Canterbury DHB

2017/18

ANNUAL PLAN

Incorporating the 2017/18
Statement of Performance Expectations &
Statement of Financial Expectations

make it better

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

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 2011. As a DHB we are categorised as a Crown Agent under the Crown Entities Act, and are accountable to the Minister of Health for the funding and provision of public health and disability services for our resident population.

This Annual Plan has been prepared to meet the requirements of the New Zealand Public Health and Disability Act, Crown Entities Act, Public Finance Act and the Ministerial expectations set in 2016/17.

The Plan also contains the DHB's Statement of Performance Expectations and Statement of Financial Expectations. These will be presented to Parliament, as part of our Statement of Intent, and used at the end of the year to compare the planned and actual performance of the DHB. Audited results will be presented in the DHB's Annual Report for 2017/18.

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 the changing needs of our population.

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 also 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.

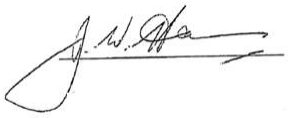
In keeping with these commitments, the actions in this Annual Plan present a picture of the collective activity that will be delivered by the Canterbury DHB and our alliance partners in the coming year.

In signing this Annual Plan, we are satisfied that it fairly represents our joint intentions and activity and is in line with Government expectations for 2017/18.

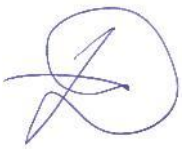
Dr John Wood
CHAIR | CANTERBURY DHB

Ta Mark Solomon
DEPUTY CHAIR | CANTERBURY DHB

David Meates
CHIEF EXECUTIVE | CANTERBURY DHB



Sir John Hansen
CHAIR | CCN DISTRICT ALLIANCE



Honourable Dr David Clark
MINISTER OF HEALTH

Honourable Grant Robertson
MINISTER OF FINANCE

May 2018

Approval of the Minister of Health

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

07 MAY 2018

Dear Dr Wood

Canterbury District Health Board 2017/18 Annual Plan

To formalise ongoing accountability and to provide surety, I have approved and signed your DHB's 2017/18 Annual Plan together with the Minister of Finance.

I would like to thank you, your board, and the DHB's staff for their efforts in developing your Annual Plan for 2017/18. I also appreciate your DHB's significant efforts to provide valuable health services to the public in a challenging environment, and I am confident that we can work together to improve outcomes for the population.

I understand your DHB has planned significant deficits for 2017/18 and the out years. I encourage your Board to consider appropriate activities to ensure that you reduce the projected deficits in the coming years. This will require a concerted effort and I trust that you will continue to work with the Ministry of Health to evaluate and improve your financial performance.

As you deliver services for your population, keep in mind that I will shortly be providing a Letter of Expectations to DHBs for the 2018/19 financial year that will provide further clarity on my priorities for DHB planning, such as public provision of health services, improving access to primary care, reducing inequalities and improving mental health services.

It is important that you participate in and support the work the Ministry of Health is leading to improve and enhance DHB performance. This engagement will be a key mechanism to support the successful management of future issues.

Please note that approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry of Health. Please ensure that you advise the Ministry as early as possible of any proposals for service change that may require Ministerial approval. Approval of the Plan also does not constitute approval of any capital business cases that have not been approved through the normal process.

Please ensure that a copy of this letter is attached to any copies of your signed Annual Plan that are made available to the public.

I look forward to working with you in the future.

Yours sincerely

Hon Dr David Clark
Minister of Health

cc Mr David Meates, Chief Executive, Canterbury District Health Board

+64 4 817 8709 Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand d.clark@ministers.govt.nz beehive.govt.nz

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Foreword from the Chair and Chief Executive

Meeting our challenges

Six years on from the Canterbury earthquakes, readers of health-sector annual plans might be forgiven for believing that the challenges of those times are now largely behind us. However, while much of our population has recovered, some people remain adversely affected, which is evident in higher demand and acuity for mental health services. In addition, our health system continues to experience extraordinary operational and organisational challenges as a result of the unique post-disaster environment.

These challenges include pressures of rapid population growth and increasing service demand, pressures on our workforce, and ongoing fiscal pressures.

In the past year, two further natural disasters have also been experienced in our region: the destructive Kaikoura quake in November 2016 and the Port Hills fires in February 2017.

Population challenges

We are the second-largest DHB in the country in terms of area and are responsible for the second-largest population—an estimated 558,830 people or 11.6% of the total New Zealand population. We also provide an extensive range of highly specialised services to people referred from other DHBs, where the services and capacity are not available. We provide the second largest number of elective and acute surgeries in the country and almost half of all elective surgery in the South Island.

Our population base continues to exceed statistical projections year on year. Our population has already reached the level predicted for 2022, which puts capacity pressure on our new hospital before it is even complete.

We currently have the largest total population over 75 in the country. The ageing population has more complicated health needs: this is one of the biggest challenges we face as a health system. We also have the fastest growing Māori population in the country, and the sixth largest Māori population by total number.

Demand challenges

We are experiencing a predictable increase in demand for mental health services post-quake, and attendance at our emergency departments are growing, with these trends are expected to continue into the coming year and beyond.

In spite of this increased demand, the successful integration of our health system and the capability of our general practice means our population is more likely to remain healthy and living in their own homes and communities; and we still have lower ED attendance rates per capita than other DHBs.

Unfortunately, our ability to manage with constrained capacity, by delivering a great deal of care in a community based setting, can be misinterpreted as indicating a population with less need. On the contrary, our primary and community services have accepted the challenge to help Canterbury manage with less hospital based capacity than it needs. But they, like our hospital services, are under pressure.

Workforce pressures

Staff from across our health system have risen to the challenges of these extraordinary times, helping to make things better and putting the needs of the patient first and foremost. However, tireless commitment takes its toll, as our 2016 Staff Wellbeing Survey revealed.

Careful planning and support for our workforce will continue to be critical in the coming year. Recruitment is commencing to support the opening of the Acute Services Building and in particular the new theatres and intensive care unit.

Facilities pressures

Our significant facilities repair and redevelopment programme continues. The new Outpatients and Acute Services buildings on the Christchurch Hospital campus are both expected to be completed by the end of 2018. These facilities will increase the number of theatres and intensive care beds supporting the Canterbury population and restore in-patient bed numbers to slightly higher than pre-quake levels.

Reductions in length of stay and managing acute medical admissions at 30% lower than the national rate has compensated for the rapid increase in our population, enabling the continued delivery of services within very constrained physical capacity. Work is also underway to progress a new health facility in Akaroa, and the Health Research and Education Facility that we will co-tenant will be a valuable teaching addition for the Christchurch Health campus.

However, it will still be many years before earthquake repairs are complete, with a number of areas still to be tackled and in need of clever funding solutions as the insurance proceeds have largely been committed. These areas include mental health services, laboratory services and car parking.

Our staff also continue to run services out of inappropriate and/or widely dispersed facilities. Theatre capacity is severely under pressure to meet growing service demands and ongoing repairs place additional pressure on staff and operating budgets. It is imperative that we determine a way forward.

Fiscal pressures

Canterbury takes it obligations to be fiscally prudent seriously and is focused on reducing waste, duplication and costs across our system.

Recent analyses have shown that Canterbury has the lowest cost growth among similar sized DHBs, and our

hospitals have been benchmarked against other large hospitals internationally as the most efficient of its peers across New Zealand and Australia.

However, government health funding per capita is currently lower than much of New Zealand, largely because central measures of population and social deprivation have not anticipated post-quake fluctuations, the movement of populations within the district, and increased migration supporting the rebuild. This is a significant challenge as we look to meet the growing costs of service demand, wage expectations and repairs.

The year ahead

Post-disaster recovery – especially psychosocial recovery – is known to take many years and at times it must seem, to many Cantabrians, that the challenges we face are relentless.

We are acutely aware that our recovery journey has been uneven. Significant achievement in some areas is diminished by what is seen as a lack of progress in others, and pressures on our staff and system have been well publicised.

Despite the challenges we face, the Canterbury Health System is internationally recognised as a high-performing, well-integrated health system that puts the patient at the centre. Without this strong baseline performance, we would be unable to cope with the continued operational challenges of unexpected events and our growing population.

This annual plan sets out the ways in which we will address our challenges and deliver health services that meet the needs of our people, both across Canterbury and further afield.

Over the coming year, we will build on our high-performing, innovative and integrated history to improve outcomes for our population. We will continue to invest in strategies that reduce the need for people to make multiple hospital visits, provide increased access to care in the community and closer to people's own homes, and continue to reduce the time people waste waiting for access to the right treatment.

In looking forward to our future, we will focus on our children and the young people of Canterbury, ensuring they have the opportunity to live the best possible lives. We will look to improve the experience of people in our health system: our patients and our workforce.

We will also carefully consider where we invest our limited resources, in order to make the biggest impact for our population.

Dr John Wood

CHAIR, CANTERBURY DHB

David Meates

CHIEF EXECUTIVE, CANTERBURY DHB

May 2018

Part I

Overview

Introducing the Canterbury DHB

1.1 Who are we

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

Canterbury has the second largest population of all 20 DHBs. We are responsible for 558,830 people, 11.6% of the total New Zealand population.

There has been a 13.2% increase in our population over the past ten years, a faster growth rate than predicted before the earthquakes. Canterbury also has the fastest growing Māori population in the country.

We own and operate five major hospital facilities: Christchurch (including Christchurch Women's), Hillmorton, Burwood, Princess Margaret and Ashburton hospitals, and almost 30 smaller rural hospitals and community bases.

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

In 2015/16: there were over 94,000 presentations to our Emergency Departments; we delivered over 71,000 first specialist assessments; 189,000 consultations with community-based specialist mental health services and 650,000 outpatient appointments. We also performed 21,039 elective surgeries and 15,500 acute surgeries; delivered 5,922 babies and discharged 117,935 patients.

We are the largest employer in the South Island, employing more than 9,000 people across all of our hospital and community sites.

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

We are the second largest DHB in the country in terms of geographical area. Canterbury DHB covers 26,881 square kilometres and six Territorial Local Authorities.

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.

1.2 What 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 2017/18 we will receive approximately $1.747 billion dollars to meet the needs of our population. In accordance with legislation and consistent with Government objectives, we use that funding to:

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

Purchase the health services provided to our population and through our collaborative partnerships and ongoing performance monitoring, ensure these services are responsive, coordinated and effective.

Provide a significant share of the specialist health and disability services delivered to our population, and also to people referred from 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 promotion and education and delivery of evidence-based public health initiatives including earthquake recovery strategies.

1.3 Our regional role

While our responsibility is primarily for our own population, the Canterbury DHB also provides an extensive range of highly specialised, complex services to people from other DHBs where the service or treatment is not available.

In 2015/16, over 7,000 people from other DHB regions were discharged from Canterbury services and over 13,000 people had an outpatient appointment with a Canterbury specialist.

Much of this demand is complex in nature and demand is growing steadily. In the five years to June 2016, there was a 20% increase in inpatient admissions and a 28% increase in demand for outpatient appointments for people referred by other DHBs.

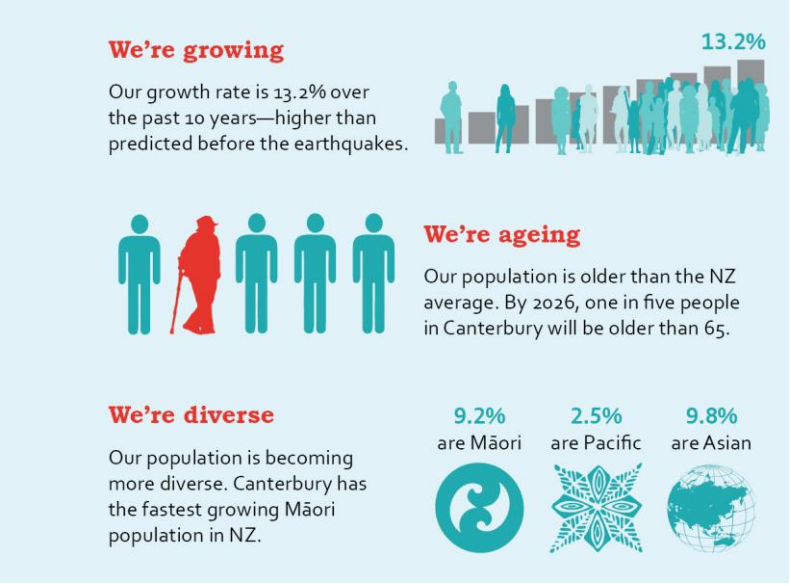
The services we provide on a regional basis include: eating disorder services, brain injury rehabilitation, child and youth inpatient mental health services, neonatal services, cardiothoracic services, neurosurgery, paediatric oncology, endocrinology, mental health forensic services and spinal services.

In addition, 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 4 million diagnostic tests, which inform 60-70% of the critical clinical decisions made across the health system.

1.4 Our population profile

Despite a small dip in our population after the earthquakes, our population has returned and we are now experiencing a greater growth rate than predicted prior to the earthquakes.

In 2017/18, we will be responsible for the health and wellbeing of 558,830 people, 11.6% of the total New Zealand population – a population level we anticipated reaching in 2022 only five years ago.



There has 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 numbers show 15.7% of our population are aged over 65, a total of 87,560 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. The ageing of our 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.

Our Asian population is proportionately our fastest growing population group. By 2026, 12.3% of our population will be Asian. However, our Māori population is also steadily increasing. We have the fastest growing Māori population in the country and the sixth largest by total population numbers of all 20 DHBs.

There are currently 51,630 Māori in Canterbury and by 2026 they will represent 10.3% of our population.

Our Māori population has a considerably different age structure that the rest of our population, with 42% of our Māori population being under 20 years of age, compared to 24% of the total Canterbury population.

1.5 Our population's health

Canterbury's total population continues to have a slightly higher life expectancy compared to the New Zealand average, with 79.8 years for males and 83.3 years for females.

Engagement with health services is positive. At the end of 2015/16, 95% of our population were enrolled with primary care, 96% of all eight months olds in Canterbury fully immunised, and fewer people were being admitted acutely to our hospitals (12,000 less people than expected, based off the national average).

However, like the rest of New Zealand, more people are living with long-term conditions such as cancer, heart disease, respiratory disease and depression leading to an increasing demand for health services.

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

All four major risk factors also have strong socio-economic gradients, so a healthier focus would contribute greatly to reducing health inequalities between population groups.

The most recent results from the 2011-2014 New Zealand Health Survey found that in Canterbury:

- 27.7% of our adult population are classified as obese, almost a third of our total population.
- 15% of our total population are current smokers and smoking rates amongst our Māori and Pacifica populations are significantly higher.
- One in every 10 adults is likely to drink in a hazardous manner.

EARTHQUAKE IMPACTS

The NZ Health Survey also reported that 20% of our population have been diagnosed with a common mental illness (such as depression or anxiety disorders) compared to just 17% 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 and supporting young people's wellbeing is a major focus for our health system.

Our Strategic Direction

1.6 National context

Like health systems world-wide, the challenges DHBs are facing are well understood. Populations are ageing, more people are developing long-term conditions, demand is increasing, treatment costs are rising, and workforce shortages are ever-present. Increasing pressure on government funding also means we have to do more with what we have.

There is a clear understanding that these pressures mean health services cannot continue to be provided in the same way they always have.

If we are to continue to improve health outcomes within current resources, we need to integrate and connect services, not only across the health system, but across all public services.

The long-term vision for New Zealand's health service is articulated through the New Zealand (NZ) Health Strategy. The overarching intent is to support all New Zealanders to 'live well, stay well, get well'.

The Strategy identifies five key themes to give the health sector 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 population or condition-specific strategies, including: He Korowai Oranga (Māori Health Strategy), 'Ala Mo'ui (Pathways to Pacific Health and Wellbeing), Healthy Ageing Strategy, Rising to the Challenge (Mental Health and Addiction Service Development Plan), the Disability Strategy and the United Nations convention on the Rights of People with Disabilities.

DHBs are also expected to commit to government priorities and provide 'better, sooner, more convenient health services,' and 'better public services'. The Minister of Health's letter of expectations signals annual expectations and priorities for DHBs. This Annual Plan outlines how the Canterbury DHB will meet the expectations set by the previous Health Minister in 2017/18, focusing on:

- Delivering against the NZ Health Strategy
- Living within our means
- Working across government
- Delivering on national health targets
- Streamlining planning including developing a longer-term outlook and regional alignment.

1.7 Regional commitment

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

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 (23.3%) 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 better address our shared challenges.

Our jointly-developed Regional Health Services Plan outlines the agreed regional activity for the next three years. Canterbury has made a strong regional commitment and takes the clinical or executive lead in a number of areas including: cancer, cardiac, major trauma and stroke services.

Our regional commitment for 2017/18 is outlined in the South Island Regional Health Services Plan.[1]

1.8 The Canterbury vision

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

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 the patient and the system.

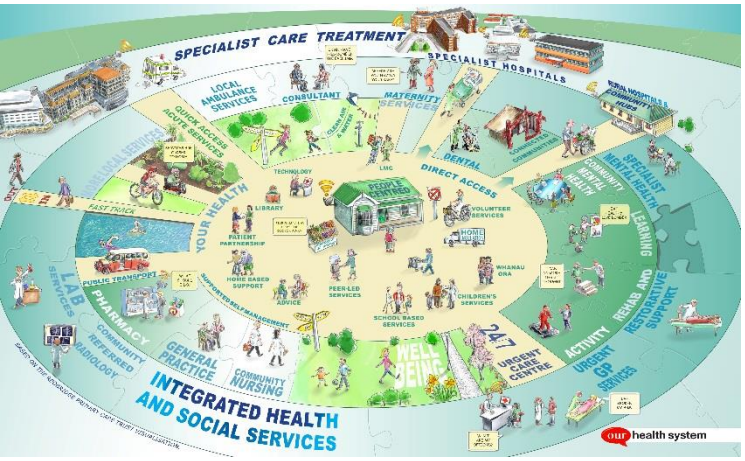
Our vision is an integrated health system that keeps people healthy and well in their own homes and communities: a connected health system, centred around the patient, that doesn't waste their time.

At the centre of our vision is our community, our whānau and our patients. 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 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, and to provide timely access to complex care and specialist advice to primary care.

[1] *The South Island Regional Health Services Plan can be found on the South Island Alliance website: www.sialliance.health.nz.*

Our vision is illustrated in the pictogram below – with the patient at the centre and connected, integrated services radiating out from the home.



In delivering against our vision, we have been purposeful and deliberate in planning how we would meet the growing demand for services, and make the best possible use of the resources we have available right across our health system.

