





A Healthier Canterbury

Annual Plan 2011-12

& Statement of Intent 2011-14









Canterbury
District Health Board
Te Poari Hauora ō Waitaha

OUR MISSION

TĀ MĀTOU MATAKITE

- To promote, enhance and facilitate the health and wellbeing of the people of Canterbury.
- Ki te whakapakari, whakamaanawa me te whakahaere i te hauora mo te orakapai o kā tākata o te rohe o Waitaha.

OUR VALUES

Ā MĀTOU UARA

- Care and respect for others.
  Manaaki me te kotua i etahi atu.
- Integrity in all we do.
  Hapai i a mātou mahi katoa i ruka i te pono.
- Responsibility for outcomes.
  Kaiwhakarite i kā hua.

OUR WAY OF WORKING

KĀ HUARI MAHI

- Be people and community focused.
  Arotahi atu ki kā tākata meka.
- Demonstrate innovation.
  Whakaatu whakaaro hihiko.
- Engage with stakeholders.
  Tu atu ki ka uru.

Explaining this Plan

The Canterbury District Health Board (DHB) is one of 20 DHBs in New Zealand, established under the New Zealand Public Health and Disability Act (NZPHD Act) in 2001, and is categorised as a Crown Agent under the Crown Entities Act 2004.

Under these Acts, DHBs were required to produce two annual planning documents: a District Annual Plan and a Statement of Intent. In 2010 the NZPHD Act was amended (*through the NZPHD Amendment Act 2010*) to allow these two documents to be combined, and in response DHBs now prepare one Annual Plan to meet the legislative requirements of the new amendment and both section 42 and 39 (8) of the NZPHD Act, and section 139 (1) of the Crown Entities Act. DHBs then extract relevant modules from this Plan to form their Statements of Intent.

In meeting the NZPHD Act requirements, we have described our strategic direction and identified our key challenges, objectives and goals. We have also outlined the actions and activity that we have planned in the coming year to meet those challenges and to deliver on the expectations and health targets set by the Minister of Health and by Government.

In meeting the Crown Entities Act requirements, we have also focused on what we seek to achieve, in terms of improving the health status of our population, and how we will measure our success. We have provided non-financial service performance forecasts and financial performance forecasts for the current year 2011/12 and subsequent two out-years 2012/13 and 2013/14.

This document has been approved by the Board of the Canterbury DHB as representative of the intentions and objectives of the Canterbury DHB for the period 1 July 2011 to 30 June 2014. In accordance with the Crown Entities Act 2004 the Statement of Intent elements have been presented to the House of Representatives.

The forecast Statements of Service and Financial Performance will be used at the end of the year to report our actual delivery compared with our planned performance. The results are audited by auditors working on behalf of the Office of the Auditor General and reported publicly in our Annual Report, which can be found along with all of our accountability documents on the Canterbury DHB website www.cdhb.govt.nz.

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Commitment from Our Board

We are pleased to present our Annual Plan for 2011/12.

This document expresses our continued commitment to the strategic vision of 'one Canterbury health system' and to improving the health and wellbeing of our population. It also articulates our commitment to meeting the expectations of the Minister of Health and our regional DHB partners by delivering on service and financial responsibilities and achieving performance targets.

Despite the extraordinary events of the past year, we remain committed to the transformation of our health system, which will ensure that people receive "*the right care and support, at the right time, from the right person in the most appropriate setting*".

However, there is an evident change in emphasis and urgency. After three major earthquakes, Canterbury is in a recovery phase and parts of our health system (like the whole of Canterbury) will never be the same. In response to reduced capacity after February 22nd some planned initiatives have been reprioritised and accelerated; others have been developed by clinical teams to ensure services are sustainable over the medium and longer term.

As we progress our transformation at a more rapid pace, we are conscious of the impact the earthquakes have had on our community. We want to ensure that people are receiving the care and support they need, and that the system is responsive and flexible during a time when all of us are more vulnerable. Led by health professionals from across the system, we will continue to develop models of care and ways of working that assist more people with our current resources. We will better support service providers to meet the needs of their clients and patients, emphasising flexibility in terms of service delivery.

In meeting the expectations of Government, we will reduce waiting times and provide services in more convenient locations and closer to people's own homes. This means delivering additional elective surgery for our population and providing more direct access to services in the community and in primary care, without the need for hospital appointments.

We will explicitly focus on our more vulnerable population groups (including older people and those who experience mental illness), who deserve certainty as they get older and as they manage their ongoing health conditions. We will support people to maintain independence, to participate in their communities and to remain well, and in their own homes, for as long as possible.

We will also contribute to a regional vision for health services and take a wider South Island approach to long-term service planning, particularly around vulnerable service areas and highly specialised services. Over the coming year, regional plans will be put into action, and we expect to make some significant decisions around the future configuration of services across the South Island.

In ensuring that our strategic and operational decisions are effective and sustainable, we will look to our advisory boards and clinical leaders - including our Consumer Council and Clinical Board, Manawhenua Ki Waitaha and clinical leadership groups like the Canterbury Clinical Network - to provide advice and direction, and to help monitor the progress of the Canterbury health system over the next 12 months.

Bruce Matheson
Chairman

Peter Ballantyne
Deputy Chairman

Hon Tony Ryall
Minister of Health

Hon Bill English
Minister of Finance

Date: June 2011

Message from the Chief Executive

The past year has been one that we will never forget. The recent earthquakes have dealt a major blow to Canterbury, having a significant and lasting impact on our lives, homes and communities. The quakes have displaced people from their homes and usual health networks, left many in cold, crowded housing and placed our population under additional stress and uncertainty about their future. All of these things will tax our population's normal resilience and make us more vulnerable to physical and mental illness.

Our health system too has been affected by the recent seismic events, with damage to health service infrastructure across the whole of Canterbury, including aged residential care facilities, pharmacies, laboratories, private medical practices and private hospitals, the premises of community-based health providers and our own DHB facilities.

We have been lucky that the Canterbury health system was in such a strong position leading into the September earthquake. We recognised that we faced significant future challenges in terms of increasing demand for services, financial constraints and workforce shortages. We knew several years ago that if we continued to deliver services in the same way, by 2020 Canterbury would need to double its workforce and physical capacity. 'Business as usual' was not, and is not, a sustainable option.

For the last three years we have been transforming the way we design, deliver and fund health services - reorienting the Canterbury health system around the needs of the individual and removing traditional barriers to improve outcomes for our population.

Our transformation is based on the collective vision of one health system focused on providing '*the right care and support, to the right person, at the right time and in the right place'*.

Canterbury's vision encapsulates Government priorities for a more personalised healthcare system that makes our population healthier, provides services closer to home, reduces pressure on hospital services and introduces three key implications in terms of service development:

- The development of services and environments that support people to stay well and to take increased responsibility for their health;
- The development of primary health care and community services to support people in community-based settings and provide a point of ongoing continuity of care; and
- The freeing-up of secondary care services and specialist resources to ensure timely and appropriate responses to episodic events and the provision of support and specialist advice as part of a person's wider journey through the system.

Our Achievements

In the past year, the Canterbury health system has collectively introduced a staggering number of new services to our population, made significant improvements to patient pathways and models of care and improved access rates, wait times and the whole patient experience for our population.

We have shifted our health system from underperformance to meeting and exceeding national standards and health targets, while maintaining tight fiscal control and a highly engaged clinical workforce. By focusing on clinical leadership, 'whole of system' flow, production planning and progressively moving activity that does not need to be delivered in a hospital into a community setting, we have established a solid platform for further improvement.

A great deal of our progress has occurred in secondary care through our *'Improving the Patient Journey'* Programme, at the primary/secondary interface through the *'Canterbury Initiative'* and in primary care through our alliance with the Canterbury Clinical Network and implementation of Canterbury's *'Better, Sooner, More Convenient'* Business Case.

Primary care, as part of the whole Canterbury health system, is demonstrating its capacity to effect positive change in population health outcomes, and our hospital and specialist services are meeting the challenges of improving productivity without compromising patient safety or service quality.

By fostering a culture of innovation, challenging old ways of doing things and strengthening partnerships across the health sector, we are making real differences for our population.

Our Challenges

The work that had already gone into reorienting and transforming the Canterbury health system helped us to pull together and, despite major disruption and damage, minimise the earthquakes' impact on the delivery of health services. This required significant hard work and effort from our workforce and from health professionals and volunteers right across the Canterbury health system, often under extreme pressure and in stressful circumstances.

While our achievements and our collective response prove that Canterbury can function as a highly effective, integrated system, the ongoing impact of the earthquakes and aftershocks are draining our system's resources. The predicted surge in health need, increased demand on emergency services, general practice after-hours services and mental health services over the next 12 months will place additional stress on a system that now has less resilience.

Limits in capacity have been managed to date through increased integration and improved productivity, but earthquake damage to our infrastructure has resulted in the loss of almost 750 beds across the system. Without careful planning and a 'whole of system' approach, physical bed capacity will be routinely exceeded in 2011/12.

These constraints will force ongoing rapid service reconfiguration, as we work around damaged infrastructure, workforce gaps and tight physical and fiscal constraints - while still responding to demographic changes and an expected surge in health need and demand. Our key challenges will be focused around managing demand, rebalancing the system, constraining cost growth, and releasing workforce capacity.

This Annual Plan provides an outline of the significant initiatives and projects we will deliver over the next year to meet our immediate challenges, support our transition back to capacity and, at the same time, transform our system to meet the challenges of the future.

It is important to emphasise that while our direction is predicated on reasonable assumptions and planning, there is no basis on which to predict activity and demand for health services after earthquakes such as Canterbury has experienced, and no comparable situation to draw upon.

However, adversity has driven innovation, much of which is already being implemented all over the Canterbury health system. In spite of the unknown factors on our immediate horizon, Canterbury has the foundations for a sustainable future and we will make ongoing, significant and tangible changes to secure that future.

It's our health system and, in the coming year, we will make it even better.

David Meates

Chief Executive, Canterbury DHB

Office of Hon Tony Ryall

Minister of Health
Minister of State Services

9 AUG 2011

Mr Bruce Matheson
Chair
Canterbury District Health Board
PO Box 1600
CHRISTCHURCH 8140

Dear Mr Matheson

Canterbury District Health Board 2011/12 Annual Plan

This letter is to advise you that together with the Minister of Finance I have approved and signed Canterbury District Health Board's (DHB) 2011/12 Annual Plan for one year. This decision acknowledges the financial uncertainty following the earthquakes and does not reflect your DHB's performance or the quality of your Annual Plan.

I appreciate that the series of earthquakes have had a significant impact on Canterbury DHB. Throughout this time, your clinicians, managers and the health service providers you contract with have had to adapt and respond to very challenging situations in order to care and support your local population. I acknowledge the tremendous effort your clinicians, managers and the rest of your team have made dealing in with these challenges. The recovery effort has been admirable.

Understandably, consideration of your 2011/12 Annual Plan has been slightly delayed as a result of the earthquakes and recovery effort. Despite the many challenges, your DHB has submitted an Annual Plan that articulates a clear strategic vision and shows a strong understanding and commitment to my expectations and targets.

This year has also seen significant change to the accountability framework for all DHBs with the introduction of annual Regional Service Plans to replace District Strategic Plans and one Annual Plan that incorporates the Statement of Intent. These changes are designed to help improve the way we plan service delivery by setting a long term direction and clear pathways to get there, through an integrated approach linking the different levels of health care.

I want to thank you for your co-operation as we transition to this new way of thinking and look forward to your continued support as we strive for improved health services for all New Zealanders.

Clinical and financial sustainability

All DHBs are expected to budget and operate within allocated funding and identify specific actions to improve financial performance in order to live within their means. This includes seeking efficiency gains and improvements in purchasing, productivity and quality aspects of your DHB's operation and service delivery.

I am pleased to see that your DHB is planning to return to breakeven over the next three years despite the challenges presented by the earthquake recovery phase. However, in view of the ongoing seismic activity there is a significant risk associated with the anticipated planned path to breakeven in 2013/14 as reflected in your Annual Plan. It is acknowledged that the detailed assessment of earthquake related costs and net of recoveries is currently work in progress and the amounts included in the Annual Plan are estimated based on available information.

Primary Care

Delivering better, sooner and more convenient services closer to home has been a priority for the Government and DHBs for a number of years. Closer integration of services across primary and secondary care and a greater range of services being delivered in the community should not only reduce pressure on hospitals but also improve the patient experience.

The importance of primary care and how delivering services in the community can relieve pressure on the hospital system has long been recognised by Canterbury DHB. I am pleased to note that a commitment in this priority area continues to be an integral part of the DHB's plans to move forward and I commend the DHB for continuing to build on Canterbury Clinical Network's Better, Sooner, More Convenient business case.

Regional Collaboration

Greater regional collaboration is a key aspect of the new accountability arrangements and supports more effective use of clinical and financial resources. Better collaboration amongst DHBs is essential to address priority vulnerable services and has the potential to maximise efficiencies through shared back office functions, as well as IT, workforce support and development and capital investment. As core elements of the National Health Board's work, I look forward to seeing the benefits of collaborative partnership with your fellow DHBs as these important regional initiatives are implemented.

