seek to ensure that any resulting agreements or arrangements do not jeopardise our ability to meet our statutory obligations in respect to our agreements with the Crown.

Anticipated service changes, identified for the period of this Plan, are highlighted on the following page.

Area Impacted	Description of Change	Anticipated Benefit	Driver
Services on the Christchurch Hospital Campus	The DHB will continue to relocate and reconfigure services to accommodate earthquake repairs and migration to the new Outpatient and Acute Services Buildings.	Increased service capacity, sustainable service delivery and improved experience.	Local
Services on the Princess Margaret Hospital Campus	The DHB will seek to relocate and reconfigure mental health services to accommodate the decanting of The Princess Margaret Hospital site.	Sustainable service delivery and improved patient experience.	Local
Rural Health Services	The DHB will support the redesign of service models across our rural communities (under the guidance of the CCN), including the development of integrated family health services and sustainable after-hours' service models.	Increased service capacity, integration and sustainable service delivery.	Local
Mental Health Services	In line with the national Mental Health Review and in response to increasing demand and evolving need, the DHB will continue to reconfigure the model of care for mental health services with a focus on building community capacity.	Increased service capacity integration, and improved patient outcomes and experience.	Local National
Alcohol and Other Drug Services	Alongside the ongoing redesign and reconfiguration of Mental Health Services, the DHB will consider alternative service models for AOD services.	Increased service capacity, integration and improved patient outcomes.	Local
Home & Community Based Support Services	The DHB will complete the redesign of the model of care for home and community-based support services to response to increasing demand and evolving need. This will also include a review of home-based support services delivered by the DHB.	Increased service capacity integration, improved patient outcomes and reduced service costs.	Local
Rehabilitation Services	The DHB will review the flow of patients across hospital and community-based rehabilitation services and consider the redesign and/or reconfiguration of current service models to meet increasing demand. This will include implementation of the recommendations of the CREST service review.	Increased service capacity, integration, improved patient outcomes and service reduced costs.	Local
Diabetes Services	The DHB will implement the recommendations of the Diabetes services review to better meet the needs of our population as part of a wider more integrated service model and in line with the national diabetes quality standards,.	Improved access, increased integration and improved patient outcomes.	Local
Maternity Services	The DHB is reviewing its Maternity Strategy and exploring how we might better meet the needs of our population as part of a wider more integrated service model. This will result in the reconfiguration and/or redesign of maternity services.	Increased service capacity, sustainable service delivery integration and improved patient outcomes.	Local
Pregnancy & Parenting Services	The DHB is reviewing pregnancy and parenting services and will explore how we might better meet the needs of our population with a specific focus on Māori and Pacific women, those living in lower decile areas and teenage mothers.	Improved access, increased integration and improved patient outcomes.	Local
Public Health Nursing Services	The DHB is reviewing its public health nursing services and will explore how we might better meet the needs of our population as part of a more integrated service model.	Improved access, increased integration and improved patient outcomes.	Local
Colposcopy Services Intellectual Disability Services After Hours General Practice Services Respiratory Services Regional ISG support	The DHB will review service capacity and costs across a number of heavily subsidised service areas and explore alternative options for service delivery.	Increased service capacity, sustainable service delivery, and reduced service costs.	Local Regional

Area Impacted	Description of Change	Anticipated Benefit	Driver
Community Pharmacy Services	Under the guidance of the CCN Alliance, the DHB will engage with pharmacy providers to implement the national pharmacy contract and redesign and develop local services in alignment with the national Pharmacy Action Plan.	Increased integration, improved service quality and improved patient outcomes.	Local National
General Surgery and General Medical Services	The DHB will review the flow of patients and capacity of our services, in response to increasing demand and evolving national expectations. This may result in the redesign and/or reconfiguration of services, including regional services delivered on behalf of our partner South Island DHBs.	Increased service capacity, improved quality and patient outcomes and sustainable service delivery.	Local Regional

Monitoring Our Performance

3.12 Improving health outcomes

DHBs have a number of different roles and associated responsibilities. In our governance role, we strive to improve health equity and health outcomes for our population. As a funder, we are concerned with the effectiveness of the health system and the return on our investment. As an owner and provider of services, we are focused on the quality of the care we deliver and the efficiency with which it is delivered.

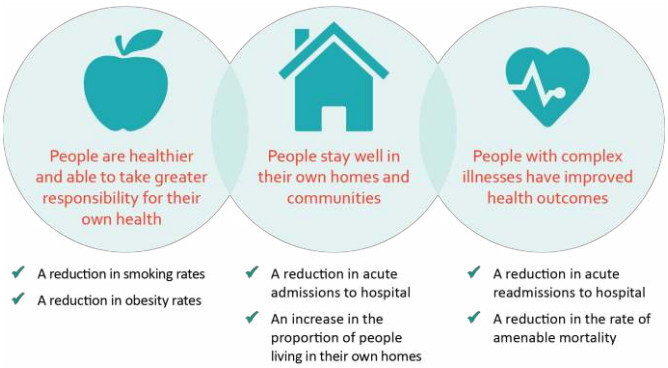
As part of our accountability to our community and Government, we need to demonstrate whether we are succeeding in achieving our objectives and improving the health and wellbeing of our population.

There is no single performance measure or indicator that can easily reflect the impact of the work we do. In line with our vision for the future of our health system, we have developed an over-arching intervention logic and system performance framework.

The framework helps to illustrate our population health and outcomes-based approach to performance improvement. It also encompasses national direction and expectations, through the inclusion of national health targets and system level measures.

At the highest level the framework reflects our three strategic objectives or goals, where we believe our success will have a positive impact on the health of our population.

Under each goal we have identified a number of population health outcomes indicators which will provide insight into how well our health system is performing over time.



The nature of population health is such that it may take a number of years to see marked improvements. Our focus is to develop and maintain positive trends over time, rather than achieving fixed annual targets.

MAIN MEASURES OF PERFORMANCE

To evaluate our performance over the shorter-term, we have identified a secondary set of contributory measures, where our performance will impact on the outcomes we are seeking. Because change will be evident over a shorter period of time, these contributory measures have been selected as our main measures of performance.

We have set performance standards for these contributory measures in order to evaluate our performance and determine if we are moving in the right direction. Tracking our performance against these indicators helps us to evaluate our success in areas that are important to our community, our Board and Government. They form an essential part of the way in which we are held to account.

These contributory measures sit alongside our annual Statement of Performance Expectations, outlining the service we plan to deliver and the standards we expect to meet in the coming year. They are also reflected in our System Level Measures Improvement Plan, where we collaborate with our partner organisations to improve health outcomes for our population.

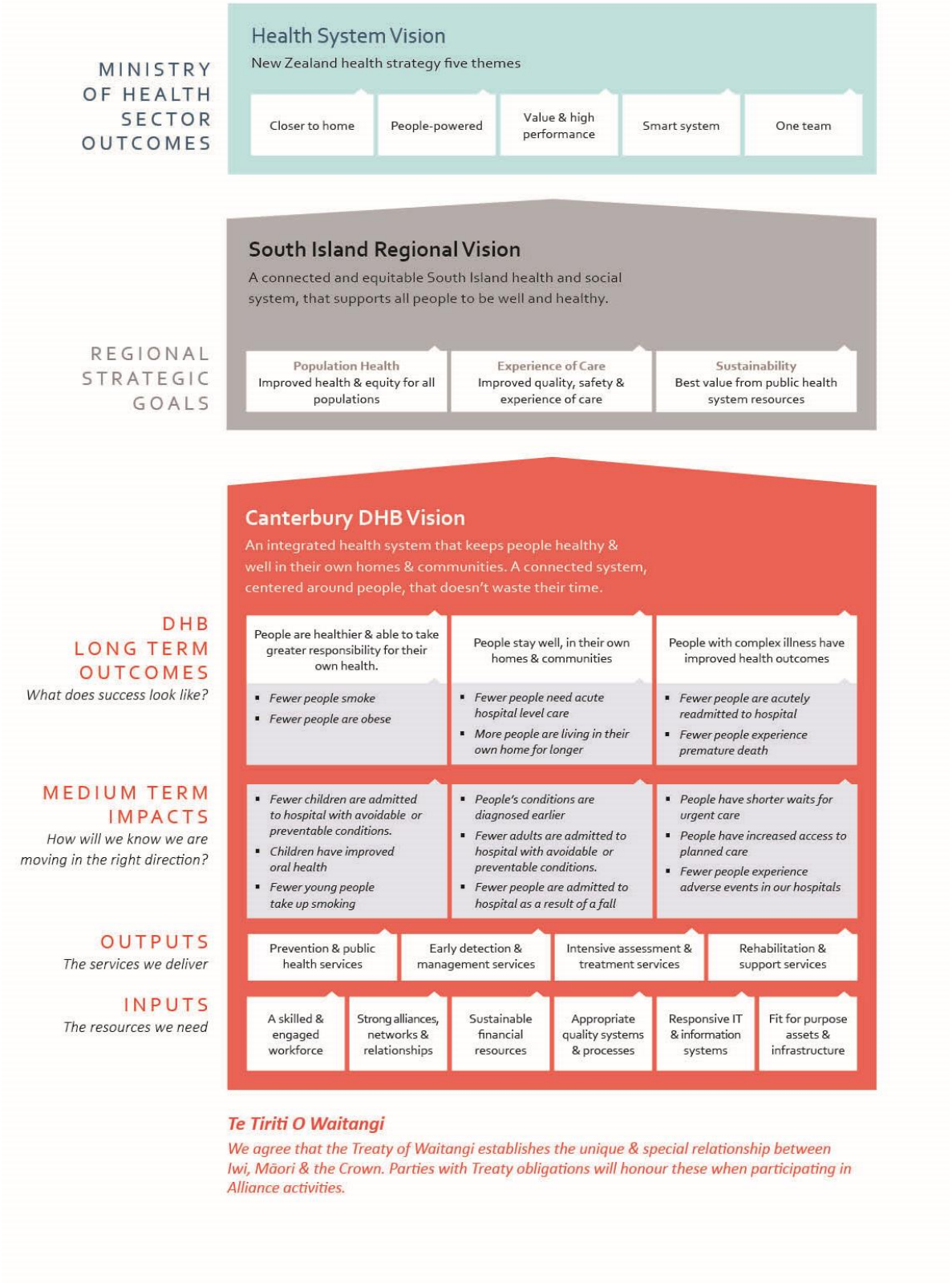
The intervention logic diagram on the following page demonstrates the anticipated value chain, by illustrating how the services we fund or provide will impact on the health of our population, contribute to the goals of the South Island Alliance, and deliver on the expectations of Government.

Our year-end service performance results are reported to our community in our Annual Report, alongside our year-end financial results.

Our Statement of Service Performance for 2018/19 can be found in the Annual Operating Intentions section of this document (page 27).

As a Crown entity, responsible for Crown assets, the DHB also provides regular financial and non-financial performance reporting to the Ministry of Health. The DHB's obligation under the Ministry's monitoring framework are highlighted in the DHB's Annual Plan.

Overarching Intervention Logic



System Outcomes

3.13 People are healthier and able to take greater responsibility for their own health

WHY IS THIS A PRIORITY?

New Zealand is experiencing a growing prevalence of long-term conditions such as cancer, heart disease, respiratory disease, diabetes and depression. These conditions are major drivers of poor health and premature mortality (death), and account for significant pressure on our health services. The likelihood of developing a long-term condition increases with age, and as our population ages the demand for health services will continue to grow. The World Health Organisation (WHO) estimates more than 70% of health funding is spent on managing long-term conditions.

Tobacco smoking, inactivity and poor nutrition are major risk factors for a number of the most prevalent of these long-term conditions. These are modifiable risk factors and can be reduced through supportive environments, improved awareness and personal responsibility for health and wellbeing. Public health services, by supporting people to make healthier lifestyle choices, will improve the quality of people's lives and reduce the burden on our health system.

Because the major risk factors also have strong socio-economic gradients, this focus will contribute to improving equity of health outcomes between population groups. To support this outcome we are investing in smoking cessation, exercise and nutrition programmes and the creation of health-promoting and supportive environments.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

A REDUCTION IN SMOKING RATES

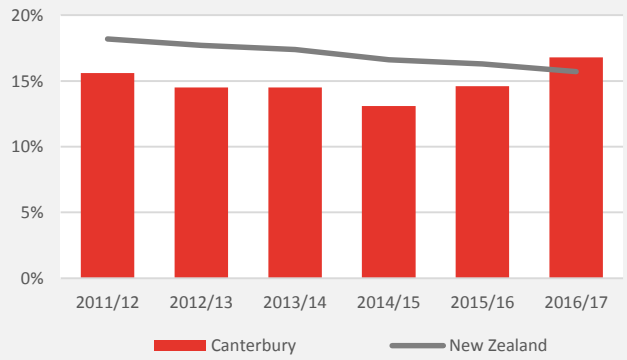
Smoking and exposure to second-hand smoke causes an estimated 5,000 premature deaths in New Zealand every year. Tobacco smoking is a major risk factor for many preventable illnesses and long-term conditions, including cancer, respiratory disease, heart disease and stroke.

In addition, tobacco and poverty are inextricably linked. In some communities, a sizeable portion of household income is spent on tobacco, meaning less money for necessities such as nutrition, education and health.

Supporting people to say 'no' to smoking is our foremost opportunity to improve health outcomes and to reduce inequalities in health status between population groups.

Data source: National NZ Health Survey [5]

Measure: Proportion of the population (15+) who smoke



A REDUCTION IN OBESITY RATES

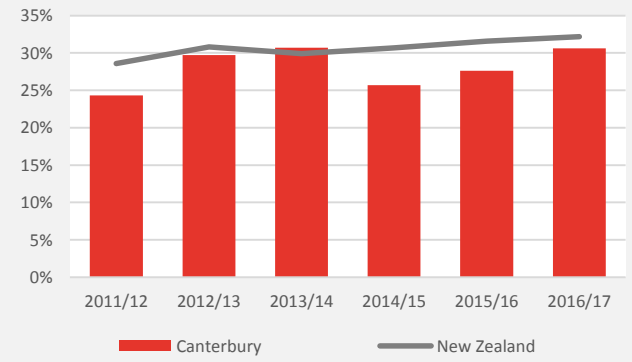
There has been a steady rise in obesity rates in New Zealand across all ages, genders and ethnicity groups. Obesity is set to overtake tobacco as the leading risk to health and the most recent (2016/17) NZ Health Survey found 32% of adults and 12% of children were obese.

Not only does obesity impact on the quality of people's lives, but it is a significant risk factor for many of the leading long-term conditions in Canterbury including heart disease, respiratory disease, diabetes and stroke.

Supporting people to achieve a healthier body weight is fundamental to improving people's wellbeing and to preventing poor health and disability at all ages.

Data source: National NZ Health Survey [6]

Measure: Proportion of the population (15+) who are obese



[5] *The NZ Health Survey is an annual survey commissioned by the Ministry of Health and collects information about the health and wellbeing of New Zealanders, the services they use and key factors that affect their health. Around 14,000 households take part in the survey with total population results presented annually and ethnicity breakdowns presented over combined time periods (due to small population numbers). For the combined period 2014-2017, 14.8% of the total Canterbury population were current smokers, compared to 39.9% of Māori and 36.5% of our Pacific population.*

[6] *The NZ Health Survey defines 'Obese' as having a Body Mass Index (BMI) of >30 or >32 for Māori and Pacific populations. Rates are available by ethnicity over the combined period 2014-2017 – 28% of the total population are obese, compared to 46.3% of Māori and 58.7% of Pacific.*

FEWER AVOIDABLE HOSPITAL ADMISSIONS

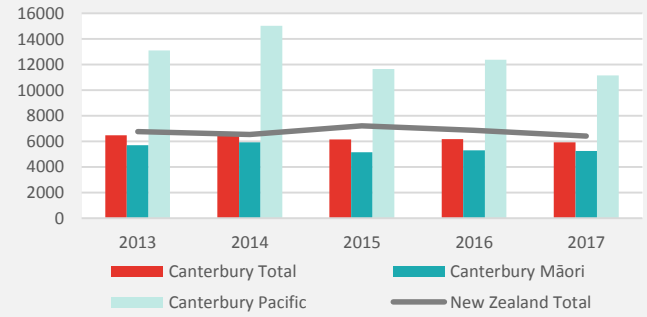
An increasing number of admissions to hospital are for conditions which are seen as preventable through lifestyle change, a reduction in risk factors, earlier intervention and the effective management of long-term conditions.