Across primary and community services, we are enabling system transformation through our role in the Canterbury Clinical Network District Alliance. Working as one team alongside healthcare leaders, professionals and providers from across Canterbury, we are redesigning service models to support the delivery of care closer to people's homes and realising opportunities to better integrate our health system.

Across our hospitals we are empowering our workforce to improve pathways and processes. The DHB is a founder of the national Health Innovation Hub. Our supportive innovation and research environment keep us at the forefront of best practice, harnessing innovations that add value and improve service performance and patient outcomes.

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.

Sharing of data has been a key enabler of this change. Delivering a smarter system with access to real-time information is helping us to improve the quality and safety of the care we provide and save patients' time.

In 2015, the Canterbury health system won the Prime Minister's Award for Public Sector Excellence in recognition of the outstanding collaboration occurring across our health system and the considerable results being achieved for the people of Canterbury.

In 2017, Canterbury DHB, Orion and Pegasus Health took home the Best Technology Solution award at the New Zealand Hi-Tech Awards for our electronic health record HealthOne – a health information solution that makes it easier for clinicians to do their job and improves safety and services for our population.

Our Challenges

1.9 Our operating environment

Meeting the health needs of a large population is complex. However, Canterbury also has a distinctly unique set of operational and organisational challenges as a result of our post-disaster environment.

POPULATION PRESSURES

Following the earthquakes, our population growth has been rapid, with a 13.2% increase over the past ten years and population levels now reaching those previously predicted for 2022.

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

Six 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, but 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. From our own population and, increasingly, the populations of neighbouring DHBs.

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

FACILITIES PRESSURE

The earthquake damage to our infrastructure was extensive and we are engaged in a significant repair and remediation programme across all of our hospital sites. The continued commitment from Government to the planned redevelopment of the Acute Services and Outpatient Buildings on the Christchurch Hospital site remains critical to our recovery. However, it will be at least another year before these buildings are operational and many years before our full earthquake repair programme is complete and our pre-quake capacity is restored.

In the meantime, the DHB is having to meet increasing demand with fewer hospital beds and a shortage of theatres. With our capacity significantly reduced, we are hiring theatres for our staff to work in and outsourcing some surgeries to ensure we can meet service demand and delivery expectations.

The increased service costs of this solution are not sustainable longer-term. Delays or deviations to the agreed redevelopment or repair programmes place additional pressure and stress on staff and operating budgets.

Repair strategies are not simple, with ongoing disruptions as we shift people, patients and services around to make repairs. While we wait for new buildings to be complete, many services are operating out of cramped, temporary or inadequate spaces.

Increasing population and heightening service demand are compounding this pressure. The DHB is already having to look forward to find solutions for increasing capacity beyond what will be restored once the redevelopment and repair programmes are complete.

WORKFORCE PRESSURES

The DHB is also working hard to maintain a safe environment and ensure the wellbeing of our workforce. We have implemented a number of initiatives to mitigate repair disruptions, however construction noise, service relocation and parking issues are causing increasing stress for staff and patients alike.

Along with increased service demand, 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. All of these factors place additional pressure on our workforce.

Our 2016 Staff and Family Wellbeing Survey shows 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.

This is further complicated by national workforce shortages. Already we are experiencing difficulties recruiting to some highly specialised positions and competing with other DHBs across the country for a limited pool of people.

If we are to going to meet the growing needs of our population, and deliver on our vision, we need to support the wellbeing of our people and attract more of the right people with the right skills to Canterbury.

FISCAL PRESSURES

Meeting growing service demand, increasing treatment and infrastructure costs, and expectations around wages and salary increases is an ongoing challenge for all DHBs. This is heightened in Canterbury by the extraordinary impacts of the earthquakes, including population funding shifts, increased service demand and the operational challenges of a significant repair programme.

Our relative health funding per capita has fallen, largely because standard measures of population and deprivation have not been designed to cope with the post-quake population fluctuations and forced migration Canterbury has experienced.

With population and deprivation levels being two of the drivers of the national population-based funding formula, the DHB is coping with a consequential and unexpected drop in revenue - despite rapid population growth and increased service demand.

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 address capacity constraints as our population continues to grow.

Significant earthquake-related operational costs are also evident in a number of areas including: increased treatment costs to meet heightened service demand; additional outsourcing costs to cover lost theatre and bed capacity; unexpected costs of supporting stranded services; and substantial depreciation and capital related charges related to repair of damaged buildings.

1.10 Critical success factors

Over the last ten years, we have been deliberate in determining the steps we will take to enable our vision: reducing the need for multiple hospital visits, increasing access to care closer to people's homes and reducing the time people waste waiting for treatment.

To ensure the long-term sustainability of our health system, further solutions need to be found to enable us to invest in the infrastructure and people needed to meet the growing demand for services and increased service delivery expectations.

The following areas represent the factors critical to our success, where we believe we need to focus in the coming year:

- Prioritising resources for the greatest impact
- Improving the flow of patients across the system
- Connecting the system electronically
- Supporting and engaging our workforce
- Collaborating on investment across sectors
- Delivering on the repair and rebuild programmes.

Our focus in 2017/18 will include supporting the North Canterbury, Kaikoura and Hurunui communities as they recover from the 2016 earthquakes.

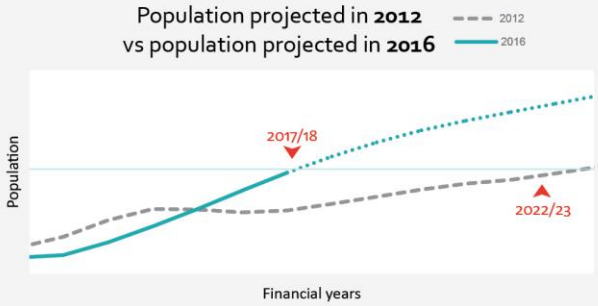
We will also be focused on working with the Ministry of Health and key government agencies to address the challenges we face and develop a sustainable pathway forward for our health system.

OUR CHALLENGES

Population increases

Canterbury's population growth is exceeding expectations—already reaching levels predicted for 2022[1]

558,830
reasons to make a difference



13.2% population growth in the last **ten** years[2]

12% of that growth in the last **six** years[2]

Fastest growing Maori population in NZ[2]

51,630 people

Largest population aged over 65 in NZ[2]

87,560 people

Demand increases

The Canterbury system has experienced unrelenting demand challenges since the earthquakes[3]

36% increase in **adult** presentations to **community** mental health services

94% increase in **adult rural** presentations to **specialist** mental health services

100% increase in **child and youth** presentations to community mental health services

15% increase in total ED presentations

52% increase in ED presentations by 25-29 year-olds

90% increase in ED presentations by people from overseas

Engaged staff under pressure

89% of staff feel they are making a contribution to the success of the DHB[4]

74% of staff feel their jobs are fulfilling[4]

38% felt excessive workload is one of the top five stressors of their job[4]

28% felt being in a damaged environment or surrounded by construction work is having a negative impact on their wellbeing[4]

Damage to health infrastructure

$518m+ in total damages to be funded within a $384m envelope

14,000 rooms damaged

47,000m2 building space demolished

700 staff displaced

50% of clinical services already moved 4 times for repairs

106 inpatient beds lost

1 Stats NZ Dec 2016 Population Projections, CDHB Detailed Business Case Projections (based off Stats NZ & CERA workforce estimates) Oct 2012
2 Stats NZ Intercensal series 2012/13, and Stats NZ Dec 2016 Population Projections | 3 CDHB Patient Management System (2009/10 - 2015/16), mental health numbers refer to new case starts | 4 CDHB 2016 Staff & Family Wellbeing Survey May 2017

Produced 21st July 2017

Part II

The Year Ahead

Delivering on National Priorities and Targets

The following section highlights the activity the DHB will undertake in the coming year to deliver on national priorities and expectations in 2017/18. These actions are taken from the alliance work plans of the Canterbury Clinical Network (CCN), the project and operational work plans across our hospital and specialist services, corporate services, and the transalpine and regional work plans we share with our partner South Island DHBs.

In collaboration with our CCN partners in our district alliance, we will also look to improve our performance against the national System Level Measures, which are focused on the longer-term health of our population. Together we have developed a System Level Measures Improvement Plan for 2017/18, identifying local health need and where we will strive to make a difference. The Improvement Plan (attached as Appendix 6) is complementary to this Annual Plan and together they provide a broader picture of the activity planned across the Canterbury health system for the coming year.

Over the last several years, we have made some positive gains for Māori in Canterbury, with strong engagement in the childhood immunisation and B4 School Checks programmes and reductions in avoidable hospitals admissions. With a collective approach from across the health system, we are determined to make further progress. Throughout this section, actions aimed at improving Māori health are indicated by the Equity Outcome Action code (EOA).

Prime Minister's Youth Mental Health Project				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Commit to continue activity to deliver on the Prime Minister's Youth Mental Health Project.	NZ Health Strategy Link - Value & High Performance	Working with High Schools and Area Schools, offer and encourage uptake of health assessments (including HEEADSSS screening) by all students new to school in years 9 and above.	Q1: Communication delivered to schools on assessments for new students. Q4: Data regarding the uptake of the service is evaluated.	PP25: Delivery of actions agreed under the Prime Minister's Youth Mental Health Project. 95% of year nine children in decile one to three schools receive a HEEADSSS assessment. >130 schools engaged with SBMHS.
		Enhance and expand the capacity of the School Based Mental Health Service (SBMHS) to support earlier intervention for vulnerable young people, including delivering clinical interventions directly to children in schools.	Q1: Individual consults available for children and/or their family. Q4: Service uptake evaluated and further opportunities identified.	
		Working with primary care, offer up to four free extended general practice consults per year to support young people aged 13 to 24 with mental health and/or alcohol or other drug issues to access support earlier. (EOA)	Q1: Consistent service criteria and specifications for extended consultations embedded. Q2: Standard reporting enabled including demographic data that supports analysis of uptake.	

Reducing Unintended Teenage Pregnancy – Better Public Services Target				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Continue to build on the substantive activities identified in your 2016/17 annual plan to reduce unintended teenage pregnancy.	NZ Health Strategy Link - People Powered	Working with the Child & Youth Alliance Workstream, establish an Interagency Advisory Group for sexual & reproductive health, to share and support cross sector initiatives and improve awareness and uptake of services by young people.	Q1: Advisory Group established. Q2: Current access and service utilisation rates reviewed. Q3: Gaps and opportunities for improvements identified.	PP38: Quarterly report on delivery of agreed Annual Plan actions.
		Collaborating with Māori and Pacific providers, review the effectiveness of current responses to unintended pregnancy and support for mothers under the age of 19. (EOA)	Q2: Stocktake/review complete. Q3: Gaps and opportunities identified.	
		Using the results of the review, develop a targeted response for young Māori and Pacific and high-dep women. (EOA)	Q4: Integrated pathways and targeted supports developed.	

Supporting Vulnerable Children – Better Public Services Target				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Commit to continue activity to contribute to the reduction in assaults on children.	One Team	Ensure all staff are screened in line with the DHB's Child Protection Policy and the requirements of the Vulnerable Children's Act.	Q4: All new staff and 'core' child health workers have been screened as required.	Contribute towards the national goal: 5% reduction in the number of children physically abused nationally.
		Continue to invest in the DHB Violence Intervention Programme and train staff in the use of the National Alert System to identify people at risk of harm.	Q1: Training sessions ongoing. Q4: Violence Intervention Programme audit result >80/100.	

Healthy Mums and Babies – Better Public Health Services Target				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Commit to activity to support women to register with a Lead Maternity Carer (LMC) in the first trimester of pregnancy with equitable rates for all population groups.	NZ Health Strategy Link - One Team	Continue to support and direct women to the Midwifery Resource Centre and Find Your Midwife site to identify and make early contact with a midwife.	Q1: HealthPathways and HealthInfo information links are in place and up to date.	PP38: Quarterly report on delivery of agreed Annual Plan actions. 80% of pregnant women are registered with a LMC in the first trimester – baseline 77% at Dec 2015.
		Support and maintain sustainability solutions for maternity service delivery in the Kaikoura and Chatham Island regions to ensure equitable access to care for women in rural areas. (EOA)	Q1: Sustainable service agreement in place in Kaikoura. Q4: Review of arrangements and service utilisation to identify opportunities.	
		Enhance and promote the DHB funded pregnancy and parenting education classes – with a particular emphasis on first time Māori, Pacific and younger pregnant women – to encourage engagement with services including registration with LMCs. (EOA)	Q2: Kaupapa Māori pregnancy and parenting education material developed. Q4: >30% of first time mothers complete a DHB pregnancy and parenting education programme.	

Keeping Kids Healthy – Better Public Health Services Target				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Commit to activity to reduce hospital admission rates for avoidable conditions for children 0-12 years of age. *Note: Oral health is one of the key drivers of avoidable admissions in this age range and there is significant variation between population groups.*	NZ Health Strategy Link - One Team	Working with the Oral Health Steering Group, implement a multiple newborn enrolment process to increase enrolment in the Community Dental Service.	Q1: Multiple newborn enrolment process implemented. Q1: Analysis of NIR, PHO and Community Dental (Titanium) enrolment registers completed. Q2: Unenrolled children identified and contacted. Q4: 95% of children (0-4) enrolled in DHB oral health services.	PP38: Quarterly report on delivery of agreed Annual Plan actions. Contribution towards the national goal: 15% reduction in hospital admission rates for avoidable conditions for children aged 0-12 – baseline 39.8 per 100,000 at June 2016. Hospital admission rates for avoidable conditions for Canterbury children aged 0-12 maintained at <31.1 per 100,000.[2]
		Undertake analysis of the National Immunisation Register (NIR), PHO and Community Dental enrolment registers to identify gaps and engage with harder-to-reach children. (EOA)		
		Working with community providers, identify opportunities to increase engagement with Community Dental Services, and reduce 'did-not-attend' rates and avoidable hospital admissions related to oral health conditions, particularly for Māori and Pacific children. (EOA)	Q1: Opportunities identified from stakeholder workshop. Q2: Work plan agreed and prioritised. Q3: Implementation underway. Q4: 90% of enrolled children (0-12) examined according to plan.	

[2] *Canterbury's hospital admission rates for avoidable conditions in children aged 0-12 years is the fourth lowest in the country (31.1 per 100,000 people at June 2016). The DHB's contribution to the national target will be to maintain this lower than average rate and to focus particularly on reducing the equity gap between Pacific and non-Pacific children. This work is further highlighted in our System Level Improvement Plan which is available on the DHB's website.*

Increased Immunisation –Health Target				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Continue current activity, in accordance with national immunisation strategies and service specifications, to maintain high coverage rates for all immunisation milestones.	NZ Health Strategy Link - Value & High Performance	Working through the Immunisation Service Level Alliance, establish an inpatient/outpatient vaccination programme for pregnant women at Christchurch Women's Hospital.	Q1: Programme in place. Q4: Increased uptake of Pertussis and Influenza vaccinations.	95% of eight-month-olds are fully immunised. 95% of two year olds are fully immunised. 95% of four year olds are fully immunised. 75% of all eligible girls are fully immunised for HPV.
		Continue to support general practice to refer unvaccinated (hard-to-reach) children to the Missed Event and Outreach Immunisation service.	Q1: Fortnightly practice-level reports provided to general practice to identify missing and unvaccinated children.	
		Enhance the general practice vaccination programme by investing in the delivery of a DTaP in schools alongside the Year 8 HPV programme. (EOA)[3] Engaging with Māori and Pacific groups, identify opportunities to promote programmes to rangatahi and pacific youth. (EOA)	Q1: Capacity and support for providing school-based DTaP programme investigated. Q2: Decision on programme options made.	

Shorter Stays in Emergency Departments – Health Target				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Identify the quality improvement activities you will undertake in response to your 2016/17 ED National Quality Framework (NQF) results.	NZ Health Strategy Link - Value & High Performance	Working through the Urgent Care SLA, refine the #CareAroundTheClock campaign to encourage people to seek treatment from the right place at the right time and reduce avoidable pressure on ED services. (EOA)	Q1: Updated campaign in place. Q4: Out of hours presentations by triage 4 and 5 patients at or below 2016/17 levels.	95% of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours. Maintain ED attendances at <178 per 1,000 people – baseline at June 2016.
		Continue to improve the utilisation of the ED observation unit, with a particular focus on appropriate staffing levels and increased flexibility/discretion around admission, to make the best use of limited resource and capacity. Continue ongoing reconfiguration of the staffing resource within ED, with particular focus on the senior staffing model, to facilitate earlier decision making and improve patient flow.	Q1: Continued monitoring of observation unit admissions. Q1: Monthly review of NQF and ED metrics to identify and implement improvements. Q4: <15% of patients admitted from ED observation to inpatient wards (nat. guidelines <20%).	
		Continue to refine the new Production Bed Planning Model, to help with the flow of patients from ED to inpatient wards.	Q4: Average time from bed allocation request to departure from ED <30 minutes.	

[3] *DTaP (adult diphtheria and tetanus vaccine and adult acellular pertussis vaccine) and Human Papillomavirus (HPV).*

Improved Access to Elective Services – Health Target				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Deliver agreed service volumes in a way that meets timeliness and prioritisation requirements and improves equity of access to services.	NZ Health Strategy Link - Value & High Performance	Review production and capacity plans and determine outsourcing needs for the 2017/18 year, in order to meet national health target and elective services patient flow indicator (ESPI) expectations.	Q1: Production and capacity planning complete. Q1: Outsourcing contracting requirements in place.	21,330 elective surgeries delivered for the improved access to elective surgery health target. 120 additional general and orthopaedic surgeries delivered. 17 bariatric surgeries delivered. Elective and Ambulatory Initiative delivered as agreed. Delivery of all national ESPI targets. SI4: Delivery in line with Standardised Intervention Rates. OS3: Elective average length of stay at or below 1.54 days.
		Participate in the South Island Regional Electives Workstream activity to determine and coordinate regional service delivery to support vulnerable South Island services and deliver against the South Island IDF (Inter-district flow) Plan.	Q1: Regional patient transfer processes agreed as necessary. Q4: Bariatric Initiative delivery in line with regional services plan. Q4: 219 regional surgeries delivered in line with electives plan.	
		Support the DNA Project Group to work with specialist services to review and reduce 'did not attend' rates particularly for Pacific and Māori patients – to improve health outcomes and make the best use of limited resources. (EOA)	Q1: Quarterly monitoring of service DNAs to raise awareness. Q2: Minimum of three services identify to participate in review. Q3: Opportunities identified and actions to address rates underway.	