Your Annual Plan incorporates a strong regional flavour. It is evident that your DHB is working to realise the benefits of regional and sub-regional collaboration, and that this influences your local service planning.

I expect to see delivery on your agreed Regional Service Plan actions as detailed in your Annual Plan and look forward to seeing greater ongoing support for the work of Health Benefits Limited in developing shared back office functions where appropriate. I also thank you for your continued commitment to work with the Health Quality and Safety Commission.

Health of Older People

The prioritisation of investment in services to ensure the health and support needs of older people are met is important. An ongoing programme will be required to manage the impact of our ageing population on health services and support the provision of high quality and sustainable services in this area.

I am pleased to see more detail in your Annual Plan on how you are planning to deliver health services for older people. I am especially interested to follow your progress in relation to addressing the respite care needs of your community and the effective use of recent additional funding for this service.

How you will provide new and expanded services for people with dementia is of importance to me as is your DHB's continued application of the comprehensive clinical assessment tool

(interRAI) currently being rolled out nationally. Better articulation of how improvements are being sought in this priority area will be expected from all DHBs in next year's Annual Plan.

Clinical Leadership

Clinical leadership is fundamental to improving patient care and has an important role in supporting overall service delivery in a number of ways. Engagement with clinical leaders aids job satisfaction for health care professionals and improves delivery of workforce initiatives. The success of clinical networks is based on clinical input working across regions and nationally to assist with overall service delivery. Clinical leadership also plays an important part in the integration of service delivery closer to home.

I expect to see clinical leadership embedded within your DHB and the ways in which you seek engagement with your clinicians continue to expand over coming years.

Health Targets

New Zealanders have high expectations that they will have access to quality health care services when they need them. The Government's Health Targets are selected to drive ongoing improvements in specific priority areas in order to meet the growing expectations of the public.

I appreciate your efforts to deliver on the Health Targets and your progress in delivering on these. It is commendable that you have identified more specific actions within your Annual Plan to ensure you achieve your planned performance on the six Health Targets.

I note that the DHB has not formally committed to the national target of 95 percent for immunisation coverage or the national target of 90 percent for cardiovascular disease (CVD) risk assessment as part of your Annual Plan. I appreciate that the earthquakes have impacted on primary care providers and the population to such an extent that identifying and recalling people for an immunisation event or a CVD risk assessment will be problematic.

I expect the DHB to continue to monitor and report performance against these two targets during 2011/12 and that the DHB will support general practices to re-establish their enrolled populations to allow systematic recall and follow-up of these target populations.

Mental Health Ringfence

I am approving your plan with the expectation that your DHB will work closely with the Ministry of Health to agree and ensure appropriate use of any currently unallocated mental health ringfence funding in line with policy.

Annual Plan Approval

Approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the National Health Board. All service change or service reconfigurations must comply with the requirements of the Operational Policy Framework, and you will need to advise the National Health Board of any proposals that may require my approval.

Additionally, acceptance of your Annual Plan does not indicate support for any capital projects requiring equity or new lending, or self-funded projects that require the support of the Capital Investment Committee. Approval of such projects is dependant on both completion of a sound business case, and evidence of good asset management and health service planning by your DHB. Approval for equity or new lending is also managed through the annual capital allocation round. I appreciate that the NHB is working closely with you as your DHB works through its immediate and future capital needs; needs which are of a high relative priority.

I would like to thank you, your Board and management for your valuable contribution and continued commitment to delivering quality health care to your population during a very difficult time and wish you every success with the implementation of your 2011/12 Annual Plan.

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

Yours sincerely

Hon Tony Ryall
Minister of Health

Hon Bill English
Minister of Finance

INTRODUCTION

Module 1

The Canterbury DHB - Who Are We?

Established under the NZPHD Act in January 2001, the Canterbury DHB is the second largest DHB in New Zealand by both geographical area and population.

We serve a population of over 510,000 people (12% of the New Zealand population). Our region encompasses Kekerengu to the North, Rangitata to the South and Arthur's Pass to the West - covering 26,881 square kilometres and comprises of the six Territorial Local Authorities: Kaikoura, Hurunui, Waimakariri, Christchurch City, Selwyn and Ashburton.

1.1 The Role and Scope of the DHB - What Do We Do?

All DHBs receive population based funding from Government - allocated on the basis of the size and demographic mix (age, gender, ethnicity and deprivation) of their resident population and their population's historic utilisation of health services. Canterbury received 11.22% of the total Vote Health funding allocated to DHBs in 2011/12.

As required under the legislation which governs DHBs we:

- *Plan* the strategic direction for health and disability services in Canterbury, in partnership with clinical leaders, stakeholders and our community and in consultation with other DHBs and service providers;
- *Fund* the majority of health services provided in Canterbury with the $1.3B of funding we receive from Government, using the relationship and service contracts we hold with health and disability service providers to ensure that services are responsive, coordinated, and focused on what is best for the person as well as the wider population;
- *Provide* hospital and specialist services for the population of Canterbury, and also for people referred from other DHBs where more specialised or higher level services are not available. Canterbury is the major tertiary provider in the South Island, with over $100m worth of services being provided for other DHBs; and
- *Promote*, protect and improve our population's health and wellbeing through health promotion, health education and the provision of evidence-based public health initiatives.

In addition to these responsibilities, we are the largest employer in the South Island, with over 9,000 people employed across our hospitals, community laboratory and numerous community bases. A similar number of people are employed in delivering health and disability services through the rest of the Canterbury health system, and are funded either directly or indirectly by the Canterbury DHB. .

In order to deliver our responsibilities we have established a clear direction and vision for the Canterbury health system and put in place appropriate governance and organisational structures, clear decision-making processes and transparent prioritisation principles to achieve that vision.

Our vision is focused providing the right care and support, to the right person at the right time and in the right place. We achieve this by adopting a 'whole of system' response - with

THE WORLD'S VIEW OF CANTERBURY

"The transformation story in Canterbury is fascinating and inspiring."

Zak Cole, Business Development Manager, Health and Biotechnology NZTE, Germany.

"The Canterbury story is inspirational."

Bonnie Brosshart, CEO, Health Quality Council, Saskatchewan, Canada.

"I'm watching four health systems in the world. Canterbury is one of those four."

Helen Bevan, Chief of Service Transformation, NHS Innovation Institute, United Kingdom.

services that support people to stay well, services delivered closer to home by highly functional and capable primary care and specialist services freed up to provide the support for people who require complex care.

At its core, our vision is centred on identifying what is best for the person in the context of what is best for a sustainable health system, doing the right thing for the patient regardless of traditional roles and organisational barriers and removing duplication and waste from the system.

The transformation of our health system is driven by empowered clinical leadership. Clinical leaders and the health workforce right across Canterbury are engaged in developing and implementing innovative solutions to improve outcomes for our population and to help make the system work properly.

We are implementing our vision through clinically led initiatives and programmes including *'Improving the Patient Journey'*, the *'Canterbury Initiative'* and, more recently, the Canterbury Clinical Network's *'Better, Sooner, More Convenient'* Business Case. These have all resulted in improved productivity and performance right across the Canterbury health system.

Governance and the Management of the DHB

The Board assumes governance of the DHB and is responsible to the Minister of Health for the DHB's overall performance and management. Its core responsibilities are to set strategic direction and develop policy that is consistent with Government objectives and improves health outcomes for our population.

The Board also ensures compliance with legal and accountability requirements and maintains relationships with the Minister of Health, Parliament and the Canterbury community. Seven Board members are elected by the Canterbury residents, and four are appointed by the Minister of Health. While responsibility for the DHB's overall performance rests with the Board, operational and management matters have been delegated to the Chief Executive, who is supported by an Executive Management Team.[1]

Planning and Funding Health and Disability Services

The Planning and Funding Division of the DHB is responsible to the Chief Executive for assessing our population's current and future health needs and determining the best mix and range of services to be purchased with the funding we receive.

In line with our vision we do not do this in isolation. We work in partnership with clinical leaders, health professions and other health providers to: understand the needs of our population; identify gaps in capacity; develop strategies that will improve outcomes for our population; and prioritise investments that will improve the quality of service delivery and enhance efficiencies across the system.

PLANNING & FUNDING

Identifying the current and future gap between the capacity of the system to deliver services and the needs of our population;

Supporting the development of new service plans and strategies in health priority areas and prioritising and implementing national health policies and strategies in relation to local need;

Undertaking and managing contractual agreements with service providers and monitoring and evaluating service delivery.

To support this approach we focus on clinically-led service design - backed by transparent prioritisation processes, shared decision making and alliance-based contracting. We hold alliance contracts and service agreements with the organisations or individuals who provide the health services required to meet the needs of our population. These include a large scale alliance with the Canterbury Clinical Network (CCN), an internal service agreement with our Hospital and Specialist Services Division and over 1,000 service agreements with external providers across the Canterbury health system.[2]

Some services are funded and contracted directly by the Ministry of Health, for example breast and cervical screening, public health services and the provision of disability services for people under the age of 65. The DHB is still responsible for monitoring and evaluating service delivery in these areas.

[1] *Refer to Appendix 3 for an overview of the organisational structure of the Canterbury DHB.*

[2] *The Canterbury Clinical Network is an alliance of Canterbury' health professionals whose initial focus is the implementation of the Better, Sooner, More Convenient Business Case approved by the Minister of Health in 2009.*

Providing Health and Disability Services – As an Owner of Services

As well as being responsible for planning and funding the health services that will be delivered in Canterbury, we also provide a significant share of those services as the '*owner*' of hospital and specialist services.

We provide these services through our Hospital and Specialist Services Division, which also manages our hospitals and many community-based facilities. While the majority of hospital and specialist services are provided from these hospitals, some specialist services are delivered from community bases or through outreach clinics in rural areas and in other DHBs. A significant proportion of our specialist mental health services are provided in community settings.

All Canterbury DHB owned and operated facilities are accredited under EQuIP4 (Evaluation and Quality Improvement Programme), which provides a framework for managing health services to ensure quality and safe care, with a significant focus on outcomes and evaluations. The Canterbury DHB has been awarded EQuIP4 accreditation status, and mandatory Ministry of Health certification, for a 3 year period to September 2012.

Our hospital and specialist services are managed as six service divisions: Medical and Surgical Services; Mental Health Services; Rural Health Services; Women's and Children's Services; Older Persons' Health and Rehabilitation Services; and Hospital Support and Laboratory Services.[3]

Promoting Community Health and Wellbeing

Good health also is determined by many factors and social determinants which sit outside of the traditional health system and the DHB's partnerships with other agencies and organisations are vital in creating and supporting social and physical environments that prevent illness and reduce the risk of ill health.

Our Community and Public Health Division provides guidance and support that helps to create healthier physical and social environments and supports collaborative ventures and initiatives that focus on keeping people well by reducing behavioural and environmental risk factors. This includes improving nutrition, increasing physical activity and reducing tobacco smoking and alcohol consumption with a focus on promoting health and wellbeing through urban design, sustainability, healthy housing and smokefree environments. Working collaboratively to provide 'safe' social and physical environments for our younger populations is a focus, as are strategies to reduce health inequalities with work prioritised in areas of high need such as education settings and Māori and Pacific communities.

Community and Public Health also lead collaboration on safeguarding water quality, biosecurity (protecting people from disease-carrying insects and other pests), the control of communicable diseases and emergency planning to ensure preparedness for a natural or biological emergency.

1.2 Our Regional Role

Because of our size, the Canterbury DHB provides an extensive range of higher level hospital and specialist services. While our responsibility is primarily for the population of Canterbury, we provide many of these higher level services to people referred from other DHBs where more specialised services are not available.

The services we provide on a regional basis include: brain injury rehabilitation; eating disorder services; child and youth inpatient mental health; forensic services; foetal medicine; gynaecological oncology; cervical cytology; paediatric neurology and respiratory services; diabetes services; paediatric surgery; neonatal transport and retrieval; haematology/oncology; cardiothoracic services; gastroenterology; respiratory medicine; neurosurgery; plastic surgery; and ophthalmology.

There are also some specialist services which Canterbury provides on a national or semi-national basis. These include: endocrinology; spinal services; paediatric oncology; and laboratory services. Canterbury is the specialist referral laboratory for all of the South Island and the lower half of the North Island, the national measles laboratory and the tertiary hub for Labnet.[4]

[3] *Refer to Appendix 4 for a more detailed overview of the services provided under each service division.*

[4] *Labnet is an alliance of public sector pathology laboratories who work together to benefit from common systems and economies of scale. It currently includes the Canterbury, Taranaki, Hawkes Bay and Nelson Marlborough DHBs.*

In addition to the hospital and specialist services we provided regionally, our Community and Public Health Division provides regional public and population health services on behalf of the Canterbury, West Coast and South Canterbury DHBs, covering the largest geographic area of any public health service in the country.