Ensuring children have the best start to life is a crucial component in the long-term health and wellbeing of our population. A reduction in these admissions will also free up hospital and specialist resources to respond to more complex and urgent cases and reduce delays in treatment.

This measure is seen as an indicator of the accessibility and effectiveness of health care and a marker of increased integrated between health and social services.

Data source: Ministry of Health Performance Reporting [7]

Measure: Rate of ambulatory sensitive hospital admission for children (0-4)	Base	Target			
	16/17	18/19	19/20	20/21	21/22
	5,919	<6,416	<6,416	<6,416	<6,416



CHILDREN HAVE IMPROVED ORAL HEALTH

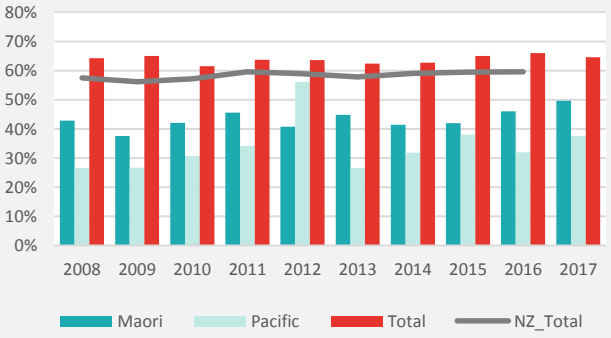
Oral health is an integral component of lifelong health and contributes to a person's self-esteem and quality of life.

Good oral health not only reduces unnecessary hospital admission, but also signals a reduction in risk factors, such as poor diet, which has lasting benefits in terms of improved nutrition and heathier body weights.

Māori and Pacific children are more likely to have decayed, missing or filled teeth. As such, improvements in the proportion of children carries-free (no holes or fillings) is also seen as a proxy indicator of the effectiveness of mainstream services in reaching those most at risk.

Data source: School and Community Oral Health Services Patient Management System (Titanium) and Statistics New Zealand Population Projections [8]

Measure: Children caries free at age five	Base	Target			
	2017	2018	2019	2020	2021
	65%	66%	66%	>66%	>66%



FEWER YOUNG PEOPLE TAKE UP SMOKING

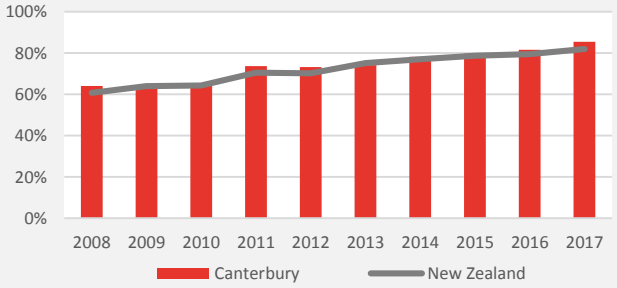
The highest prevalence of smoking is amongst younger people and preventing young people from taking up smoking is a key contributor to reducing smoking rates across our total population.

Because Māori and Pacific people have higher smoking rates, reducing the uptake amongst Māori and Pacific youth provides a significant opportunity to improve long-term health outcomes for these population groups.

A reduction in the uptake of smoking by young people is seen as a proxy indicator of the success of our health promotion activity, and a change in the social and environmental factors that support healthier lifestyles.

Data source: National ASH Year 10 Survey [9]

Measure: 'Never smokers' amongst Year 10 students	Base	Target			
	2017	2018	2019	2020	2021
	86%	>82%	>82%	>82%	>82%



[7] *This measure is a national DHB performance indicator (SI1) and refers to hospitalisations for conditions considered preventable including: asthma, vaccine-preventable diseases, dental conditions and gastroenteritis. The measure is defined as a (non-standardised) rate per 100,000 people and results differ to those previously presented, reflecting updated national data provided by the Ministry of Health to June 2017. The DHB's aim is to maintain performance below the national rate (reflecting fewer people presenting to hospital) and reduce equity gaps between populations, the Dec 2017 rate for the total population was slightly higher (6,010) but still trending down and below the national average.*

[8] *This measure is a national DHB performance indicator (PP11) and is reported annually for the school year. Ethnicity results are calculated by undertaking a data match between the Oral Health Service Patient Management System (Titanium) and Primary Care Enrolment data.*

[9] *The ASH Survey is an annual survey of around 30,000 Year 10 students across New Zealand. Run by Action on Smoking & Health the survey has been used to monitor student smoking since 1999 and provides valuable insights into tobacco use trends amongst young people. The DHB's aim is to continue to remain above the national average. For more detail see www.ash.org.nz.*

3.14 People stay well in their own homes and communities

WHY IS THIS A PRIORITY?

When people are supported to stay well and can access the care they need closer to home and in the community, they are less likely to experience acute illness or the kind of complications that might lead to a hospital-level intervention or residential care. This is better in terms of people's health outcomes and quality of life, and it also reduces the pressure on our hospitals and frees up health resources. Studies show countries with strong primary and community care systems have lower rates of premature death from heart disease, cancer and stroke. They also achieve these health outcomes at a lower cost than countries with systems that focus more heavily on a specialist or hospital level response.

Health services also play an important role in supporting people to regain functionality after illness and supporting people to remain independent for longer. Even where returning to full health is not possible, access to responsive, needs-based rehabilitation, pain management and palliative care services can help to improve the quality of people's lives.

The general practice team is a vital point of ongoing continuity, particularly in terms of improving care for people with long-term conditions and supporting people to stay well as they age. We are investing in general practice services, community-based allied health and diagnostic services and home-based support services, with the aim of improving access to services closer to people's homes and enabling earlier intervention, diagnosis and treatment.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

A REDUCTION IN ACUTE HOSPITAL ADMISSIONS

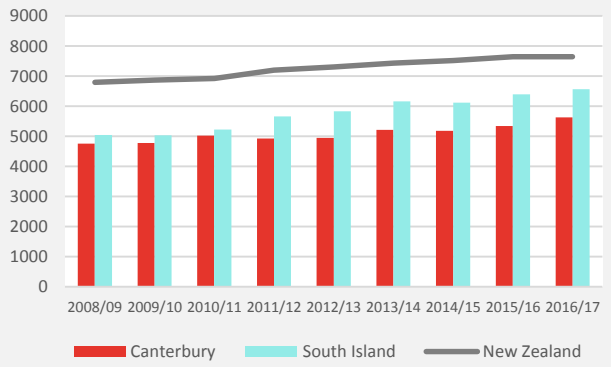
Acute (unplanned) hospital admissions account for almost one third of all admissions in New Zealand. However, with the right approach, people can live healthier lives and avoid the deterioration of their condition that leads to acute illness, hospital admission, complications and even death.

Reducing acute hospital admissions and the length of time people spend in our hospitals also has a positive effect on the health system, enabling more efficient use of specialist resources that would otherwise be captured responding to demands for urgent care.

Acute hospital admissions are used as a proxy indicator of improved long-term conditions management and access to timely and appropriate treatment in the community.

Data source: National Minimum Data Set

Measure: Rate of acute medical admissions to hospital (age standardised, per 100,000 people)



MORE PEOPLE LIVING IN THEIR OWN HOME

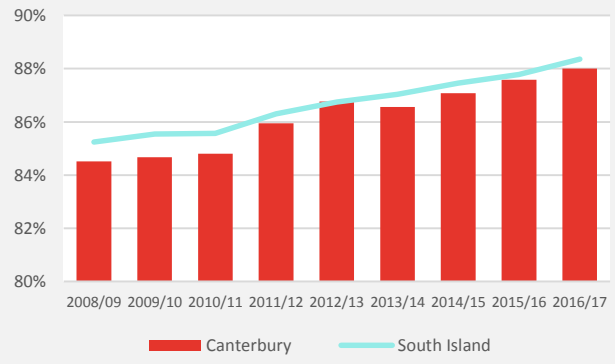
While living in residential care is appropriate for a small proportion of our population, studies have shown a higher level of satisfaction and better long-term outcomes when people remain in their own homes and positively connected to their local communities.

Living in residential care is also a more expensive option and resources could be better spent providing home-based support and packages of care to help people stay well in their own homes.

An increase in the proportion of older people living in their own homes is seen as a proxy indicator of how well the health system is managing age-related and long-term conditions and responding to the needs of our older population.

Data source: SIAPO Client Claims Payment System

Measure: Proportion of the population (75+) living in their own home



PEOPLE'S CONDITIONS ARE DIAGNOSED EARLIER

Timely access to diagnostics, by improving clinical decision-making, enables earlier and more appropriate intervention and treatment. This contributes to both improved quality of care and improved health outcomes.

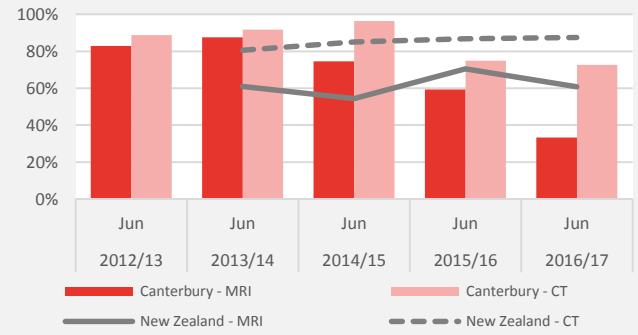
People also want certainty regarding access to health services when they need it, without long waits for diagnosis or treatment.

Wait times for diagnostics therefore be seen as a proxy indicator of the effectiveness of our health system and our ability to match capacity with demand, particularly when we are seeking to minimise wait times and operating within a constrained environment.

Data source: DHB Patient Management System

Measure: People receiving their non-urgent MRI or CT scan within six weeks

	Base	Target			
	16/17	18/19	19/20	20/21	21/22
MRI	73%	90%	90%	90%	90%
CT	33%	95%	95%	95%	95%



FEWER AVOIDABLE HOSPITAL ADMISSIONS

An increasing number of admissions to hospital are for conditions which are seen as preventable through lifestyle change, a reduction in risk factors, earlier intervention and the effective management of long-term conditions.

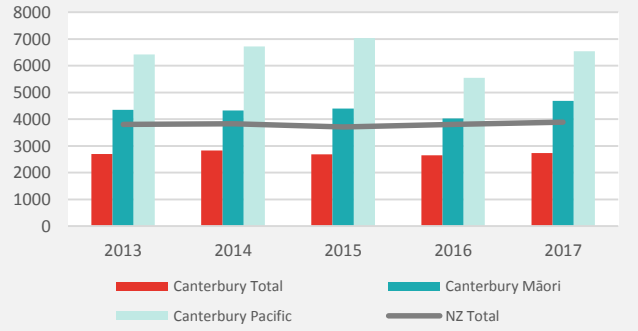
Not only will a reduction in avoidable admissions contribute to improved health outcomes for our population, it will also free up hospital and specialist resources to respond to more complex and urgent cases and reduce delays in treatment.

A key factor in reducing avoidable hospital admissions is improved coordination between primary and secondary services. As such, this measure is seen as an indicator of the accessibility and effectiveness of health care and a marker of increased integrated between health and social services.

Data source: Ministry of Health Performance Reporting [10]

Measure: Rate of ambulatory sensitive hospital admission for adults (45-64)

Base	Target			
16/17	18/19	19/20	20/21	21/22
2,737	<3,892	<3,892	<3,892	<3,892



FEWER FALLS-RELATED HOSPITAL ADMISSIONS

Compared to older people who do not fall, those who do experience prolonged hospital stays, loss of confidence and independence and an increased risk of institutional care.

With an ageing population, our focus on reducing harm from falls will help people to stay well and independent and reduce the demand for hospital and residential care services.

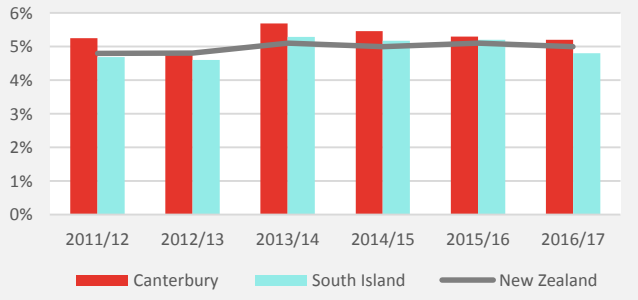
Solutions to preventing falls include appropriate medications use, improved physical activity and nutrition, access to restorative support and rehabilitation and a reduction in personal and environmental hazards.

This measure is seen as an indicator of the responsiveness of our system to the needs of our older population, as well as a measure of the quality of the services being provided.

Data source: National Minimum Data Set [11]

Measure: Population (75+) admitted to hospital as a result of a fall

Base	Target			
16/17	18/19	19/20	20/21	21/22
5.2%	<5.5%	<5.5%	<5.5%	<5.5%



[10] This measure is a national DHB performance indicator (SI1) and refers to hospitalisations for conditions considered preventable including: asthma, vaccine-preventable diseases, dental conditions and gastroenteritis. The measure is defined as a (standardised) rate per 100,000 people and results differ to those previously presented, reflecting updated national data provided by the Ministry of Health to June 2017. The DHB's aim is to maintain performance below the national rate (reflecting fewer people presenting to hospital) and reduce equity gaps between populations, the December 2017 rate for the total population was slightly lower (2,690) relatively stable and below the national average.

[11] The target for this measures has been set with the aim of maintaining rates in line with national performance, but allowing for an anticipated increase in falls related to our ageing population. From 2013/14 results reflect the updated population in line with the 2013 Census.

3.15 People with complex illness have improved health outcomes

WHY IS THIS A PRIORITY?

For people who do need a higher level of intervention, timely access to high quality specialist care and treatment is crucial in delivering a positive outcome, supporting recovery or slowing the progression of illness. Improved access and shorter wait times are seen as indicative of a well-functioning and sustainable system, able to match capacity to demand and managing the flow of patients to ensure people receive the service they need when they need it.

As the primary provider of hospital and specialist services in Canterbury, this goal also considers the effectiveness and the quality of the treatment we provide. Adverse events, ineffective treatment or unnecessary waits can cause harm and result in longer hospital stays and complications that have a negative impact on the health of our population. Ineffective or poor quality treatment and long waits also impact on people's experience of care and confidence in the health system, waste resources and add unnecessary cost.

We are in midst of a significant facilities redevelopment, remediation and repair programme and capacity within our hospital services is currently severely limited. In order to meet both the physical and emotional needs of our growing population, we are focusing on improving the flow of patients across our system and reducing duplication of effort to maintain service access while reducing waiting times for treatment.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

A REDUCTION IN ACUTE READMISSIONS

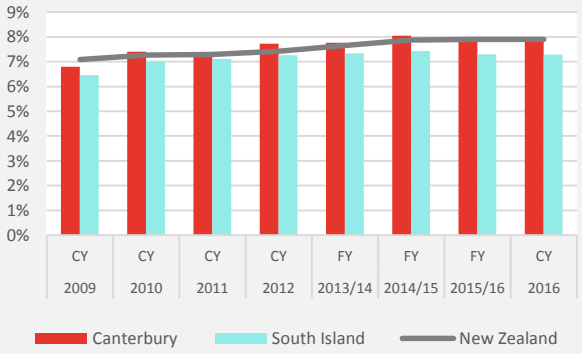
As well as reducing public confidence and driving unnecessary costs, patients who are readmitted to hospital are more likely to experience negative longer-term outcomes.

Key factors in reducing acute readmissions include good patient safety and quality standards, appropriate discharge planning and transition processes, and improved care coordination at the interface between services. Ensuring people receive effective (and safe) treatment in our hospitals and appropriate support and care on discharge.

Readmission rates are therefore a useful marker of the quality of care being provided and the level of integration between service providers. These rates are also a good counter-measure to productivity measures such as reductions in lengths of stay.