Faster Cancer Treatment – Health Target				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Identify the sustainable service improvement activities you will implement to improve access, timeliness and quality of cancer services.	NZ Health Strategy Link - One Team	Using dashboard monitoring, support discussion with specialities who are missing the 31 and 62 day targets by less than three days and identify opportunities to reduce process delays.	Q1: FCT patient tracking dashboard implemented. Q3: Plan of action agreed with relevant clinical teams.	PP29: Improved waiting times for diagnostic services. 90% of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks. 85% of patients receive their first cancer treatment (or other management) within 31 days of date of decision-to-treat.
		Review inter-DHB referrals to understand the point in the pathway where the referrals need to be made to ensure compliance with the targets - pilot with the head and neck pathway.	Q1: Pressure points documented. Q2: Crucial date of referral defined and agreed with the referring DHB.	
		Using high suspicion of cancer data, identify urology patients treated for cancer using hormone therapy, to streamline their pathways and improve compliance with national targets.	Q2: Query build for the identification of appropriate patients established. Q3: Revised process in place.	
		Engage in the regional Te Waipounamu Māori Cancer Pathway Project to support improvements for Māori. (EOA)	Q4: Agreed actions and recommendations implemented.	

Better Help for Smokers to Quit – Health Target				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Provide an integrated approach to delivery of ABC between primary care services.	NZ Health Strategy Link - One Team	Monitor the DHB's Tobacco Control Plan to support an integrated approach to achieving Smokefree Aotearoa 2025.	Q1: Continued delivery against the Tobacco Control Plan. Q2: Plan reviewed.	90% of PHO-enrolled patients who smoke have been offered brief advice and support to quit. 90% of pregnant women who identify as smokers upon registration with a LMC are offered brief advice and support to quit smoking. 95% of hospitalised patients who smoke are offered brief advice and support to quit smoking.
		Implement Year II of the Motivational Conversations Programme to support health professionals to have difficult conversation with patients about risk behaviours and healthier lifestyles.	Q1: Ongoing uptake of motivational training by GPs. Q4: 25 training events delivered.	
		Support development of Canterbury's new Stop Smoking Service (Te Hā Waitaha) and monitor enrolments by referrer type and ethnicity to identify opportunities for improvement. (EOA)	Q1: Quarterly monitoring of referrals and enrolments. Q4: Increased enrolment rates.	
		As an integral part of the Te Hā Waitaha service, implement a programme that incentivises pregnant women to stop smoking. (EOA)	Q1: Programme in place. Q4: Increased enrolments rates for pregnant women.	

Raising Healthy Kids - Health Target				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Identify activities to sustain efforts and progress towards achieving the Raising Healthy Kids target by December 2017. *Refer also actions under the Childhood Obesity Action Plan.*	NZ Health Strategy Link - Closer to Home	Monitor the delivery of B4 School Checks (B4SC) and referrals to the Healthy Lifestyle Coordination Service by ethnicity and deprivation to ensure all children are being appropriately assessed and referred for support where needed. (EOA)	Q1: Quarterly audit of assessments and referrals. Q4: 90% of Māori and Pacific children, and children living in high deprivation areas, receive their B4SC.	95% of all children identified as obese at their B4SC are offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions. SI5: Delivery of Whānau Ora.
		Invest in a range of lifestyle, nutrition and activity services to provide general practice teams with multiple referral options when referring overweight children and their families – particularly Māori and Pacific children, and children living in high deprivation areas. (EOA)	Q1: Referral pathway in place for BeSmarter, Triple P, Appetite for Life, Active Families and Green Prescription Programmes. [4] Q2: Audit of referrals and programme uptake by ethnicity. Q3: Implementation of actions to address any gaps identified.	
		Implement Year II of the Motivational Conversations Programme to support health professionals to have difficult conversation with patients.	Q1: Ongoing uptake of motivational training by GPs. Q4: 25 training events delivered.	

[4] *BeSmarter is a healthy living tool that generates discussion using a visual guide that brings together elements of healthy eating and daily activity such as sleep, eating together and minimising takeaway food in a single colour handout that can be filled in with a family. Triple P (Positive Parenting Programme) is a group lifestyle programme offered to the parents of overweight or obese children.*

Bowel Screening

Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Contribute to development activities for the national bowel screening programme. *Note: Canterbury go live for the national programme is 2018/19.*	NZ Health Strategy - Value & high Performance	Working with the Regional Alliance, participate in the delivery of actions to position the South Island for the rollout of the national Bowel Screening Programme (NBSP).	Q1: Workforce and IT support for NBSP rollout included in regional work plans. Q4: Regional Bowel Screening Centre progressing as planned.	PP29: improved waiting times for diagnostic services. 90% of people receive their urgent diagnostic colonoscopy within two weeks. 70% of people receive non-urgent diagnostic colonoscopy within six weeks. 70% of people receive their surveillance colonoscopy within twelve weeks of the planned date.
		Establish a Canterbury NBSP Project Team to position the Canterbury DHB for the rollout of the NBSP, and to sustainably meet future colonoscopy wait time targets.	Q1: NBSP Project Plan agreed. Q1: Primary and secondary NBSP clinical leads identified. Q4: Future colonoscopy capacity requirements identified.	
		Working with primary care, identify priority 'at risk' populations and actions to engage these population in readiness for the NBSP rollout. (EOA)	Q3: Options for engaging at risk populations identified. Q4: Resource implications identified and considered.	

Mental Health

Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Improve our population's mental health and wellbeing by increasing uptake of treatment and support earlier in the course of mental illness, with a particular focus on supporting our population exhibiting increased need following the earthquakes.	NZ Health Strategy Link - Value & High Performance	Working with primary care, implement a brief intervention telephone service to support people with mild to moderate symptoms, particularly young people and people in rural settings. (EOA)	Q1: Telephone service implementation underway. Q2: Standard reporting enabled including demographic data that support analysis of uptake.	PP38: Six monthly report on delivery of agreed Annual Plan actions. 95% of people engaged with mental health or AOD services are enrolled with a PHO. 80% of young people (0-19) referred to specialist mental health and addiction services are seen within 3 weeks 95% of young people (0-19) referred to specialist mental health and addiction services are seen within 8 weeks.
		Continue to support implementation of the Equally Well programme, enhancing the role of primary care in promoting the physical health of people with mental health conditions.[5]	Q1: Consistent service criteria and specifications embedded for extended consultations. Q2: Standard reporting enabled including demographic data that supports analysis of uptake.	
		Working with He Waka Tapu, implement an online support service for Māori exiting AOD treatment to promote and support their recovery following treatment. (EOA)	Q1: Implementation underway. Q2: Outcomes reporting in place. Q4: 200 users accessing the tool.	
Improve mental health service quality including reducing waiting times for child and youth specialist services.		Explore the feasibility of developing a whole of system wait times report for child and youth services, broken down by demographics. (EOA)	Q1: Workgroup established. Q2: Wait time report under development.	
		Monitor demand and wait time data to identify pinch points across the system, in response to the changing need of our population following the earthquakes.	Q2: Data reviewed. Q4: Opportunities identified to inform future service redesign and better meet demand.	
		Complete the reconfiguration of Child, Adolescent and Family Mental Health Services (CAFS) to streamline access and better address capacity issues.[6]	Q1: Quarterly monitoring of the CAFS reconfiguration progress and service impact.	
		Explore opportunities to work with Māori and Pacific providers to focus on identified areas of concern. (EOA)	Q1: Review of Māori and Pacific health focus areas underway. Q4: Opportunities presented.	

[5] Equally Well is a programme of collaborative action to address poor physical health outcomes of people experiencing mental health and/or addiction issues. The reference here refers to the provision of up to four free general practice extended consults for physical health.
[6] The reconfiguration includes development of: a brief intervention and support pathway; a CAFS wide choice system (to provide timely interventions and release clinical resource for specialist intervention and support); and a pathway for CYF consult/liaison and focusing on children with Oranga Tamariki in the first instance and providing limited school based consultation/liaison and brief intervention.

Implementing the Healthy Ageing Strategy				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Deliver on priority actions identified in the Healthy Ageing Strategy 2016, including: working with ACC, HQSC and the Ministry of Health to further develop and measure the progress of integrated falls and fracture prevention services and working with the Ministry and wider sector to develop future models of care.	NZ Health Strategy Link - Closer to Home	Collaborating with ACC, reduce hospital admission related to falls, by enhancing our community-based Falls and Fracture Prevention Service and increasing the availability of strength and balance rehabilitation programmes.	Q1: Existing Community Strength and Balance classes identified. Q2: Recommendations and outcomes identified by the Falls Co-Design working Group. Q4: Implementation underway.	PP23: Implementing the Healthy Ageing Strategy. >1,200 referrals to the Falls Prevention Service. >3,000 places available at Community Strength and Balance Classes. >95% of long-term HBSS clients have an interRAI assessment and have a completed care plan in place. >75% of ARC residents have had a subsequent interRAI long term care facility assessment within 230 days of the previous assessment. >56 people participate in the regional Walking in Another Shoes training programme.
		Working with the Ministry and local providers, continue to develop and implement future models of home based support services (HBSS): as per Part-B of the national In-Between Travel Settlement.	Q1: Continued implementation of the Travel settlement. Q4: Delivery of the Community Services Redesign work plan.	
		Working with the Ministry implement the Pay Equity settlement across all eligible providers and services.	Q1: Pay equity funding model implemented. Q3: Wash-up and transfer from transitional model complete.	
		Continue to monitor interRAI data and trends to identify opportunities to improve the service quality, timeliness, and ensure access to appropriate levels of care and support. (EOA)	Q1: Quarterly review of interRAI assessment data. Q2: Two quality improvement / service development initiatives identified and underway.	
		Working with the Regional Alliance, support delivery of the Health of Older People work plan – with particular focus on strengthening dementia pathways.	Q1: Continued development of local dementia care pathways. Q4: Relevant actions within the HOP work plan delivered	
Identify actions to regularise and improve the training of the kaiāwhina (non-regulated) workforce across home based and community support services.	NZ Health Strategy Link - Closer to Home	Working with local service providers, encourage the training and development of home based and community support workers and Allied Health Assistants through the Careerforce training programme.	Q4: Training being monitored as required under legislation. Q4: New staff enrolled in Careerforce training within three months of commencing in roles.	PP23: Implementing the Healthy Ageing Strategy.
		Using the Calderdale Framework principles, develop and implement Clinical Task Instructions (CTIs) for Allied Health Assistants and Home Based Support Services (HBSS) workers.	Q2: CTIs for Allied Health Assistants developed. Q4: CTIs for HBSS staff developed (in partnership with HBSS providers).	
		Working with the Māori Health Team, consider opportunities to embed cultural competence training within the Calderdale Framework. (EOA)	Q4: Equity Lens (HEAT) applied to locally developed Calderdale Framework training programmes.	

Living Well With Diabetes

Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Continue to implement the actions in Living Well with Diabetes – a plan for people at high risk of or living with diabetes 2015-2020 in line with the Quality Standards for Diabetes Care.	NZ Health Strategy Link - Closer to Home	Continue to support general practice to deliver care and support to patients with diabetes, in line with clinical guidelines and minimum standards, to avoid unnecessary hospital admissions and adverse outcomes.	Q4: Services reviewed against the Diabetes Quality Standards. Q4: 90% of the population identified with diabetes have had an annual HbA1c test.	Implement actions from Living Well with Diabetes Plan. >75% of people identified with diabetes and having an HbA1c test have good or acceptable glycaemic control (HbA1c <64 mmol/mol).
		Monitor access to screening services that support people with diabetes to stay well, to identify equity gaps and opportunities for improvement. (EOA)	Q2: Six monthly demographic analysis of access rates, including retinal screening and high risk podiatry care. Q3: Opportunities investigated.	
		Support the CCN Integrated Diabetes Services Development Group, to work with culturally diverse communities to develop and deliver diabetes workshops to engage groups that have been harder-to-reach in diabetes programmes. (EOA)	Q1: Workshop group established. Q4: Four culturally appropriate education workshops delivered for Pacific, Indian, Māori and Chinese communities. Q4: One youth-focused education workshop delivered.	

Disability Support Services

Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Identify the mechanisms and processes in place to support people with a disability when they interact with hospital based services.	NZ Health Strategy Link - One Team	Through the newly formed DHB Disability Steering Group, implement the improvement actions identified in the DHB's Disability Action Plan.	Q1: Ongoing progress against actions in the Plan.	PP38: Six monthly report on delivery of agreed Annual Plan actions.
		Leveraging off the work of the CCN Collaborative Care Programme, seek to ensure electronic shared care plans identify goals and actions for people with a disability. (EOA)	Q4: Personalised Care Plans enabled to identify people's disability, health goals and key supports.	
		Working with people with disabilities and their families, develop an eLearning tool to capture their experience in our system to increase disability awareness amongst Canterbury DHB staff. (EOA)	Q3: eLearning tool developed. Q4: eLearning tool promoted.	

Implementation of the Childhood Obesity Plan

Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Commit to progress DHB-led initiatives in line with the regional childhood obesity plan, with a focus on addressing equity. *Note: Refer also to actions under the Raising Healthy Kids Health Target.*	NZ Health Strategy Link - Closer to Home	Participate in the implementation of the South Island Regional Obesity (Healthy Weight) Programme.	Q1: Common regional protocols, pathways and guidelines applied.	PP38: Six monthly report on delivery of agreed Annual Plan actions. 50% of children and families referred to lifestyle programmes take up the opportunity.
		Invest in the PHO Healthy Lifestyle Coordination Service to provide an integrated approach to identify, refer and support lifestyle change for overweight and obese children and their families.	Q1: Referral pathway in place for access to lifestyle programmes. Q1: Ongoing dissemination and promotion of Eating and Activity Guidelines.	
		Review the uptake of Active Families and Triple P to identify opportunities to improve uptake by Māori and Pacific children and their families. (EOA)	Q1: Quarterly review of programme uptake by ethnicity.	

Child Health

Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Support national work under way to improve the health outcomes for children, young people and their families serviced by Oranga Tamariki, particularly young people in care.	NZ Health Strategy Link - Value & High Performance	Review service access to identify barriers for young people in accessing timely care and ensure children in care receive Gateway Assessments to support earlier intervention. Working with the Gateway Team, prioritise assessments for Māori and Pacific children who have not previously received an assessment (EOA).	Q2: Data on historic Gateway Assessments collated. Q3: Data cross-matched and gaps in assessments identified. Q4: 95% of children in care have received a Gateway Assessment.	PP38: Six monthly report on delivery of agreed Annual Plan actions.
		In line with the DHB's Child Protection Policy, continue to support an integrated response for vulnerable and at risk children and raise awareness amongst staff through training in the identification of harm and neglect and the use of the National Alert System.	Q1: Continued utilisation of the e-Prosafe alert system. Q2: Ongoing training of clinical staff. Q4: VIP audit scores of 80/100 maintained.	
		Working with Oranga Tamariki, support and resource the provision of care to vulnerable children and young people through the Canterbury Children's team with a focus on extending coverage to rural areas (EOA).	Q1: Continued participations in the Local Governance Group. Q1: Ongoing monitoring of referrals and outcome metrics. Q4: Children's team expanded to cover the wider district.	

Implementation of the Pharmacy Action Plan

Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Continue to deliver on the national Pharmacy Action Plan.	NZ Health Strategy Link - One Team	Working through the Pharmacy Service Level Alliance, promote the role of the Pharmacist in the health care team.	Q2: Pharmacy focused health literacy, cultural competency, and motivational conversations training package developed.	PP38: Six monthly report on delivery of agreed Annual Plan actions. >1,500 people referred to Medication Use Reviews and Medication Therapy Assessments (to reduce harm from medications use). Increased uptake of MURs and MTAs by high need population groups.
		Implement a public awareness campaign to raise people's understanding about what they can expect from their pharmacist. Apply a cultural awareness lens to reach high need communities. (EOA)	Q1: Baseline survey of consumer's complete. Q2: Campaign developed and implemented.	
		Support local implementation of national contracting arrangements, once agreed, to support the vision of integrated pharmacist services in the community.	Q4: Agreed decisions actioned.	

Supporting Primary and Community Service Integration				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
DHBs must describe activity to demonstrate how they are working with their district alliances to move care closer to home for people through improved integration with the broad health and disability sector (eg primary care, disability services, and ambulance services).	NZ Health Strategy Link - Closer to Home	Working through the CCN Urgent Care SLA, continue to enhance and refine community based acute demand management services and ambulance pathways to better support people in the community rather than in hospital.	Q1: Quarterly review of effectiveness of acute demand programme by ethnicity. Q4: One new initiative, to get people to present at the right place, implemented.	>400 patients utilise COPD / Heart Failure ambulance pathways. >30,000 urgent care packages provided in the community. >1,000 patients with Acute Care Plans. Rate of acute bed days maintained below the national average at ≤292 per 1,000 people IFHS practices complex patient use ED services less than the Canterbury average. First of the new agreed Rural Models implemented.
		Support the continued development and promotion of models that enhance care and self-management for patients with complex conditions. (EOA)	Q2: Personalised Care Plans launched. Q3: Process for identifying high-need patients agreed.	
		Continue to invest in the Integrated Family Health Services (IFHS) Programme, to support the development of new models of care in general practice. Engage IFHS groups in the enhanced management of complex patients and patients with long-term conditions, to reduce unnecessary hospital admissions.	Q1: Ongoing refinement of funding models to support IFHS and complex care development. Q4: Further 6% increase in the number of practices engaged in the IFHS process. Q4: Traffic Lighting complex patient identification operational in six IFHS groups.	
		Working through the Rural Health Workstream, develop and implement sustainable health service models for rural communities, through the rural sustainability programme. (EOA) [7]	Q4: Scoping of model commenced for Selwyn and Rakaia, Methven and Akaroa. Q4: Sustainable models presented for Huranui and Oxford.	
Improve performance against the national System Level Measures.	One Team	Working through the joint SLM Steering Group, refresh and refine Canterbury's Improvement Plan outlining joint activity to achieve the new national System Level Measures.[8]	Q1: Implementation of agreed Improvement Plan underway. Q4: Confirmation of measures and updated actions for 2018/19.	Improved performance against the national SLM in line with the 2017/18 Improvement Plan.