The significant regional role that Canterbury plays in terms of service delivery for the South Island was emphasised during the recent earthquakes, by the short-term pressure placed on almost every other DHB in the country. Canterbury's load was able to be supported during the immediate emergency period, initially by our neighbouring South Island DHBs and then by others around the country. However, this pressure would have been unsustainable, and a national risk, had Canterbury not been able to resume core service delivery in such a short time.

Collaboration with the West Coast

Canterbury has a particularly close and long-standing relationship with the West Coast DHB, and the two DHBs have established a formal arrangement to enable closer clinical collaboration and joint service provision. Formalising our partnership has enabled us to actively plan the assistance we provide, build a more appropriate workforce in both locations and improve patient safety, without having any detrimental affect on services provided to either of our populations.

As part of this arrangement, Canterbury and the West Coast share a joint Chief Executive and senior clinical and management expertise. A number of joint clinical and non-clinical appointments have been made over the past year including: Director of Allied Health, Paediatrician SMO, Clinical Director of Mental Health, Procurement Specialist, HR and payroll positions and service development management positions, as well as joint Board members. A number of secondments and training opportunities have also been realised, which will better support a more experienced and sustainable workforce in both regions.

This arrangement also allows the Canterbury and West Coast DHBs to share 'back office' services and tools, develop aligned patient pathways, joint clinical work streams and common data sets - reducing duplication and waste between the two DHBs, without increasing overall wage and salary costs.

SERVICES PROVIDED BY CANTERBURY IN 2009/10 FOR THE REST OF THE SOUTH ISLAND:

- Over 72,700 community laboratory tests, 23,800 of those for South Canterbury DHB;
- 288 maternity consults or clinics, 106 of those for mothers from the West Coast;
- Mental health services for more than 670 patients, 276 of those from Southern DHB;
- Over 26,000 outpatient services including first specialist assessments, dialysis and sleep apnoea services;
- Cancer radiotherapy services for 477 patients, 271 from Nelson-Marlborough DHB; and
- Over 3,700 personal health inpatient services including cardiology, neurosurgery, orthopaedics, respiratory, paediatric oncology, neonatal, haematology and ophthalmology services.

IDENTIFYING OUR CHALLENGES

Module 1

Health System Pressures - Drivers for Change

Analysing the demographics and health profile of our population gives us a baseline against which to measure the impact of what we do. It also helps to identify those areas where our population might be disadvantaged compared to the rest of New Zealand, or where one population group within our population may be experiencing poorer health outcomes than others. This information helps to guide the prioritisation and allocation of resources and effort and influence the choices that we make.

1.3 Canterbury's Population and Health Profile

The need to change the way we design and deliver services is starkly apparent in the future demographic projections for the Canterbury population. These demographics, particularly the age, ethnicity and economic status of our population, will have a number of very serious capacity implications on our health services if we do not alter our traditional approach to health service delivery.

CANTERBURY DHB DEMOGRAPHICS

Canterbury has the largest total population over 75 of all 20 DHBs.

By 2026, one fifth of the total Canterbury population will be over 65 years of age.

By 2026 our population aged over 85 will have doubled.

As we age we consume more health resources.

People aged over 85 utilise three times the health care resources of other age groups.

Demographics [5]

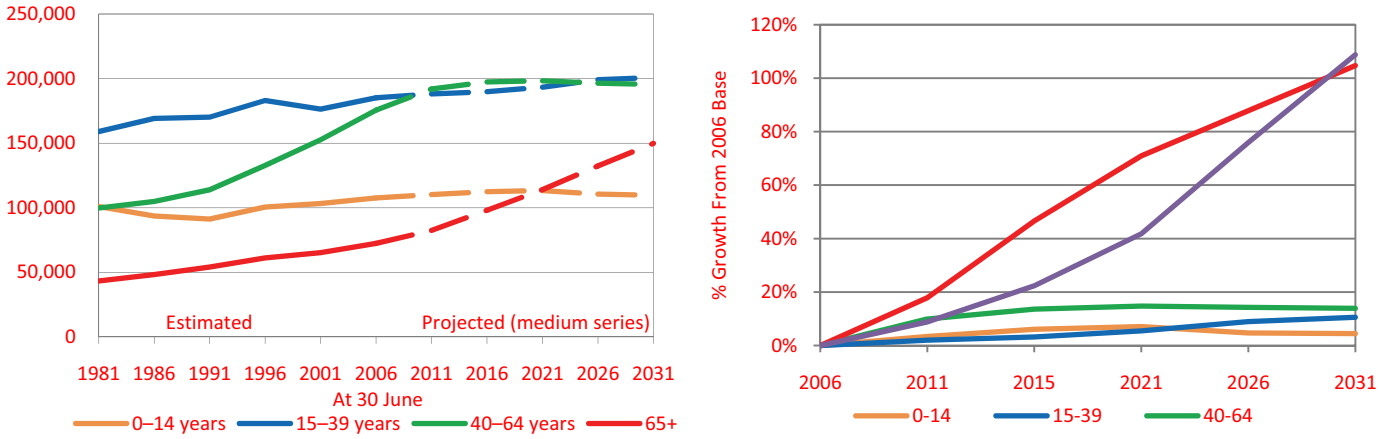
Canterbury is currently the second largest DHB in New Zealand by population, with a 10% growth in the total Canterbury population occurring between the 2001 and 2006 Census. Our population is projected to grow a further 16% by 2021.

Like the national population, our population is ageing and as we age, we develop more complicated health needs and co-morbidities (multiple health conditions), and therefore have a higher consumption of health resources than people in younger age groups. This is partly driven by growing trends of a number of long-term conditions that become more common with age, including: heart disease, stroke, cancers, respiratory disease and dementia. This is clearly evident in Canterbury, where the demand for services used by older population groups is growing at a faster rate than the growth in our population.

- Canterbury has the largest total population over 75 of all 20 DHBs. We will continue to have the largest population over 75 for the next 15 years which puts significant pressure on our workforce and on our financial and physical capacity.
- The proportion of our population aged over 65 is projected to increase to a fifth of our total population by 2026 - an 82% increase in the total number of people aged over 65 between 2006 and 2026, when 117,390 people in Canterbury will be 65 or older. The total number of people over 75 will increase from 31,460 to 55,270 by 2026, and the number over 85 will nearly double from 7,800 to 15,160.

[5] *Data in this section is based on 2001 Census and actual population projections from the 2006 Census information from Statistics NZ.*

Figure 1: CDHB population by age and rate of change: Statistics New Zealand medium projections



Like the age of our population, ethnicity is also a strong indicator of the need for health services. Māori are over-represented in terms of long-term conditions, which they develop at an earlier age, and have higher rates of preventable hospital admissions. Unless health inequalities are actively addressed, our increasing Māori population will require additional access to health services.

- Māori make up 7.2% of the total Canterbury population but have a more youthful population and a higher fertility rate, meaning that our Māori population is growing faster than that of the rest of our population.
- Together, children and young people (aged 0-24) make up over half (54.6%) of the Māori population in Canterbury. However, our older Māori population is also increasing, with the proportion of the total Māori population aged over 65 projected to more than double from 3.3% in 2006 to 8.6% by 2026.

Our Asian population is proportionally our fastest growing demographic, and projections suggest that by 2026 Canterbury's total Asian population will have almost doubled. We need to consider the needs of this population group in future planning.

Earthquake effects on our Population

It is going to be very important to monitor the movement of population and enrolment with primary care in Canterbury so that trends can be calculated for planning purposes. It will also be important to monitor deprivation levels to carefully consider long term effects of the earthquake on the health of our population. At this stage we do not have official figures with regards to population change in Canterbury and must rely on research and comparison with other natural disasters until over population resettles.

Recent research comparing the Christchurch situation with other natural disasters in developed countries and using school roles to track migration patterns suggests 'It is likely that gross out-migration is likely to be less than 2.5% after 12 months. The existing trend of increasing population and strong in-migration in Christchurch City is likely to offset that decrease, meaning that the impact of the earthquake on population may be a one-off shock, rather than a long term decline.'

'Speculatively, its seems likely that while some in-migration is likely to be displaced due to a drop in economic activity in some sectors, other immigration will be induced by new activity, particularly the construction sector'.[6]

In planned for the coming year we have assumed that any slight drop in over-all population numbers will be offset by a drop in deprivation levels and by a short term increase in demand for health services.

[6] *Tom Love; Population Movement After Natural Disasters: a literature review and assessment of Christchurch data, Sapere Research Group, Wellington, April 2011.*

Health Behaviours and Risk Factors [7]

Supporting our people to make healthier lifestyle choices and reduce risk behaviours presents an opportunity to significantly improve people's health and wellbeing and to reduce inequalities in health status and the demand for complex care.

Compared to the rest of the country, our population has lower obesity levels, eats more fruit and vegetables and are less likely to be regular smokers. Nonetheless, the negative health outcomes associated with poor health behaviours and risk factors, such as a sedentary lifestyle, poor nutrition, obesity, hazardous drinking and tobacco smoking represent a significant burden on the Canterbury health system.

Child and adolescent obesity in New Zealand has increased dramatically over recent years and is associated with long-term (chronic) conditions such as diabetes, asthma and sleep apnoea, as well as social discrimination, poor self esteem and depression.[8]

Hazardous drinking has a wide range of adverse effects on health, including cirrhosis of the liver, pancreatitis, high blood pressure, haemorrhagic stroke, and a range of cancers. It also contributes to death and injury on the roads, suicide, assaults and domestic violence and some mental health disorders. Hazardous alcohol consumption during pregnancy, can lead to birth defects in infants, including foetal alcohol syndrome.

HEALTH FACTS FOR CANTERBURY

- Canterbury has slightly lower obesity levels than the rest of the country, but nearly a quarter of our adult population (15+) are classified as obese (24.5%).
- More than 5,700 children in Canterbury were classified as obese in 2007/08.
- On average, our population is slightly more likely to drink in a hazardous manner (18.4%) than other New Zealanders (17.7%). This corresponds to around 89,000 people.
- 18.3% of our population regularly smoke, lower than the national average of 19.9%. However, one in four Canterbury teenagers (15-19) currently smoke and 90% of smokers have started smoking by the age of 18.
- Smoking rates amongst Māori are significantly higher than non-Māori. Māori women in Canterbury are almost two and a half times more likely to smoke.

Tobacco smoking remains the major risk factor for several of the major long-term conditions cancer, diabetes, cardiovascular disease and respiratory disease. Tobacco also disproportionately impacts on Māori and Pacific populations and is seen as a substantial contributor to socio-economically based inequalities in health.[9]

Social and economic factors, such as education, housing, and income, are also now widely accepted as contributing greatly to a person's health. These determinants form the environment within which our population's health can be improved, and they present a concern for Canterbury, as for many people these factors have been negatively impacted by the recent earthquakes.

Household overcrowding, for example, can lead to an increased risk of infectious illnesses such as rheumatic fever, meningococcal disease and ear, nose and throat infections. Prior to the earthquakes, 6.6% of our total population, and over 30% of our Pacific population were living in overcrowded households, compared to 11.4% of the population nationally (2006).

Health Status and Service Utilisation

When compared to national figures, the Canterbury population has significantly lower avoidable mortality (death) rates but similar leading causes of mortality - four of the top five leading causes are consistent.[10]

- Cardiovascular diseases of the circulatory system, including ischaemic heart disease and stroke, account for the majority of deaths in Canterbury (40%).
- Cancers are the second most common cause of death (28%), followed closely by diseases of the respiratory system, including Chronic Obstructive Pulmonary Disease (COPD).

[7] *Unless otherwise indicated data is sourced from Public Health Information Online, using 2006 data, www.phionline.moh.govt.nz.*

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

[9] *Age-standardised prevalence rates of current daily smokers 15+ years 2006/07 New Zealand Health Survey.*

[10] *NZ Health Information Service (2009) Mortality Demographic Data: NZ Health Information Service, Wellington NZ.*

- Diabetes is an underlying causative factor of many circulatory diseases, as well as being the seventh highest cause of death in Canterbury, and therefore contributes significantly to avoidable mortality in Canterbury.
- It is also important to note (when considering future planning) that the World Health Organisation predicts that depression will be the second highest cause of disability globally by 2020.

In terms of hospital admissions, many are considered 'avoidable', where earlier identification and treatment could have prevented the deterioration that resulted in the hospital admission, and are seen as opportunities for improving health outcomes for our population.

- The leading causes of avoidable hospitalisation in Canterbury are similar to the rest of New Zealand: respiratory infections, angina, dental conditions and ear, nose and throat infections.
- However, falls are a major cause of avoidable hospital admission in Canterbury, and our rate for falls amongst older people is significantly higher than the national rate. 1,744 in every 100,000 people aged 65+ are hospitalised as a result of a fall in Canterbury, compared to 1,588 per 100,000 nationally.
- There were 2,937 admissions to Canterbury hospitals for people aged 65+ as a result of a fall in 2009/10.