Data source: Ministry of Health Performance Reporting [12]

Measure: Rate of acute readmissions to hospital within 28 days of discharge (unstandardised)



A REDUCTION IN AMENABLE MORTALITY

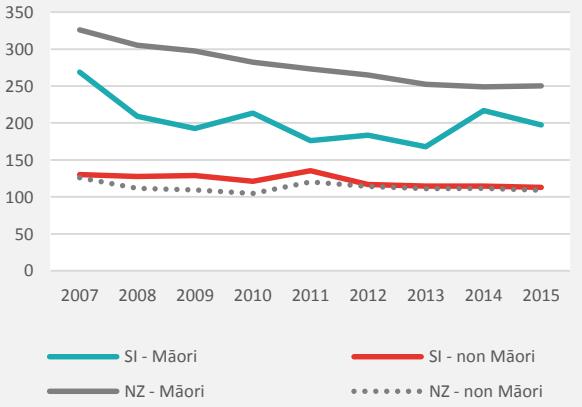
Amendable mortality is defined as premature death (before age 65) from conditions that could have been avoided through lifestyle change, earlier intervention and effective management and treatment.

There are many economic, social and environmental factors that have an influence on people's life expectancy. However, timely diagnosis and access to safe and effective treatment are crucial factors in improving survival rates for complex illnesses such as health disease and cancer.

A reduction in the rate of amendable mortality can be used reflect the responsiveness of the health system to the needs of people with complex illness, and as an indicator of access to timely and effective care and treatment.

Data source: National Mortality Collection [13]

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



[12] *This measure is a national DHB performance indicator (OS8) and is under review by the Ministry of Health. Due to ongoing refinement of the definition, results differ to previous years. The DHB has chosen to present unstandardised rate as this enables closer analysis of performance while the definition is confirmed. Data is three months in arrears, with results being the year to March.*

[13] *The performance data for this measures is sourced from the national mortality collection which classifies the underlying cause of all deaths registered in New Zealand. Data is released three years in arrears and the 2015 results are provisional.*

SHORTER WAITS FOR URGENT CARE

Emergency Departments (EDs) are often seen as a barometer of the efficiency and responsiveness of both the hospital and the wider health system.

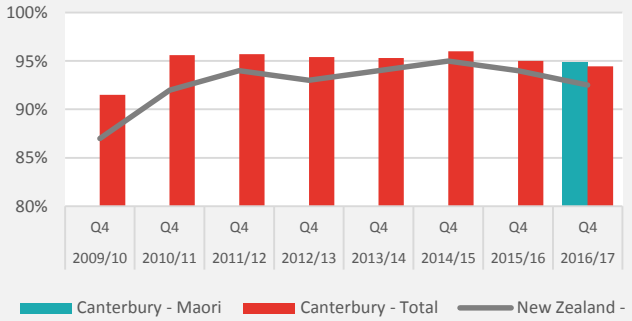
Long waits in ED are linked to overcrowding, poor patient experience, longer hospital stays and negative outcomes for patients. Enhanced performance will not only contribute to improved patient outcomes by enabling early intervention and treatment, but will improve public confidence and trust in our health services.

Solutions to reducing ED wait times address the underlying causes of delay and span not only our hospital services but the wider health system. In this sense, this indicator is a marker of the responsiveness of our whole system to the urgent care needs of our population.

Data source: DHB Patient Management System [14]

Measure: People admitted, discharged or transferred from ED within 6 hours

Base	Target			
16/17	18/19	19/20	20/21	21/22
94.4%	95%	95%	95%	95%



SHORTER WAITS FOR PLANNED CARE

Access to elective services (including specialist assessment, treatment and surgery) improves the quality of people's lives by removing pain or discomfort, slowing the progression of disease and helps to restore independence and wellbeing.

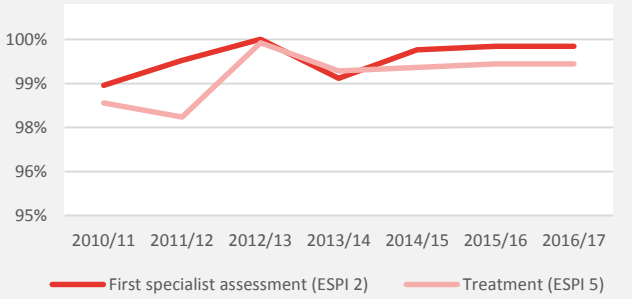
Improved performance against these measures requires us to make the most effective use of our limited resources to ensure wait times are minimised, while a year-on-year increase in volumes is delivered.

In this sense, these indicators are a marker of hospital efficiency and, with constrained capacity across our system, a proxy for how well we are managing the flow of patients across our services.

Data source: Ministry of Health Elective Services Website [15]

Measure: People receiving specialist assessment and treatment within set time frames

Base	Target			
16/17	18/19	19/20	20/21	21/22
ESPI2 99.8%	100%	100%	100%	100%
ESPI5 99.3%	100%	100%	100%	100%



FEWER ADVERSE EVENTS IN OUR HOSPITALS

Adverse events, as well as causing avoidable harm to patients, reduce public confidence and contribute unnecessary costs into the system. Improving patient safety and quality standards in our hospitals will greatly improve outcomes for patients.

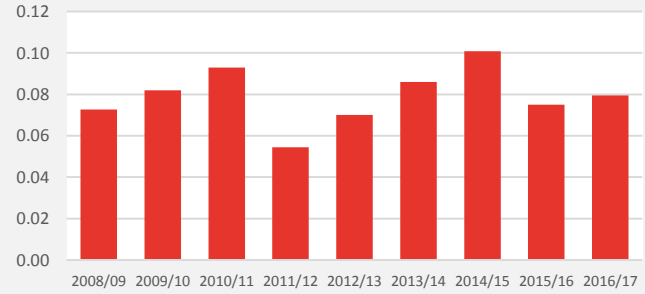
Patient falls are particularly important, as patients who experience a serious fall are more likely to have prolonged hospital stays, loss of confidence, conditioning and independence and an increased risk of institutional care.

Achievement against this measure provides an indication of the quality of our services. This indicator is also seen as a marker of the engagement of staff and clinical leaders in improving processes and patient safety.

Data source: DHB Incident Reporting System [16]

Measure: Rate of falls with a severity assessment code (SAC) of level 1 & 2

Base	Target			
16/17	18/19	19/20	20/21	21/22
0.08	<0.09	<0.09	<0.09	<0.09



[14] *This measure is a national performance measure (Shorter Stays in ED). Standards are set nationally and in line with national expectations and reporting, the results presented refer to the final quarter of each year (April – June).*

[15] *These measures are part of the national Elective Services Patient Flow Indicators (ESPIs) set and are a measure of whether DHBs are meeting expectations at key points in a patient's journey. ESPI 2 refers to the wait from referral to a person's first specialist assessment. ESPI 5 refers to the wait from the point from when treatment was agreed until treatment is delivered. Standards are set nationally and in line with national expectations and reporting, the results presented refer to the final month of each year (June).*

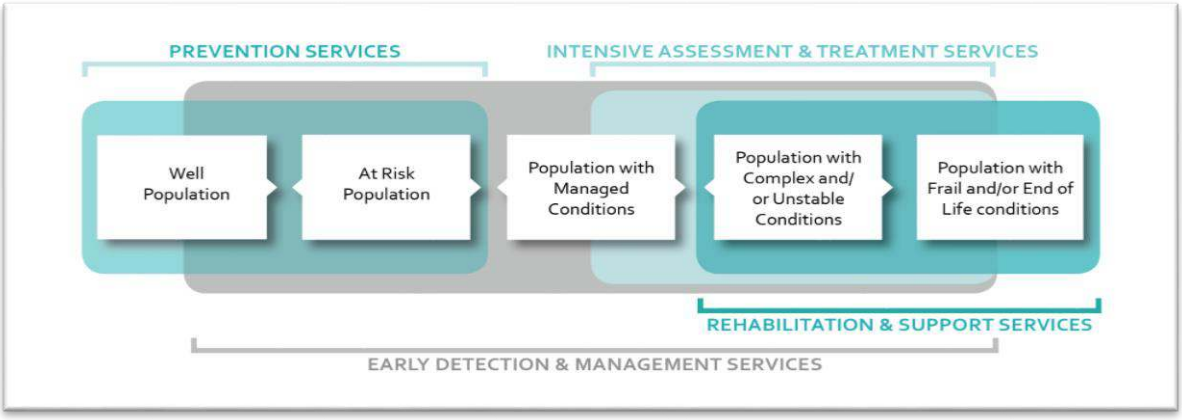
[16] *The Severity Assessment Code (SAC) is a numerical score given to an incident based on the outcome of the incident and the likelihood that it will recur. Level 1 and 2 incidents are those with both the highest likelihood and consequence. The rate is per 1,000 inpatient beds and the 2016/17 result differs from that pervious published, being updated to include the full year's result.*

Part IV

Annual Operating Intentions

What can you expect from us?

Service Performance Expectations



4.1 Evaluating our performance

As both the major funder and provider of health services in Canterbury, the decisions we make and the way in which we deliver services have a significant impact on people's health and wellbeing.

Having a limited resource pool and a growing demand for health services, we are strongly motivated to ensure we are delivering the most effective and efficient services possible.

Over the longer term, we evaluate the effectiveness of our decisions by tracking the health of our population against a set of desired population health outcomes, encompassed in our Outcomes Framework. These longer-term health indicators are highlighted in the Monitoring Our Performance section.

On an annual basis, we evaluate our performance by providing a forecast of the services we plan to deliver and the standards we expect to meet. The results are then presented in our Annual Report at year end.

The following section presents the Canterbury DHB's Statement of Performance Expectations for 2018/19.

IDENTIFYING PERFORMANCE MEASURES

Because it would be overwhelming to measure every service delivered, services have been grouped into four service classes. These are common to all DHBs and reflect the types of services provided across the full health and wellbeing continuum (illustrated above):

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

Under each service class we have identified a mix of service measures that we believe are important to our community and stakeholders and provide a fair indication of how well the DHB is performing.

In health, the number of people who receive a service can be less important than whether enough of the right people received the service, or whether the service was delivered at the right time.

To ensure a balanced, well rounded picture, the mix of measures identified address four key aspects of service performance:

Access (A)
How well are people accessing services, is access equitable, are we engaging with all of our population?

Timeliness (T)
How long are people waiting to be seen or treated, are we meeting expectations?

Quality (Q)
How effective is the service, are we delivering the desired health outcomes?

Experience (E)
How satisfied are people with the service they receive, do they have confidence in us?

SETTING STANDARDS

In setting performance standards, we consider the changing demography of our population, areas of increasing demand and the assumption that resources and funding growth will be limited.

Targets reflect the strategic objectives of the DHB: increasing the reach of prevention programmes; reducing acute or avoidable hospital admissions; and maintaining access to services - while at the same time reducing waiting times and delays in treatment.

We also seek to improve the experience of people in our care and public confidence in our health system.

While targeted interventions can reduce service demand in some areas, there will always be some demand the DHB cannot influence such as demand for maternity, dementia or palliative care services.

It is not appropriate to set targets for these services, however they are an important part of the picture of health need and service delivery in our region. Service level estimates have been provided to give context in terms of the use of resources across our health system.

Wherever possible, past years' results have been included to give context in terms of current performance levels and what we are trying to achieve.

SETTING PERFORMANCE EXPECTATIONS

With a growing diversity and persistent inequalities across our population, achieving equity of outcomes is an overarching priority for the DHB. All of our targets are universal, with the aim of reducing disparities between population groups.

A number of focus areas have been identified as health priorities for Māori and the associated measures will be reported by ethnicity in our Annual Report.

Canterbury is still contending with the ongoing consequences of the earthquakes. The operational impact is being felt, most markedly, in an increased demand for mental health and emergency services and reduced capacity within our hospitals due to the loss of buildings and space. The relentless disruption from repairs and construction is also having a negative impact on services and on the wellbeing of our staff.

In considering this pressure and our reduced capacity, we have retained 2017/18 standards against a number of our discretionary measures. However, many of the performance targets presented in our forecast are national expectations set for all DHBs.

While we remain committed to maintaining high standards of service delivery, some national expectations (particularly those relating to increased delivery in our hospitals) will be particularly challenging in our current operating environment.

NOTES FOR THE READER

Rather than repeating footnotes, the following symbols have been used in the performance tables:

Δ Performance data is provided by external parties and baseline results can be subject to change, due to delays in invoicing or reporting.

† Performance data relates to the calendar year rather than the financial year.

◇ Many national targets and performance measures are set to be achieved by the final quarter of any given year. In line with national expectations, baselines refer to the final quarter (April-June).

E Services are demand driven and no targets have been set for these service lines. Estimated service volumes have been provided to give context in terms of the use of health resources

◆ This measure has been identified as a key focus area for Māori. Progress by ethnicity will be reported in the DHB's Annual Report.

4.2 Where does the money go?

In 2018/19 the DHB will receive approximately $1.822 billion dollars with which to purchase and provide the services required to meet the needs of our population.

The table below presents a summary of our anticipated financial split for 2018/19, by service class.

	2018/19
Revenue	**Total $'000**
Prevention	45,646
Early detection and management	356,194
Intensive assessment & treatment	1,139,717
Rehabilitation & Support	280,267
Total Revenue - $'000	**1,821,824**
Expenditure	**Total $'000**
Prevention	47,264
Early detection and management	376,047
Intensive assessment & treatment	1,201,928
Rehabilitation & Support	295,060
Total Expenditure - $'000	**1,920,299**
Surplus/(Deficit) - $'000	**(98,475)**

4.3 Prevention services

WHY ARE THESE SERVICES SIGNIFICANT?

Prevention services are publically funded services that promote and protect the health of the whole population or targeted sub-groups. These services seek to address individual behaviours by targeting physical and social environments and norms that can influence and support people to make healthier choices and are distinct from treatment services.

The four leading long-term conditions—cancer, cardiovascular disease, diabetes, and respiratory disease—make up 80% of the disease burden for our population. By supporting people to make healthier choices, we can reduce the risk factors that contribute to these conditions. High-need population groups are also more likely to engage in risky behaviours, or live in environments less conducive to making healthier choices. Prevention services are therefore one of our foremost opportunities to target improvements in the health of high-need populations and reduce inequalities in health status and health outcomes. Prevention services are designed to spread consistent messages to a large number of people and can therefore also be a very cost-effective health intervention.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Population Health Services – Healthy Environments				
These services address aspects of the physical, social, and built environment in order to protect health and improve health outcomes.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Number of submissions providing strategic public health input and expert advice to inform policy in the region and/or nationally	Q [17]	73	116	E. 90
Licensed alcohol premises identified as compliant with legislation	Q [18]	87%	79%	90%
Number of exotic mosquitoes crossing the border and establishing in the region	Q	0	0	0
Networked drinking water supplies compliant with Health Act	Q [19]	94%	96%	97%

Population-Based Screening Services				
These services help to identify people at risk of developing a long-term condition and support earlier intervention and treatment. Success is reflected by engagement in programmes and high coverage rates across the population.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Four-year-olds provided with a B4 School Check (B4SC)	A [20] ◆	91%	93%	90%
Four-year-olds (identified as obese at their B4SC) offered a referral for clinical assessment and family based nutrition, activity and lifestyle intervention	Q [21] ◇◆	new	95%	95%
Women aged 25-69 having a cervical cancer screen in the last three years	A [22] ◆	74%	74%	80%
Women aged 50-69 having a breast cancer screen in the last two years	A [22] ◆	77%	76%	70%

[17] The expected number of submissions varies in a given year and will be higher, for example, when Territorial Authorities are consulting on their draft long-term plans. This measure includes submissions and formal comments on proposed legislative changes, draft national policy statements, commissions of inquiry, and local government policy statements, regional, district and long-term plans, sanitary works infrastructure planning and resource consent applications. It may not be necessary for the DHB to submit if it is involved in the planning or pre-consultation phase.