Commitment to Quality and Patient Safety				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Demonstrate how the DHB will improve patient experience, as measured by the Health Quality & Safety Commission national patient experience survey in the area: 'Including family or someone close to the patient in discussions about their care'.	NZ Health Strategy Link - Value & High Performance	Complete the Admission and Discharge modules from the Releasing Time to Care Programme, to support clinical teams to increase patient involvement in decision-making about their care.	Q2: Teams complete assessment of areas for improvement. Q3: Process improvements embedded.	PP38: Six monthly report on delivery of agreed Annual Plan actions. >30% response to national inpatient experience survey. Improved patient survey results for the question 'Did you feel you received enough information from the hospital on how to manage your condition after discharge?' – baseline 54% at June 2016.
		Evaluate the learnings from the Health Quality & Safety Commission's 'Always Event' pilot, to inform ways we can work better in partnership with families and whānau. (EOA)	Q1: Participation in the Always Event pilot. Q3: Planned approach to delivering improvements agreed.	
		Working through the Child Health Consumer Advisory Group, seek to improve onsite feedback processes for capturing patient and family suggestions and complaints.	Q1: Existing blue box feedback system in paediatrics reviewed. Q4: Revised system evaluated for use in adult services.	

[7] *The rural communities of focus for 2016/17 are: Hurunui, Oxford, Selwyn, Rakaia, Methven, Rangiora, Ashburton, Akaroa and Kaikoura.*
[8] *Canterbury's System Level Improvement Plan is attached as Appendix 6 to this Plan.*

Living Within Our Means

Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Commit to managing your finances prudently and in line with Ministerial expectations. Ensure all planned financials align with previously agreed results.	NZ Health Strategy Link - Value & High Performance	Working through the CCN Alliance, develop and implement the System Level Improvement Plan to support people to stay well and to manage and meet people's needs in the community rather than in our hospital services.	Q1: System Level Improvement Plan agreed. Q4: Improvements realised.	Delivery of year-end financial performance in line with agreed Annual Plan results.
		Review and refine demand forecasting and capacity planning to reduce the operation costs of outsourcing and avoid the financial penalties associated with missing electives targets.	Q4: Electives delivery in line with agreed production plans.	
		Review demand, capacity and operational costs across all service areas to reduce duplication and waste, and identify opportunities to enhance efficiency. Seek approval to align service models and intervention rates with national service specifications or accepted practice in other DHBs, in order to direct resources into the areas of greatest need.	Q1: Ongoing review of services. Q1: Ongoing implementation of consequential service changes.	

Commitment to Regional Activity

Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Identify any significant actions the DHB is undertaking to deliver on the Regional Service Plan priorities.	NZ Health Strategy Link - One Team	Provide input into the development of a regional model for cardiac services, ensuring equitable access to service for people across the South Island. (EOA)	Q2: STEMI Pathway implemented (with St John Ambulance). Q4: Single South Island cardiac services model agreed and implementation underway.	SI2: Delivery of actions in support of the regional health services plan.
		Continue to support the delivery of a sustainable organised stroke services locally and regionally.	Q4: Regional intra-arterial clot retrieval protocols in place.	
		Continue to support the provision of a planned and consistent approach to the provision of major trauma services.	Q2: Regional destinations policy agreed and in place.	
		Continue to support the provision of a planned and consistent regional approach to the assessment and treatment of people with Hepatitis C.	Q1: Continued support to enable regional data collection. Q4: Integrated Hepatitis C approach in place locally.	
		Support development of a consistent regional approach to strengthening AOD pathways, incorporating the new Substance Addiction Compulsory Assessment and Treatment (SACAT) Legislation.	Q1: Continued input into the development of a model of care for AOD services. Q3: Capacity requirements of SACAT implementation considered and identified.	

Local and Regional Enablers

2.1 Enhancing our organisational strength and capability

Investing in our People				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Identify any particular workforce issues that need to be addressed at a local level around capability and capacity (numbers) and include key actions and milestones.	NZ Health Strategy Link - One Team	Support the improved wellbeing of our people through the ongoing implementation of the workforce Wellbeing Strategy.	Q4: 12 General Wellbeing workshops delivered. Q4: 11 Strengths workshops delivered.	Improved wellbeing outcomes evident in bi-annual engagement survey. Māori recruited onto a health career pathway (100 individuals across South Island). Māori graduates transitioned into health sector workforce (25 individuals across the South Island).
		Implement frameworks and programmes to develop people's leadership capability and provide them with the confidence and technical skills to play a leadership role in the organisation.	Q2: Leadership and Talent Framework in place. Q3: Operational leadership learning and development programme in place. Q2: Data literacy learning and development programme in place.	
		Continue to lead the regional delivery of the Kia Ora Hauora Māori Workforce Development Service to support Māori health workforce capacity development across the South Island. (EOA)	Q1: Quarterly updates on delivery against regional plan.	

Connecting Our Information Systems				
Expected Focus		Actions to Improve Performance	Milestones	Measure of Success
Demonstrate how the DHB is regionally aligned and where it is leveraging digital hospital investments including: Rollout of EMRAM Stage 3 & 4 capabilities and replacement of legacy Patient Information Systems.[9]	NZ Health Strategy Link - Smart System	Continue to take the lead in developing South Island information systems and expand and enhance the capability of Health Connect South and HealthOne to improve clinical decision-making and patient care at any point in the system.	Q1: Health Connect South available to all primary care providers in the South Island. Q2: Two major external parties provided access to HealthOne.	PP38: Delivery of actions agreed in the Annual Plan. SI2: Quarterly reports from regional leads. 80% of GP referrals are sent electronically. 90% of the population have an integrated patient-centric clinical record available. All South Island DHBs using HealthOne / Health Connect South.
		Continue to rollout electronic patient observation and management tools across our hospitals, ensuring all major facilities meet EMRAM stage 5.	Q1: MedChart rollout complete across all DHB hospitals. Q2: PatientTrack rollout complete across all DHB sites.	
		Continue to rollout the single South Island Patient Information Care System (PICS) across Canterbury DHB facilities to streamline care and reduce duplication of effort across the South Island.	Q1: PICS Burwood operational. Q2: PICS Ashburton underway.	

[9] *New Zealand public hospitals are being assessed against an international benchmark, the Electronic Medical Record Adoption Model (EMRAM). The model consists of eight stages through which DHBs move towards achieving a digitally enabled hospital.*

Financial Summary

Further details on the DHB's financial outlook and assumptions for 2017/18 can be found in Appendix 5 of this Plan.

2.2 Prospective Statement of Financial Performance – to 30 June 2020

Statement of Comprehensive Income	2015/16 Actual $'000	2016/17 Actual $'000	2017/18 Plan $'000	2018/19 Plan $'000	2019/20 Plan $'000
REVENUE					
Ministry of Health revenue (Note 1)	1,538,949	1,573,724	1,660,767	1,707,439	1,756,663
Other government revenue	29,270	28,932	31,120	32,364	33,659
Earthquake repair revenue redrawn	9,882	10,712	7,800	18,500	23,800
Other revenue	44,391	42,740	47,231	51,489	63,909
Total Revenue	**1,622,492**	**1,656,108**	**1,746,918**	**1,809,792**	**1,878,031**
EXPENSE					
Personnel	675,097	704,206	745,725	782,293	817,612
Outsourced (Note 2)	26,920	25,907	25,032	24,597	24,159
Clinical supplies	133,550	142,878	148,168	153,904	164,563
Earthquake building repair costs	9,882	10,712	7,800	18,500	23,800
Infrastructure & non clinical (excl Earthquake repairs)	101,729	105,685	99,225	102,425	105,546
Payments to non-DHB providers	606,747	643,176	684,378	698,582	685,388
Interest	5,575	3,932	200	-	-
Depreciation and amortisation	57,739	56,268	59,704	69,572	71,237
Capital charge expense	5,726	16,177	30,330	34,458	67,242
Total Expense	**1,622,965**	**1,708,941**	**1,800,562**	**1,884,331**	**1,959,547**
Surplus/(Deficit)	**(473)**	**(52,833)**	**(53,644)**	**(74,539)**	**(81,516)**
OTHER COMPREHENSIVE REVENUE & EXPENSE					
Revaluation of property, plant & equipment	91,753	-	-	-	-
Impairment of property, plant & equipment	-	(1,491)	-	-	-
Total Comprehensive Income/(Deficit)	91,280	(54,324)	(53,644)	(74,539)	(81,516)

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

2.3 Prospective Financial Performance by Output Class - to 30 June 2020

Prospective Summary of Revenues and Expenses by Output Class	2017/18 Plan $'000	2018/19 Plan $'000	2019/20 Plan $'000
Early Detection and Management			
Total Revenue	349,602	362,185	375,841
Total Expenditure	360,848	377,636	392,710
Net Surplus/(Deficit)	**(11,246)**	**(15,451)**	**(16,869)**
Rehabilitation & Support			
Total Revenue	268,745	278,418	288,916
Total Expenditure	276,946	289,831	301,400
Net Surplus/(Deficit)	**(8,201)**	**(11,413)**	**(12,484)**
Prevention			
Total Revenue	37,752	39,111	40,586
Total Expenditure	38,430	40,218	41,823
Net Surplus/(Deficit)	**(678)**	**(1,107)**	**(1,237)**
Intensive assessment & treatment			
Total Revenue	1,090,819	1,130,078	1,172,688
Total Expenditure	1,124,338	1,176,646	1,223,614
Net Surplus/(Deficit)	**(33,519)**	**(46,568)**	**(50,926)**
Consolidated Surplus/(Deficit)	(53,644)	(74,539)	(81,516)

Service Configuration

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 New Zealand 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 2017/18. However, in our current circumstances, there are obvious service coverage risks related to resource and capacity constraints, infrastructure damage, rebuild delays, and changing service demand patterns following the earthquakes.

We are working with neighbouring DHBs and the Ministry of Health to assess and alleviate these risks, but anticipate that meeting national expectations will be a significant challenge in the coming year.

SERVICE REDESIGN

Through our CCN Alliance, we are working with our primary and community partners to redesign the way we deliver health services to better meet the needs of our population and 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.

We also anticipate new models of service delivery will be needed as we seek to address our capacity and resource constraints. Consistent with our shared decision-making principles, we look to our clinically-led alliance 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.

At times, we may wish to negotiate, enter into, or amend current service agreements or arrangements to assist in meeting our objectives and delivering against the vision and goals outlined in this Plan. 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.

Listed below are the anticipated service changes for the coming year.

CHANGE	AREA IMPACTED	DESCRIPTION OF CHANGE	BENEFIT	DRIVER
Location and configuration of services	Services on the Christchurch Hospital Campus	Relocation and reconfiguration of services to accommodate earthquake repairs and in line with the completion of the Acute Services and Outpatient Services Buildings.	Continued and sustainable service delivery.	Local
Location and configuration of services	Mental Health Services	Relocation and reconfiguration of services to accommodate the decanting of The Princess Margaret Hospital site.	Continued and sustainable service delivery.	Local
Provider of services	Food Services	On expiry of the current external contract, the DHB will take over the provision of Food Services by bringing the service in-house.	Increased service capacity and integration.	Local
Redesign of service model	Home and Community Based Support Services	Under the guidance of the CCN Health of Older People Workstream and Community Services Service Level Alliance, the DHB will seek to redesign the model of care for Home and Community Based Support Services.	Increased service capacity and integration, and improved patient outcomes.	Local
Redesign of service model	Mental Health Services	Under the guidance of the CCN Mental Health Workstream, the DHB will seek to further develop the model of care for mental health services in response to increasing demand and evolving need.	Increased service capacity and integration, and improved patient outcomes.	Local
Possible redesign of services models	Alcohol and Drug Services	The DHB is working with service providers and regional DHB partners to align the South Island's model of care with national changes to the Alcohol and Drug legislation.	Alignment with national service specifications and equitable access.	National

CHANGE	AREA IMPACTED	DESCRIPTION OF CHANGE	BENEFIT	DRIVER
Redesign of service model and contracting arrangements	Community Pharmacy and Pharmacist Services	Under the guidance of the CCN Pharmacy Service Level Alliance, the DHB will engage with pharmacy providers to implement the national pharmacy contracting arrangements and develop local services in alignment with the national Pharmacy Action Plan.	Increased service integration, improved service quality and improved patient outcomes.	Local National
Provider and configuration of service	Maternity Services	The DHB has issued an expression of interest in the delivery of maternity services in Kaikoura to work alongside the integrated model of care.	Continued and sustainable local service delivery.	Local
Potential reconfiguration of services	Kaikoura Services	The DHB is working with local providers and other agencies to address emerging demand post-disaster. This may include reconfiguration of services to meet population need.	Continued and sustainable local service delivery.	Local
Potential redesign of service models	Falls and Fragility Fracture Prevention Services	The DHB is working with the Accident Compensation Corporation to further develop the service model for Falls and Fragility Fracture Service and enhance prevention strategies.	Increased service integration, and improved patient outcomes.	Local
Potential redesign of service models	Rural Services in: - Akaroa - Ashburton - Hurunui - Waimakariri - Oxford	Under the guidance of the CCN Rural Health Workstream, the DHB is working to redesign models of care across rural communities, including the development of integrated family health services and sustainable after-hours' models to meet growing demand.	Increased service capacity and integration; equity of access to services.	Local
Potential redesign of service models	Elective and Acute Services	The DHB is reviewing the flow of patients and the capacity of its service, in line with increasing demand and expectations of service delivery. Solutions may result in the redesign of service models and impact on the configuration of some services.[10]	Increased service capacity and improved patient safety, experience and outcomes.	Local Regional
Potential redesign of service models, change of provider and/or location of service	Secondary and Tertiary Care Services	The DHB is reviewing demand, capacity and operating costs across all of its service areas, in order to prioritise resources onto areas of the most immediate or greatest need. This includes aligning practice and intervention rates with national service specifications and accepted practice in other DHBs, and may impact on the configuration and scope of some services.	Reduction in operating costs, increased capacity in priority service areas, and greater patient and system returns.	Local Regional

[10] This work is largely being driven by the DHB's Elective Services Redesign (100 Days), Frail Older Person's Pathway, Enhanced Recovery After Surgery (ERAS), Faster Cancer Treatment and Theatre Utilisation Programmes to ensure we live within our means.

Part III

Managing Our Business

Organisational Strength

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

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

3.1 Organisational 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 further encourage a focus on the patient through our annual Quality Improvement and Innovation Awards. These awards recognise excellence and quality improvement not only in our hospitals but across the wider Canterbury health system.

EFFECTIVE LEADERSHIP

To support good governance, we have an outcomes-based decision-making and accountability framework that enables system leaders and our community to provide direction and monitor service performance.

Clinical leadership and consumer engagement is intrinsic to our success and we ensure strategic and operational decisions are fully informed through the following formal mechanisms:

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

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

Clinical leadership and consumer input into decision making is also embedded at all levels of our organisation, across primary and secondary services and across our local and regional alliance workstreams.

STRATEGIC PARTNERSHIPS

Working collaboratively has enabled us to respond to the changing needs of our population over the past six years and continues to be a critical factor in achieving our goals and objectives. The DHB's major strategic partnerships include:

The Canterbury Clinical Network (CNN): the district alliance is where the DHB and its partner organisations come together to improve the delivery of health care and realise opportunities to improve health outcomes. This includes the development of Canterbury's System Level Improvement Plan for 2017/18 which is attached to this Plan (Appendix 6).

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 workstreams.

Transalpine Partnership: an initial priority of connecting up the Canterbury and West Coast health systems and formalising clinical pathways is now helping to enable sustainable access to specialist services for the West Coast population. The two DHBs now share senior clinical and management expertise, corporate services teams and information systems.

3.2 Commitment to quality

Our approach to improving the quality of the services we deliver is in line with the New Zealand Triple Aim: Improved quality, safety and experience of care; improved health and equity for all populations; and best value for public health resources.

Working with the South Island Quality and Safety Alliance, we implement quality improvements through a community of practice and support each other to meet our commitments to the national Health Quality and Safety Commission (HQSC) programmes.

The national HQSC Quality and Safety markers are used by our governance groups, alongside the Australian Health Roundtable benchmarking, to monitor the effectiveness of our improvement activity and patient safety in our services. Performance is reported regularly to the DHB's Clinical Board, the Board's Quality, Finance, Audit & Risk Committee, and annually to our community through our Quality Accounts which can be found on the DHB's website.

Contracted services are also aligned with national quality standards, and auditing of contracted providers includes quality audits.

The Canterbury DHB has a focus over the coming year on improving the patient experience of care in our services and this is highlighted in Part II of this Plan.

3.3 Performance management

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 fortnightly by the Executive Team and monthly by the DHB Board and its Quality, Finance, Audit and Risk Committee. The DHB's performance is also presented in a public forum to the Board's Community and Public Health and Hospital Advisory Committees.

The DHB also reports monthly and quarterly to the Ministry of Health against key service and financial reporting indicators (refer to Part IV for the non-financial performance framework and expectations).

On an annual basis, our performance is audited against our Statements of Performance and Financial Expectations (Appendix 4 and 5). The results are published annually in the DHB's Annual Report.

At a broader level, we monitor our performance over the long-term against a core set of desired population outcomes, which help to evaluate the effectiveness of our strategies and investments decisions. Our goals are captured in the DHB's Outcome Framework which defines success from a whole of health system perspective and is used as a means of evaluating the success of our collective initiatives.

Further detail on the DHB's outcome goals can be found in the DHB's Statement of Intent.

3.4 Asset management

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

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

In line with the new Treasury requirements for monitoring investments across government, the DHB is developing an extensive ten-year Long-term Investment Plan. This Investment Plan will reflect the impact changing patterns of demand and new models of care will have on our future asset requirements and will support our investment decision going forward.

As part of the development of the Long-term Plan, the DHB is also seeking to improve investment thinking and develop and monitor performance metrics to ensure we are investing wisely.

Refer to Appendix 5 of this Plan for the DHB's major capital investments for 2017/18. The DHB's high-level asset performance metrics can be found in the Statement of Intent and Annual Report.

3.5 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.

3.6 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. The key output is the collection, laundering and delivery of laundry.

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 also has an interest in the following partnerships which support the delivery of our vision:

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

The New Zealand Health Partnership Limited: is owned and jointly funded by all 20 DHBs, and aims to enable DHBs to collectively maximise and benefit from shared service opportunities. Canterbury is participating in the Finance, Procurement and Supply Chain programme, with the Partnership facilitating the move to a shared services model for the provision of these services.

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

We do not intend to acquire shares or interests in any other companies, trust or partnerships in 2017/18.