Long-term conditions, such as cardiovascular, cancer, respiratory disease and diabetes, are significantly affected by the age, ethnicity and deprivation of our population. Hospitalisations for CVD and cancers in Canterbury are very low before 45 years of age, after which they increase dramatically, reaching a peak in the over 65 age range. A similar pattern is observed for diseases of the respiratory system, although an additional peak is apparent in the 0-4 age range. Recently released national data indicates that Canterbury has a higher than expected registration rate for cancers but a lower than expected mortality rate. Further work will need to be undertaken to understand the meaning of these differences.

In consideration of our populations' demographic and health profile, we have identified a set of population and disease priorities for particular focus in an effort to support people to stay well and to reduce the burden of long-term conditions and the need for complex care and intervention. Our focus on these areas is evident throughout this document and in the goals and objectives we have identified for the coming year.

- ***Canterbury Population Priorities: Older Persons' Health; Child and Youth Health; and Māori Health.***
- ***Canterbury Disease Priorities: Mental Health; CVD; Diabetes; Respiratory Disease and Cancer.***

1.4 Our Operating Environment

Responding to the Inevitable

Like most health systems in the world faced with increasing demand for services, it became apparent in Canterbury that 'business as usual' was not a sustainable option. Analysis indicated that if we continued to deliver services in the same way, by 2020 Canterbury would need to double its workforce and physical capacity.

KEY APPROACHES TO SERVICE DESIGN

- Developing services that support people to take increased responsibility for their health.
- Developing primary and community services to support people in a community based setting and provide a point of ongoing continuity.
- Freeing up secondary and specialist resource to be responsive to episodic events, more complex cases and the provision of advice to primary care.

Responding to this challenge required an immediate focus on managing resources and capacity, while at the same time implementing a medium-term strategic response and a clear long-term vision. In the short term, we must maintain a vigilant focus on productivity, continuously improving systems and services and reducing waste and duplication to ensure that we are achieving the highest level of output possible. In the medium term, we are focused on the goal of reorienting the wider health system around the individual in their own home, supported by high quality primary care and easy (timely) access to the right specialist services.

In 2006/07 the Canterbury community had long waiting times for elective procedures, and primary care had little access to diagnostics and to specialist advice. Elective performance was poor, with less than 30% of the

required additional electives target actually being delivered, and performance on measures such as average length of stay and day of surgery admissions was low. Christchurch Hospital was frequently in gridlock.

However, these weaknesses were combined with important strengths, including strong performance in our emergency departments and acute care, a strong primary care infrastructure and a traditionally strong focus on public health – including screening and immunisation.

In a period of three years, we have worked collectively to make step changes in productivity and to transform the way we design, deliver and fund health services in Canterbury. We have achieved this by implementing a programme of rapid clinically led change across the whole of the health system, ensuring health services in both community and hospital settings work together in the best interests of the person, the population and the system overall.

The central philosophy is a 'whole of system' approach to making the system work properly – providing the right care and support, to the right person, at the right time and in the right place.

Engagement of the whole of Canterbury's health workforce has been critical to our success in developing and implementing innovative solutions to cope with increasing demand. Our new way of working is embedded in participatory training programmes including *'XcelR8'* and *'Particip8'* and the adoption of alliance frameworks which empower health professionals to improve the effectiveness and efficiency of the system.

The result of our transformation has been a higher level of performance, measured in both health outcomes and productivity gains, and a better positioning of the Canterbury health system to achieve longer-term sustainability – improving access to services, reducing waiting times and enabling us to do more (and see more people) with our current resources.

Demonstrating High Performance

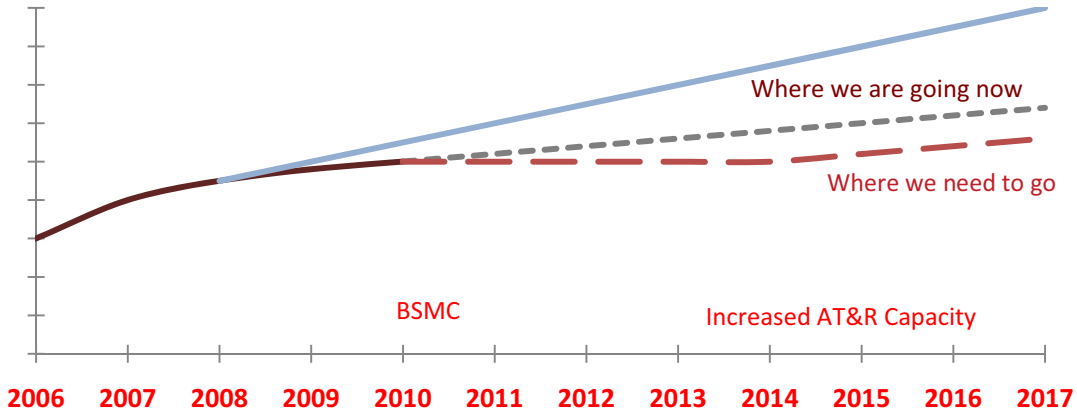
Canterbury's performance in acute services has been particularly strong in the context of national trends in acute care. Growth in acute admissions is a major source of pressures on hospital resources. If a health system is to be sustainable, acute growth needs to be better managed. An inability to constrain growth in acute medical admissions will lead to overall health system failure.

In spite of the high level of age-related demand in Canterbury, we now have the lowest age-standardised rate of acute medical admissions of any large DHB in the country. Canterbury has delivered a 13% reduction in the growth rate of acute medical admissions over the last 10 years, outperforming all other DHBs.

If Canterbury's rate had been as high as the national acute medical admission rate, we would have had to cope with an additional 11,883 acute medical admissions into our hospitals in 2009/10. The rate of acute medical discharges in 2009/10 is actually lower, compared to national rates, than in 2006/07 – a significant achievement for the DHB with the largest population aged over 75 in the country.

Our acute medical discharges also dropped further from national rates than case weights, indicating that the average complexity of acute discharges is increasing. This is consistent with our strategic direction: shifting less serious acute care into community settings and freeing up hospitals for those cases with the highest level of complex need.

Figure 2: Canterbury's Acute Medical Discharge Trajectory



This performance reflects the strengths of our 'whole of system' philosophy, with collective approaches being taken in our emergency departments and acute community services, as well as a specific focus on acute demand management programmes in primary care.

As a consequence of Canterbury's strong primary care sector and longstanding focus on acute demand management, we have been able to provide comprehensive packages of care and new acute demand management services that support patients in the community - without the need for hospital appointments.

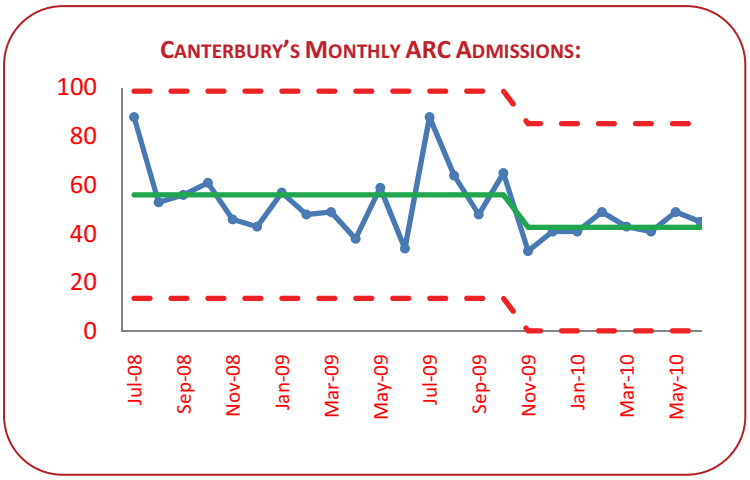
The strength of general practice in Canterbury provides a strong foundation for further service development in long-term conditions management and increased integration with hospital services. The Canterbury Clinical Network (CCN) is an alliance-based group which drives the implementation of Canterbury's *Better, Sooner, More Convenient* Business Case and builds on the gains that have already been made in primary care and the linkages between community and hospital based health services. The Business Case is in its second year of implementation and is closely aligned with the strategic direction of the DHB – seeking to improve the quality and effectiveness of services and improve the use of resources across the whole of the Canterbury health system.

An important part of our approach for better use of resources was improvement of the pathways between primary and secondary services, with a particular focus on referral mechanisms, access to diagnostics and improved discharge processes. The clinically led development of patient pathways through our '*Canterbury Initiative*' has improved the quality of referrals, driven an increased conversion rate from specialist assessment to surgery and reduced 'did not attend' rates. 300 patient pathways now exist between Canterbury's primary and secondary services, and over 10,000 procedures that would previously have required a hospital appointment have been delivered in the community, closer to patients' own homes.

Canterbury has also seen a marked improvement in hospital performance; in 2009/10 we delivered against our elective health targets, while reducing the relative rate of acute workload. This indicates a shift of resources from acute work to elective procedures and a consequential increase in the productive use of health resources for the people of Canterbury.

Gridlock was historically a major operational problem in Christchurch Hospital facilities. However, with improved patient flow and production planning, we are making better use of our existing capacity, and Christchurch Hospital has reduced 'hours in gridlock' by 95% since 2006/07. Our clinically led '*Improving the Patient Journey*' programme has been an important enabler of increased productivity overall, achieving higher throughput and extracting the greatest value from existing capacity.

With an ageing population, increasing demand for services provided to the elderly, especially aged residential care and home based support services, can have a major impact on the long-term sustainability of the health system. Early entry into Aged Residential Care (ARC) is a substantial driver of costs across Canterbury and the wider health system. Canterbury has introduced initiatives to improve the assessment of health needs for the elderly and has developed new, restorative approaches to home based support services.



Early results show that the trend of increased admissions to ARC has fallen, and the decrease in rest home admissions is accelerating – suggesting a change to historical demand patterns. Managing demand for ARC is an important factor in the longer-term sustainability of Canterbury health services.

Challenges still exist. Demand is still increasing. However, the gains and transformation we have been able to effect in Canterbury have put us in a strong position to take on these challenges. We have a better understanding of the drivers of demand in our system, we have an engaged workforce and strong clinical leadership, and we have tangible evidence that real change is possible.

Workforce Pressures

Our ability to continue to transform our health system relies heavily on having the right people, with the right skills, in the right place. As a greater proportion of our population reaches traditional retirement age, concerns arise over the availability of sufficient workforce to meet predicted increases in demand. Changing workforce patterns and the expectations of younger staff also put pressure on traditional working models.

Canterbury has placed emphasise on the urgency of transforming the way we work. We have focused on engaging our workforce in the development of alternative and improved models of care to ensure we can continue to provide quality services and meet the needs of our population in the future.

CANTERBURY'S WORKFORCE:

- 9,000 CDHB employees.
- 16,000 people employed across the wider Canterbury health system.
- 12.9% of our workforce is over 60, compared to 9.7% three years ago.
- The average age of our workforce is 46, slightly higher than the all-DHB average of 44.9 years. The average age in rural areas is significantly higher, at 51.3.
- 42% of our workforce is employed on a permanent part-time basis.

Integrated patient pathways and models of care have increased working partnerships between community, primary and secondary health professionals – improving continuity of care for patients and improving workforce satisfaction as empowered health professionals take a lead in improving service models, reducing duplication and increasing direct patient care time.

Clinically led *'Making Time for Caring'* strategies have increased direct patient care time on hospital wards, improving both patient outcomes and workforce satisfaction.

The introduction of telemedicine, outreach clinics and joint DHB appointments has allowed specialists to provide services and supervision to rural areas and to health professionals in other DHBs without a significant increase in workforce numbers, and has improved service quality and workforce satisfaction.

With the introduction of dedicated education units, we have been able to increase the number of clinical placements for nursing students available across our hospitals and enabled the Christchurch Institute of Technology to expand its Bachelor of Nursing intake to over 200 nurses. Our training programmes are well recognised - we employ 110 new graduate nurses every year into our hospital and specialist services, and our pass rates for medical registrars (FRACP Part II written exam) is consistently above national averages (in 2011 it was 100% - the best in New Zealand and Australasia).

Our focus on engaging and empowering our workforce is further evident in turnover rates, which in Canterbury are relatively low: the average time spent working in Canterbury DHB services is 9 years, compared to an average of less than 8 years across all DHBs.

Fiscal Pressures

Sitting alongside increasing demand for services and workforce challenges, the health sector also faces fiscal pressures. Government has given clear signals that we need to rethink how we deliver improved health outcomes in more cost-effective ways, and Canterbury has taken up this challenge.

EVERY DAY THE CANTERBURY DHB SPENDS:

- $1,447,332 on CDHB employee wages;
- $346,055 on Aged Residential Care (ARC);
- $79,203 on home based support services;
- $66,176 on laboratory testing; and
- $359,453 on pharmaceuticals.

Numerous factors contribute to fiscal pressures: the costs of meeting wage and salary increases; the demand for diagnostics and residential care; rising prices and treatment-related costs such as pharmaceuticals and clinical supplies; and increased expectations from the Ministry of Health, our clinical workforce and our community, particularly around the availability of new and more technologically advanced (but more expensive) treatments.

We have implemented a number of mechanisms and strategies to minimise cost growth, reduce waste and duplication and achieve long-term financial sustainability. These include 'lean thinking' processes, clinically led service transformation and regional collaboration. However, it is the partnerships and alliances that we have

established over the past two years that have made the real difference in enabling us to avoid unnecessary costs, ensure value for our investment and live within budget.