[18] New Zealand law prevents alcohol retailers from selling alcohol to young people aged under 18 years, with the aim of reducing alcohol-related harm for this age group. Controlled Purchase Operations involve sending supervised volunteers (under 18 years) into licensed premises. If the volunteer is refused alcohol the licensed premise is said to have complied with the Sale and Supply of Alcohol Act. Compliance can be seen as a proxy measure of the success of education and training for licensed premises and reflects a culture that encourages a responsible approach to alcohol.

[19] This measure relates to the percent of (water) network supplies compliant with sections 69V and 69Z of the Health Act 1956. This includes all classes of supplies (large, medium, minor, small and rural agricultural).

[20] The B4 School Check is the final core check, under the national Well Child/Tamariki Ora schedule, which children receive at age four. It is free and includes assessment of vision, hearing, oral health, height and weight, allowing concerns to be identified and addressed early.

[21] This measure is a national performance measure (Raising Healthy Kids). Obesity is particularly concerning in children as it is associated with a wide range of health conditions and increased risk of illness. It can also affect a child's immediate health, educational attainment and quality of life. The referral allows families to access support to maintain healthier lifestyles.

[22] The cervical and breast screening measures refer to participation in national screening programmes and standards are set nationally. Cervical cancer is one of the most preventable cancers and breast cancer one of the most common. Risk increases with age and regular screening reduces the risk of dying from cancer by allowing for earlier intervention and treatment.

Health Promotion and Education Services				
These services inform people about risk factors, and support them to make healthy choices. Success is evident through increased engagement which leads over time to more positive behaviour choices and a healthier population.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Mothers receiving breastfeeding and lactation support in the community	A [23]	1,033	1,026	>600
Babies exclusively/fully breastfed on LMC discharge (six weeks)	Q [24] ◆	72%	74%	75%
Babies exclusively/fully breastfed at three months	Q [25]◆	59%	61%	70%
Eligible schools supported by the Health Promoting Schools framework	A [26]	89%	90%	>75%
People provided with Green Prescriptions for additional physical activity support	A [27]	3,095	3,800	>3,000
Green Prescription participants more active six-eight months after referral	Q	75%	-	50%
Smokers, enrolled with a PHO, receiving advice and support to quit smoking (ABC)	Q [28]◇◆	88%	90%	90%
Smokers, identified in hospital, receiving advice and support to quit smoking (ABC)	Q ◇◆	98%	95%	95%
Pregnant women, identified as smokers at confirmation of pregnancy with an LMC, receiving advice and support to quit smoking (ABC)	Q [29]◇◆	93%	93%	90%

Immunisation Services				
These services reduce the transmission and impact of vaccine-preventable diseases, both routinely and in response to specific risk. Engagement in programmes and high coverage rates are indicative of a well-coordinated, successful service.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Children fully immunised at eight months of age	A ◇◆	96%	95%	95%
Proportion of eight-month-olds 'reached' by immunisation services	Q [30]◇	98%	99%	95%
Young women (Year 8) completing the HPV vaccination programme	A [31]†◆	43%	59%	75%
Older people (65+) receiving a free influenza ('flu') vaccination	A [32]†◆	74%	63%	75%

[23] This programme aims to improve breastfeeding rates and to create a supportive breastfeeding environment. Evidence shows that infants who are not breastfed have a higher risk of developing chronic illnesses during their lifetimes. The percentage of babies being breastfed can demonstrate the effectiveness of consistent health promotion messages during the antenatal, birthing and early postnatal period.

[24] Breastfeeding measures are part of the national Well Child/Tamariki Ora Quality Framework and standards are set nationally. The baselines reflect six monthly results and the 3 month measure result for 2016/17 relates to the six months to December 2017.

[25] Well Child provider breastfeeding data (3-months) is not able to be combined, performance from the largest provider (Plunket) is presented.

[26] The Health Promoting Schools Framework supports a school community's capacity to create and sustain environments that improve and maintain health and wellbeing. Eligible schools have been defined as decile 1-4 and years 1-8. 'Engaged' schools have a current action plan.

[27] A Green Prescription is a health professional's written advice to a patient to be physically active, as part of their health management. Standards are set nationally and performance data is sourced from a national patient survey competed by Research NZ on behalf of the Ministry of Health. In 2016/17 a decision was made nationally to shift to biannual surveys. The next surveys will be in 2017/18 and 2019/20.

[28] Evidence shows that the majority of smokers want to quit and need help to do so. The ABC programme has a cessation focus and refers to the health professional Asking about smoking status, providing Brief advice and providing Cessation support. The provision of profession advice and cessation support is shown to increase the likelihood of smokers making quit attempts and the success rate of those attempts.

[29] Data for this measure is sourced from the Ministry of Health's national Maternity Dataset which covers approximately 80% of pregnancies nationally. As such, the measure is seen as developmental and results are used to indicate trends rather than absolute performance. Standards have been set nationally in line with the other smoking targets.

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

[31] The Human Papillomavirus (HPV) vaccination aims to protect young people from HPV infection and the risk of developing HPV-related cancers later in life. The programme consists of two vaccinations and is free to young women (and men) 9-26 years of age. The target for 2018/19 is the proportion of girls born in 2005 completing the programme. Canterbury's HPV programme differs to that provided in other regions, being primarily a general practice based programme complimented by a school-based programme launched in February 2016.

[32] Almost one in four New Zealanders are infected with influenza each year. Influenza vaccinations can reduce the risk of flu-associated hospitalisation and have also been associated with reduced hospitalisations among people with diabetes and chronic lung disease. The vaccine is especially important for people at risk of serious complications, including people aged over 65, pregnant women and people with long-term or chronic conditions. The population data sources for this measure changed in 2016/17, from PHO enrolment registers to 2013 Census population projections. Results from previous years are not directly comparable.

4.4 Early detection and management services

WHY ARE THESE SERVICES SIGNIFICANT FOR THE DHB?

The New Zealand health system is experiencing an increasing prevalence of long-term conditions, so-called because once diagnosed people usually have them for the rest of their lives. Some population groups suffer from these conditions more than others and prevalence increases with age.

Our vision of an integrated system presents a unique opportunity. For most people, their general practice team is their first point of contact with health services and is vital as a point of continuity and in improving the management of care for people with long-term conditions. By promoting regular engagement with primary and community services, we are better able to support people to stay well, identify issues earlier, and reduce complications, acute illness and unnecessary hospital admissions. Our integrated approach is particularly effective where people have multiple conditions requiring ongoing intervention or support.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

General Practice Services				
These services support people to maintain and manage their health and wellbeing and avoid unnecessary hospital admissions. High levels of enrolment and engagement with general practice are indicative of an accessible and responsive service.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Proportion of the population enrolled with a Primary Health Organisation (PHO)	A ◆	95%	94%	95%
Newborns enrolled with a PHO by three months of age	A [24]◆	82%	80%	85%
Young people (0-19) accessing brief intervention counselling in primary care	A [33]Δ	610	679	>500
Adults (20+) accessing brief intervention counselling in primary care	A [33]Δ	5,505	5,861	>4,500
Number of integrated HealthPathways in place across the health system	Q [34]	499	644	>600
Proportion of general practices using the primary care patient experience survey	E [35]	new	42%	>60%

Long-Term Condition Services				
These services are targeted at people with high health needs with the aim of reducing complications and crisis through earlier intervention and treatment and by supporting people to better manage and control their conditions.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Number of spirometry tests provided in the community rather than in hospital	A [36]Δ	1,742	1,897	>2,000
Number of skin lesions (growths, including cancer) removed in primary care	A Δ	2,820	2,520	>2,000
People receiving subsidised diabetes self-management support when starting insulin	A Δ	392	381	>300
Population identified with diabetes having an HbA1c test in the last year	A [37]Δ◆	89%	89%	90%
Population with diabetes having an HbA1c test and acceptable glycaemic control	Q [37]Δ◆	75%	75%	>75%
Eligible population having a cardiovascular disease risk assessment in the last five years	A [38]◇◆	87%	85%	90%

[33] The Brief Intervention Counselling service supports people with mild to moderate mental health concerns, including depression and anxiety. The service includes the provision of free counselling sessions (or extended consultations) and include face-2-face and phone consultations.
[34] Clinically designed HealthPathways support general practice teams to manage medical conditions, request advice or make secondary care referrals. The pathways support consistent access to treatment and care no matter where people present. The results differ to those previously published as the count now only reflects community clinical pathways and not supporting resource pages.
[35] The Patient Experience Survey is a national online survey to determine patients' experience in primary care and how well their overall care is managed. The survey has been piloted in a small number of DHB regions and is now being rolled-out across the country. The information will be used to improve the quality of service delivery and patient safety.
[36] Spirometry is a tool for measuring and assessing lung function for a range of respiratory conditions. Providing this service in the community means people do not need to wait for a hospital appointment and conditions can be identified and treated earlier.
[37] Diabetes is a leading long-term condition and contributor to many other conditions. An annual HbA1c test (of blood glucose levels) is a means of assessing the management of people's condition. A level of less than 64mmol/mol reflects an acceptable blood glucose level.
[38] Cardiovascular disease is one of the leading causes of death in Canterbury. By identifying those at risk of cardiovascular disease early, we can help people to change their lifestyle, improve their health and reduce the chance of a serious event. Targets and eligible population is set nationally: Māori, Pacific or Indian: males 35-74, females 45-74; all other males 45-74 and females 55-74.

Oral Health Services				
These services help people maintain healthy teeth and gums and support lifelong health and wellbeing. High levels of enrolment and timely access to treatment are indicative of an accessible and efficient service.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Children (0-4) enrolled in DHB-funded oral health services	A [39]†◆	61%	62%	95%
Children (0-12) enrolled in DHB funded oral health services, who are examined according to planned recall	T [39]†◆	90%	90%	90%
Adolescents (13-17) accessing DHB-funded oral health services	A [39]†	62%	61%	85%

Pharmacy and Referred Services				
These are services which a health professional uses to help diagnose or monitor a health condition. While largely demand driven, timely access to services enables improved clinical decision-making and reduces unnecessary delays in treatment.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Number of laboratory tests completed for the Canterbury population	A Δ	2.5m	2.8m	E.<2.8m
Number of subsidised pharmaceutical items dispensed in the community	A [40]Δ	6.5m	6.8m	E.<8m
People on multiple medications receiving medication management support	A [41]Δ	1,355	1,361	>1,200
People (65+) being dispensed 11 or more long term medications (rate per 1,000)	Q [42]†	4.6	4.2	E.4.6
Number of community-referred radiology tests completed	A Δ	44,404	45,227	E.>40,000
People receiving their urgent diagnostic colonoscopy within two weeks	T [43]◇	92%	94%	90%
People receiving their Magnetic Resonance Imaging (MRI) scans within six weeks	T [43]◇	59%	33%	90%
People receiving their Computed Tomography (CT) scans within six weeks	T [43]◇	75%	73%	95%

[39]These measures are national DHB performance measures (PP12 and 13) and standards are set nationally. Oral health is an integral component of lifelong health and wellbeing. Early and regular contract with oral health services helps to sets live-long patterns and reduce risk factors such as poor diet, which have lasting benefits in terms of improved nutrition and healthier body weights.

[40] This measure relates to pharmaceutical items dispensed by community pharmacies to people living in the community. Hospital dispensed items are excluded. This may still include some may include some non-Canterbury residents who had prescriptions filled while in Canterbury.

[41] The Medical Management Review programme helps to ensure the safe and appropriate use of medications. The programme offers more intense medication therapy assessments for the most complex patients and less complex medication use reviews for others.

[42]The use of multiple medications is most common in the elderly and can lead to reduce drug effectiveness or negative outcomes. Concerns include increased adverse drug reactions, poor drug interactions and higher costs for the system with little health benefits. Multiple medication use requires monitoring and review to validate whether all of the medications are complimentary and necessary.

[43] These measures are national DHB performance measures (PP29) and refer to non-urgent scans. By improving clinical decision-making, timely access to diagnostics enables earlier and more appropriate intervention and treatment. This contributes to improved quality of care and health outcomes and by reducing long waits for diagnosis or treatment, improves people's confidence in the health system. A colonoscopy is a test that looks at the inner lining of a person's large intestine (rectum and colon). Standards are set nationally and in line with national reporting, the results presented refer to the final month of each year (June).

4.5 Intensive assessment and treatment services

WHY ARE THESE SERVICES SIGNIFICANT?

Intensive assessment and treatment services are more complex services provided by specialists and health professionals working closely together. They are usually provided in hospital settings, which enables the co-location of expertise and equipment. A proportion of these services are delivered in response to acute events, others are planned and access is determined by clinical triage, treatment thresholds, capacity, and national service coverage agreements.

Timely access to intensive assessment and treatment can significantly improve people's quality of life through corrective action and is crucial to improving survival rates for complex illness such as cancer. Responsive services and timely access to treatment also enable people to establish more stable lives and result in improved confidence in the health system.

As an owner of specialist services, the DHB is committed to ensuring the quality of its service provision. Adverse events and delays in treatment, as well as causing harm to patients, drive unnecessary costs. Improved processes will support patient safety, reduce the number of events causing injury or harm, and improve health outcomes for our population.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Quality and Patient Safety				
These quality and patient safety measures are national markers championed and monitored by the NZ Health Quality & Safety Commission. High compliance levels indicate robust quality processes and strong clinical engagement.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Staff compliant with good hand hygiene practice	Q [44]◇	78%	83%	80%
Hip and knee replacement patients receiving routine antibiotics before surgery	Q ◇	98%	98%	95%
Inpatients (aged 75+) receiving a falls risk assessment	Q ◇	100%	97%	90%
Response rate to the national inpatient patient experience survey	E [45]	37%	16%	>30%
Proportion of patients who felt 'hospital staff included their family/Whānau or someone close to them in discussions about their care'	E	50%	57%	65%

Maternity Services				
These services are provided to women and their families through pre-conception, pregnancy, childbirth and the early months of a baby's life. Demand driven, service utilisation is monitored to ensure services are accessible and responsive to need.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Women registered with a LMC by 12 weeks of pregnancy	A [46]†◆	77%	78%	80%
Number of maternity deliveries in Canterbury DHB facilities	A	5,922	6,048	E.6,000
Proportion of maternity deliveries made in Primary Birthing Units	Q [47]	14%	14%	>13%

[44] *The quality markers are national performance measures set to drive improvement in key areas. High compliance indicates robust quality processes and strong clinical engagement. Standards are set nationally and results refer to the final quarter of each year (April-June).*

[45] *There is growing evidence that patient experience is a good indicator of the quality of health services. Better experience, stronger partnerships with consumers, and patient and family-centred care have been linked to improved health, clinical, financial, service and satisfaction outcomes. The inpatient patient experience survey runs quarterly in all District Health Board hospitals and covers four key domains of patient experience: communication, partnership, co-ordination and physical and emotional needs.*

[46] *Early registration with a Lead Maternity Carer (LMC) is encouraged to promote the good health and wellbeing of mother and the developing baby. Data is sourced from the national Maternity Clinical Indicators report.*

[47] *The DHB aims to increase people's acceptance and confidence in using primary birthing units rather than having women give birth in secondary or tertiary facilities when it is not clinically indicated. This enables the best use of resources and ensures limited secondary services are more appropriately available for those women who need more complex or specialist intervention.*

Acute and Urgent Services				
These are services delivered in response to accidents or illnesses that have an abrupt onset or progress rapidly. While largely demand driven, not all acute events require hospital treatment. Because early intervention can reduce the impact of the event, multiple options and shorter waiting times are indicative of a responsive system.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Number of acute demand packages of care provided in community settings	A [48] Δ	33,010	34,853	>30,000
Number of presentations at Canterbury Emergency Departments (ED)	A [49]	94,251	96,854	E.<105k
Proportion of the population presenting in ED (per 1,000 people)	Q	177	173	<178
Patients (referred with a high suspicion of cancer and a need to be seen within two weeks) receiving their first treatment within 62 days of referral.	T ◇	70%	85%	90%
Average acute inpatient length of stay (bed days per 1,000 people)	Q [50]	2.39	2.40	<2.35