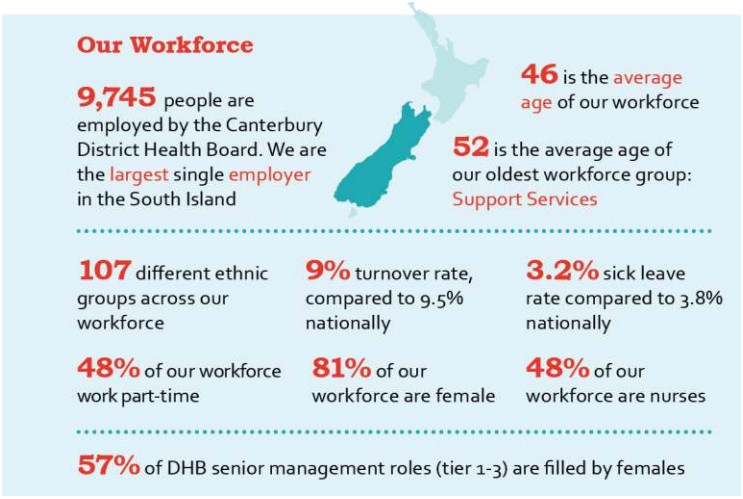
Organisational Capability

3.7 Investing in our people

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

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

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



Following the earthquakes, our bi-annual workforce engagement surveys show that workforce wellbeing and resilience has emerged alongside leadership capability as one of the biggest challenges for our health system. Acknowledging the links to engagement, productivity and the quality of patient care, a significant long-term commitment is being made to support wellbeing of our staff.

Continued development of our workforce and their leadership capability also remains a key strategy for enabling the transformation of our health system and meeting the increasing demand for services.

We will continue to identify available talent and expand our workforce capability through participation in national and regional initiatives, links with the education sector, sharing of training resources and support for internships and clinical placements.

The DHB will also take the South Island lead for Kia Ora Hauora, aimed at increasing the number of Māori working in health; and invest in Rural Learning Centres, to encourage people to work rurally by reducing isolation factors and providing peer support.

The DHB's key actions to support our people and build capability to deliver against national expectations in 2017/18 are highlighted in Part II of this document.

3.8 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 is central to our vision and, by allowing us to realise opportunities to reduce waste and duplication, is a key factor in the future sustainability of our health system.

For these reasons, information management is also a national priority and DHBs are expected to implement the national Health Information Technology Plan.

The South Island DHBs have determined collective actions to deliver on the national Plan 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; Health Connect South, the award winning HealthOne, and the Electronic Referral Management System (ERMS).

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, and replacing our old hospital-based patient administration system with the new single South Island Patient Information Care System (PICS).

Key information investment and activity in line with the delivery of national expectations in 2017/18 are highlighted in Part II of this document.

3.9 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.

The $650 million redevelopment across our Burwood and Christchurch Hospital sites will allow us to regain some of the capacity lost after the earthquakes and will support the implementation of improved models of care. It will also allow us to make efficiency savings by co-locating and consolidating services.

At the same time, the DHB is also delivering on a substantial earthquake repair programme to restore our lost capacity. Close alignment and timing of the redevelopment and repair programmes is essential to support the safe delivery of care and to avoid costly and wasteful investment in short-term solutions.

Anticipated activity for 2017- 2019 includes: [11]

Christchurch Hospital Campus: Both the new Acute Services Building and the new Outpatient Building are scheduled for completion in 2018. Construction of the Energy Centre, Carpark and Tunnel is also expected during the period covered by this Plan.

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 an appropriate facility.

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 DHB will also consider facilities solutions for a number of other sites over the coming year including: the relocation of mental health services on The Princess Margaret Hospital site and car parking solutions for the Christchurch Hospital campus.

Longer-term master-planning is underway to determine the future use of existing buildings and facilities on the Christchurch Hospital Campus. This includes Parkside and Canterbury Health Laboratories, and mental health services on the Hillmorton Campus.

3.10 Cross-sector investment

Recognising the wider influences that shape the health and wellbeing of our population, the Canterbury DHB works in partnership with other public and private 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 on a number of social investment initiatives aimed at improving the health and wellbeing of the most vulnerable in our community.

Major activity for 2017/2018 includes:

Canterbury Children's Team: The DHB will continue its commitment to the development of this MSD-led collaborative partnership, to better support vulnerable children and their families in the Canterbury District.

The Integrated Safety Response Pilot: The Canterbury 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 MSD and Pegasus Health to develop a new prototype primary care service to support people back into employment when they are on the jobseeker support benefit (with health condition deferred).

The All Right? Social Marketing Campaign: The DHB continues to work in partnership with the Mental Health Foundation to support and improve people's mental health and wellbeing after the earthquakes. The campaign has been well received and is informed by international evidence and local research.

Strength and Balance Programme: The DHB is working in collaboration with ACC as part of their Live Stronger for Longer Strategy, which focuses on injury prevention. This work will enhance the DHB's Falls Prevention Programme by providing increased access to community-based Strength and Balance Programmes. The approach is anticipated to minimise the risk of falls for older people by identifying and addressing key risks.

[11] Note: Operational oversight and decisions on operational costs for the Christchurch Hospital Campus redevelopments have been transitioned to the Ministry of Health.

Part IV

Monitoring Our Performance

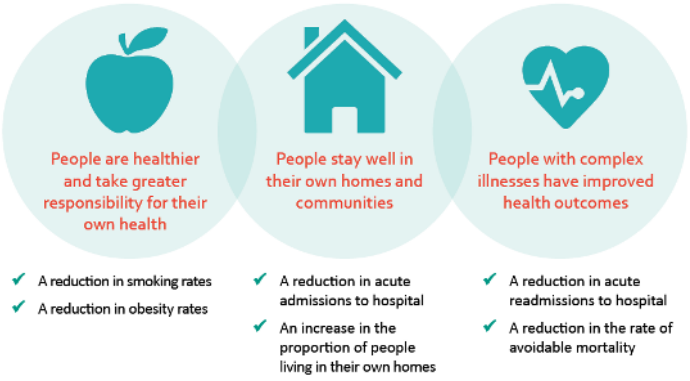
Making a Difference

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.

DHBs have a number of different roles and associated responsibilities. In our governance role, we are striving to improve health outcomes for our population; as a funder, we are concerned with the effectiveness of the health system and the return on our investment; and as an owner and provider of services, we are concerned with the quality of the services we deliver and the efficiency with which we deliver them.

There is no single performance measure or indicator that can easily reflect the impact of the work we do.

In developing our vision, we established three high-level strategic objectives.



Alongside these objectives, we have identified a number of associated long-term population health outcomes that are important to our stakeholders and, over time, will provide an insight into how well our health system is performing. These main measures of performance are set out in detail in our Statement of Intent and reported annually in our Annual Report.

The desired outcomes and objectives are also captured in our local Outcomes Framework which defines success from a whole of health system perspective. This Framework is shared with our alliances as a means of evaluating the success of our collective initiatives. A number of the main measures of performance are also found in Canterbury's System Level Measures Improvement Plan, where key actions are identified to improve performance (refer to Appendix 5).

The DHB's Intervention Logic diagram illustrates how our actions will impact on the health of our population, contribute to the goals of the South Island region, and deliver on the expectations of Government (refer to Appendix 3).

4.1 Accountability to our community

Over the shorter term, we evaluate our performance by monitoring ourselves against a forecast of the services we plan to deliver and the standards we expect to meet.

The results are then reported to our community in our Annual Report alongside our year-end financial performance.

Our statement of performance expectations presents the DHB's planned performance for 2017/2018 and is attached to this document as Appendix 4.

The DHB's forecast of financial performance for 2017/2018 is attached as Appendix 5.

Refer to the DHB's website for copies of the Statement of Intent and Annual Report: www.cdhb.health.nz.

4.2 Accountability to our Minister

As a Crown entity, responsible for Crown assets, the DHB also provides regular financial and non-financial performance reporting to the Ministry of Health on a monthly, quarterly, and annual basis.

The DHB's obligations include quarterly performance reporting in line with the Ministry's non-financial monitoring framework. This framework aims to provide a rounded view of performance in key priority areas, rather than across all health services or DHB activity, and uses a mix of performance markers across four dimensions. These dimensions reflect the DHB's functions as governor, funder, owner and provider of health and disability services:

- Policy Priorities (PP): achieving Government priority goals, objectives and targets
- System Integration (SI): meeting service coverage requirements and supporting sector inter-connectedness
- Ownership (OS): providing quality services efficiently
- Outputs (OP): purchasing the right mix and level of services with acceptable financial performance.

Three additional dimensions are covered in 2017/18:

- Health Strategy (HS): delivery of aligned actions
- Developmental (DV): no target or expectation set
- System Level Measure (SLM): also part of the national framework.

The national framework and expectations for 2017/18 are set on the following pages.

National Reporting Framework 2017/18

National Performance Measure	2017/2018 Performance Expectation		
HS: Supporting delivery of the New Zealand Health Strategy	Quarterly highlight report against the Strategy themes.		
PP6: Improving the health status of people with severe mental illness through improved access	Age 0-19	>3.1% of the population access special services.	
	Age 20-64	>3.1% of the population access special services.	
	Age 65+	>3.0% of the population access special services.	
PP7: Improving mental health services using wellness and transition (discharge) planning	95% of clients discharged will have a quality transition or wellness plan in place.		
	95% of audited files meet accepted good practice.		
PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	80% of people seen within 3 weeks.		
	95% of people seen within 8 weeks.		
PP10: Oral Health - Mean DMFT score at Year 8		Year 1	0.77
		Year 2	0.77
PP11: Children caries-free at five years of age		Year 1	66%
		Year 2	67%
PP12: Utilisation of DHB-funded dental services by youth (School Year 9 up to and including age 17 years)		Year 1	85%
		Year 2	85%
PP13: Improving the number of children enrolled in DHB funded dental services	% of children (age 0-4) enrolled.	Year 1	95%
		Year 2	95%
	% of children (0-12) not examined according to planned recall.	Year 1	≤10%
		Year 2	≤10%
PP20: Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)			
Focus Area 1: Long term conditions	Report on activities in the Annual Plan.		
Focus Area 2: Diabetes services	Implement actions from Living Well with Diabetes.		
	Improve or, where high, maintain, the proportion of patients with good or acceptable glycaemic control (HbA1C indicator).		
Focus Area 3: Cardiovascular health	90% of the eligible population have had their cardiovascular risk assessed in the last 5 years.		
	Report on percentage of eligible Māori men in the PHO aged 35-44 years who have had their cardiovascular risk assessed in the past 5 years.		
Focus Area 4: Acute heart service	70% of high-risk patients receive an angiogram within 3 days of admission.		
	95% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days.		
	95% of patients undergoing cardiac surgery at the regional cardiac centres have completion of Cardiac Surgery registry data collection within 30 days of discharge.		
Focus Area 5: Stroke services	8% or more of potentially eligible stroke patients are thrombolysed 24/7.		
	80% of stroke patients are admitted to a stroke unit or an organised stroke service with demonstrated stroke pathway.		
	80% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission.		
PP21: Immunisation coverage	95% of two year olds fully immunised		
	95% of four year olds fully immunised		
	75% of girls fully immunised – HPV vaccine		
	75% of 65+ year olds immunised – Influenza vaccine		
PP22: Actions to improve system integration including System Level Measures	Report on activities in the Annual Plan.		
PP23: Implementing the Healthy Ageing Strategy	Report on activities in the Annual Plan.		
	95% of older people who have received long-term home and community support services in the last three months have had an interRAI Home Care or Contact Assessment and have completed care plan.		

PP25: Prime Minister's youth mental health project	Initiative 1: School Based Health Services (SBHS)	Report on implementation of SBHS in decile one to three secondary schools, teen parent units and alternative education facilities and actions undertaken to implement *Youth Health Care in Secondary Schools: framework for continuous quality improvement* in each school with SBHS.
	Initiative 3: Youth Primary Mental Health	As reported through PP26 (see below).
	Initiative 5: Responsiveness of Primary Care to Youth	Report on actions to ensure high performance of the youth service level alliance (SLA) or equivalent and actions of the SLA to improve health of the DHB's youth population.
PP26: The Mental Health & Addiction Service Development Plan	Focus Area 1: Primary Mental Health	Report as specified.
	Focus Area 2: District Suicide Prevention and Postvention	Report as specified.
	Focus Area 3: Improving Crisis Response Services	Report as specified.
	Focus Area 4: Improving outcomes for children	Report as specified.
	Focus Area 5: Improving employment and addressing the physical health needs of people with low prevalence conditions.	Report as specified.
PP27: Supporting Vulnerable Children		Report on activity in the Annual Plan.
PP29: Improving waiting times for diagnostic services	95% of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days).	
	95% of accepted referrals for CT scans will receive their scan within 6 weeks (42 days).	
	90% of accepted referrals for MRI scans will receive their scan within 6 weeks (42 days).	
	90% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive), 100% within 30 days.	
	70% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within 90 days.	
	70% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date, 100% within 120 days.	
PP30: Faster cancer treatment		85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.
PP31: Better help for smokers to quit in public hospitals	95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking.	
PP32: Improving the quality of ethnicity data collection in PHO and NHI registers		Report on progress with implementation and maintenance of Ethnicity Data Audit Toolkit (EDAT).
PP33: Improving Māori enrolment in PHOs		Meet and/or maintain the national average enrolment rate of 90%.
PP36: Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders		Reduce the rate of Māori under the Mental Health Act (s29) by establishing a quality initiative to look at rates of CTO use for Māori and where earlier intervention could assisted in reducing those rates.
PP37: Improving breastfeeding rates		60% of infants are exclusively or fully breastfed at three months.
PP38: Delivery of response actions agreed in annual plan		Report on activity in the Annual Plan.
SI1: Ambulatory sensitive hospitalisations	0-4 years	See SLM improvement plan included as Appendix to this Plan.
	45-64 years	Ambulatory Sensitive Admission rates for adults 45-64 years maintained <2,524 per 100,000.[12]
SI2: Delivery of Regional Plans	Provide a progress report on behalf of the region agreed by all DHBs within that region.	
SI3: Ensuring delivery of Service Coverage	Report progress towards resolution of exceptions to service coverage identified in the Annual Plan, and not approved as long term exceptions, and any other gaps in service coverage (as identified by the DHB or by the Ministry).	
SI4: Standardised Intervention Rates	Major joint replacement procedures - target intervention rate of 21 per 10,000 of population.	
	Cataract procedures - target intervention rate of 27 per 10,000 of population.	
	Cardiac surgery - target intervention rate of 6.5 per 10,000 of population.	
	Percutaneous revascularizations - target rate of at least 12.5 per 10,000 of population.	
	Coronary angiography services - target rate of at least 34.7 per 10,000 of population.	

[12] *Note this baseline is 12 months to September 2016.*

SI5: Delivery of Whānau Ora	Focus Area 1: Engagement with Commissioning Agencies		Report as specified.
	Focus Area 2: Mental Health		Report as specified.
	Focus Area 3: Asthma		Report as specified.
	Focus Area 4: Oral Health		Report as specified.
	Focus Area 5: Obesity		Report as specified.
	Focus Area 6: Tobacco.		Report as specified.
SI7: SLM total acute hospital bed days per capita			As specified in the jointly agreed (by district alliances) SLM Improvement Plan.
SI8: SLM patient experience of care			As specified in the jointly agreed (by district alliances) SLM Improvement Plan.
SI9: SLM amenable mortality			As specified in the jointly agreed (by district alliances) SLM Improvement Plan.
SI10: Improving cervical screening coverage			80% coverage for all ethnic groups and overall (ages 25-69).
SI11: Improving breast screening rates			70% coverage for all ethnic groups and overall (ages 50-69).
OS3: Inpatient Average Length of Stay (LOS)		Elective LOS	1.54 days (closer to 75th centile of national performance).
		Acute LOS	2.35 days (closer to 75th centile of national performance).
OS8: Reducing Acute Readmissions to Hospital			TBA – indicator definition currently under review.
OS10: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections	Focus Area 1: Improving the quality of data within the NHI	New NHI registration in error (causing duplication) – Group A	Group A >2% and <= 4% Group B >1% and <=3% Group C >1.5% and <=6%
		Recording of non-specific ethnicity in new NHI registrations	>0.5% and <= 2%
		Update of specific ethnicity value in existing NHI record with non-specific value	>0.5% and <= 2%
		Validated addresses excluding overseas, unknown and dot (.) in line 1	>76% and <= 85%
		Invalid NHI data updates	TBA
	Focus Area 2: Improving the quality of data submitted to National Collections	NBRS collection has accurate dates and links to National Non-admitted Patient Collection (NNPAC) and the National Minimum Data Set (NMDS)	>= 97% and <99.5%
		National Collections File load Success	>= 98% and <99.5%
		Assessment of data reported to NMDS	>= 75%
		Timeliness of NNPAC data	>= 95% and <98%
	Focus Area 3: Improving quality of the Programme for the Integration of Mental Health data (PRIMHD)	Provide reports as specified about data quality audits.	
Output 1: Mental health output Delivery Against Plan			Volume delivery for specialist Mental Health and Addiction services is within 5% variance (+/-) of planned volumes for services measured by FTE; 5% variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day; actual expenditure on delivery of programmes or places is within 5% (+/-) of the year-to-date plan.
DV4: Improving patient experience			No performance expectation/target.
DV6: SLM youth access to and utilisation of youth appropriate health services			No performance expectation/target.
DV7: SLM number of babies who live in a smoke-free household at six weeks post-natal			No performance expectation/target.