Canterbury's approach to redesigning service models, and closing the gap between capacity and the needs of our population, has engaged health professionals from across the system in prioritisation and service management. By shifting decision-making into the hands of those on the front line of service delivery, we have improved health outcomes while introducing technical efficiencies that eliminate waste and duplication and reduce cost pressures.

Over the past three years we have improved access to services, reduce waiting times and met and exceeding national targets. It is all the more impressive that these improvements have been achieved at the same time as we reduced our significant deficit from over $16M to a predicted breakeven position prior to the September earthquake.

CANTERBURY FINANCIAL RECOVERY

Fiscal pressures will always be a challenge, but there are still opportunities to add value to the activities that we undertake and to direct funding into services that will provide us with the greatest return in terms of improved health outcomes for our population.

1.5 Immediate Issues - Earthquake Recovery

Canterbury was in a strong position leading into the September earthquake: on track to break even as planned, and in a good position to deliver better, sooner, more convenient healthcare to our population.

Physical capacity in our hospitals was becoming increasingly constrained, but plans were under development to further reduce the growth in acute admissions and average length of stay with the implementation of increased community based services. The work to reduce aged residential care admission rates had created enough spare bed capacity to enable relocation of people within Christchurch from damaged facilities after the September earthquake.

However, February 22nd dealt a major blow to the Canterbury health system.

Like homes, businesses and public infrastructure, health services sustained significant damage. This damage not only affected almost all Canterbury DHB owned and operated facilities (particularly the Christchurch Hospital site and our community mental health sector base near the inner city), but also health service infrastructure across the whole of Canterbury including: aged residential care facilities, pharmacies, laboratories, private medical practices and private hospitals and the premises of community-based health providers.

The February earthquake also displaced many patients from their homes and communities, and consequently from their health providers and health records. Many people have temporarily relocated either out of Christchurch city or into rental properties, temporary villages or the homes of friends and relatives. 500 older people were relocated out of damaged aged residential care facilities and moved to safe locations around the country (in Canterbury or to other DHBs).

We know the colder months can be challenging at the best of times, and for many people this winter will be much tougher and more testing. Unemployment numbers are predicted to rise, housing is temporary or crowded (with people taking in friends and family) and transport links and social infrastructure such as community centres, schools, pharmacies and general practices have been damaged.

EARTHQUAKE DAMAGE

Capacity limitations in available beds for hospital and ARC admission will severely test the ability of the system to meet winter demands.

Christchurch Hospital will have to operate with 35 fewer beds for the next year, and Christchurch's ARC bed capacity has been reduced by 635 beds (14%).

Over 7,500 treatment rooms, wards and office spaces across our facilities were damaged by the September earthquake, with further infrastructure and facilities damage occurring in February and June.

While our response to the earthquakes proved that we can function as a highly effective, integrated system, the ongoing impact of the earthquakes (and aftershocks) is placing extraordinary pressure on our resources. We have lost significant capacity across the whole of Canterbury, and the predicted surge in health need over the next 12 months will place additional stress on a system that is now more fragile and has less resilience. There are real and immediate concerns about the predicted increase in the level of demand and our reduced capacity.

The major deficit in sound housing, and the means to heat it, will lead to an accentuated increase in winter illness and acute admissions. People under stress will be more susceptible to falling ill, and overcrowding of homes, schools and office spaces will allow flu viruses to spread more quickly. As the stress of changed circumstances taxes our populations' normal resilience, an increase in demand for mental health services is anticipated, particularly at primary and community levels.

Loss of personal income and interruption of transport links will reduce people's access to their usual health providers - interrupting the continuity of care, exacerbating chronic illness and potentially increasing admissions to hospital and demand for ARC. Over 700 of our own staff have been displaced and over 6% of homes across Canterbury (8,187 homes) are not being lived in. Displacement of people from their normal homes is higher amongst the more deprived populations. This creates a challenge for general practice to maintain connection and return to routine delivery of services such as immunisation, diabetes reviews and cardiovascular risk assessments.

Canterbury's health workforce has shown a real willingness to work in difficult conditions, but the constraints are impacting on sick leave, staff retention and overall efficiency as services are split apart. Many community agencies and health providers are working out of temporary premises with reduced resources. Although people are tackling the challenge willingly, uncertainty about the future and the stress of aftershocks is taking an inexorable toll. This is one of the most significant risks on future sustainability of our health services.

Canterbury's Earthquake Recovery Plan

We have completed a comprehensive Health System Recovery Plan, consisting of over 200 projects and initiatives designed to restore capacity and improve service delivery across Canterbury. This is a working document that will guide our activities over the months and years ahead.

Many clinical teams from throughout our health system have had input into this plan and bringing ideas together, and while some initiatives are new, others represent an acceleration of previously planned activity.

All the recovery initiatives have a common theme: providing treatment and care either in or as close as possible to people's own homes. This philosophy isn't new and was already an underlying foundation of our Vision 2020 philosophy and the Canterbury Clinical Network's Business Case.

EARTHQUAKE RECOVERY

Our critical focus is for people to stay safe and well through winter, particularly those who are already vulnerable, such as the elderly or infirm, young children and the socioeconomically disadvantaged.

There is an urgent need to accelerate our move towards a more effective, efficient and integrated health system - focused on the patient and their family and based, wherever possible, in the community.

The Recovery Plan is grouped into three categorises: Recover, Transition and Future, and over the next year the plan will evolve as new initiatives are identified and current ones implemented. Many of the initiatives are already up and running - either delivering services or increasing capacity in the system.

- Three medical wards have opened at The Princess Margaret Hospital to replace some of the 109 in patient beds that can no longer be used at Christchurch Hospital due to difficulty evacuating immobile patients from Riverside Block (levels 4 & 5).
- A 23 hour ward has been established at Christchurch Hospital as a short-stay ward to accommodate patients post-surgery - to speed the discharge process and reduce bed requirements in surgical services.
- A Vulnerable People's Team was established to support vulnerable people and relocate residents of damaged aged residential care facilities in the first weeks after the earthquake. They continue to work tirelessly and are now focused on the return of older Canterbury residents as beds become available.
- Canterbury's Acute Demand Management Services has been extended to enable general practice teams to take preventative action with their more vulnerable patients. Utilisation of the service has increased by more than 20%, from 14,000 urgent episodes per annum, to more than 18,000 on an annualised basis. This

equates to more than three wards of inpatient activity, even assuming a shorter than average length of stay for these patients if they had been admitted – a significant increase in system capacity.

- Theatre capacity is now a key constraint and alternative strategies are being developed including extended sessions and various forms of outsourcing for capacity. Theatre utilisation has been re-planned to absorb displaced activity (due to damaged facilities).
- A Community Rehabilitation Enablement and Support Team (CREST) is up and running to support patients into appropriate home-based rehabilitation services after discharge from hospital. They've already supported more than 125 people since the service started, and by the end of June they will be in a position to take direct referrals from general practice, thereby avoiding hospital admission. It is anticipated that over 1,500 people will go through the service over the coming year.
- Free flu vaccinations are being provided to anyone under 18 this winter. The vaccine is also free to those aged over 65, pregnant women and people with chronic health conditions such as diabetes and asthma. 17,000 people under 18 had already received a free vaccination.
- Access pathways for entry into mental health services (including alcohol and other drug, residential and community support services) have been streamlined, removing the requirement for a separate needs assessment process to determine eligibility. Access now occurs via direct negotiation between community and hospital providers, reducing duplication and wait time for consumers, and providing a system-wide view of capacity and demand. This has been so successful that a new model of care is being developed to support these processes in the long term.

A number of these Recovery Plan initiatives are highlighted through this document in terms of the actions and services to be delivered in the coming year. The Canterbury health system's recent history of working together to make change and improve population outcomes has set us in good stead for the challenges to come.

While the earthquakes have significantly heightened our challenges, they have not changed them. Canterbury was already on a solutions-oriented trajectory to cope with increasing demand and stretched capacity. We have simply reached crisis point much sooner than expected and must accelerate our response and work harder to achieve the vision and the outcomes our community deserves.

1.6 Key Challenges and Critical Success Factors

The following areas represent the four major factors that are critical to our success, where failure would significantly threaten the achievement of the strategies, goals and priorities outlined in this plan.

- Managing Demand. It is critical that we manage the ever-increasing demand for services. If demand continues to grow at projected rates, we will not have sufficient physical and workforce capacity to maintain service delivery, even at current levels. Projected demand for acute services will 'crowd out' non-urgent services, waitlists will grow and the quality of service delivery will be adversely affected.

  We need to constrain the growth in ED attendances and acute medical admissions, against a backdrop of a rapidly ageing population. We already have a low base of both (well below national averages) however, we need to improve our current performance and address the challenge of further reducing the barriers to accessing urgent general practice care.

  We also need to accelerate the implementation of strategies for reducing acute hospital admissions and length of stay for our population over the age of 75, or we will run out of bed capacity and increase the flow of people into aged residential care.

- Constraining Cost Growth. It is critical that we constrain the cost of delivering services. If an increasing share of our funding continues to be directed into meeting cost growth, our ability to invest in new equipment, technology and initiatives that allow us to meet future demand will be severely restricted.

  We will continue to focus on initiatives, which have contributed to our past successes: reducing variation, duplication and waste; doing the basis well; developing our workforce capacity; and supporting united systems with a strong focus on primary and community-based service delivery, consolidating back-office functions and joint appointments.

We need to continue to strengthen investment in clinical leadership. By enabling clinical input and leadership in operational processes and decision-making, we can make robust and clinically acceptable efficiencies across the whole system. Clinical leaders and providers in the front line of health care are in the best position to decide how services should be delivered in order to improve quality and technical efficiency, and it is only with their support that change will be long-lasting.

- Rebalancing the System. It is critical that we continue to reorient our health system to make the most effective use of available resources, build capacity and integrate patient pathways across the system. If traditional barriers remain, they will restrict our ability to introduce more effective service delivery models.

  Canterbury has created a permissive environment which allows innovators to move forward quickly and inspire others to make similar change. To continue this momentum, we need to change the way we fund, contract and monitor services and make a step change in our approach to infrastructure to allow further integration of activity and information, including shared patient records and management systems.

  We also need to realign service expenditure. Only by applying new funding at a proportionally greater rate to primary and community services (including district nursing and home based support services) can we support the continued shift of activity to the community, which will enable us to better manage demand growth and achieve further productivity gains from integrating services.

- Releasing Workforce Capacity. It is critical that we continue to unlock the potential of our workforce by redesigning service models and engaging health professionals in the vision and change needed to meet the future demands of our population.

  Canterbury has already adopted clinical governance and leadership models that drive technical efficiencies, reduce duplication and release clinical staff to provide more direct patient care. We will continue to invest in similar programmes that improve workforce satisfaction and increase capacity, including investment in technology that supports new ways of working (e.g. telemedicine), professional education and development programmes and good employer practices that support staff retention.

  As we move forward in a more constrained environment, a secondary associated risk is that our workforce and health professionals from across the system will become disengaged from leading and supporting the changes required to ensure longer-term sustainability. We need to continue to emphasise clinical/management partnerships, clinical leadership and ongoing engagement in the future vision through participatory programmes and alliance frameworks.

Our direction is predicated on reasonable assumptions and planning. However, it is important to emphasise that there is no basis upon which to predict activity and demand for health services after earthquakes such as Canterbury has experienced, and no comparable situation to draw upon.

We will implement our Recovery Plan to tackle immediate demand issues and restore capacity across our health system. We will work closely with primary and community providers, CERA and other agencies and organisations to accelerate initiatives to keep people well and healthy in their own homes. We will also closely monitor access and utilisation trends across the whole of the Canterbury health system to identify where in the system support is required to meet patient need, gauge how the system is functioning as a whole and encourage a 'whole of system' perspective to managing our recovery.

Ultimately however, we are dealing with a large element of the unknown over the next 12 months, and this plan should be read with that in mind. We can plan, based on some key assumptions, but in essence we have to be prepared to respond quickly and flexibly to changing circumstances and challenges.

STRATEGIC DIRECTION

Module 2

What will a Sustainable Health System Look Like?

Increasing demand for services, international clinical workforce shortages and rising costs mean that the whole of the health system faces an unsustainable future. In response to these challenges, significant changes are being made to the way in which health services are designed and delivered.

These changes are being driven at all levels through the New Zealand health system, in line with the wider strategic context for health outlined in the New Zealand Health Strategy, the New Zealand Disability Strategy and the New Zealand Māori Health Strategy (He Korowai Oranga).[11]

These national strategies, combined with the Minister of Health's annual letter of expectations and the New Zealand Public Health and Disability Act, provide the guidance for policy and planning at national, regional and local levels. The New Zealand Health Strategy in particular outlines objectives for the health of the New Zealand population and focuses on the role of DHBs in tackling inequalities in health (refer to Appendix 2).