Elective and Arranged Services				
These are medical and surgical services provided for people who do not need immediate hospital treatment. Their assessment or treatment is booked or arranged. Maintaining access while reducing waiting times is indicative of an efficient service.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Number of First Specialist Assessments provided	A	71,244	72,049	E.>60,000
Proportion of First Specialist Assessments that were non-contact (virtual)	Q [51]	17%	17%	>10%
Number of elective/arranged surgical discharges (surgeries provided)	A ◇ [52]	21,039	21,456	21,782
Proportion of people receiving their elective coronary angiography within 3 months	T [53]	98%	97%	95%
Proportion of people receiving their surgery on the day of admission	E [54]	91%	91%	90%
Average elective inpatient length of stay (bed days per 1,000 people)	Q [50]	1.54	1.54	<1.54
Number of outpatient consultations provided	A	671,705	672,348	E.>650k
Outpatient appointments where the patient was booked but did not attend (DNA)	Q [55]	5%	4%	<5%

[48] Acute demand packages of care are provided through Canterbury's community-based Acute Demand Management Service with the aim of supporting people in their own homes or in the community rather than presenting to hospital for treatment.
[49] This measure is aligned to the national Shorter Stays in ED measure and counts presentations to Christchurch and Ashburton Hospitals. In line with the national definition. This measure excludes those who do not wait and those with pre-arranged appointments.
[50] This measure is a national DHB performance measure (OS3). By shortening the average length of stay, the DHB delivers on the national improved hospital productivity priority and frees up beds and resources to provide more elective (planned) surgery.
[51] Non-contact assessments are those where advice or assessment is provided without the need (or the wait) for a hospital appointment. This direction aligns to the DHB's vision of reducing waiting times and unnecessary delay in treatment for patients.
[52] This measure is a national DHB performance measure (PP45) and only includes surgeries aligned to the national electives definition.
[53] This is a national performance measure (PP29). A coronary angiogram is an x-ray test used to determine if a person's coronary arteries are blocked or narrowed and can help determine the type of treatment needed. Timely access to this treatment supports improved outcomes for patients. In line with national reporting, baselines relate to the final month of the year (June).
[54] When elective surgery is delivered on the day of admission, it makes surgery less disruptive for patients who can spend the night before in their own home and indicates effective planning on behalf of services who are not delaying or cancelling surgeries.
[55] When patients fail to turn up to scheduled appointments, it can negatively affect their recovery and long-term outcomes and it is costly in terms of wasted resources for the DHB. This measure is calculated as the proportion of all medical and surgical outpatient appointments where the patient was expected to attend on the day, but did not.

Specialist Mental Health and Alcohol and Other Drug (AOD) Services				
These are services for those most severely affected by mental illness and/or addictions who require specialist intervention and treatment. Reducing waiting times, while meeting demand for services, is indicative of a responsive and efficient service.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Proportion of the population (0-19) accessing specialist mental health services	A [56Δ]	3.5%	3.7%	>3.1%
Proportion of the population (20-64) accessing to specialist mental health services	A Error! ookmark not defined.Δ	3.4%	3.8%	>3.1%
People referred for non-urgent mental health and AOD services seen within 3 weeks	T [57]	76%	77%	80%
People referred for non-urgent mental health and AOD services seen within 8 weeks	T [57]	93%	94%	95%
Acute inpatients accessing community services within 7 days of discharge	Q [58]	79%	78%	80%

[56] These access measures are national DHB performance measures (PP6), and standards are set based on the expectation that 3% of the population will need access to specialist level mental health services during their lifetime. Results are provided by the Ministry of Health and reflect services reporting through to the national PRIMHD database. This measure undercounts service provision where local providers are not set up to report to the national system. The short timeframe presented does not reflect the extent of increased in demand for mental health services in Canterbury: access rates in December of 2010 (prior to the earthquakes) were 1.7% for youth and 2.2% for adults.

[57] The wait time measures are national DHB performance measures (PP8). Data is sourced from the Ministry's national PRIMHD database and results and standards are set nationally. Results are provided three months in arrears.

[58]This measure is seen as an indicator of suicide prevention activity and patient safety, reflecting continued support for people who have experienced an acute psychiatric episode requiring hospitalisation. Research indicates that people have increased vulnerability immediately following discharge, including higher risk for suicide, while those leaving hospital with a formal discharge plan and links with community services and supports are less likely to experience early readmission. Data is sourced from the national NZ Mental Health and Addictions KPI Programme reports (indicator KPI 19) and standards are set nationally.

4.6 Rehabilitation and support services

WHY ARE THESE SERVICES SIGNIFICANT?

Rehabilitation and support services provide people with the assistance they need to live safely and independently in their own homes, or regain functional ability, after a health related event. These services are considered to provide people with a much higher quality of life as a result of people being able to stay active and positively connected to their communities. This is evidenced by less dependence on hospital and residential care services and a reduction in acute illness, crisis or deterioration leading to acute admission or readmission into our hospitals.

Even when returning to full health is not possible, timely access to responsive support services enables people to maximise their independence. In preventing deterioration, acute illness or crisis, these services have a major impact on the sustainability of our health system by reducing acute service demand and the need for more complex interventions. These services also support patient flow by enabling people to go home from hospital earlier.

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

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Assessment, Treatment and Rehabilitation (AT&R) Services				
These services restore or maximise people's health or functional ability following a health-related event such as a fall, heart attack or stroke. Largely demand-driven, success is measured through appropriate service referral following an event.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Number of admissions into hospital-based AT&R services	A	3,371	3,442	E. 3,000
Proportion of AT&R inpatients discharged to their own home rather than ARC	Q [59]	86%	88%	>80%
Proportion of inpatients referred to an organised stroke service (with demonstrated stroke pathway) after an acute event	Q	80%	80%	80%
People accessing community-based pulmonary rehabilitation courses	A [60]	261	325	>200
People (65+) accessing the community-based falls prevention service	A [61]	1,973	1,815	>1,200

Home-Based Support Services				
These are services designed to support people to continue living in their own homes and to maintain their functional independence. Largely demand driven, clinical assessment ensures access to services is appropriate and equitable.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
People supported by CREST services	A [62Δ]	1,726	1,741	>1,600
People supported by district nursing services	A [Δ]	7,532	7,798	E. 7,000
People supported by long-term home-based support services	A [Δ]	8,129	7,922	E. 8,000
Proportion of the population (65+) supported by long-term, home-based support services	A [Δ]	10.3%	9.8%	E. 10%
People supported by long-term, home and community support services who have had a clinical assessment of need using the InterRAI assessment tool	Q [63Δ]	96%	97%	95%
People supported by hospice or home-based palliative services	A [Δ]	3,617	4,060	E. 4,000

[59] While living in Aged Residential Care (ARC) is appropriate for a small proportion of our population, for most people remaining safe and well in their own homes provides a higher quality of life. A discharge home reflects the quality of services in terms of assisting that person to regain their functional independence. The measure excludes those who were ARC residents prior to AT&R admission.

[60] Respiratory or lung diseases are a key driver of a significant portion of avoidable hospital admissions in Canterbury, particularly over winter. Pulmonary Rehabilitation Programmes are designed to help patients with Chronic Obstructive Pulmonary Disease (a type of obstructive lung disease) to manage their symptoms and learn breathing, diet, exercise and day-to-day living techniques to better manage their condition.

[61] Falls are one the leading causes of hospital admission for people aged over 65. The aim of the Falls Prevention Programme is to provide better care for people both 'at-risk' of a fall, or following a fall, and to support people to stay safe and well in their own homes.

[62] The CREST service provides a range of home-based rehabilitation services to facilitate people's early discharge from hospital, or to avoid admission entirely, through proactive GP referral. The measure is the number of people having received unique packages of care.

[63] The International Residential Assessment Instrument (InterRAI) is a suite of evidence-based geriatric assessment tools used nationally. The tools support clinical decision making and care planning. Evidence-based practice guidelines ensure assessments are of high quality and people receive appropriate and equitable access to services irrespective of where they live.

Respite and Day Support Services				
These services provide people with a break from a routine or regimented programme, so that crisis can be averted or a specific health need can be addressed. Largely demand driven, access to services is expected to increase over time, as our population ages and more people are supported to remain in their own homes.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
People supported by mental health crisis respite services	A Δ	886	904	E.>850
Occupancy rate of mental health crisis respite beds	A[64]Δ	74%	73%	85%
Older people supported by day care services	A[65]Δ	804	728	E.>550
Older people accessing aged care respite services	A[66]Δ	1,706	1,715	E.>1,500
Proportion of people supported by aged care respite services who are discharged to their own home	Q[67]Δ	85%	86%	>80%

Aged Residential Care Services				
With an ageing population, demand for aged residential care (ARC) is expected to increase. However a reduction in demand for lower-level residential care is indicative of more people being successfully supported for longer in their own homes. The DHB subsidises ARC for people who meet the national thresholds for care.	Notes	2015/16 Result	2016/17 Result	2018/19 Target
Proportion of the population (75+) accessing rest home level services in ARC	A [68]Δ	4.95%	4.57%	E.<5.0%
Proportion of the population (75+) accessing hospital-level services in ARC	A Δ	6.13%	5.99%	E.<6.5%
Proportion of the population (75+) accessing dementia services in ARC	A Δ	2.54%	2.45%	E. 2.5%
Proportion of the population (75+) accessing psychogeriatric services in ARC	A Δ	0.84%	0.84%	E. 0.8%
People entering ARC having had a clinical assessment of need using InterRAI	Q [63]Δ	99%	88%	95%

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

[65] *Includes people accessing day care services in the community and in ARC and refers largely to people aged 65+ but also other 'older' people close in age and interest.*

[66] *The baselines differ to results previously printed (1,620 and 1,629) due to late invoicing and improved data matching.*

[67] *Respite services aim to support people for short durations, to regain function or to give carers a break. Discharge home (rather than staying on in ARC) reflects the quality of services in terms of assisting that person to regain or maintain their functional independence.*

[68] *These ARC measures refer to people accessing DHB funded ARC services and excludes people choosing to enter ARC and pay privately and people living independently in a retirement village. The Canterbury region has historically had higher ARC rates than national levels. Access rates for more complex care such as dementia and psychogeriatric care are driven by the age of our population and less amendable. However, by providing high quality health services for older people to help them maintain health, and remain in their own homes for longer, we expect to see a reduction in demand for rest-home-level care relative to the more complex care intervention.*

Financial Performance Expectations

4.7 Canterbury's financial outlook

Funding from the Government, via the Ministry of Health, is the main source of DHB funding. This is supplemented by revenue agreements with ACC, research grants, donations, training subsidies, patient co-payments and service payments from other DHBs.

Like the rest of the health sector, the Canterbury DHB is experiencing growing financial pressure from increasing demand and treatment costs, increasing wage settlements and heightened public expectations.

However, unlike other DHBs, we are also having to manage the extraordinary impacts of the country's largest natural disaster. These include: revenue volatility resulting from population and deprivation shifts; increased service demand; and the operational challenges of providing services in the midst of a significant and ongoing repair programme.

It is incredibly challenging to meet financial expectations while addressing the heightened needs of a more vulnerable population and rebuilding almost all of our entire health infrastructure.

Earthquake and rebuild costs continue to be evident in a number of areas: increased treatment costs; additional outsourcing to support service delivery while capacity is reduced; unplanned repair costs; construction delays; depreciation; and capital charges.

Lost capacity costs: Our theatre and bed capacity was reduced by the earthquakes and the Christchurch Hospital redevelopment is considerably behind schedule. Construction costs are escalating and while we wait for the new facilities to be complete, we are incurring significant additional costs to hire theatres and outsource surgeries. The delays are also impacting on our ability to achieve anticipated savings from the consolidation of services.

Repair costs: A significant proportion of our repair work is not covered by insurance proceeds. While we received the maximum $320 million insurance pay-out under our collective sector policy, damage estimates were over $518 million. Our repair programme has required, and will continue to require, ruthless prioritisation to remain affordable.

Depreciation and capital charges: Included in the cost pressures related to the earthquakes are the depreciation and capital charges the DHB must pay to the Crown. Because these are driven off upward movements in asset valuations, our repair work has resulted in significant additional unanticipated charges. In 2018/19, Canterbury will pay an estimated $25 million in capital charges to the Crown, on the assumption that earthquake settlement insurance proceeds redrawn as equity to date will be reclassified as donated assets (as not sourced from the Crown) and will not attract capital charge.

Increasing demand costs: Demand patterns have also changed. In line with other international recovery profiles, the post-disaster impacts on the health and well-being of our population are being acutely felt. This is particularly evident in the increased demand for mental health services with new presentations to children's services especially high.

Post-earthquake population increases, changes in demand, and workforce shortages also mean that even after the DHB's new Outpatient and Acute Services facilities come online, capacity will continue to be stretched. Further solutions will need to be found to meet growing demand and further investment in facilities, technology and workforce will be needed.

The DHB is working with the Ministry of Health and other key government agencies to establish a stable and sustainable pathway forward for our health system that considers our unique operating challenges.

There is no easy solution, and improving the health of our population is the only way to reduce the demand curve. Savings will be made, not in dollar terms, but in costs avoided through earlier intervention and more effective use of available resources. While these gains may be slow, this is the basis on which we will build a more effective and sustainable health system. The DHB is committed to continuing its deliberate strategy in this regard.

The DHB is committed to continuing to review services and service models to ensure we are using our resources in the most effective and efficient way. Anticipated service changes in the coming year are highlighted on page 31 of this document.

4.8 Planned results

It is anticipated that the Canterbury DHB will receive $1.822 billion of total revenue, from all sources, with which to meet the needs of our population and the significant cost increases of Multi Employment Collective Agreements and other pay settlements reached in (and impacting on) 2018/19.

The Canterbury DHB is forecasting a $98.5 million deficit result for the 2018/19 year.

The $98.5 million forecast deficit takes into account Canterbury's allocated share of population based funding (demographic and cost pressures). It also takes into account $5.5 million in additional mental health funding (provided by the Ministry to cover increased demand for mental health services following the earthquakes) and 'neutral' revenue items that come with associated expenditure (such as pay equity settlements, the Mana Ake mental health support in school initiative and the Free Under 14s general practice programme).

OUT-YEARS' SCENARIO

Our remaining unspent earthquake insurance proceeds are held by the Crown on behalf of the DHB. We are able to draw down these proceeds as revenue to offset earthquake-related operating repair costs and as equity to offset capitalised repair costs. However, equity drawdowns incur a capital charge in addition to the operational impact of depreciation.

Interest, depreciation and capital charge costs arising from earthquake repairs and assets revaluation will have a significant impact on our out-year financials. These costs will increase significantly on completion of the Outpatients Building and Energy Centre (2018/19) and the Acute Services Building (2019/20).

The combined annual depreciation, interest and capital charge will increase from $69 million in 2015/16 to approximately $132 million by 2020/21.

The interplay between the nature of earthquake repairs, new building codes and construction cost escalations continues to be dynamic. Anticipated repair costs have been included but an accurate total overall cost is still difficult to pre-determine.

Also, due to the recognition of insurance proceeds in 2012/13 (as required under current NZ accounting standards and resulting in a surplus of $287M in 2012/13), some future costs are not able to be offset with the corresponding inflow of insurance proceeds. This creates a timing mismatch in current and out-years.

The post-earthquake reality in Canterbury will continue to create a high level of uncertainty with regards to both revenue and expenditure in out-years.