Part V

Further Information for the Reader

Appendices and Attachments

Appendix 1	Glossary of Terms
Appendix 2	Intervention Logic Diagram (Statement of Intent 2016-2020)
Appendix 3	Canterbury DHB Statement of Performance Expectations 2017/18
Appendix 4	Canterbury DHB Statement of Financial Expectations 2017/18
Appendix 5	Canterbury's System Level Improvement Plan 2017/18

Documents of interest

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

- Canterbury DHB Statement of Intent 2016-2020
- Canterbury DHB Māori Health Action Plan 2017/18
- Canterbury DHB Public Health Action Plan 2017/18
- Canterbury DHB Quality Accounts 2017/18
- South Island Regional Health Services Plan 2017/18

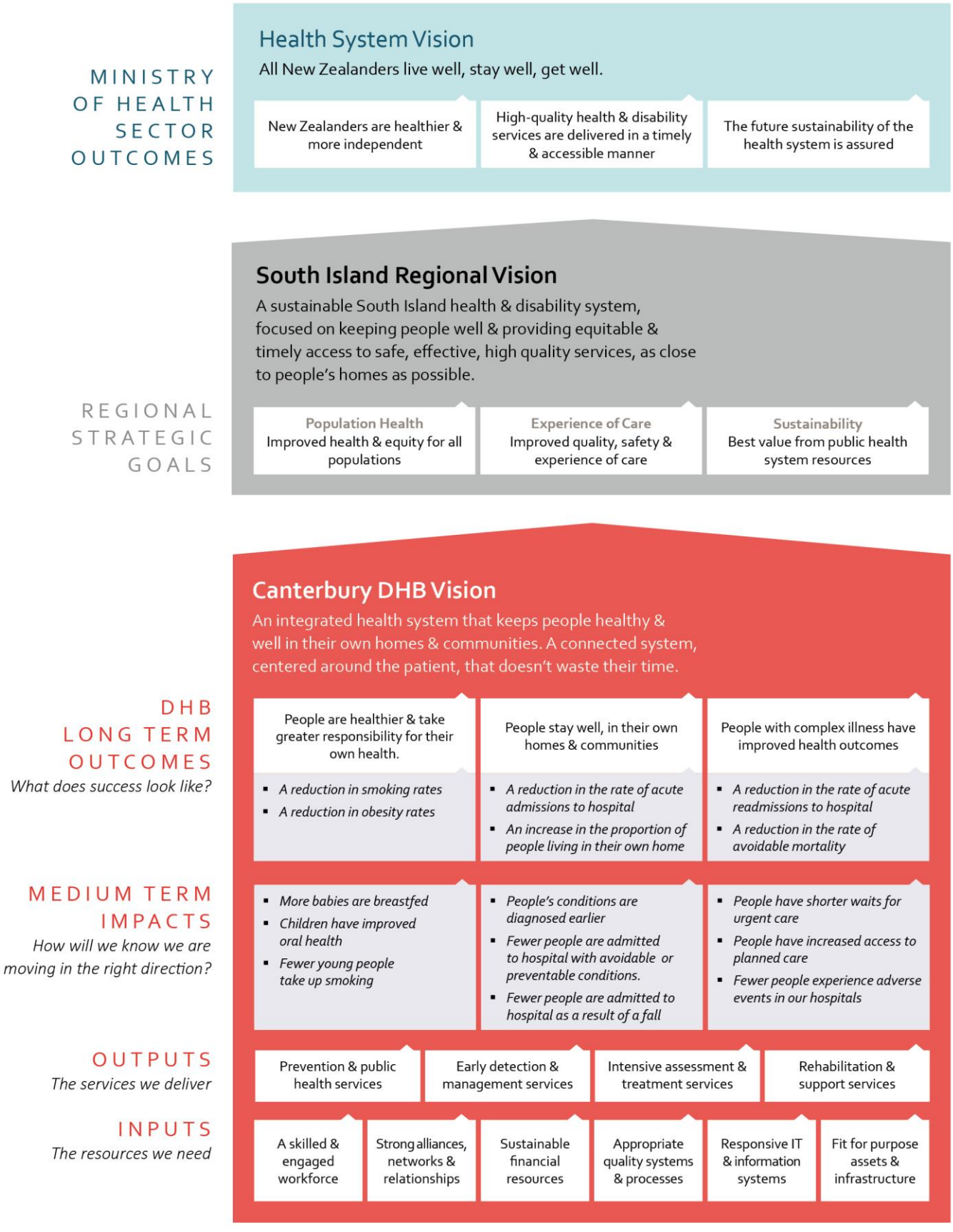
References

Unless specifically stated, all Canterbury DHB documents referenced in this Plan are available on the Canterbury DHB website: www.cdhb.health.nz. All 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 Canterbury Clinical Network 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, and rolling 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.

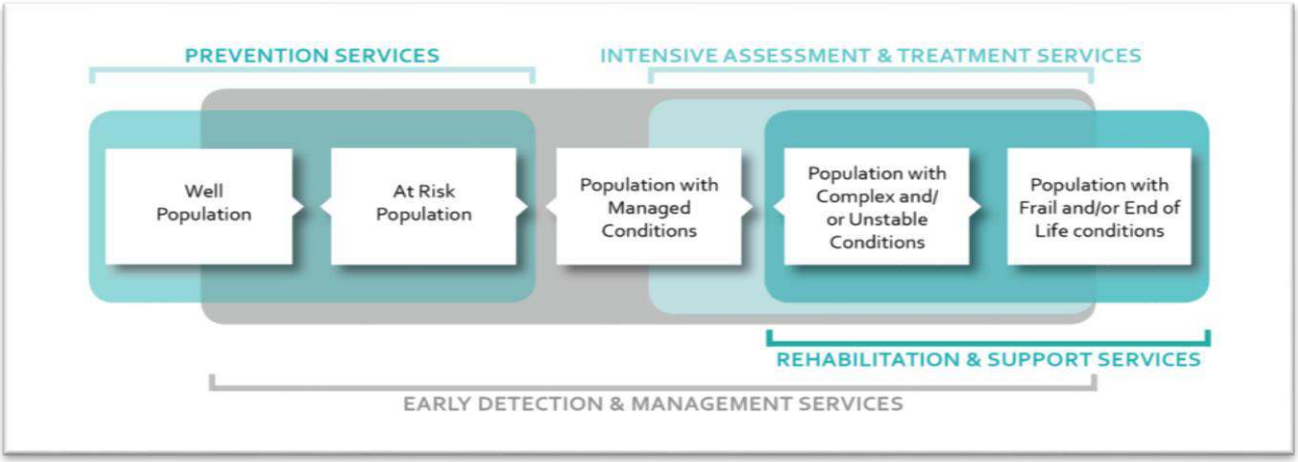
Appendix 2: Intervention Logic Diagram



Te Tiriti O Waitangi

We agree that the Treaty of Waitangi establishes the unique & special relationship between Iwi, Māori & the Crown. Parties with Treaty obligations will honour these when participating in Alliance activities.

Appendix 3: Statement of Performance Expectations



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.

With a limited pool of resources 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. These longer term health indicators are highlighted in our Statement of Intent which can be found on our website: www.cdhb.health.nz.

Over the shorter term, we evaluate our performance on an annual basis by providing a forecast of the services we plan to deliver and the standards we expect to meet. Service performance is monitored against these expectations and the results are presented in our Annual Report.[13]

The following section presents the Canterbury DHB's statement of performance expectations for 2017/2018.

Because it would be overwhelming to measure every service delivered, services have been grouped into four service classes. These reflect the full health and wellbeing continuum (illustrated above): from keeping people healthy and well, through identifying and treating illness, to supporting people to age well.

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

In presenting our performance picture, the number of people who receive a service is often less important than whether enough of the right people received the service, or whether the service was delivered at the right time. We have therefore presented a mix of measures that address four key aspects of performance: Access (A); Timeliness (T); Coverage (C); and Quality (Q).

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 coverage of prevention programmes, reducing acute or avoidable hospital admissions, and maintaining access to services—while reducing waiting times and delays in treatment.

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

It should be noted that while targeted interventions can reduce service demand in some areas, there will always be some services 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.

[13] *The DHB's Annual Report is tabled in Parliament every year and is available on our website: www.cdhb.health.nz.*

PERFORMANCE EXPECTATIONS

Like all DHBs, with a growing diversity and persistent inequalities across our population, achieving equity of outcomes is an overarching priority.

All of our targets are universal and have been set with the aim of bringing performance for all population groups to the same level. Working with local stakeholders, the DHB has identified a number of key areas of focus to improve Māori health. These indicators are identified in this forecast (◆) and will be reported by ethnicity in our year-end Annual Report to highlight progress in reducing equity gaps for Māori.

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 our 2016/17 standards against a number of our discretionary measures. However, many of the performance targets presented in our forecast for 2017/18 are national expectations set for all DHBs, including the six national health targets. While we remain committed to maintaining high standards of service delivery, we note that some of these expectations will be particularly challenging in our current operating environment.

NOTES

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.

◇ National Health Targets are set to be achieved by the final quarter of any given year. In line with national performance reporting, baselines refer to the final quarter (April-June) result.

◆ This measure has been identified as a key priority area for Māori, and progress by ethnicity will be reported in the Annual Report.

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

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, in this way, 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 be a very cost-effective health intervention.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Health Promotion and Education Services				
These services inform people about risk, 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	2014/15 Results	2015/16 Result	2017/18 Target
Mothers receiving breastfeeding support and lactation support in the community	A [14]	1,058	1,033	>600
Babies exclusive/fully breastfed at LMC discharge (4-6 weeks)	Q [15] ◆	71%	na	75%
Babies exclusive/fully breastfed at 3 months	Q [15] ◆	57%	59%	60%
Priority schools supported by the Health Promoting Schools framework	C [16]	91%	89%	>70%
People provided with Green Prescriptions for additional physical activity support	A [17]	2,797	3,095	>3,000
Green Prescription participants more active 6-8 months after referral	Q	62%	75%	50%
Smokers enrolled with a PHO, receiving advice and support to quit smoking (ABC)	C [18] ◇◆	89%	88%	90%
Smokers identified in hospital, receiving advice and support to quit smoking (ABC)	C ◇◆	96%	98%	95%
Pregnant women, identified as smokers at confirmation of pregnancy with an LMC, receiving advice and support to quit smoking (ABC)	C [19] ◇◆	98%	93%	90%
Women smokefree at two weeks postnatal	Q [20] ◆	90%	88%	95%

[14] 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.

[15] These measure are part of the national WellChild/Tamariki Ora (WCTO) Quality Framework and standards are set nationally. The Framework covers health promotion, education, screening and support services and checks are provided free to all New Zealand children from birth to five years. Results are published by the Ministry of Health. The 2015/16 results reflect the six months to December 2015. The full year and the 2016/17 results were not available at the time of printing.

[16] The Health Promoting Schools Framework addresses health issues through a national approach based on activities within the school setting that can impact on health. 'Priority' schools are low decile, rurally isolated, and/or have a high proportion of Māori and/or Pacific children.

[17] 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 2017 a decision was made nationally to shift to biannual surveys. The next survey will be in 2017/18.

[18] These are a national performance targets based on evidence that professionals providing brief advice to smokers is shown to increase the chances of smokers making quit attempts. The ABC programme refers to the health professional Asking about smoking status, providing Brief advice and providing Cessation support. Targets are set nationally.

[19] This measure is collected via the National Maternity Dataset which covers approximately 80% of pregnancies nationally. The measure is a developmental measure nationally and results are used to indicate trends rather than absolute performance. Targets are set nationally.

[20] This measure is part of the national Well-Child/Tamariki Ora Quality Framework, standards are set nationally. The 2015/16 results reflect the six months to December 2015. The full year and the 2016/17 results were not available to the DHB at the time of printing.

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	2014/15 Results	2015/16 Result	2017/18 Target
Four-year-olds provided with a B4 School Check (B4SC)	C [21] ◆	91%	91%	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 [22] ◇◆	new	new	95%
Proportion of children referred to lifestyle programmes who take up the programme	Q	new	new	>50%
Women aged 25-69 having a cervical cancer screen in the last 3 years	C [23] ◆	75%	74%	80%
Women aged 50-69 having a breast cancer screen in the last 2 years	C [23] ◆	79%	77%	70%

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	2014/15 Results	2015/16 Result	2017/18 Target
Children fully immunised at eight months of age	C ◇◆	94%	96%	95%
Proportion of eight-month-olds 'reached' by immunisation services	Q [24] ◇	98%	98%	95%
Young women (Year 8) completing the HPV vaccination programme	C [25] †◆	38%	43%	75%
Older people (65+) receiving a free influenza ('flu') vaccination	C [26]†◆	74%	74%	75%

[21] The B4 School Check is the final core WellChild/Tamariki Ora check, which children receive at age four. It is free, and includes assessment of vision, hearing, oral health, height and weight, allowing health concerns to be identified and addressed early in a child's development.
[22] This measure is the new national Raising Healthy Kids health target, introduced in Q1 of 2016/17.
[23] 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.
[24] 'Reached' is defined as those children fully immunised, as well as those whose parents have been contacted and provided advice and support to enable them to make informed choices for their children - but have chosen to decline immunisations or opt off the NIR.
[25] 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 2017/18 is the proportion of girls born in 2004 completing the programme. The delivery of Canterbury's HPV programme differs to that provided in other regions, being primarily a general practice based vaccination programme. A school-based programme was launched in February 2016 to complement and support the general practice programme.
[26] The denominator for this measure has changed, from the number of people enrolled with a PHO to the Census population, which has had a negative impact on results for the 2016/17 year and means results from previous years will not be directly comparable.

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 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?

Primary Care (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	2014/15 Results	2015/16 Result	2017/18 Target
Proportion of the population enrolled with a Primary Health Organisation (PHO)	C ◆	95%	95%	95%
Young people (0-13) enrolled with general practice where their visits are free	A	new	98%	95%
Young people (0-19) accessing brief intervention counselling in primary care	A [27] Δ	611	610	>500
Adults (20+) accessing brief intervention counselling in primary care	A [27] Δ	5,565	5,505	>3,500
Number of skin lesions (growths, including cancer) removed in primary care	A Δ	2,583	2,820	>2,000
Number of integrated HealthPathways in place across the health system	Q [28]	555	499	>500
Proportion of general practices using the primary care patient experience survey	Q [29]	-	new	>35%
Avoidable hospital admission rate for children aged 0-4 (per 100,000 people)	Q [30] ◆	6,154	6,211	<6,476

Long-term Conditions Management Services				
These services are targeted at people with high health needs due to having a long-term or chronic condition. High levels of enrolment and engagement levels are indicative of a successful service.	Notes	2014/15 Results	2015/16 Result	2017/18 Target
Spirometry tests provided in the community rather than in a hospital setting	A [31] Δ	1,682	1,742	>1,000
Eligible population having a cardiovascular disease risk assessment in the last 5 years	C [32] ◇◆	82%	87%	90%

[27] The Brief Intervention Counselling Service aims to support people with mild to moderate mental health concerns, including depression and anxiety, to improve their health outcomes and quality of life. The service includes the provision of free counselling sessions and extended consultations and results include face-2-face and phone consultations.

[28] The clinically designed HealthPathways support general practice teams to manage medical conditions, request advice or make secondary care referrals in Canterbury. The pathways support consistent access to treatment and care no matter where people present.

[29] 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.

[30] Some admissions to hospital are seen as avoidable through early intervention and treatment, and the rate of these admissions provides an indication of the accessibility and effectiveness of primary care and the interface between primary and secondary services. The measure is a national DHB performance indicator (SI1) and is defined as the standardised rate per 100,000 population. The DHB's aim is to maintain performance below the national rate (which reflects less people presenting to hospital) and to reduce the equity gap between population groups. The results presented differ to those previously presented, being based off the latest national series provided by the Ministry of Health – to June 2016. Baselines have been reset to reflect the current series and results are to June of each year.

[31] 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 identify earlier. Volumes include those tests delivered by general practice and mobile community respiratory providers.

[32] Cardiovascular disease is one of the leading cause 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 age bands are set nationally: Māori, Pacific or Indian, males 35-74, females 45-74 and all other males 45-74 and females 55-74.

People receiving subsidised diabetes self-management support from their general practice team when starting insulin	A Δ	389	392	>300
Population identified with diabetes having an HbA1c test in the last year	C [33] Δ	88%	89%	90%
Population with diabetes having an HbA1c test and acceptable glycaemic control	Q [33] Δ	77%	75%	>75%

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	2014/15 Results	2015/16 Result	2017/18 Target
Children (0-4) enrolled in DHB-funded oral health services	C †◆	69%	61%	95%
Children (0-12) enrolled in DHB oral health services examined according to planned recall	T †◆	86%	90%	90%
Adolescents (13-17) accessing DHB-funded oral health services	C †	62%	62%	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, and is therefore indicative of a successful service.	Notes	2014/15 Results	2015/16 Result	2017/18 Target
Number of laboratory tests completed for the Canterbury population	A Δ	2.4m	2.5m	E.<2.8m
Number of subsidised pharmaceutical items dispensed in the community	A [34] Δ	6.3m	6.5m	E.<8m
People on multiple medications receiving support via the Medical Management Review programme	A [35] Δ	1,326	1,355	>1,500
Number of community-referred radiology tests completed	A Δ	44,720	44,404	E.>40,000
People receiving their urgent diagnostic colonoscopy within 2 weeks	T [36] [37] ◇	96%	92%	90%
People receiving their Magnetic Resonance Imaging (MRI) scans within 6 weeks	T [36] ◇	75%	59%	90%
People receiving their Computed Tomography (CT) scans within 6 weeks	T [36] ◇	96%	75%	95%

[33] Diabetes is a leading long-term conditions and contributor to many other conditions. An annual HbA1c test (of a patient's blood glucose levels) is a means of assessing the management of their condition - a level of less than 64mmol/mol reflects an acceptable blood glucose level.
[34] This measure covers pharmaceutical items dispensed by community pharmacies to people living in the community. Hospital dispensed items are excluded, however results may still include some non-Canterbury residents who had prescriptions filled while in Canterbury.
[35] The Medical Management Review programme helps to ensure the safe and appropriate use of medications. The programme now also offers more intense medication therapy assessments for the most complex patients and less complex medications use reviews for others – baselines have been adjusted to reflect both aspects of the programme.
[36] These diagnostic measures are national DHB performance measures (PP29) and baselines are as at the final month of the year (June) in line with national results published by the Ministry of Health. Targets are set to match national standards set for all DHBs. The wait times refer to non-urgent MRI and CT scans.
[37] A colonoscopy is a test that looks at the inner lining of a person's large intestine (rectum and colon). A colonoscopy helps find ulcers, colon polyps, tumors, and areas of inflammation or bleeding, and to determine treatment.

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, capacity, treatment thresholds 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.[38]	Notes	2014/15 Results	2015/16 Result	2017/18 Target
Rate of staff compliance with good hand hygiene practice	Q [39] ◇	77%	78%	80%
Hip and knee replacement patients receiving routine antibiotics before surgery	Q [40] ◇	98%	98%	95%
Hip and knee replacement patients receiving antiseptic skin preparation in surgery	Q [40] ◇	100%	100%	100%
Response rate to the national inpatient patient experience survey	Q [41]	17%	37%	>30%
Proportion of patients who felt they 'received enough information from the hospital on how to manage their condition after discharge'	Q [42]	56%	54%	>64

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	2014/15 Results	2015/16 Result	2017/18 Target
Women registered with a Lead Maternity Carer (LMC) by 12 weeks of pregnancy	C [43] †◆	77%	77%	80%
Number of maternity deliveries in Canterbury DHB facilities	A	5,897	5,922	E.6,000
Proportion of maternity deliveries made in Primary Birthing Units	A [44] Δ	12%	14%	>13%
Babies exclusively breastfeeding on hospital discharge	Q [45]	80%	79%	75%

[38] These quality measures are national markers monitored by the NZ Health Quality & Safety Commission. Performance reporting is aligned to the HQSC reports (being the quarter to June of each year) and standards are set nationally.