2.1 National Direction - 'better, sooner, more convenient' health care

Alongside these overarching national health strategies, the National Health Board has recently released the strategic directional document '*Trends in Service Design and New Models of Care: A Review*'.[12] This document provides a high-level summary of emerging worldwide trends and international responses to the pressures and challenges facing the health sector, which will help guide DHBs.

These trends emphasise shifts in service delivery across the health system, based on the premise that an aligned, system-wide approach, focused on the patient rather than the disease, is required to ensure equitable and inclusive health service delivery and to meet increasing demand within a constrained environment.

This re-orientation is consistent with the expectations of Government, particularly the commitment to *'better, sooner, more convenient'* healthcare for all New Zealanders and the provision of services closer to people's own homes. There is a clear focus on greater regional collaboration between DHBs.

Hospitals are recognised as a key support and a setting for highly specialised care, with the importance of timely and accessible complex care being paramount. However, more of the less-complex services (traditionally provided in hospital settings) will be provided in the community. Supported by clinical networks and multidisciplinary teams, the focus will shift to enhancing people's ability to manage their own health and to stay well - reducing long waiting times and the current unsustainable growth in demand for hospital and specialist services.

FOUR MAJOR NATIONAL SHIFTS

- Targeted prevention, self management and home based services.
- Integrated family health centres, partnerships and networks.
- Hospital clusters with regional service provision.
- Managed specialisation and consolidation into a smaller number of centres/hubs.

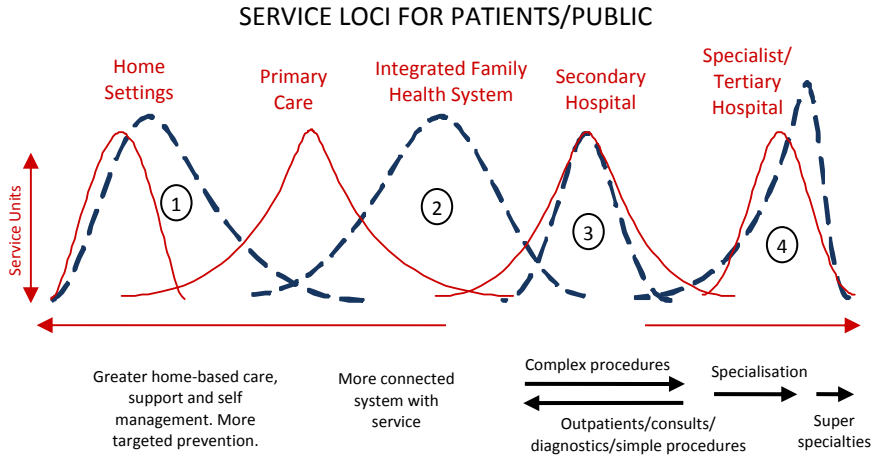
The following diagram (Figure 3) is adapted from the national document and describes a 'whole of system' shift in the way health services are delivered – with the solid line representing current service configuration and the

[11] *These national strategies are available on the Ministry of Health website, www.moh.govt.nz.*

[12] *Trends in Service Design and New Models of Care: A Review, 2010, Ministry of Health, www.nationalhealthboard.govt.nz.*

dotted line representing future service configuration. These follow a general theme of '*localise where possible, centralise where necessary*' and present four major service shifts within the health system.

Figure 3 - Pictorial representation of shifts in service trends



These national policy shifts are already reflected in Canterbury's improved primary care access to diagnostics, development of integrated patient pathways and provision of procedures such as skin lesion removals in general practice - without the need for a hospital appointment. These changes support people to get the care they need more quickly, from the most appropriate provider.

The development of Integrated Family Health Centres and Networks (IFHCs) and more collaborative partnerships between health professionals (e.g. general practitioners, pharmacists, nurses, dieticians and physiotherapists) will further support enhanced primary and community services and allow hospital and specialist services to focus on meeting the increasing demand for more intensive treatment and complex care.

Increased Collaboration

The national direction also includes accelerated collaboration between DHBs to reduce duplication and waste, maximise clinical and financial resources and ensure the ongoing sustainability of health services. This includes clear expectations that alongside the blurring of traditional primary and secondary roles, the role of hospitals and the provision of specialised (tertiary) services will be critically reviewed and consolidated across regions.

The National Health Board has identified five 'vulnerable' services that will become national services in the next year: Clinical Genetics, Paediatric Pathology, Paediatric Metabolic Services, Paediatric Cardiology and Paediatric Cardiac Surgery. These services will be planned and funded centrally instead of by individual DHBs. They were chosen because issues around their small size, specialist retention or critical mass make them vulnerable if they are not managed in a coordinated way across the country.

A second set of services have been identified for national service improvement: Cardiac Surgery, Paediatric Oncology, Paediatric Gastroenterology, Neurosurgery and Major Trauma. National service improvement programmes and associated clinical networks will be established in each of these service areas, but services will still be funded and provided by individual DHBs.

A Long Term Health Sector Plan is currently being drafted by the National Health Board (expected in June 2011). This Plan will provide high-level direction for public health services over the next 20 years. Focusing on service planning and new models of care the Plan will describe the challenges the sector faces and models of care that offer solutions and implications for the way service are configured in the future.

The finalised Plan will guide decisions about service configuration and investment at all levels of the system and support DHBs in their long-term local and regional planning. The National Health Board will use the Plan to inform their review of DHB's regional and local plans.

2.2 Regional Direction - equity, quality, sustainability, engagement

All five South Island DHBs face similar pressures to ensure the future sustainability of health services, achieve the priorities of Government and continue to deliver high quality, responsive health services.

Like Canterbury, other South Island DHBs are changing the way they work within their local districts to alleviate these pressures. However, as individual DHBs we cannot make a large enough impact to ensure the future sustainability of services, particularly more highly specialised and complex services.

With a relatively small total South Island population and limited health resources, we must be more focused on how we respond regionally to deliver the best outcomes for our populations. Implementing diverse but similar individual responses to our collective challenges duplicates effort and investment and leads to further service inequality between DHBs.

The South Island DHBs are committed to delivering national expectations and accelerating regional collaboration. We have collectively agreed a regional direction and key principles that will inform regional service development, service configuration and infrastructure requirements over the next several years. Our regional direction aligns with national policy and international trends, and has been articulated in the South Island's Regional Health Services Plan.[13]

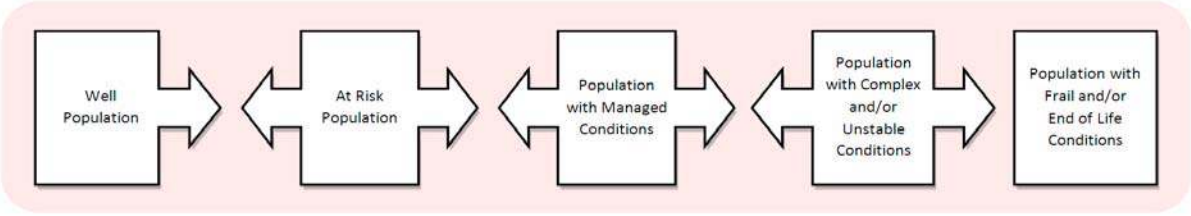
Our collective vision is a clinically and fiscally sustainable South Island health system - focused on keeping people well and providing equitable and timely access to safe, effective and high quality health and disability services, as close to people's homes as possible.

The regional direction is based around the following concepts:

- More health care will be provided at home and in the community;
- Secondary and tertiary services will be provided across DHB boundaries;
- Flexible models of care and new technologies will support service delivery in different environments from those traditionally recognised;
- Health professionals will work differently to coordinate patient care and ensure a smooth transition for patients between appropriate levels of care and providers;
- Clinical networks and partnerships between clinicians and management will support the delivery of quality health services across the health continuum.

These concepts align to our South Island generic model of care, which ensures a consistent approach to understanding the full range of health needs a person may have over their lifetime. The model (illustrated below in Figure 3) is based on similar national and international models and focuses health planning on the patient's need and the provision of the right service (or treatment), at the right time and in the most appropriate place - at each stage of the continuum of care from 'wellness' to 'end of life'.

Figure 4 - Generic (patient-centred) Continuum of Care



This way of working prompts the development of integrated patient pathways across the system and supports service redesign and improvements to the patient journey by questioning the gaps and blockages. In this sense, the model supports quality clinical outcomes by identifying with the needs of the patient. It also encompasses a Whānau Ora approach by taking a holistic view of the person (or population) and the determinants of health that influence people's wellbeing.

[13] *South Island Regional Health Services Plan 2010, South Island Shared Services Agency Limited.*

Supported by analysis of populations, this approach will facilitate discussion around the most appropriate service and facility configurations across the South Island and challenge the current boundaries between providers to focus on the patient. In doing this, we will improve patient flow by introducing more flexible workforce models, better sharing patient information and connecting formerly disparate services across service levels and DHB regions.

An Alliance Approach

Regional service planning in the South Island is implemented through active work streams based around priority service areas. These areas have been identified nationally, regionally or locally as clinically 'vulnerable', in high demand, or key enablers to support change.

Six service areas have been prioritised: Cancer; Child Health; Health of Older People; Mental Health; Procurement; and Information Technology.

In order to better support regional planning and delivery, the South Island DHBs have adopted a modified Alliance Framework. An Alliance Framework was chosen because it enables the rapid implementation of complex and evolving service models, without disrupting current organisational structures. More importantly, an alliance takes relationship contracting to a higher level, where the participants remove barriers to getting the right thing done by eliminating misalignment of organisational interests for the good of the system.

THE MODEL TRIGGERS A SERIES OF QUESTIONS:

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

What do we need to do to ensure early detection and early intervention?

What do we need to do to support people to self-manage in a community setting, avoid unnecessary hospital admissions and slow the progression or deterioration of their condition?

What do we need to do to ensure that when people require complex interventions, hospital care, specialist advice or diagnostics that they are available at the right time and to a high quality standard?

What do we need to do to provide appropriate and restorative support services so that people can regain their functional independence after injury or illness and avoid further complications?

What do we need to do to support and respect people dying with dignity and to meet their needs?

The South Island Chief Executives have formed an Alliance Leadership Team to take responsibility for coordination of regional health service planning under an Alliance Governance Board consisting of the Chairs of the five South Island DHBs. The South Island Alliance Charter, implementation framework and concept of good faith are outlined in the South Island Health Services Plan.

Formal service level alliances will be formed and resourced for each of the priority service areas to support the South Island to respond to immediate challenges and pressures in the coming year. Under Lead Chief Executives and a South Island Alliance Management Team, each service level alliance will be responsible for establishing its long-term strategic objectives and plan of action.[14] Appendix 7 outlines the 2011/12 action plans for each service areas.

One of the South Island's major strengths is in the collegial relationships that exist between clinical teams and support the development of sub-regional and regional quality improvement strategies, patient pathways and service models. Each service level alliance will be clinically led and have active clinical input, with multidisciplinary representation from primary care as well as from hospital and specialist services.

2.3 Local Direction - Bringing it all together

The 'continuum of care' approach is not new in Canterbury. For the last three years we have been transforming the way we design, deliver and fund health services - reorienting the Canterbury health system around the needs of the individual and removing traditional boundaries and barriers to improve outcomes for our population. In this sense, while '*we plan for a population, we deliver for an individual*'.

[14] *The existing Southern Cancer Network is captured under the Alliance Framework as a principle work stream, and some of its processes will be adjusted over time to broaden clinical input and ensure an integrated approach to health service delivery.*

Developing the Vision

In 2007 we initiated a process of working with over 1,000 stakeholders, providers, consumers and health professionals from across the system to address the challenges the Canterbury health system faced with increasing demand and an ageing population. We knew that if we didn't actively transform services, by 2020 - just to stand still - we would need: 2,000 more aged residential care beds; 20% more GPs; and another Christchurch Hospital.

We began to enhance integration and reorient ourselves around the needs of our patients rather than our needs as providers. In undertaking our transformation, we agreed it is not just about hospitals, but about a responsive and sustainable system where providers work collaboratively to wrap care around the individual. With strong clinical leadership, we developed innovative models of care, reconfigured traditional service delivery models and redesigned patient pathways.

Our Vision is a holistic system with a seamless flow of care, rather than a series of individual events - a system that provides the right care and support, to the right person, at the right time, in the right place.

Figure 5: Canterbury - One Health System (adapted from The King's Fund UK: www.kingsfund.org.uk)

The challenges in Canterbury are the same as those faced by other DHBs: increasing demand for services, workforce pressures and funding constraints. The element which is different is the scale on which such effects take place. The Canterbury population exceeds half a million people across a very large geographic region.

Already we have made a significant change in the type and location of services being provided in Canterbury, and we are seeing real improvement in the health environment and in health outcomes. Clinically led programmes such as '*Improving the Patient Journey*', the '*Canterbury Initiative*' and the CCN Business Case are making our vision a reality.

- By investing in peer support, health promotion, self management and rehabilitation programmes, we are supporting people to take more responsibility for their own health;
- By enhancing general practice access to diagnostics, simplifying the transfer of care between settings and providing access to specialist advice without the need for a hospital appointment, services traditionally provided in hospitals are now being provided in the community; and
- By supporting the provision of less complex services in community settings, we are freeing up our secondary care capacity to cope with growing and increasingly complex demand.