4.9 Major assumptions

Revenue and expenditure estimates for out-years have been based on current government policy, service delivery models and demand patterns. Changes in the complex mix of any of the contributing factors will impact on our results. In preparing our financial forecasts, we have made the following assumptions:

- The DHB will retain early payment arrangements.
- Out-years funding is assumed at the Treasury's mid-scenario forecasts for Canterbury DHB.
- Operating deficits will be fully funded as equity, including the 2017/18 deficit funding yet to be received. The DHB has retained this assumption despite recent experiences where the deficit funded has been significantly less than the deficit result at year-end.
- Capital charge for out-years is based on the current rate of 6%. Any rate change in the future is assumed to be financially neutral.
- Any targeted funding to meet additional mental health service provision will be sustainable over the longer-term.
- The $5.5M per annum funding provided by the Ministry of Health in 2016 for a three year period, to cover increased demand for mental health services following the earthquakes will cease in 2019 and the Ministry will actively work with Canterbury DHB to ensure adequate funding to meet Mental Health service pressures.
- Costs of compliance with any new national expectations will be cost neutral or fully funded, as will any legislative changes, sector reorganisation or service devolvement.
- Assumption of responsibility for the population of the Chatham Islands will be cost neutral to the Canterbury DHB. The DHB is yet to clarify the funding stream to enable remediation of local facilities inherited in 2015.
- Funding for pay equity settlements will be cost-neutral and fully funded.
- $180 million (being the undrawn portion of Canterbury's $320 million earthquake settlement proceeds transferred to the Crown to minimise capital charge expenses, as at June 2018), will be available to the DHB to fund the earthquake repair and reinstatement programme as required.
- As agreed with the Ministry of Health, the revenue and equity timing of the earthquake insurance draw down will be flexible and based on DHB requests rather than necessarily matching the earthquake capital and operating repair spend for a particular year.
- Capital charge associated with earthquake settlement proceeds redrawn as equity will be waived by the Crown.
- Additional saving targets requiring service changes and/or Ministerial consent are approved in a timely manner.
- Work will continue on the redevelopment of Canterbury facilities in accordance with the detailed business case agreed with the Ministry and previous Cabinet. Associated capital expenditure that will take place during the term of this Plan has been included.
- Revaluations of land and buildings will continue, and will impact on asset values. In addition to regular periodic revaluations, further impairment in relation to earthquakes may be necessary.
- Employee cost increases for other expired wage agreements, including minimum wage flow-on impact if any, will be settled on fiscally sustainable terms, inclusive of step increases and the impact of accumulated leave revaluation. External provider increases will also be settled within available funding levels.
- Treatment related costs will increase in line with known inflation factors and foreseen adjustments for the impact of growth within services.

- National and regional savings initiatives and benefits will be achieved as planned.
- Transformation strategies will not be delayed or derailed due to sector or legislative changes and investment to meet increased earthquake-related demand will be prioritised and approved, in line with the Board's strategy.
- There will be no further disruptions associated with natural disasters or pandemics. Revenue and expenditure have been budgeted on current and expected operations with no disaster.

4.10 Bridging the gap

While health continues to receive a large share of government funding, if we are to be sustainable, we must rethink how we will meet our population's need within a more moderate growth platform.

Since establishing our vision in 2006, we have been purposeful and deliberate in planning how we would meet growing demand for health services and make the best use of the resources we have available.

In the past eight years, our ability to absorb revenue and cost impacts related to the earthquakes has largely been delivered by slowing our growth rate of acute demand, reducing our dependence on aged residential care, reorganising laboratory services, and removing waste and duplication from our system.

Alongside the effective transformation of our health system, we are also focused on delivering efficiency and quality improvements to take the wait and waste out of our system. In the coming year, we will consider all options and opportunities to bridge the gap between revenue and expenditure including:

- Integrating systems, services and processes to remove variation, duplication and waste.
- Empowering clinical decision-making to reduce delays and improve the quality of care.
- Improving production planning to ensure we use our resources in the most effective way.
- Focusing expenditure on areas that are essential, and reducing the outsourcing of services.
- Prioritising investment into services that meet the most immediate demand, deliver maximum health benefits and are sustainable longer-term.
- Aligning policies and practice with other DHBs and with national service specifications to reduce treatment and service costs.
- Acknowledging fiscal constraints and limitations when considering the implementation of new technologies, initiatives or services.
- Reviewing service capacity and costs across heavily subsidised service areas and exploring alternative options for service delivery.
- Restraining cost growth including moderating treatment, back office, support, and FTE costs.
- Objectively reviewing and, where appropriate, realigning economic useful life of fixed assets to fit-for-purpose actuality and best practices.
- Supporting the South Island Alliance to implement tighter cost controls and make purchasing improvements to limit the rate of cost growth by taking a lead in the regional Procurement and Supply Chain Workstream.

Anticipated service changes for 2018/19 are outlined in the Managing our Business section of this document.

4.11 Capital investment

NATIONAL BUSINESS CASES

The detailed business case for the redevelopment of the Christchurch Hospital site was approved in March 2013. Construction of both the Outpatients and Acute Services Buildings have been significantly delayed. The Outpatients Building is now scheduled for completion in late 2018 and the Acute Services Building is scheduled for completion in the second half of 2019.

The detailed business case for replacement of our patient administration systems with one South Island Patient Information Care System was approved by in 2014. Burwood was the first go-live site and Ashburton and Christchurch Hospital will go live in 2018/19.

The indicative business case for the relocation of mental health services from The Princess Margaret Hospital (which assumed the project would be fully equity funded by the Crown), was approved in 2017. Development of a detailed business case for this critical capital project is underway and expected to be completed in 2018.

An indicative business case for the future of the Christchurch Hospital Campus is being completed. This critical project is part of the blueprint for the ongoing development of the campus, as foreshadowed in the approved 2013 detailed business case outlined above. The plan addresses immediate needs as well as providing the foundation for the longer development solution for the campus to meet service and capacity demands.

The DHB has also completed an initial strategic assessment in regards to investment in a facility for Canterbury's tertiary laboratory and pathology services. This has been submitted to the Ministry of Health for consideration and the DHB will look to progress with the development of an indicative business case in due course.

CAPITAL EXPENDITURE

Subject to the appropriate approvals, Canterbury's capital expenditure budget for the 2018/19 year totals $134 million, and is comprised of:

- $15M for the new Outpatients facility (excluding the earthquake programme of works funded portion, see below) in line with the approved detailed business case and additional scope.
- $76 million for the capital expenditure portion of the strategic earthquake programme of works (including $14.6M for the Tunnel and $57M for the new Outpatients facility in excess of the $15M funded by the Crown, see above).
- $5 million in progress payments for the South Island Patient Information Care System.
- $38 million for other new/replacement assets and systems.

Anticipated investment for out-years includes:

- Strategic Information Technology developments towards a digital hospital including: further implementation of the Patient Information Care System, Electronic Medication Management, HealthOne and investment in the patient portal.
- Repair and reinstatement of the Christchurch Hospital Energy Centre and Carpark.
- Completion of the Rangiora and Akaroa IFHC redevelopments in line with approvals.
- Continued repair and reinstatement of assets under the DHB's earthquake repair programme.
- Relocation of mental health services currently located on the Princess Margaret Hospital site.
- Repurposing of the Canterbury Health Laboratories building per outcome of future detailed planning.
- Further Christchurch Hospital Campus redevelopment, incorporating the future of services currently located in earthquake damaged and/or below building code facilities (such as the Riverside, Parkside and Food Services buildings).

Out-years capital planning will also consider the future use of existing buildings and facilities, in line with our earthquake repair programme, and in response to population growth and service demand. This will include buildings on the Christchurch Hospital and Hillmorton Hospital campuses.

Any lengthy construction delays, changes in building codes or cost price increases for major redevelopment or repair projects are likely to have a significant impact on planned expenditure.

4.12 Debt and equity

In February 2017, all DHB Crown debts were converted to equity as part of the debt/equity translation process. Effective from 2016/17, DHBs have no Crown debt. The pre-approved debt for the new Acute Services Building will also be translated to equity.

The Canterbury DHB repaid equity to the Crown of $180 million over 2013/14 and 2014/15 as part of our contribution towards the Burwood and Christchurch Hospital redevelopments.

The extent of damage to Canterbury DHB's insured facilities and equipment is well in excess of $518 million. However, the collective sector insurance in place at the time of the earthquake meant we were only able to access a total maximum loss capacity of $320 million. The gap between the insurance settlement and the total cost of the repairs will need to be met from our existing funds.

In June 2014, we paid $290 million (being the unspent portion of the $320 million as at June 2014) of our earthquake settlement insurance proceeds to the Crown to minimise capital charge expenses (arising from an abnormal surplus through recognising the settlement proceeds as income under current NZ accounting standards). As agreed with the Ministry of Health, the $290 million is being progressively drawn down to fund the ongoing earthquake repair work.

The forecast amount drawn down as at 30 June 2018, is $110 million (a mix of revenue and equity) leaving a balance of $180 million yet to be drawn. This is now unlikely to be sufficient in light of unplanned costs coming out of this settlement related to the redevelopment of the Acute Services Building and completion of the Boiler House and Energy Centre.

Taking into account projected equity movements over the next four years, the Crown's equity in the DHB will rise from $518 million as at June 2017 to $1.033 billion by June 2021. The higher equity balance will result in a significant increase in the capital charge payable to the Crown.

4.13 Additional considerations

Under the NZ Public Health and Disability Act, no DHB may dispose of land without approval of the Minister of Health. Ministerial approval will only be given where the DHB has complied with its statutory clearance and public consultation obligations under the Act.

Anticipated activity for 2018/19 includes the potential disposal of a parcel of land on St Asaph Street and two parcels of land on Tuam Street as part of a land swap with Otakaro and Land Information New Zealand (LINZ) within the Health Precinct. The DHB has also recently sought to dispose of two other land parcels: one on Maddison's Road in Templeton to facilitate City Council infrastructure arrangements, and one on Lincoln Road in Hillmorton to accommodate the new city cycle lanes and a road widening project.

We are yet to determine the future of the former Christchurch Women's Hospital site in the central city and the Princess Margaret Hospital site in Cashmere. Over the coming year we will also consider the future use of all of our rural hospitals.

ACTIVITIES FOR WHICH COMPENSATION IS SOUGHT

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

ACQUISITION OF SHARES

Before the Canterbury DHB or any of our associates or subsidiaries can subscribe for, purchase, or otherwise acquire shares in any company or other organisation, our Board will consult the responsible Minister(s) and obtain their approval.

ACCOUNTING POLICIES

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

4.14 Group statement of comprehensive revenue and expense

As at 30 June for the years ending 2016/17 to 2020/21

	2016/17 Actual $'000	2017/18 Actual $'000	2018/19 Plan $'000	2019/20 Plan $'000	2020/21 Plan $'000
REVENUE					
Ministry of Health revenue (Note 1)	1,573,724	1,647,882	1,726,350	1,781,977	1,852,241
Other government revenue	28,932	36,948	37,172	38,102	39,054
Earthquake repair revenue redrawn	10,712	3,240	5,300	14,100	17,800
Other revenue	42,740	48,028	53,002	55,523	57,488
Total Revenue	**1,656,108**	**1,736,098**	**1,821,824**	**1,889,702**	**1,966,583**
EXPENSE					
Personnel	704,206	755,125	810,649	856,362	895,346
Outsourced (Note 2)	25,907	28,801	28,451	28,020	27,637
Clinical supplies	142,871	144,638	143,990	152,100	160,031
Earthquake building repair costs	10,712	3,240	5,300	14,100	17,800
Infrastructure & non clinical (excl Earthquake repairs)	105,569	99,887	105,685	113,973	115,055
Payments to non-CDHB providers	643,176	679,356	742,871	723,626	731,277
Depreciation and amortisation	56,268	58,657	57,909	70,142	70,191
Capital charge and interest expense	20,232	30,353	25,444	48,128	61,868
Total Expense	**1,708,941**	**1,800,057**	**1,920,299**	**2,006,451**	**2,079,205**
Surplus/(Deficit)	**(52,833)**	**(63,959)**	**(98,475)**	**(116,749)**	**(112,622)**
OTHER COMPREHENSIVE REVENUE & EXPENSE					
Revaluation of property, plant & equipment	(1,791)	-	-	-	-
Impairment of property, plant & equipment	300	-	-	-	-
Total Comprehensive Income/(Deficit)	**(54,324)**	**(63,959)**	**(98,475)**	**(116,749)**	**(112,622)**

Note 1: Includes Inter District Flow and Inter-DHB revenue
Note 2: Excludes outsourced electives payments to Non-CDHB Providers

4.15 Group statement of financial position

As at 30 June for the years ending 2016/17 to 2020/21

	30/06/17 Actual $'000	30/06/18 Actual $'000	30/06/19 Plan $'000	30/06/20 Plan $'000	30/06/21 Plan $'000
CROWN EQUITY					
Contributed capital	90,073	132,470	281,569	872,883	997,771
Revaluation reserve	289,058	289,058	289,057	289,057	289,057
Accumulated surpluses	138,702	74,743	(23,732)	(140,481)	(253,103)
Total Equity	**517,833**	**496,271**	**546,894**	**1,021,459**	**1,033,725**
REPRESENTED BY:					
CURRENT ASSETS					
Cash & cash equivalents	1,985	1,678	-	-	-
Trade & other receivables	72,652	90,391	90,393	90,393	90,393
Inventories	9,118	11,171	11,170	11,170	11,170
Restricted assets	11,815	14,577	14,577	14,577	14,577
Investments	1,350	750	750	750	750
Total Current Assets	96,920	118,567	116,890	116,890	116,890
CURRENT LIABILITIES					
NZHPL sweep bank account	16,505	17,376	48,920	36,917	5,082
Trade & other payables	106,936	111,190	111,190	111,190	111,190
Employee benefits	156,703	171,361	163,361	163,361	163,361
Restricted funds	12,111	14,593	14,593	14,593	14,593
Total Current Liabilities	292,255	314,520	338,064	326,061	294,226
Net Working Capital	(195,335)	(195,953)	(221,174)	(209,171)	(177,336)
NON CURRENT ASSETS					
Property, plant, & equipment	693,087	670,749	740,694	1,202,726	1,183,845
Intangible assets	25,940	27,635	33,535	34,065	33,377
Restricted assets	296	16	16	16	16
Total Non-Current Assets	719,323	698,400	774,245	1,236,807	1,217,238
NON CURRENT LIABILITIES					
Employee benefits	6,155	6,176	6,177	6,177	6,177
Total Non-Current Liabilities	6,155	6,176	6,177	6,177	6,177
Net Assets	**517,833**	**496,271**	**546,894**	**1,021,459**	**1,033,725**

4.16 Group statement of movements in equity

As at 30 June for the years ending 2016/17 to 2020/21

	2016/17 Actual $'000	2017/18 Actual $'000	2018/19 Plan $'000	2019/20 Plan $'000	2020/21 Plan $'000
Total equity at beginning of the year	199,933	517,833	496,271	546,894	1,021,459
Total comprehensive revenue and expense for the year	(54,324)	(63,959)	(98,475)	(116,749)	(112,622)
OTHER MOVEMENTS					
EQUITY REPAYMENTS					
Annual depreciation funding repayment	(1,861)	(1,861)	(1,861)	(1,861)	(1,861)
EQUITY INJECTIONS					
Earthquake repair capital redrawn	11,100	9,258	72,000	12,000	10,000
Kaikoura facility contribution	2,000	-	-	-	-
Operating deficit support (Note 3)	-	35,000	63,959	98,475	116,749
New facilities redevelopment assets transferred from the Crown - original equity value (Note 4)	130,000	-	15,000	258,100	-
Debt to Equity swap - new facilities (Note 4)	85,000	-	-	224,600	-
Debt to equity swap - debt as at June 2016	145,985	-	-	-	-
Total Equity at End of the Year	**517,833**	**496,271**	**546,894**	**1,021,459**	**1,033,725**

Note 3: Assume year end equity for deficit support is recognised in the financial year it is received and not booked in the year the deficit occurred.

Note 4: 2019/20 amount is indicative only and subject to the final cost and agreed debt vs equity split of the Acute Services Building asset to be transferred from the Crown.