[39] This measure is based on ward audits of medical and surgical wards conducted according to Hand Hygiene NZ standards.

[40] Cefazolin and cefuroxime are antibiotics recommended as routine for hip and knee replacements to prevent infection complications. Skin preparation with antiseptic is also recommended to prevent infection.

[41] 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.

[42] This is a question in the national inpatient patient experience survey under the coordination domain and reflects patients responding yes, or definitely/yes to the question posed. The focus is on supporting people to manage at home after discharge and to reduce readmissions.

[43] This measure comes from the national Maternity Collection and updated data for 2015/16 was provided by the Ministry in line with the adoption of this measure as one of the new national Better Public Services measures. The aim is to engage mothers with the health system early in their pregnancy to promote good health and wellbeing of both mother and baby.

[44] The DHB aims to increase people's acceptance and confidence in using primary birthing units rather than having women birth in secondary or tertiary facilities when it is not 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.

[45] The percentage of babies being breastfed can demonstrate the effectiveness of consistent health promotion messages during the antenatal, birthing and early postnatal period. Standards are set in alignment with World Health Organisation recommendations.

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	2014/15 Results	2015/16 Result	2017/18 Target
General practices providing telephone triage outside business hours	C	92%	93%	95%
Acute demand packages of care provided in community settings	A [46] Δ	31,182	33,010	>30,000
Presentations at Canterbury Emergency Departments (ED)	A [47]	91,253	94,251	E.<96,000
Proportion of the population presenting at ED (per 1,000 people)	Q	177	177	<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 ◇	73%	70%	90%
Acute inpatient average length of hospital stay (standardised)	Q [48]	2.40	2.39	<2.35

Elective/Arranged Services

These are medical and surgical services provided for people who do not need immediate hospital treatment, where their assessment or treatment is booked or arranged. Maintaining access while reducing waiting times is indicative of an efficient service.	Notes	2014/15 Results	2015/16 Result	2017/18 Target
First Specialist Assessments provided	A [49]	72,069	71,244	E.>60,000
Proportion of First Specialist Assessments that were non-contact (virtual)	Q [50]	19%	17%	>10%
Elective/arranged surgical discharges (surgeries provided)	A ◇ [51]	20,353	21,039	21,330
Proportion of people receiving their elective coronary angiography within 3 months	T [52]	98%	98%	95%
Proportion of people receiving their surgery on the day of admission	Q [53]	91%	91%	90%
Elective inpatient average length of hospital stay (standardised)	Q [48]	1.57	1.54	<1.54
Outpatient consultations provided	A	651,259	671,705	E.>600k
Outpatient appointments where the patient was booked but did not attend (DNA)	Q [54]	5%	5%	<5%

[46] Acute demand packages are provided through Canterbury's community-based Acute Demand Management Service with the aim of supporting people to be treated in their own homes or in the community rather than having to present to hospital for treatment.
[47] This measure is aligned to the national Shorter Stays in ED Health Target and counts presentations to both Christchurch and Ashburton Hospital EDs –this measure excludes those who do not wait and those with pre-arranged appointments.
[48] This measure is a national DHB performance measure (OS3). By maintaining shorter lengths of stay, the DHB delivers on the national improved hospital productivity priority and frees up beds and resources to provide more elective surgery. Importantly, addressing the factors that influence a patient's length of stay includes: reducing the rate of patient complications and infection, better use of the time clinical staff spend with patients, and integration activity to support patients to return home sooner. Performance is balanced against readmission rates to ensure earlier discharge is appropriate and service quality remains high.
[49] This measure counts both medical and surgical assessments but counts only the first specialist assessments (where the specialist determines treatment) and not follow-ups or consultations after treatment has occurred.
[50] 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.
[51] This measure is aligned to the national Electives Health Target and does not include all surgery or procedures delivered by the DHB.
[52] A coronary angiogram is an x-ray test used to determine if a person's coronary arteries are blocked or narrowed, where and by how much. This is a national performance measure (PP29) and baselines are as at the final month of the year (June) in line with national results published by the Ministry of Health. An angiogram can help determine the type of treatment needed such as angioplasty or stent, coronary artery bypass surgery or medical therapy. Timely access to this treatment supports improved outcomes for patients.
[53] When elective surgery is delivered as a day case or on the day of admission, it makes surgery less disruptive for patients who can spend the night before in their own home and indicates effective planning on behalf of services who are not delaying or cancelling surgeries.
[54] 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. 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.

Specialist Mental Health 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 an increasing demand for services, is indicative of a responsive and efficient service.	Notes	2014/15 Results	2015/16 Result	2017/18 Target
Proportion of the population (0-19) accessing specialist mental health services	C [55] Δ	3.5%	3.5%	>3.1%
Proportion of the population (20-64) accessing to specialist mental health services	C [55] Δ	3.2%	3.4%	>3.1%
People referred for non-urgent mental health and alcohol and other drug services seen within 3 weeks	T [56]	73%	76%	80%
People referred for non-urgent mental health and alcohol and other drug services seen within 8 weeks	T [56]	90%	93%	95%

Specialist Assessment, Treatment and Rehabilitation (AT&R) Services				
These are services provided to restore functional ability and enable people to live as independently as possible. An increase in the proportion of older people discharged home, rather than into aged residential care (ARC), reflects a successful outcome.	Notes	2014/15 Results	2015/16 Result	2017/18 Target
Admissions into inpatient AT&R services	A Δ	3,462	3,371	E.>3,000
Inpatients (aged 75+) who received a falls assessment	Q [57] ◇	96%	100%	90%
Admissions into Older Person's Health AT&R services by direct community referral	Q [58]	21%	20%	>20%
Proportion of OPH AT&R inpatients discharged to their own home rather than ARC	Q [59] Δ	87%	86%	>80%

[55] These measures are national DHB performance measures (PP6), and standards are set based on the expectation that at least 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 only those 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. It should also be noted that the short timeframe presented does not reflect the extent of the increase 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.

[56] These measures are national DHB performance measures (PP8). Performance results are provided nationally, three months in arrears.

[57] While there is no single solution to reducing falls, an essential first step is to assess each individual's risk of falling, and act accordingly. In line with national expectations, the DHB aims to assess all the falls risk of all older inpatients and develop a falls plan to reduce risk.

[58] This is a subset of the total AT&R services: age-related AT&R services provided by the Older Person's Health Division of the DHB. The purpose of direct referral is to improve support for at risk older people by allowing an intervention to prevent an adverse event, rather than only taking referrals post an event – i.e. following an inpatient hospital stay.

[59] While living in 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 from AT&R to home (rather than ARC) 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.

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 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 demand, unnecessary ED presentations 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?

Rehabilitation 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	2014/15 Results	2015/16 Result	2017/18 Target
People accessing community-based pulmonary rehabilitation courses	A [60]	222	261	>200
People (65+) accessing community-based falls prevention programmes	A [61]	1,686	1,973	>1,500
People referred to an organised stroke service (with demonstrated stroke pathway) after an acute event	Q	80%	80%	80%
People referred to cardiac rehabilitation services after an acute event	Q [62]	15%	22%	30%

Home and Community-Based Support Services				
These services aim to 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	2014/15 Results	2015/16 Result	2017/18 Target
People supported by CREST services, on hospital discharge or GP referral	A [63] Δ	1,770	1,726	>1,500
People supported by district nursing services	A Δ	7,765	7,532	E.>7,000
People supported by long-term home-based support services	A Δ	8,641	8,129	E.>8,000
Older people (65+) receiving long-term home and community support services who have had a clinical assessment of need using the interRAI assessment tool	Q [64] Δ	94%	96%	95%
People supported by hospice or home-based palliative services	A Δ	3.934	3,617	E.>3,000

[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, which include breathlessness, coughing and wheezing. The programmes run for eight weeks and people learn breathing, diet, exercise and day-to-day living techniques to better manage their condition. This measure includes people attending community-based DHB funded pulmonary rehabilitation programmes in Ashburton and Christchurch.

[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] Cardiovascular Disease is one of the leading causes of death in Canterbury. This measure counts those accessing Phase 2 (outpatient) cardiac rehabilitation on discharge from hospital, with the aim of supporting people to modify their lifestyles following an acute event.

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

[64] 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 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 are expected to increase over time, as more people are supported to remain in their own homes.	Notes	2014/15 Results	2015/16 Result	2017/18 Target
Older people accessing day care services	A [Δ65]	832	804	E.>550
People accessing mental health crisis respite services	A [Δ]	774	886	E.>750
Occupancy rate of mental health crisis respite beds	A[66 Δ]	70%	74%	85%
People accessing aged care respite services	A [Δ]	1,424	1,620	E.>1,000

Aged Residential Care Services				
With an ageing population, demand for aged related care (ARC) is expected to increase, but 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	2014/15 Results	2015/16 Result	2017/18 Target
Number of ARC rest home bed-days provided	A [Δ]	528,795	501,688	E.<676k
Number of ARC hospital bed-days provided	A [Δ]	471,724	494,185	E.<507k
Number of ARC dementia bed-days provided	A [Δ]	231,066	239,996	E.>220k
Number of ARC psycho-geriatric bed-days provided	A [Δ]	67,833	70,562	E.>65k
People entering ARC having had a clinical assessment of need using interRAI	Q [64 Δ]	99%	99%	95%

[65] *Includes people accessing day care services in the community and in ARC.*

[66] *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.*

Appendix 4: Meeting Our Financial Challenges

Canterbury's financial outlook

Government funding, 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 and patient co-payments.

While health continues to receive a large share of national funding, clear signals have been given that the health sector must rethink how it will meet the needs of our populations within a more moderate growth platform. It is clear that DHBs are expected to operate within existing resources and approved financial budgets.

Like the rest of the health sector, the Canterbury DHB is experiencing growing financial pressure from increasing demand, treatment costs, 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 including: population funding shifts, increased service demand and the operational challenges of a significant repair programme.

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

Earthquake related costs are evident in a number of areas: increased treatment costs to meet heightened demand; additional outsourcing costs to support service delivery while our capacity is reduced; and the unplanned costs of recovery and repair work.

A significant proportion of our repair work is not covered by our 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 will require ruthless prioritisation to remain affordable.

The Burwood Hospital redevelopment was behind schedule which impacted on the DHB's ability in achieving anticipated savings from the consolidation of services. Our DHB-wide theatre and bed capacity is reduced and until our new facilities are completed, we will have to carry significant additional costs for hiring theatres and outsourcing surgeries.

Included in the unplanned costs 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 the repair work (on top of planned redevelopment) results in significant annual charges. In 2017/18 Canterbury will pay an estimated $30.3 million in capital charges to the Crown, adding additional pressure to our already tight fiscal environment.

Demand patterns continue to change. 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. International evidence would suggest we could expect continued population impacts for up to a decade.

Our situation is further exacerbated by the interplay between local population fluctuations and the national population based funding mechanism. The funding formula was never designed to deal with the kind of dynamic population shifts and demand changes we have experienced. From Canterbury's perspective, the formula has the wrong inputs and is not proving to be a flexible or sensitive enough mechanism in a post-quake environment.

Planned results

In 2017/18 the Canterbury DHB will receive $1.747 billion of total revenue with which to meet the needs of our population and manage the significant cost increases of recent Multi Employment Collective Agreement (MECA) settlements.

The Canterbury DHB is predicting a $53.6 million deficit result for the 2017/18 year.

The $53.6 million forecast deficit takes into account the net effect of all the known prior year's funding movements, including Canterbury's share of demographic and cost pressures and pharmaceutical investment funding provided to DHBs by the Ministry of Health and the $5.5 million in additional mental health funding (provided in 2016 for a fixed three-year period to cover increased demand for mental health services following the earthquakes).

The additional mental health funding supported our response to changing mental health demand patterns by allowing us to invest further in a range of targeted initiatives and services where demand is highest.

While the extra funding acknowledged the sustained pressure on our mental health services, it does not address all of Canterbury's earthquake related mental health challenges, as evidenced by the ongoing demand for mental health services.

In the period ahead, the DHB will work with the Ministry to address our concerns with regards to the sustainability of funding of mental health services.

Both revenue and external provider expenditure includes the recent allocation of $25.2 million of pay equity funding to Canterbury. While this is expected to be cost neutral for those specifically covered by the settlement, we are unable to predict the additional

costs in relation to flow-on expectations from other professional groups and providers.

OUT-YEARS' SCENARIO

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

This uncertainly is driven by a number of interrelated factors including: revenue volatility resulting from population and deprivation shifts; changing health demands post-earthquake; costs of servicing an unenrolled rebuild population; earthquake repair costs; unforeseen delays in the redevelopment programme; and unknown costs in assuming responsibility for the Chatham Islands.

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, assets revaluation and the new Burwood and Christchurch Hospital facilities will have a significant impact on our out-year financials. These costs will increase significantly on the completion of the Acute Services Building and other significant earthquake damaged replacement facilities such as Outpatients and the Energy Centre. The combined annual depreciation, interest and capital charge will increase by $69.5 million (from $69 million in 2015/16 to approximately $138.5 million by 2019/20).

Whilst independent cost assessments have been received for a number of earthquake repair projects, the final interplay between the nature of repairs, new building codes and construction cost escalations is dynamic. Estimates of the anticipated 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), 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.

Major assumptions

Revenue and expenditure estimates for out-years have been based on current government policy settings, services 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:

- Out-years funding is assumed at the Treasury's mid-scenario forecasts for Canterbury DHB.
- The DHB will retain early payment arrangements.
- The DHB will receive deficit funding equivalent to forecast operating deficits as equity.
- Deficit funding associated with the 2016/17 deficit is not required to be recorded in Canterbury DHB closing equity as at June 2017 i.e. it will be recorded in 2017/18.
- 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.
- 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. This includes assumption of responsibility for the population of the Chatham Islands which was to be cost neutral.
- Funding for pay equity settlements will be cost neutral as they will be fully funded.
- $290 million, (being the yet to be spent portion of Canterbury's $320 million earthquake settlement proceeds as at 2015 and transferred to the Crown to minimise capital charge expenses), will be available to the DHB to be drawn down as required to fund the DHB's earthquake repair and reinstatement programme.
- As agreed with the Ministry of Health, the revenue and equity timing of the 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.
- Work will continue on the redevelopment of Canterbury facilities in accordance with the detailed business case agreed with the Ministry and Cabinet. Capital expenditure associated with the redevelopment 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 expired wage agreements will be settled on fiscally sustainable terms, inclusive of step increases and the impact of accumulated leave revaluation. External provider increases will also be settled within available funding levels.
- Treatment related costs will increase in line with known inflation factors, reasonable price charge impacts on providers, 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.

Bridging the gap

There is no 'quick-fix' solution to ensuring the clinical and financial sustainability of our health system.

Improving the health and wellbeing of our population is the only way to truly get ahead of the demand curve. While these gains may be slow, they are already evident, and are the foundation from which we will build a more effective and sustainable health system.

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 seven years, we have absorbed over $89 million in revenue and cost impacts related to the earthquakes, over and above the $100.4 million revenue deficit and $12.5 million equity deficit funding received from government over the same period.

This has largely been delivered by achieving lower rates of acute demand, reducing our dependence on aged residential care, reorganising laboratory services, and removing waste and duplication from our system.

We are committed to continuing our deliberate strategy in this regard – working across the whole of our system to deliver on our vision and improve long-term health outcomes for our population.

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.
- Restraining cost growth including moderating treatment, back office, support and FTE costs.
- 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 2017/18 are outlined in the Service Configuration section of this Plan (Part II).

NATIONAL SUPPORT

Significant earthquake-related service planning and delivery challenges continue to be experienced. The DHB has requested the assistance of the Ministry of Health and other government agencies in addressing a number of these issues, including:

- Standard funding methodologies are unable to account for the dynamic population changes following the Canterbury earthquakes. We need a clear and stable future funding path.
- Standard measures of population deprivation are proving to be insensitive and were never designed to cope with a post-disaster environment. We need an interim fix to account for the impacts of forced migration and secondary stressors.
- Delays and choices being made in relation to the redevelopment and repair of our infrastructure are creating additional financial pressures. We need improved understanding of the operational impacts of short-term capital decisions.
- Traditional measures of demand, focused on hospital outputs, mask the true need of our population. We need to enable measures that consider the whole picture as we drive towards a more integrated system.

Capital investment

NATIONAL BUSINESS CASES

In March 2013, the detailed business case for the redevelopment of Burwood and Christchurch Hospital sites was approved by Cabinet and the Capital Investment Committee. The Burwood redevelopment has been completed and the Acute Services Building and Outpatient Building on the Christchurch Hospital campus are now scheduled for completion in 2018/19.

The business case and implementation plan for replacement of our legacy patient administration systems with one South Island Patient Information Care System (PICS) was approved by Cabinet in 2014.

Burwood was the first go-live site and we are currently progressing with the staged implementation in alignment with the new facility timeframe.

The Canterbury DHB has also submitted an indicative business case for the relocation of mental health services from the Princess Margaret Hospital site, which were originally destined to be migrated to the Christchurch Hospital campus, as part of the 2013 detailed business case.

This indicative business case, which assumed the project will be fully equity funded by the Crown, was approved by the then Minister of Health in September 2017. Development of a detailed business case for this critical capital project is in progress and expected to be completed in early 2018.

CAPITAL EXPENDITURE

Subject to the appropriate approvals, Canterbury's capital expenditure budget totals $42 million for the 2017/18 year, and is comprised of:

- $5 million capital expenditure portion of the strategic earthquake programme of works.67
- $5 million Patient Information Care System.
- $2 million Electronic Medication Management.
- $30 million other new/replacement assets and systems.

Anticipated investment for 2017-2020 includes:

- Strategic Information Technology developments, including implementation of the Patient Information Care System, Electronic Medication Management, HealthOne, and investment in the patient portal—towards a digital hospital.
- Completion of the facilities redevelopment on the Christchurch Hospital site (Acute Services Building) in line with the approved detailed business case.
- Repair and reinstatement of the Christchurch Hospital Energy Centre, Carpark, Tunnel and Outpatient Building.
- 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.

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

Out-years capital planning will also consider the future use of existing buildings and facilities, in line with our earthquakes repair programme and, in response to population growth, service capacity issues. These will include Parkside on the Christchurch Hospital campus, Canterbury Health Laboratories and buildings on the Hillmorton Hospital campus.