Strong cross-sector leadership has enabled Canterbury to improve access to services, reduce delays and waiting times, make better use of our valuable health workforce and remove duplication, variation and waste from our system. The most recent evidence of the success of our transformation is the resilience with which we have coped with the recent seismic events in Canterbury, resuming many core health services within days of the February earthquake.

New Horizons – Recovery, Transition, Future

However, challenges still exist. The challenges we face are not short-term pressures to which there is a 'quick fix' solution. While we were in a strong position prior to the earthquakes, they have dealt a major blow to health system infrastructure. The February earthquake in particular has reduced our capacity, dislocated our population and left us with a sense of uncertainty as we move into the new year.

To achieve our vision and regain the capacity lost in February, we need to be brave, maximise the new opportunities that exist and take the next steps in our transformation. The Canterbury population deserves a resilient, responsive and sustainable health system.

Opportunities still lie in breaking down the boundaries that we have been eroding over the past several years. These boundaries are created by traditional organisational structures, funding and contracting mechanisms, and traditional views of the roles of health professionals and of the DHB. Changes need to extend all the way through the system. No individual provider or group of providers can do this alone; every part of the system needs to be working in harmony.

We are still focused on making the system work and achieving the best long-term outcomes for our population. By improving the design and quality of the care we provide, we will be able to do more (and see more people) with the resources available and free up capacity in the system to meet future demand.

We will continue to realise our vision through greater clinical leadership, tailored local solutions and the shifting of activities to the right place where they can have the greatest impact - earlier in the path of both illness and wellness. This is the way we have delivered success to date and the way we intend to continue to deliver success in 2011/12.

SEEING THE CHANGES IN CANTERBURY

Providing Services Closer to Home

300 patient pathways now support primary care to deliver services previously delivered in hospital settings and improve patient flow between primary and secondary care.

10,000+ procedures have been delivered in the community that would have previously required a hospital visit, including over: 1,700 spirometry tests; 1,100 sleep assessments; and the removal of 4,500 skin lesions.

631 Māori participated in the new Māori Diabetes/CVD screening programme to ensure early detection for at-risk Māori, and 120 patients received subsidised diabetes self management support from their GP teams.

Reducing Demand

Canterbury GPs made over 24,000 direct referrals to over 60 hospital departments and community based radiology, ensuring prompt care for their patients.

14,500 patients were provided with acute packages of care, reflecting the extensive community based activity focused on keeping people out of hospital.

Over 11,300 calls a month are answered by the nurse-led phone triage service, providing callers with after-hours health advice and guidance across Canterbury and directing people to the most appropriate care.

More Effective Hospital Services

15,636 elective surgeries were delivered exceeding the health target. 78% of this elective surgery was delivered on the day of admission, making surgery less disruptive for patients who can spend the night before in their own homes and freeing up beds previously being used unnecessarily.

99% of patients now wait less than six months for their First Specialist Assessment, and when we give a commitment to treat, 98% of patients are treated within six months.

Since August 2010, 100% of people have received their radiation oncology treatment within 6 weeks, compared to 81% in 2007/08.

The average length of stay in Canterbury hospitals has dropped to below the national average, and our acute readmission rate is one of the lowest in the country.

IMPROVING HEALTH OUTCOMES FOR OUR POPULATION

Module 2

What are we trying to Achieve?

This section presents an overview of how we will demonstrate whether we are making a positive change in health outcomes for our population and the population of the wider South Island. Our aim is to improve the effectiveness and quality of services to enable people to make healthier choices, remain well and enhance their quality of life. This section explains how we will measure the change of environment and health status over time.

In line with the functions and responsibilities of a DHB, we will deliver on the priorities and expectations of the Minister and Ministry of Health in order to achieve the Government's long-term vision: *"All New Zealanders lead longer, healthier and more independent lives*".

At a regional level, in support of the national vision, the South Island DHBs are working collectively to deliver "*A clinically and fiscally sustainable South Island Health System where services are provided as close to people's homes as possible*." In order to contribute to this regional vision and improve health outcomes for our individual populations, we are making associated shifts in the way we work and interact regionally. These shifts are focused on the achievement of three key strategic goals or regional outcomes:

- The development of services that support people to stay well and take increased responsibility for maintaining their own health and wellbeing.

  Strategic Goal: People take greater responsibility for their own health.

- The development of primary and community services that support people in community-based settings and provide a point of ongoing continuity of care.

  Strategic Goal: People stay well in their own homes and communities.

- The freeing-up of secondary care services and specialist resources to ensure timely and appropriate responses to episodic events and the provision of support and specialist advice as part of a person's wider journey through the system.

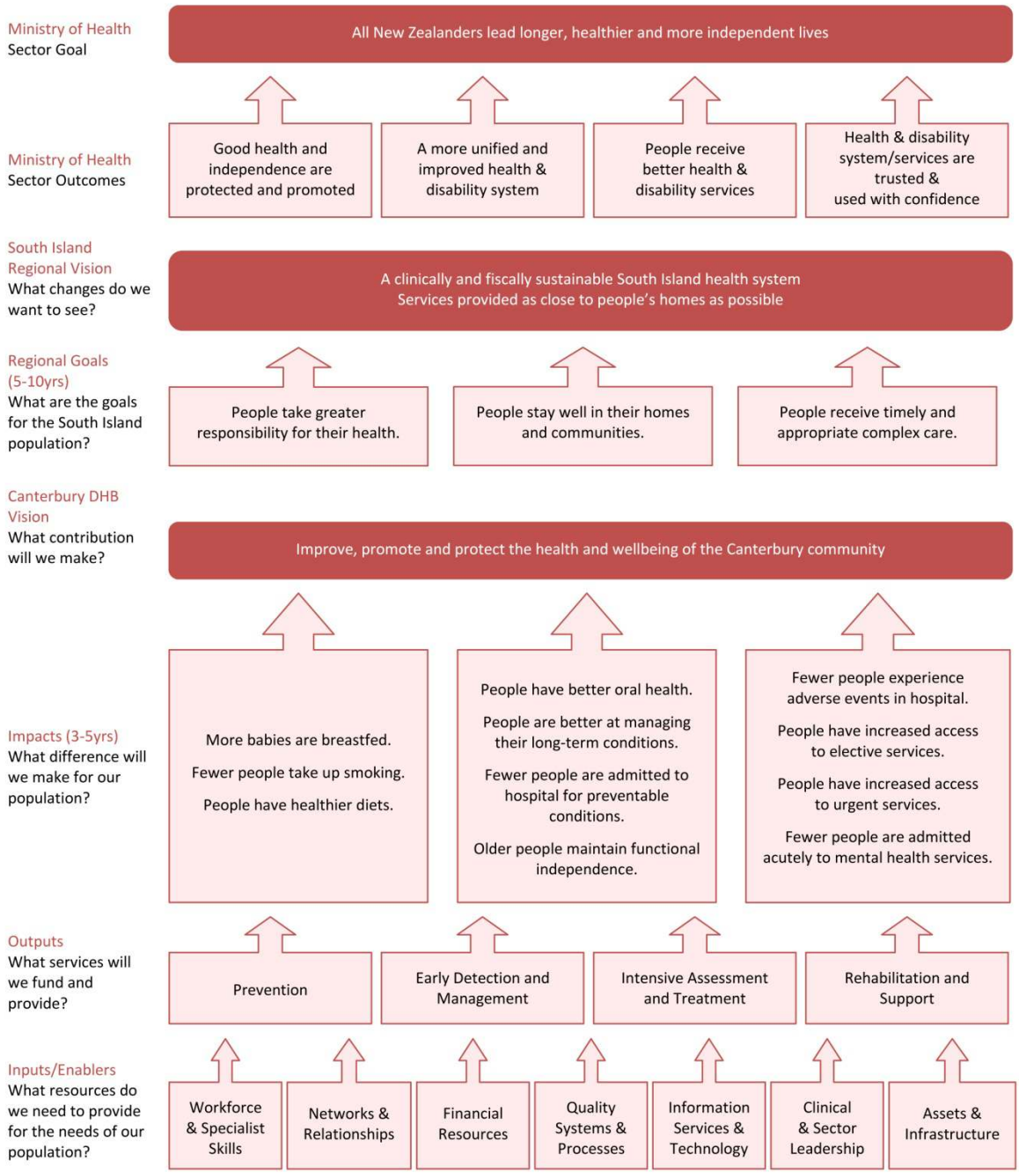
  Strategic Goal: People receive timely and appropriate complex care.

For each strategic goal, the five South Island DHBs have identified a core set of regional performance measures, at a population outcome level, which will demonstrate whether we are achieving these goals and thus making a positive change in the health of our collective population. These are long-term outcome measures (5-10 years in the life of the health system) and as such, we are aiming for a measureable change in the health status of the South Island population over time, rather than a fixed target.

In order to contribute to these outcomes, the South Island DHBs have considered what impact the outputs we fund and provide will have on the health of our populations. We have identified areas where individual DHB performance will have an impact on achievement of regional outcomes and collectively agreed a core set of related medium-term (3-5 years) impact performance measures or 'main measures'. Each DHB has set local targets against these main measures to evaluate the impact service delivery will have over the next three years.

The following intervention logic diagram visually demonstrates the value chain of how the outputs individual DHBs fund or provide have an impact on the health of their population and result in the achievement of long-term regional outcome goals and the expectations and priorities of Government.

Figure 6 – Intervention Logic Diagram



STRATEGIC GOAL

2.5 People take Greater Responsibility for their Own Health

Expectation

Population health and prevention programmes, through enhanced education and support, ensure people are better protected from harm, are more informed of the signs and symptoms of ill health and are supported to reduce risk behaviours and modify lifestyles in order to maintain good health. They create health-promoting physical and social environments which support people to take more responsibility for their own health and make healthier choices.

Why is this Outcome a Priority?

New Zealand is experiencing a growing prevalence of long-term conditions such as diabetes and cardiovascular disease, which are major causes of poor health and account for a significant number of presentations in primary care and admissions to hospital and specialist services. With an ageing population, the burden of long-term conditions will increase. The World Health Organisation (WHO) estimates more than 70% of health funding is spent on long-term conditions.

Tobacco smoking, inactivity, poor nutrition and rising obesity rates are major and common contributors to a number of the most prevalent long-term conditions. These are avoidable risk factors, preventable through a supportive environment, improved awareness and personal responsibility for health and wellbeing. Supporting people to make healthy choices will enable people to attain a higher quality of life and to avoid, delay or reduce the impact of long-term conditions.

OUTCOMES MEASURES LONG TERM (5-10 YEARS)

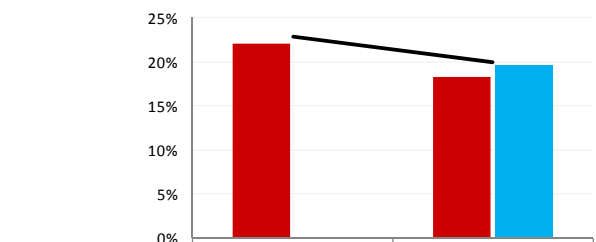
Associated Regional Outcome Measures - We will know we are succeeding when there is:

A reduction in smoking rates.

- *Tobacco smoking kills an estimated 5,000 people in New Zealand every year, including deaths due to second-hand smoke exposure. Smoking is a major contributor to preventable illness and long-term conditions, such as cancer, respiratory disease, heart disease and strokes.*
- *In addition, tobacco and poverty are inextricably linked. In some communities, a sizeable portion of household income is spent on tobacco, resulting in less money being available for necessities such as nutrition, education and health. Supporting our population to say no to tobacco smoking is our foremost opportunity to reduce inequalities and target improvements in the health of populations with high need.*

Data sourced from national NZ Health Survey via PHI Online.[15]

Long-term Outcome Measure: The percentage of the population (15+) who smoke.



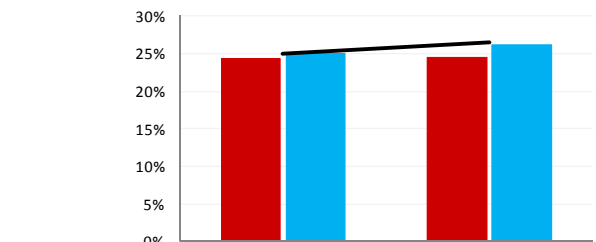
	2002/03	2006/07
Canterbury	22.0%	18.3%
South Island		19.5%
National Average	22.9%	19.9%

A reduction in obesity rates.