4.17 Group statement of cash flow

As at 30 June for the years ending 2016/17 to 2020/21

	2016/17 Actual $'000	2017/18 Actual $'000	2018/19 Plan $'000	2019/20 Plan $'000	2020/21 Plan $'000
CASH FLOW FROM OPERATING ACTIVITIES					
Cash provided from:					
Receipts from Ministry of Health	1,570,290	1,642,515	1,726,350	1,781,977	1,852,241
Earthquake repair revenue redrawn	10,712	3,240	5,300	14,100	17,800
Other receipts	94,967	67,993	88,396	91,726	94,485
Interest received	2,113	1,552	1,778	1,899	2,057
	1,678,082	1,715,300	1,821,824	1,889,702	1,966,583
Cash applied to:					
Payments to employees	720,349	760,305	838,258	875,775	914,565
Payments to suppliers	934,510	932,270	1,006,688	1,012,406	1,032,581
Capital charge and interest paid	21,282	30,352	25,444	48,128	61,868
GST - net	(3,886)	(1,338)	-	-	-
	1,672,255	1,721,589	1,870,390	1,936,309	2,009,014
Net Cash Flow from Operating Activities	**5,827**	**(6,289)**	**(48,566)**	**(46,607)**	**(42,431)**
CASH FLOW FROM INVESTING ACTIVITIES					
Cash provided from:					
Sale of property, plant, & equipment	728	460	-	-	-
Receipt from investments and restricted assets	35,345	43,758	-	-	-
	36,073	44,218	-	-	-
Cash applied to:					
Purchase of investments & restricted assets	35,928	43,158	-	-	-
Purchase of property, plant, & equipment	45,277	38,346	61,754	50,004	50,622
	81,205	81,504	61,754	50,004	50,622
Net Cash Flow from Investing Activities	**(45,132)**	**(37,286)**	**(61,754)**	**(50,004)**	**(50,622)**
CASH FLOW FROM FINANCING ACTIVITIES					
Cash provided from:					
Equity Injections					
Earthquake repair capital redrawn	11,100	9,258	15,000	12,000	10,000
Kaikoura facility contribution	2,000	-	-	-	-
Operating deficit support	-	35,000	63,959	98,475	116,749
	13,100	44,258	78,959	110,475	126,749
Cash applied to:					
Annual depreciation funding repayment	1,861	1,861	1,861	1,861	1,861
	1,861	1,861	1,861	1,861	1,861
Net Cash Flow from Financing Activities	**11,239**	**42,397**	**77,098**	**108,614**	**124,888**
Net increase/(decrease) in cash and cash equivalents	(28,066)	(1,178)	(33,222)	12,003	31,835
Cash and cash equivalents at beginning of year	13,546	(14,520)	(15,698)	(48,920)	(36,917)
Cash and cash equivalents at end of year	**(14,520)**	**(15,698)**	**(48,920)**	**(36,917)**	**(5,082)**

4.18 Summary of revenue and expenses by arm

As at 30 June for the years ending 2016/17 to 2020/21

	2016/17 Actual $'000	2017/18 Actual $'000	2018/19 Plan $'000	2019/20 Plan $'000	2020/21 Plan $'000
Funding Arm					
REVENUE					
Ministry of Health revenue	1,504,084	1,581,224	1,654,090	1,707,251	1,774,425
Other government revenue	2,027	2,713	1,927	2,058	2,109
Other revenue	436	927	948	972	996
Total Revenue	**1,506,547**	**1,584,864**	**1,656,965**	**1,710,281**	**1,777,530**
EXPENSE					
Personal Health	1,102,942	1,159,425	1,236,548	1,260,110	1,309,273
Mental Health	160,518	163,044	168,780	172,486	179,701
Disability Support	250,950	282,149	295,760	309,291	317,196
Public Health	4,155	4,438	4,517	2,863	2,925
Maori Health	1,864	1,856	1,869	1,881	1,919
Total Expense	**1,520,429**	**1,610,912**	**1,707,474**	**1,746,631**	**1,811,014**
Surplus/(Deficit)	**(13,882)**	**(26,048)**	**(50,509)**	**(36,350)**	**(33,484)**
Other comprehensive revenue and expense	-	-	-	-	-
Total Comprehensive Income/(Deficit)	**(13,882)**	**(26,048)**	**(50,509)**	**(36,350)**	**(33,484)**
Governance & Funder Admin					
REVENUE					
Ministry of Health revenue	4,197	3,992	3,712	3,897	4,091
Other government revenue	4	-	-	-	-
Other revenue	80	10	11	10	10
Total Revenue	**4,281**	**4,002**	**3,723**	**3,907**	**4,101**
EXPENSE					
Personnel	8,288	9,129	9,626	9,864	10,107
Outsourced	920	1,442	1,507	1,492	1,477
Clinical supplies	167	206	210	214	218
Infrastructure & non clinical (excl Earthquake repairs)	(4,674)	(5,754)	(7,884)	(7,927)	(7,965)
Depreciation and amortisation	41	362	264	264	264
Total Expense	**4,742**	**5,385**	**3,723**	**3,907**	**4,101**
Surplus/(Deficit)	**(461)**	**(1,383)**	**-**	**-**	**-**
Other comprehensive revenue and expense	-	-	-	-	-
Total Comprehensive Income/(Deficit)	**(461)**	**(1,383)**	**-**	**-**	**-**

4.19 Summary of revenue and expenses by arm—continued

As at 30 June for the years ending 2016/17 to 2020/21

	2016/17 Actual $'000	2017/18 Actual $'000	2018/19 Plan $'000	2019/20 Plan $'000	2020/21 Plan $'000
Provider Arm					
REVENUE					
Ministry of Health revenue	942,696	994,222	1,033,151	1,093,834	1,153,462
Other government revenue	26,901	34,235	35,245	36,044	36,945
Earthquake repair revenue redrawn	10,712	3,240	5,300	14,100	17,800
Other revenue	42,224	47,091	52,043	54,541	56,482
Total Revenue	**1,022,533**	**1,078,788**	**1,125,739**	**1,198,519**	**1,264,689**
EXPENSE					
Personnel	695,918	745,996	801,023	846,498	885,239
Outsourced	24,987	27,359	26,944	26,528	26,160
Clinical supplies	142,704	144,432	143,780	151,886	159,813
Earthquake building repair costs	10,712	3,240	5,300	14,100	17,800
Infrastructure & non clinical (excl Earthquake repairs)	110,243	105,641	113,569	121,900	123,020
Depreciation and amortisation	56,227	58,295	57,645	69,878	69,927
Capital charge and interest expense	20,232	30,353	25,444	48,128	61,868
Total Expense	**1,061,023**	**1,115,316**	**1,173,705**	**1,278,918**	**1,343,827**
Surplus/(Deficit)	**(38,490)**	**(36,528)**	**(47,966)**	**(80,399)**	**(79,138)**
OTHER COMPREHENSIVE REVENUE & EXPENSE					
Revaluation of property, plant & equipment	(1,791)	-	-	-	-
Impairment of property, plant & equipment	300	-	-	-	-
Total Comprehensive Income/(Deficit)	**(39,981)**	**(36,528)**	**(47,966)**	**(80,399)**	**(79,138)**
In House Elimination					
REVENUE					
Ministry of Health revenue	(877,253)	(931,556)	(964,603)	(1,023,005)	(1,079,737)
Total Revenue	**(877,253)**	**(931,556)**	**(964,603)**	**(1,023,005)**	**(1,079,737)**
EXPENSE					
Payments to internal providers	(877,253)	(931,556)	(964,603)	(1,023,005)	(1,079,737)
Total Expense	**(877,253)**	**(931,556)**	**(964,603)**	**(1,023,005)**	**(1,079,737)**
Surplus/(Deficit)	-	-	-	-	-
Other comprehensive revenue and expense	-	-	-	-	-
Total Comprehensive Income/(Deficit)	-	-	-	-	-

4.20 Summary of revenue and expenses by arm—continued

As at 30 June for the years ending 2016/17 to 2020/21

	2016/17 Actual $'000	2017/18 Actual $'000	2018/19 Plan $'000	2019/20 Plan $'000	2020/21 Plan $'000
CONSOLIDATED					
REVENUE					
Ministry of Health revenue	1,573,724	1,647,882	1,726,350	1,781,977	1,852,241
Other government revenue	28,932	36,948	37,172	38,102	39,054
Earthquake repair revenue redrawn	10,712	3,240	5,300	14,100	17,800
Other revenue	42,740	48,028	53,002	55,523	57,488
Total Revenue	**1,656,108**	**1,736,098**	**1,821,824**	**1,889,702**	**1,966,583**
EXPENSE					
Personnel	704,206	755,125	810,649	856,362	895,346
Outsourced	25,907	28,801	28,451	28,020	27,637
Clinical supplies	142,871	144,638	143,990	152,100	160,031
Earthquake building repair costs	10,712	3,240	5,300	14,100	17,800
Infrastructure & non clinical (excl Earthquake repairs)	105,569	99,887	105,685	113,973	115,055
Payments to non-DHB providers	643,176	679,356	742,871	723,626	731,277
Depreciation and amortisation	56,268	58,657	57,909	70,142	70,191
Capital charge and interest expense	20,232	30,353	25,444	48,128	61,868
Total Expense	**1,708,941**	**1,800,057**	**1,920,299**	**2,006,451**	**2,079,205**
Surplus/(Deficit)	**(52,833)**	**(63,959)**	**(98,475)**	**(116,749)**	**(112,622)**
OTHER COMPREHENSIVE REVENUE & EXPENSE					
Revaluation of property, plant & equipment	(1,791)	-	-	-	-
Impairment of property, plant & equipment	300	-	-	-	-
Total Comprehensive Income/(Deficit)	**(54,324)**	**(63,959)**	**(98,475)**	**(116,749)**	**(112,622)**

Part V

Appendices

Further Information for the Reader

Appendices

Appendix 1	Glossary of Terms
Appendix 2	Minister of Health's Letter of Expectations 2018/19
Appendix 3	Statement of Accounting Policies 2018/19

Documents of interest

The following documents can be found on the Canterbury's DHB's website: www.cdhb.health.nz. Read in conjunction with this document, they provide additional context to the picture of health service delivery and transformation across the Canterbury health system.

- Canterbury DHB Annual Plan
- Canterbury System Level Measures Improvement Plan
- Canterbury DHB Public Health Action Plan
- Canterbury Disability Action Plan
- South Island Regional Health Services Plan
- Canterbury DHB Quality Accounts

References

Unless specifically stated, all Canterbury DHB documents referenced in this document are available on the Canterbury DHB website: www.cdhb.health.nz. Referenced regional document are available from the South Island Alliance Programme Office website: www.siapo.health.nz. Referenced Ministry of Health documents are available on the Ministry's website: www.health.govt.nz. The Crown Entities Act 2004 and the Public Finance Act 1989, referenced in this document, are available on the Treasury website: www.treasury.govt.nz.

Appendix 1 Glossary of Terms

ADMS	Acute Demand Management Service	Refers to the service whereby general practice and acute community nursing deliver packages of care that enable people who would otherwise need an ED visit or hospital admission to be treated in the community or in their own homes.
CCN	The Canterbury Clinical Network District Alliance	The CCN is a collective alliance of healthcare leaders, professionals and providers from across the Canterbury Health System. The Alliance provides leadership to enable the transformation of the health system in collaboration with system partners and on behalf of the population.
CREST	Community Rehabilitation Enablement and Support Team	Community Rehabilitation Enablement and Support Team supports the frail elderly who would otherwise be re-admitted to hospital or residential care. The Team is a collaboration across primary and secondary services and has been instrumental in reducing acute demand for hospital services and rates of aged residential care.
	Crown Entity	A generic term for a range of government entities that are legally separate from the Crown and operate at arm's length from the responsible or shareholding Minister, but are included in the financial statements of the Government.
ERMS	Electronic Referral Management System	ERMS is available from the GP desktop, and enables referrals to public hospitals and private providers to be sent and received electronically. Developed in Canterbury, it is now being rolled out South Island-wide and has streamlined the referral process by ensuring referrals are efficiently directed to the right place and receipt is acknowledged.
ESPIs	Elective Services Patient flow Indicators	The Elective Services Patient flow Indicators are a set of six indicators developed by the Ministry of Health to measure whether DHBs are meeting required performance standards in terms of the delivery of elective (non-urgent) services including wait times from referral to assessment and wait times from decision to treatment.
	Health Connect South	A shared regional clinical information system that provides a single repository for clinical records across the South Island. Already implemented in Canterbury, West Coast and South Canterbury, it is being rolled out across the rest of the South Island.
interRAI	International Resident Assessment Instrument	A suite of geriatric assessment tools that support clinical decision making and care planning by providing evidence-based practice guidelines and ensuring needs assessments are consistent and people are receiving equitable access to services. Aggregated data from the assessments is also used as a planning tool to improve the quality of health services and better target resources across the wider community according to need.
NHI	National Health Index	An NHI number is a unique identifier assigned to every person who uses health and disability services in NZ.
	Outcome	A state or condition of society, the economy or the environment, including a change in that state or condition (e.g. a change in the health status of a population).
PBF	Population-Based Funding	The national formula used to allocate each of the twenty DHBs a share of the available national health resources.
PHO	Primary Health Organisation	Funded by DHBs, PHOs ensure the provision of essential primary health care services to people who are enrolled with them, either directly or through its provider members (general practice). The aim is to ensure general practice services are better linked with other health services to ensure a seamless continuum of care.
	Public Health Services	The science and art of preventing disease, prolonging life and promoting health and efficiency through organised community effort.
	Secondary Care	Specialist care that is typically provided in a hospital setting.
	Primary Care	Professional health care received in the community, usually from a general practice team, covering a broad range of health and preventative services.
SIAPO	South Island Alliance Programme Office	A project office that supports the five South Island DHBs to work together to support the delivery of clinically and financially sustainable service across the South Island.
	Tertiary Care	Very specialised care often only provided in a smaller number of locations.

Appendix 2 Minister of Health's Letter of Expectations

Hon Dr David Clark

MP for Dunedin North
Minister of Health Associate Minister of Finance

Dr John Wood
Chair
Canterbury District Health Board
PO Box 1600
CHRISTCHURCH 8140

Dear Dr Wood

Letter of expectations for District Health Boards and Subsidiary Entities for 2018/19

This letter sets out the Government's expectations for District Health Boards (DHBs) and their subsidiary entities for 2018/19.

The Government wishes to signal an increased priority for primary care, mental health, public delivery of health services, and a strong focus on improving equity in health outcomes.

This Government listened to New Zealanders, and campaigned on these concerns. We will deliver on our democratic mandate to ensure New Zealand has a strong and effective public health service that we can all be proud of. To achieve this we want the public health service to be accessible and affordable for all New Zealanders, and to ensure that appropriate services are provided in the right locations at the right times.

Our Approach

Our Government wants to improve population health. Population health approaches and services are essential components of strategies to address determinants of health and achieve better health equity and wellbeing. I expect DHBs to work closely with and support their local public health units and health promotion providers. New Zealanders have made it clear that they are concerned about the increasing unaffordability of primary health services, regional inequity of access to secondary health services, and inadequate mental health service provision nationwide.

Our Government takes a longer term view. To this end, we will review the primary care funding formula and DHB targets, as well as wider sector settings. The Ministerial Advisory Group will also advise me on further opportunities to improve equitable health outcomes for all New Zealanders including how the system needs to change to enable those improvements. It is expected that you will be fully supportive of this work, and where appropriate will provide direct contribution.

We intend to better resource primary care in order to deliver better health outcomes, and to reduce the growing pressure on emergency services. In Budget 2018, we will lay out our plan to reduce the cost of access to primary care for New Zealanders.

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In our first 100 days we have introduced legislation to increase access to medicinal cannabis, and launched the Government Inquiry into Mental Health and Addiction. We expect your staff and members of your community to participate in the Inquiry and I expect you will encourage your people to do this.

Funding

There is no doubt that there has been a low priority on funding health in recent years. In contrast to other countries, core Crown health expenditure in New Zealand dropped as a proportion of the overall economy between 2008 and 2017. It is a credit to those who serve across the health sector that health outcomes have held up as well as they have despite nine years of under investment. Please pass on my sincere thanks to your staff for their commitment and service to the public, particularly during difficult times.

The Government is committed to delivering a well-funded public health service. That is why we will invest $8 billion to meet cost pressures and deliver new initiatives over the next four years. While this is more generous than before, much of the new funding will be absorbed in the service improvements already signalled by the Government. The public will rightly want to see the health system delivering more for them in return for the increased investment.