Debt and equity

In February 2017, all existing DHB's Crown debts were converted to equity as part of the Crown's debt/equity translation process. The pre-approved debt for the new Acute Services Building will also be translated to equity. Effective from 2016/17, DHBs will have no Crown debt. Any cost differential between increased capital charge and reduced interest expense arising from the debt/equity conversion will be adjusted for by additional funding for a two-year period (i.e. neutral impact to the operating result until mid-2018/19).

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 nature of the collective sector insurance in place at the time of the earthquake meant a total maximum loss capacity of $320 million. While we were able to obtain the entire $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 of our earthquake settlement proceeds to the Crown to minimise capital charge expenses. As agreed with the Ministry of Health, the $290 million is being progressively drawn down to fund earthquake repair work.

For the safety of patients and staff we need to complete our repair and reinstatement programme without delay. The inherent shortfall between the insurance settlement and the full cost of repairs means we will need to access the full $290 million earthquake settlement proceeds as agreed.

The forecast drawdown as at 30 June 2017, is $98 million (a mix of revenue and equity), leaving a balance of $192 million yet to be drawn, as either revenue or equity depending on the type of repairs. This is now unlikely to be sufficient in light of recent costs coming out of this settlement related to the redevelopment of the Acute Service Building, completion of the boiler house and energy centre, and costs related to the migration of stranded mental health services.

Taking into account equity movements over the next four years (such as earthquake proceeds redrawn as equity, debt to equity conversion, equity for the Acute

[67] Cost for significant earthquake projects managed by the Ministry will only be charged to the DHB on completion and transfer of the assets. No transfer is expected in 2017/18.

Services Building and deficit funding), the Crown's equity in the DHB will rise from $518 million as at June 2017 to $1.152 billion by June 2020.

Additional considerations

DISPOSAL OF LAND

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 2017-2019 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 is also proposing disposal 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 considering the future use of the former Christchurch Women's Hospital site in the central city and the Princess Margaret Hospital site in Cashmere. The future use of these sites will be determined following completion of the Acute Services Building and Outpatients Building and the decanting of services from the Princess Margaret Hospital.

We are considering the future use of all of our rural hospitals in line with our rural sustainability project. It is unlikely that all of the rural hospitals will continue to operate in their current form.

Due process will be undertaken with regard to the sale of any DHB land.

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 the DHB's Statement of Intent 2016-2020 available on our website: www.cdhb.health.nz.

Statement of Financial Expectations

Group statement of comprehensive revenue and expense

For the years ending 2015/16 to 2019/20

	2015/16 Actual $'000	2016/17 Actual $'000	2017/18 Plan $'000	2018/19 Plan $'000	2019/20 Plan $'000
REVENUE					
Ministry of Health revenue (Note 1)	1,538,949	1,573,724	1,660,767	1,707,439	1,756,663
Other government revenue	29,270	28,932	31,120	32,364	33,659
Earthquake repair revenue redrawn	9,882	10,712	7,800	18,500	23,800
Other revenue	44,391	42,740	47,231	51,489	63,909
Total Revenue	**1,622,492**	**1,656,108**	**1,746,918**	**1,809,792**	**1,878,031**
EXPENSE					
Personnel	675,097	704,206	745,725	782,293	817,612
Outsourced (Note 2)	26,920	25,907	25,032	24,597	24,159
Clinical supplies	133,550	142,878	148,168	153,904	164,563
Earthquake building repair costs	9,882	10,712	7,800	18,500	23,800
Infrastructure & non clinical (excl Earthquake repairs)	101,729	105,685	99,225	102,425	105,546
Payments to non-DHB providers	606,747	643,176	684,378	698,582	685,388
Interest	5,575	3,932	200	-	-
Depreciation and amortisation	57,739	56,268	59,704	69,572	71,237
Capital charge expense	5,726	16,177	30,330	34,458	67,242
Total Expense	**1,622,965**	**1,708,941**	**1,800,562**	**1,884,331**	**1,959,547**
Surplus/(Deficit)	**(473)**	**(52,833)**	**(53,644)**	**(74,539)**	**(81,516)**
OTHER COMPREHENSIVE REVENUE & EXPENSE					
Revaluation of property, plant & equipment	91,753	-	-	-	-
Impairment of property, plant & equipment	-	(1,491)	-	-	-
Total Comprehensive Income/(Deficit)	**91,280**	**(54,324)**	**(53,644)**	**(74,539)**	**(81,516)**

Note 1: Includes Inter-District Flow and Inter-DHB revenue

Note 2: Excludes outsourced electives payments to Non-DHB Providers

Group statement of financial position

As at 30 June for the years ending 2015/16 to 2019/20

	30/06/16 Actual $'000	30/06/17 Actual $'000	30/06/18 Plan $'000	30/06/19 Plan $'000	30/06/20 Plan $'000
CROWN EQUITY					
Contributed capital (Note 3)	(282,151)	90,073	204,689	833,367	934,022
Revaluation reserve	290,849	289,058	289,058	289,058	289,058
Accumulated surpluses	191,235	138,702	85,058	10,519	(70,997)
Total Equity	**199,933**	**517,833**	**578,805**	**1,132,944**	**1,152,083**
REPRESENTED BY:					
CURRENT ASSETS					
Cash & cash equivalents	13,546	1,985	-	8,012	4,899
Trade & other receivables	69,349	72,652	126,292	147,187	154,164
Inventories	9,432	9,118	9,118	9,118	9,118
Restricted assets	8,060	11,815	11,815	11,815	11,815
Assets held for sale	540	-	-	-	-
Investments	1,000	1,350	1,350	1,350	1,350
Total Current Assets	101,927	96,920	148,575	177,482	181,346
CURRENT LIABILITIES					
NZHPL sweep bank account	-	16,505	2,250	-	-
Trade & other payables	100,886	106,936	93,936	93,936	93,936
Employee benefits	154,321	156,703	156,700	156,700	156,700
Restricted funds	14,297	12,111	12,111	12,111	12,111
Total Current Liabilities	269,504	292,255	264,997	262,747	262,747
Net Working Capital	(167,577)	(195,335)	(116,422)	(85,265)	(81,401)
NON CURRENT ASSETS					
Property, plant, & equipment	499,233	693,087	667,633	1,188,027	1,204,038
Intangible assets	14,386	25,940	33,453	36,041	35,305
Restricted assets	6,237	296	296	296	296
Total Non-Current Assets	519,856	719,323	701,382	1,224,364	1,239,639
NON CURRENT LIABILITIES					
Employee benefits	6,361	6,155	6,155	6,155	6,155
Borrowings (Note 3)	145,985	-	-	-	-
Total Non-Current Liabilities	152,346	6,155	6,155	6,155	6,155
Net Assets	**199,933**	**517,833**	**578,805**	**1,132,944**	**1,152,083**

Note 3: Existing borrowings from the Crown were translated to equity, effective February 2017. The pre-approved Crown debt for the Christchurch Hospital campus facility redevelopment will be transacted as equity when the completed asset is transferred to the DHB.

Group statement of movements in equity

For the years ending 2015/16 to 2019/20

	2015/16 Actual $'000	2016/17 Actual $'000	2017/18 Plan $'000	2018/19 Plan $'000	2019/20 Plan $'000
Total equity at beginning of the year	77,014	199,933	517,833	578,805	1,132,944
Total comprehensive revenue and expense for the year	91,280	(54,324)	(53,644)	(74,539)	(81,516)
OTHER MOVEMENTS					
EQUITY REPAYMENTS					
Assets disposal net proceeds remitted to Crown	-	-	-	-	(20,000)
Annual depreciation funding repayment	(1,861)	(1,861)	(1,861)	(1,861)	(1,861)
EQUITY INJECTIONS					
Earthquake repair capital redrawn	33,500	11,100	10,000	57,000	41,000
Kaikoura facility contribution	-	2,000			
Operating deficit support (Note 4)	-	-	106,477	74,539	81,516
New facilities redevelopment assets transferred from the Crown (original equity value)	-	130,000	-	274,400	-
New facilities redevelopment assets transferred from the Crown (approved debt swapped to equity value)	-	85,000	-	224,600	-
Debt to equity swap - debt as at June 2016	-	145,985	-	-	-
Total Equity at End of the Year	**199,933**	**517,833**	**578,805**	**1,132,944**	**1,152,083**

Note 4: 2017/18 includes 2016/17 deficit support. Out years deficit support is accrued in the year the deficit occurs.

Group statement of cash flow

For the years ending 2015/16 to 2019/20

	2015/16 Actual $'000	2016/17 Actual $'000	2017/18 Plan $'000	2018/19 Plan $'000	2019/20 Plan $'000
CASH FLOW FROM OPERATING ACTIVITIES					
Cash provided from:					
Receipts from Ministry of Health	1,554,809	1,570,290	1,643,309	1,689,283	1,737,781
Earthquake repair revenue redrawn	9,882	10,712	7,800	18,500	23,800
Other receipts	30,316	94,967	94,230	99,042	103,517
Interest received	2,463	2,113	1,579	2,967	3,033
	1,597,470	1,678,082	1,746,918	1,809,792	1,868,131
Cash applied to:					
Payments to employees	699,786	720,349	763,497	799,887	835,030
Payments to suppliers	844,786	934,510	959,831	980,414	986,038
Interest paid	4,910	5,107	200	-	-
Capital charge	5,726	16,175	30,330	34,458	67,242
GST - net	639	(3,886)	-	-	-
	1,555,847	1,672,255	1,753,858	1,814,759	1,888,310
Net Cash Flow from Operating Activities	**41,623**	**5,827**	**(6,940)**	**(4,967)**	**(20,179)**
CASH FLOW FROM INVESTING ACTIVITIES					
Cash provided from:					
Sale of property, plant, & equipment	(22)	728	-	-	20,000
Receipt from investments and restricted assets	14,148	35,345	-	-	-
	14,126	36,073	-	-	20,000
Cash applied to:					
Purchase of investments & restricted assets	13,775	35,928	-	-	-
Purchase of property, plant, & equipment	66,929	45,277	41,762	592,554	96,612
	80,704	81,205	41,762	592,554	96,612
Net Cash Flow from Investing Activities	**(66,578)**	**(45,132)**	**(41,762)**	**(592,554)**	**(76,612)**
CASH FLOW FROM FINANCING ACTIVITIES					
Cash provided from:					
Equity Injections					
Earthquake repair capital redrawn	33,500	11,100	10,000	57,000	41,000
Kaikoura facility contribution	-	2,000	-	-	-
Operating deficit support	12,500	-	52,833	53,644	74,539
Equity contribution to redeveloped ASB facilities transferred from the Crown (Note 5)	-	-	-	499,000	-
	46,000	13,100	62,833	609,644	115,539
Cash applied to:					
Asset disposal proceeds remitted to Crown	-	-	-	-	20,000
Annual depreciation funding repayment	1,861	1,861	1,861	1,861	1,861
	1,861	1,861	1,861	1,861	21,861
Net Cash Flow from Financing Activities	**44,139**	**11,239**	**60,972**	**607,783**	**93,678**
Net increase/(decrease) in cash and cash equivalents	19,184	(28,066)	12,270	10,262	(3,113)
Cash and cash equivalents at beginning of year	(5,638)	13,546	(14,520)	(2,250)	8,012
Cash and cash equivalents at end of year (Note 6)	**13,546**	**(14,520)**	**(2,250)**	**8,012**	**4,899**

Note 5: Shown for transparency and completeness purpose. Historically, such transactions are accounted as 'book transactions' i.e. no actual cash exchanges.

Note 6: Includes NZHPL sweep bank account balance.

Summary of revenue and expenses by arm

Forecast Operating Statement Years ending 2015/16 to 2019/20

	2015/16 Actual $'000	2016/17 Actual $'000	2017/18 Plan $'000	2018/19 Plan $'000	2019/20 Plan $'000
Funding Arm					
REVENUE					
Ministry of Health revenue	1,476,806	1,504,084	1,586,742	1,631,160	1,678,124
Other government revenue	1,401	2,027	1,959	2,008	2,058
Other revenue	1,417	436	-	-	-
Total Revenue	**1,479,624**	**1,506,547**	**1,588,701**	**1,633,168**	**1,680,182**
EXPENSE					
Personal Health	1,061,537	1,102,942	1,162,869	1,202,660	1,242,319
Mental Health	146,326	160,518	162,889	168,181	168,847
Disability Support	243,760	250,950	278,575	283,321	288,258
Public Health	3,506	4,155	4,676	4,873	3,758
Maori Health	2,210	1,864	2,061	1,941	1,961
Total Expense	**1,457,339**	**1,520,429**	**1,611,070**	**1,660,976**	**1,705,143**
Surplus/(Deficit)	**22,285**	**(13,882)**	**(22,369)**	**(27,808)**	**(24,961)**
Other comprehensive revenue and expense	-	-	-	-	-
Total Comprehensive Income/(Deficit)	**22,285**	**(13,882)**	**(22,369)**	**(27,808)**	**(24,961)**
Governance & Funder Admin					
REVENUE					
Ministry of Health revenue	2,749	4,197	3,841	3,893	3,946
Other government revenue	61	4	48	49	50
Other revenue	194	80	187	192	197
Total Revenue	**3,004**	**4,281**	**4,076**	**4,134**	**4,193**
EXPENSE					
Personnel	7,082	8,288	8,448	8,680	8,830
Outsourced	2,120	920	888	879	870
Clinical supplies	38	167	168	171	174
Infrastructure & non clinical (excl Earthquake repairs)	(5,242)	(4,674)	(5,471)	(5,639)	(5,724)
Depreciation and amortisation	42	41	43	43	43
Total Expense	**4,040**	**4,742**	**4,076**	**4,134**	**4,193**
Surplus/(Deficit)	**(1,036)**	**(461)**	**-**	**-**	**-**
Other comprehensive revenue and expense	-	-	-	-	-
Total Comprehensive Income/(Deficit)	**(1,036)**	**(461)**	**-**	**-**	**-**

Summary of revenue and expenses by arm—continued

Forecast Operating Statement Years ending 2015/16 to 2019/20

	2015/16 Actual $'000	2016/17 Actual $'000	2017/18 Plan $'000	2018/19 Plan $'000	2019/20 Plan $'000
Provider Arm					
REVENUE					
Ministry of Health revenue	909,986	942,696	996,876	1,034,780	1,094,348
Other government revenue	27,808	26,901	29,113	30,307	31,551
Earthquake repair revenue redrawn	9,882	10,712	7,800	18,500	23,800
Other revenue	42,780	42,224	47,044	51,297	63,712
Total Revenue	**990,456**	**1,022,533**	**1,080,833**	**1,134,884**	**1,213,411**
EXPENSE					
Personnel	668,015	695,918	737,277	773,613	808,782
Outsourced	24,800	24,987	24,144	23,718	23,289
Clinical supplies	133,512	142,711	148,000	153,733	164,389
Earthquake building repair costs	9,882	10,712	7,800	18,500	23,800
Infrastructure & non clinical (excl Earthquake repairs)	106,971	110,359	104,696	108,064	111,270
Interest	5,575	3,932	200	-	-
Depreciation and amortisation	57,697	56,227	59,661	69,529	71,194
Capital charge expense	5,726	16,177	30,330	34,458	67,242
Total Expense	**1,012,178**	**1,061,023**	**1,112,108**	**1,181,615**	**1,269,966**
Surplus/(Deficit)	**(21,722)**	**(38,490)**	**(31,275)**	**(46,731)**	**(56,555)**
OTHER COMPREHENSIVE REVENUE & EXPENSE					
Revaluation of property, plant & equipment	91,753	-	-	-	-
Impairment of property, plant & equipment	-	(1,491)	-	-	-
Total Comprehensive Income/(Deficit)	**70,031**	**(39,981)**	**(31,275)**	**(46,731)**	**(56,555)**
In House Elimination					
REVENUE					
Ministry of Health revenue	(850,592)	(877,253)	(926,692)	(962,394)	(1,019,755)
Total Revenue	**(850,592)**	**(877,253)**	**(926,692)**	**(962,394)**	**(1,019,755)**
EXPENSE					
Payments to internal providers	(850,592)	(877,253)	(926,692)	(962,394)	(1,019,755)
Total Expense	**(850,592)**	**(877,253)**	**(926,692)**	**(962,394)**	**(1,019,755)**
Surplus/(Deficit)	-	-	-	-	-
Other comprehensive revenue and expense	-	-	-	-	-
Total Comprehensive Income/(Deficit)	-	-	-	-	-

Summary of revenue and expenses by arm—continued

Forecast Operating Statement Years ending 2015/16 to 2019/20

	2015/16 Actual $'000	2016/17 Actual $'000	2017/18 Plan $'000	2018/19 Plan $'000	2019/20 Plan $'000
CONSOLIDATED					
REVENUE					
Ministry of Health revenue	1,538,949	1,573,724	1,660,767	1,707,439	1,756,663
Other government revenue	29,270	28,932	31,120	32,364	33,659
Earthquake repair revenue redrawn	9,882	10,712	7,800	18,500	23,800
Other revenue	44,391	42,740	47,231	51,489	63,909
Total Revenue	**1,622,492**	**1,656,108**	**1,746,918**	**1,809,792**	**1,878,031**
EXPENSE					
Personnel	675,097	704,206	745,725	782,293	817,612
Outsourced	26,920	25,907	25,032	24,597	24,159
Clinical supplies	133,550	142,878	148,168	153,904	164,563
Earthquake building repair costs	9,882	10,712	7,800	18,500	23,800
Infrastructure & non clinical (excl Earthquake repairs)	101,729	105,685	99,225	102,425	105,546
Payments to non-DHB providers	606,747	643,176	684,378	698,582	685,388
Interest	5,575	3,932	200	-	-
Depreciation and amortisation	57,739	56,268	59,704	69,572	71,237
Capital charge expense	5,726	16,177	30,330	34,458	67,242
Total Expense	**1,622,965**	**1,708,941**	**1,800,562**	**1,884,331**	**1,959,547**
Surplus/(Deficit)	**(473)**	**(52,833)**	**(53,644)**	**(74,539)**	**(81,516)**
OTHER COMPREHENSIVE REVENUE & EXPENSE					
Revaluation of property, plant & equipment	91,753	-	-	-	-
Impairment of property, plant & equipment		(1,491)	-	-	-
Total Comprehensive Income/(Deficit)	**91,280**	**(54,324)**	**(53,644)**	**(74,539)**	**(81,516)**

Appendix 5: System Level Improvement Plan

ANNUAL PLAN AND STATEMENT OF PERFORMANCE EXPECTATIONS

Produced May 2018
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Canterbury District Health Board
PO Box 1600, Christchurch
www.cdhb.health.nz

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