Capital Planning

I expect that your DHB will continue to focus on long term capital planning. This work should include service planning and understanding the state of your assets. I anticipate the need to prioritise the available capital funding, and your work in this area will assist in this process. I also require you to continue to work regionally when developing business cases for investment.

Accountability for Improved Performance

We will hold DHB Chairs directly accountable for their DHB's performance. We expect Boards to be highly engaged and to hold Chief Executives and management tightly accountable for improved performance within each DHB, particularly in relation to equity of access to health services and equity of health outcomes.

Under the previous government, relationships across the health sector became strained. My expectation is that the Ministry Advisory Group will work with the Ministry of Health to strengthen these relationships.

I trust that you will work with your regional DHBs to support regional delivery of services where appropriate. There should be strong shared responsibility and accountability across regions to ensure that regional services are delivered well and support equity of access for the population.

I expect that you will incorporate and share best practice innovation with the wider sector. Clinical leaders play a key role in this work. Strong and proactive relationships with the Ministry, other DHBs, primary health organisations (PHO), non-governmental organisations, and other stakeholders across the sector will be required. I am looking for increased collaboration across all parts of our health

service to deliver more affordable primary care, improved elective surgery volumes, improvements in equity of access to services, and a higher quality of care.

I will be meeting and speaking with you frequently during the year to discuss performance, and I will be looking particularly closely at your ability to work together to deliver in the Government's priority areas, and to keep within budget.

Workforce

To deliver affordable, accessible and quality care, workforce changes will be needed. This includes greater utilisation of different workforces in primary care settings. With a growing and aging population, there will be more work for all, and an increased emphasis on the use of generalist workforces for less specialised tasks will be required. Health care professionals from allied health, nursing, medicine and related fields will need to operate at the top of their scope of practice. I expect DHBs to be bold in their vision for change while also remaining responsive to the concerns raised by the workforce.

I understand DHB Chief Executives have collectively signed up to having Care Capacity Demand Management fully in place in all DHBs by July 2021 with oversight of progress and feedback on milestones monitored by the Safe Staffing and Health Workplaces Governance Group. I encourage you to proceed with timely implementation and expect that acute mental health inpatient services are a first priority. I also encourage you to address wider workforce development to better respond to mental health issues, in line with the *Mental Health and Addiction Workforce Action Plan*.

Additionally, to ensure greater community-based care and assist in workforce development, I expect all DHBs to adhere to the Medical Council's requirement for Community Based Attachments for interns.

We are also interested in expanding the role of health-based professionals in school settings. This includes considering the role of health-based professionals in primary and early education in the future, and extending School Based Health Services so all secondary schools have a comprehensive youth health service.

Expansion of PHARMAC model to manage hospital medicines

PHARMAC's role in managing hospital medicines has steadily increased. Most recently, since 2013 PHARMAC has made decisions on the adoption of new technology in hospital medicines. In my letter of 27 April 2018, I confirmed that from 2018/19 the full budget management responsibility for all remaining hospital medicines will move from DHBs to PHARMAC, in order to support our wider health priorities.

National Patient Flow

As you will be aware, National Patient Flow is a new developmental national collection that the Ministry and DHBs have been implementing over the past three years. The collection will provide information at key points of the patient journey through secondary and tertiary care, helping DHBs to quantify unmet referred

demand for services, and to better understand and improve their patient management processes.

I anticipate that this will become a core national collection in the future, and I expect DHBs to continue working in partnership with the Ministry with a focus on improving data submission and data quality for the National Patient Flow collection during 2018/19.

Planning for 2018/19 and the future

We are focused on ensuring better health outcomes for the public, and have clear expectations for all DHBs. This includes the following.

- Increasing the rate of organ donations. DHBs are expected to manage the associated costs within their baselines.
- Improving the health and wellbeing of infants, children and youth. I expect that your 2018/19 annual plan shows how you will achieve this, particularly for Māori, Pacific people, and people living in high areas of deprivation.
- Improving equity and reducing the burden caused by long term conditions, in particular diabetes. I expect DHBs in their contracts with PHOs to explicitly require improvements in performance and reporting. I expect DHBs to incentivise PHOs to demonstrate improvement in primary care settings and increase PHO accountability for effectively managing long term conditions with particular regard to diabetes.
- The Government also wants to support our health system to implement a strong response to climate change, this will include working with other DHBs, other agencies and across Government. Plans to address climate change and health, need to incorporate both mitigation and adaptation strategies, underpinned by cost benefit analysis of co-benefits and financial savings.

Your DHB's annual plan for 2018/19 will need to reflect my expectations. In addition, I am not requiring your DHB to refresh your Statement of Intent in 2018/19. However, I will expect all DHBs to demonstrate a renewed focus on their strategic direction by refreshing their Statements of Intent in 2019/20.

Finally, I would like to thank you and your DHB again for your ongoing work to improve the health of New Zealanders. The public deserves the highest standards of leadership and performance, and by working together we can ensure that improvements are made for our population.

Yours sincerely

Hon Dr David Clark
Minister of Health

Appendix 3: Statement of Accounting Policies 2018/19

10.13 Statement of accounting policies

The prospective financial statements in Canterbury DHB's Annual Plan and Statement of Intent for the year ended 30 June 2019 are prepared in accordance with Section 38 of the Public Finance Act 1989 and they comply with NZ IFRS, as appropriate for public benefit entities. PBE FRS42 states that the (prospective) forecast statements for an upcoming financial year should be prepared using the same standards as the statements at the end of that financial year.

The following information is provided in respect of this Plan:

(i) Cautionary Note

The financial information presented 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 Canterbury DHB expects to take place.

(iii) Assumptions

The main assumptions underlying the forecast are noted in Section 8 of the Annual Plan.

REPORTING ENTITY AND STATUTORY BASE

Canterbury DHB is a district health board established by the New Zealand Public Health and Disability Act 2000. The 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 has designated itself and its subsidiaries, as public benefit entities (PBEs) for financial reporting purposes.

The consolidated financial statements of Canterbury DHB consist of Canterbury DHB and its subsidiaries:

- Canterbury Linen Services Ltd (100% owned)
- Brackenridge Services Ltd (100% owned)

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. Canterbury DHB does not operate to make a financial return. Canterbury DHB will adopt the following accounting policies consistently during the year and apply these policies for the prospective financial statements.

BASIS OF PREPARATION

The financial statements have been prepared on a going concern basis, and the accounting policies have been applied consistently throughout the period.

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 the Crown Entities Act 2004, which includes the requirement to comply with New Zealand generally accepted accounting practice (NZ GAAP).

The financial statements have been prepared in accordance with Tier 1 PBE accounting standards.

Measurement basis

The financial statements are prepared on the historical cost basis except that land and buildings are stated at their fair values.

Functional and presentation currency

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

Changes in accounting policies

The accounting policies set out below have been applied consistently to all periods presented in these consolidated financial statements.

SIGNIFICANT ACCOUNTING POLICIES

Basis for Consolidation

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

Income tax

Canterbury DHB is a crown entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under section CW38 of the Income Tax Act 2007.

Goods and services tax

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

The net GST paid to, or received from Inland Revenue, including the GST relating to investing and financing activities, is classified as a net operating cash flow in the statement of cash flows. Commitments and contingencies are disclosed as exclusive of GST.

Revenue

Ministry of Health population-based funding

Canterbury DHB receives annual funding from the Ministry of Health, which is based on population levels within the Canterbury DHB region.

Ministry of Health population-based revenue for the financial year is recognised based on the funding entitlement for that year.

Inter-district flows

Inter-district patient inflow revenue occurs when a patient treated within Canterbury DHB's district is domiciled outside of the district. Inter-district patient inflow revenue is recognised when eligible services are provided.

Ministry of Health other contracts

The revenue recognition approach for Ministry of Health contract revenue depends on the contract terms. Those contracts where the amount of revenue is substantively linked to the provision of quantifiable units of service are treated as exchange contracts and revenue is recognised as Canterbury DHB provides the services.

Other contracts are treated as non-exchange and the total funding receivable under the contract is recognised as revenue immediately, unless there are substantive conditions in the contract. If there are substantive conditions, revenue is recognised when the conditions are satisfied. A condition could include the requirement to provide services to the satisfaction of the Ministry of Health to receive or retain funding.

Revenue for future periods is not recognised where the contract contains substantive termination provisions for failure to comply with the service requirements of the contract. Conditions and termination provisions need to be substantive, which is assessed by considering factors such as the past practice of the Ministry of Health. Judgement is often required in determining the timing of revenue recognition for contracts that span a balance date and multi-year funding arrangements.

ACC revenue

ACC contract revenue is recognised as revenue when eligible services are provided and any contract conditions have been fulfilled.

Provision of other services

Revenue derived through the provision of other services to third parties is recognised in proportion to the stage of completion at the balance date, based on the actual service provided as a percentage of the total services to be provided.

Donations and bequests

Donations and bequests received with restrictive conditions are treated as a liability until the specific terms from which the funds were derived are fulfilled. Until the conditions attached have been fulfilled, the assets received are treated as restricted assets.

Vested or donated physical assets

For assets received for no or nominal consideration, the asset is recognised at its fair value when Canterbury DHB obtains control of the asset. The fair value of the asset is recognised as revenue, unless there is a use or return condition attached to the asset.

The fair value of vested or donated assets is usually determined by reference to the cost of purchasing the asset if the asset is new, or reference to market information for assets of a similar type, condition, or age for used assets.

Donated services

Volunteer services received are not recognised as revenue or expenses by Canterbury DHB.

Operating lease payments

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

Equity

Equity is measured as the difference between total assets and total liabilities.

In accordance with IPSAS 1, repayments of capital to the Crown, as well as contributions from the Crown under Vote Health capital appropriations are recorded in contributed capital.

Revaluation reserve

This reserve relates to the revaluation of property, plant and equipment to fair value.

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 term deposits

Investments in bank term deposits are measured at the amount invested.

Trade and other receivables

Trade and other receivables are non-interest bearing and receipt is normally within 30-day terms. Therefore, the carrying value of receivables approximates their fair value. Trade and other receivables are subsequently stated at amortised cost less any provision for impairment. Bad debts are written off during the period in which they are identified. A receivable is considered impaired when there is evidence that Canterbury DHB will not be able to collect the amount due. The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

Inventories

No inventories are pledged as security for liabilities; however, some inventories are subject to retention of title clauses.

Inventories held for distribution, or consumption in the provision of services, that are not issued on a commercial basis are measured at cost (calculated using the weighted average cost method) adjusted when applicable for any loss of service potential. Inventories acquired through non-exchange transactions are measured at fair value at the date of acquisition.

Other inventories are stated at cost (calculated using the weighted average method).

The amount of any write-down for the loss of service potential or from cost to net realisable value is recognised in the surplus or deficit in the period of the write-down.

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.

Employee entitlements

Defined contribution plans

Obligations for contributions to defined contribution plans are recognised as an expense in the surplus or deficit as incurred.

Defined benefit plans

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

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

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

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

Presentation of employee entitlements

Non-vested long service leave and retirement gratuities are classified as non-current liabilities; all other employee entitlements are classified as current liabilities.

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 Canterbury DHB is liable for all its claims costs for a period of five years up to a specified maximum. At the end of the five year period, Canterbury 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.

Property, plant and equipment

Owned assets

Except for land and buildings, and the assets vested from the Crown items of property, plant and equipment are stated at cost, less accumulated depreciation and impairment losses.

Revaluations

Land, buildings and building fitout (excluding leased building fitout) are revalued to fair value as determined by an independent registered valuer, with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every five years. Any increase in value of a class of land and buildings is recognised directly to equity unless it offsets a previous decrease in value recognised in the statement of comprehensive revenue and expense. Any decreases in value relating to land and buildings are debited directly to the revaluation reserve, to the extent that they reverse previous surpluses and are otherwise recognised as an expense in other comprehensive revenue. Additions to land and buildings between valuations are recorded at cost.

The carrying values of revalued assets are assessed annually to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the off-cycle asset classes are revalued.

Land and building revaluation movements are accounted for on a class-of-asset basis.

Disposal of property, plant and equipment

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

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

Depreciation

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

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

Type of asset	Useful life	Depreciation rate
Buildings structure	35 – 90	1.1 – 2.9%
Buildings infrastructure & fitout	15 - 60	3.3 – 6.7%
Temporary buildings	2 - 20	5.0 – 50.0%
Leasehold improvements	3 - 20	5.0 – 33.3%
Plant, equipment and vehicles	3 - 20	5.0 – 33.3%

The residual value and useful life of assets are reviewed, and adjusted if applicable, annually. Buildings structure, buildings infrastructure and fitout, and temporary buildings have been shown separately this year, and the useful life is shown as the total useful life (the remaining useful life had been shown in prior years). The depreciation rates of these assets have not been changed, so there is not impact on the depreciation expense.

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 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.

Work in progress is recognised at cost less impairment and is not depreciated.

Subsequent costs

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

Intangible assets

Software development and acquisition

Expenditure on software development activities, resulting in new or substantially improved software and processes, is capitalised if the product or process is technically and operationally feasible and Canterbury DHB has sufficient resources to complete development. The expenditure capitalised includes the cost of materials, direct labour and an appropriate proportion of overheads. Staff training and other costs associated with maintaining computer software are recognised as an expense when incurred. Capitalised development expenditure is stated at cost less accumulated amortisation and impairment losses.

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

Amortisation

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

Type of asset	Estimated life	Amortisation rate
Software	2-15 years	6.7 – 50.0%

The residual value and useful life of assets are reviewed, and adjusted if applicable, annually. The useful life of certain software has been adjusted during the year, resulting in a minor reduction in amortisation expense shown.

Non-cash-generating assets

Property, plant, and equipment and intangible assets held at cost that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable service amount. The recoverable service amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is determined using an approach based on either a depreciated replacement cost approach, restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of information. If an asset's carrying amount exceeds its recoverable service amount, the asset is regarded as impaired and the carrying amount is written-down to the recoverable amount. The total impairment loss is recognised in other comprehensive or income.

The reversal of an impairment loss is recognised in other comprehensive or income.

Impairment

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

If the estimated recoverable amount of an asset is less than its carrying amount, the asset is written down to its estimated recoverable amount and an impairment loss is recognised in the surplus or deficit.

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

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

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

Estimated recoverable amount of other assets is the greater of their fair value less costs to sell and value in use. The value in use is the depreciated replacement cost for an asset where the future economic

benefits or service potential of the asset are not primarily dependent on the asset's ability to generate net cash inflows and where Canterbury DHB would, if deprived of the asset, replace its remaining future economic benefits or service potential.

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

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

An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised.

Borrowings

Borrowings are recognised initially at fair value plus transaction costs. Subsequent to initial recognition, borrowings are stated at amortised cost using the effective interest method.

Borrowings are classified as current liabilities unless Canterbury DHB has an unconditional right to defer settlement of the liability for at least 12 months after balance date.

Foreign currency

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

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

Related Parties

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.

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.

Associates

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

Critical accounting estimates and assumptions

The preparation of financial statements in conformity with IPSAS 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 highlighted in the following notes.

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.

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.

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, advances in medical technology, and expected disposal proceeds from the future sale of the assets.

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

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

In light of the Canterbury earthquakes, Canterbury DHB continuously reviews the carrying value of land and buildings.

Leases classification

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

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

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

Standards issued but not yet effective and not early adopted

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

Financial instruments

In January 2017, the XRB issued PBE IFRS 9 Financial Instruments. PBE IFRS 9 replaces PBE IPSAS 29 Financial Instruments: Recognition and Measurement. PBE IFRS 9 is effective for annual periods beginning on or after 1 January 2021, with early application permitted. The main changes under PBE IFRS 9 are:

- New financial asset classification requirements for determining whether an asset is measured at fair value or amortised cost.
- A new impairment model for financial assets based on expected losses, which may result in the earlier recognition of impairment losses.
- Revised hedge accounting requirements to better reflect the management of risks.

Canterbury DHB plans to apply this standard in preparing its 30 June 2022 financial statements. Canterbury DHB has not yet assessed the effects of the new standard.

STATEMENT OF INTENT

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