- *There has been a rise in obesity in New Zealand in recent decades, and the 2006/07 NZ Health Survey found that one in four adults (26.5%) and one in twelve children (8.3%) were obese. This has significant implications for rates of cardiovascular disease, diabetes, respiratory disease and some cancers, as well as poor psychosocial outcomes and reduced life expectancy.*
- *Supporting our population to maintain healthier body weights through improved nutrition and increased physical activity levels is fundamental to improving the health and wellbeing of our population and to the prevention and management of long-term conditions and disability at all ages.*

Data sourced from national NZ Health Survey via PHI Online.[15]

Long-term Outcome Measure: The percentage of the population (15+) who are obese.[16]



	2002/03	2006/07
Canterbury	24.3%	24.5%
South Island	25.0%	26.2%
National Average	25.0%	26.5%

[15] *The NZ Health Survey is collected by the Ministry of Health and available on PHI Online. The survey was undertaken in 2003/04 and 2006/07, and the next survey is currently underway.*

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

IMPACT MEASURES MEDIUM TERM (3-5 YRS)

Over the next three years we seek to make a positive difference (impact) on the health and wellbeing of the Canterbury population by contributing to the longer-term outcomes. The effectiveness of the services the DHB funds and provides, and the contribution we make, will be evaluated using the following impact measures:

More babies are fully and exclusively breastfed.

- *Breastfeeding helps lay the foundations of a healthy life for baby, contributing positively to infant health and wellbeing and potentially reducing the likelihood of obesity later in life. This in turn contributes to the wider wellbeing of mothers.*
- *Although breastfeeding is natural, it sometimes doesn't come naturally, so it's important that mothers have access to appropriate support and advice.*
- *Successful health promotion and engagement, access to services and a change in social and environmental factors, influence and support breastfeeding.*

Data sourced from Plunket via the Ministry of Health.[17]

The percentage of Canterbury babies fully/exclusively breastfed at 6 weeks.

	Actual 2009	Target 11/12	Target 12/13	Target 13/14
Māori	61.2%	64.0%	67.0%	70.0%
Pacific	53.5%	67.0%	69.0%	71.0%
Total	66.6%	67.0%	69.0%	71.0%

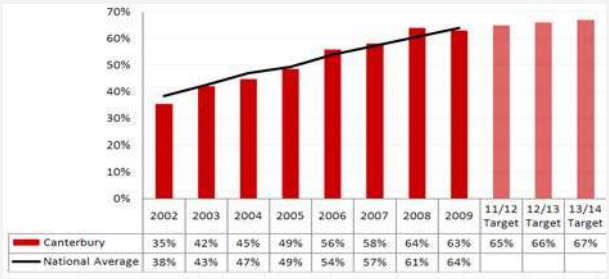
Fewer young people take up tobacco smoking.

- *Reducing smoking prevalence is dependant on increasing smoking cessation and preventing young people from taking up smoking. Over 90% of smokers have started smoking by 18 years of age, and the highest prevalence of smoking is amongst young people, with approximately one in every four Canterbury teenagers 15-19 currently smoking.*
- *A reduction in the uptake of smoking is seen as a proxy measure of successful health promotion and engagement, access to smoking cessation services and a change in the social and environmental factors that influence risk behaviours.*

Data sourced from national Year 10 ASH Survey.[18]

The percentage of 'never smokers' among Year 10 Canterbury students.

Actual 2009	Target 11/12	Target 12/13	Target 13/14
63%	65%	66%	67%



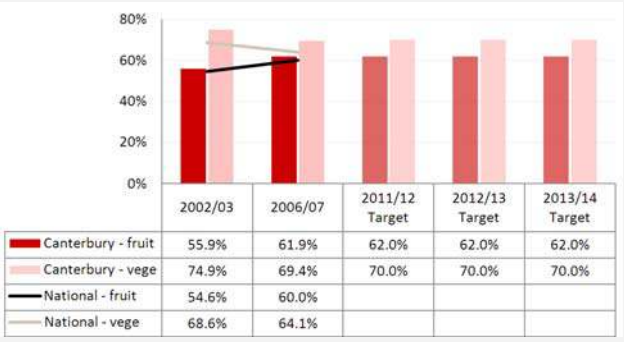
More adults have healthier diets.

- *Good nutrition is fundamental to health and the prevention of disease and disability. Nutrition-related risk factors (such as high cholesterol, high blood pressure and obesity) jointly contribute to two out of every five deaths in NZ each year.*[19]
- *Appropriate fruit and vegetable consumption helps to protect our population against obesity, cardiovascular disease, diabetes and some common cancers and contributes to maintaining a healthy body weight.*
- *An increase in fruit and vegetable consumption is seen as a proxy measure of successful health promotion and engagement and a change in the social and environmental factors that influence people to make healthier choices.*

Data sourced from the national NZ Health Survey.[15]

The percentage of the population (15+) having the recommended servings of fruit and vegetables.

	Actual 06/07	Target 11/12	Target 12/13	Target 13/14
Fruit 2+	61.9%	62%	>62%	>62%
Veg 3+	69.4%	70%	>70%	>70%



[17] *Data is reported annually on calendar years for the national DHB performance indicator S17. The 2008 data shown here differs from that reported in previous publications as a result of updated data recently provided by the Ministry.*

[18] *The ASH survey provides a point prevalence data set and is reported annually on calendar years.*

[19] *Niki Stefanogiannis: Nutrition and the burden of disease in NZ; 1997–2011, Public Health Intelligence, Ministry of Health, Wellington.*

STRATEGIC GOAL

2.6 People Stay Well in their Own Homes and Communities

Expectation

Primary and community services support people to access intervention, diagnostics and treatment and to better manage illness or long-term conditions. These services assist people to detect health conditions earlier, making treatment and interventions easier and reducing the complications of injury and illness.

Why is this Outcome a Priority?

For most people, their general practice team is their first point of contact with health services. Primary care can deliver services sooner and closer to home and is one of the most effective ways to prevent disease through screening, early detection and timely provision of treatment. Primary care is also vital as a point of continuity and effective coordination across the continuum of care, and for improving the management of care for people with long-term conditions.

Supporting primary care are a range of health professionals including midwives, community nurses, social workers, aged residential care providers, Māori health providers and pharmacists who work in the community, often with the neediest families. These providers have prevention and early intervention perspectives that link people with other services and community agencies and further support them to stay well and manage long-term conditions. Studies show that countries with strong primary and community care systems have lower rates of death from heart disease, cancer and stroke, and that they achieve better health outcomes for lower cost than those countries with systems that focus on specialist level care.

With an ageing population, the South Island will require strong primary care and community support, including residential care, respite and responsive short-term and home-based support. If long-term conditions are managed effectively, crises and deterioration can be reduced and health outcomes improved. Even where returning to full health is not possible, access to flexible, responsive, needs-based services can support people to maximise function with the least restriction and dependence.

This means fewer people need hospital-level or long-stay interventions, and those who do have a greater chance of returning to a state of good health and slowing the progression of disease. This is not only a better health outcome for our population, but it reduces the rate of acute and unplanned hospital admissions and frees up health resources, allowing them to be directed to other priority areas.

OUTCOMES MEASURES LONG TERM (5-10 YEARS)

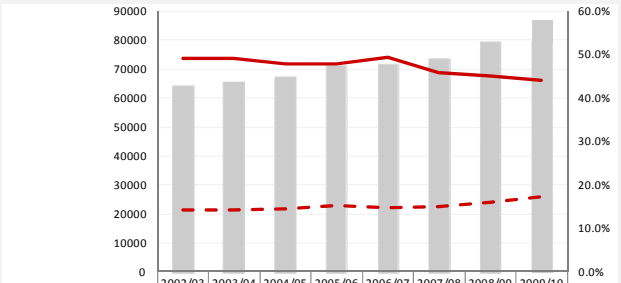
Associated Regional Outcome Measures - We will know we are succeeding when there is:

A reduction in 'avoidable' presentations to hospital Emergency Departments (EDs).

- *Supporting people to seek early intervention and providing access to alternative urgent care pathways will ensure people are being given the right treatment in the right place - reducing unnecessary presentations to ED. Early intervention will not only improve health outcomes for our population, but also reduce avoidable pressure on hospital resources and enable investment in other priority areas.*
- *A decrease in the ratio between the number of people presenting at ED and those being admitted is seen as a proxy measures of whether people are appropriately presenting at ED and whether people are being better managed in more appropriate locations.*

Data Sourced from National Minimum Data Set and individual DHBs.

Long-Term Outcome Measure – The percentage of the Canterbury population presenting at ED and the percentage admitted.[20]



	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10
ED Presentations	64352	65770	67600	71279	71952	73693	79317	87091
% Popn w/ED visit	14.2%	14.3%	14.5%	15.2%	14.8%	15.0%	16.0%	17.3%
% ED Admitted	49.0%	49.2%	47.8%	47.9%	49.3%	45.8%	45.1%	44.2%

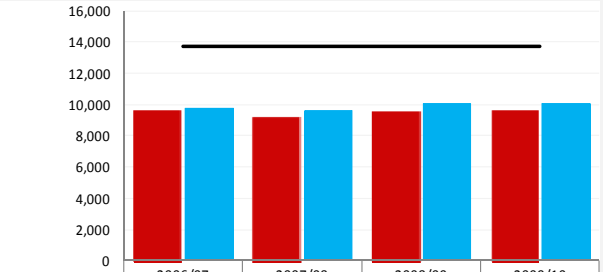
[20] *'Admitted' is defined as in the Ministry of Health national ED Health Target. Note that only Canterbury figures are shown.*

An increase in the proportion of the population supported to manage their long-term conditions.

- *The impact of long-term conditions in terms of quality of life and cost to the health system is significant. By improving the management of these conditions, people are supported to live more stable, healthier lives, without the deterioration that leads to acute illness and crisis.*
- *Acute medical admissions can be used as a proxy measure of the improved management of long-term conditions by indicating that they are being better managed earlier, without escalation to an event needing urgent and complex intervention.*
- *Reducing acute admissions also has a significant effect on productivity in hospital and specialist services - enabling more efficient use of health resources that would otherwise be taken up by demand for urgent and acute care.*

Data sourced from SISSAL.

Long-term Outcome Measure – The age-standardised rate of acute admissions to hospital per 100,000 people.



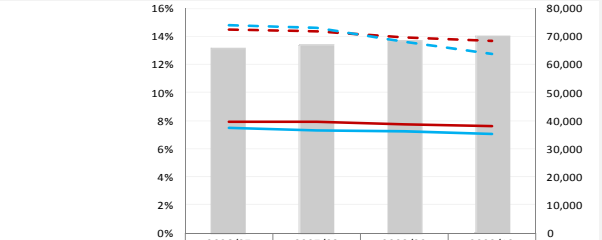
	2006/07	2007/08	2008/09	2009/10
Canterbury	9592	9106	9515	9540
South Island	9734	9575	10069	10043
New Zealand				13710

An increase in the proportion of the population aged over 65 supported to live well, in their own homes.

- *While living in Aged Residential Care (ARC) is appropriate for a small proportion of our population, Canterbury rates are above national averages. When people receive adequate support for their needs to be managed, remaining in their own homes is considered to provide a much higher quality of life as a result of staying active and positively connected to their communities.*
- *Living in ARC facilities can be associated with a more rapid functional decline than 'ageing in place'. It is also a more expensive option, and resources could be better spent providing appropriate levels of support to people so that they can stay well, and in their own homes for as long as possible.*

Data sourced from SISSAL Client Claims Payment System.

Long-term Outcome Measure – The percentage of the population (65+) in ARC and those receiving Home Based Support Services.



	2006/07	2007/08	2008/09	2009/10
Canterbury Population 65+	65365	66765	68140	69925
Canterbury % ARC	7.9%	7.9%	7.7%	7.6%
South Island % ARC	7.5%	7.3%	7.2%	7.1%
Canterbury % HBS	14.5%	14.4%	13.9%	13.7%
South Island % HBS	14.8%	14.6%	13.6%	12.8%

IMPACT MEASURES MEDIUM TERM (3-5 YRS)

Over the next three years we seek to make a positive difference (impact) on the health and wellbeing of the Canterbury population by contributing to the longer-term outcomes. The effectiveness of the services the DHB funds and provides, and the contribution we make, will be evaluated using the following impact measures:

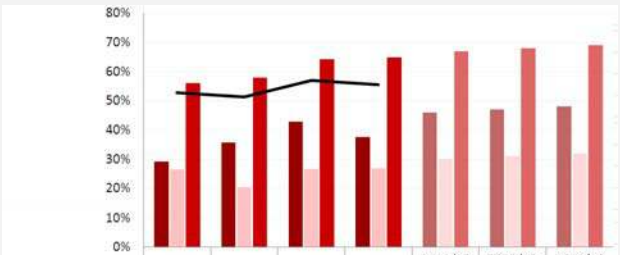
More children have good oral health.

- *Good oral health demonstrates early contact with health promotion and prevention services and reduced risk factors, such as poor diet, which has lasting benefits in terms of improved nutrition and healthier body weights. Oral health is also an integral component of lifelong health and impacts a person's comfort in eating (and ability to maintain good nutrition in old age), self esteem and quality of life.*
- *Māori children are three times more likely to have decayed, missing or filled teeth, and improved oral health is a proxy measure of equity of access and the effectiveness of mainstream services in targeting those most in need.*
- *While water fluoridation can significantly reduce tooth decay across all population groups, less than 5% of children in Canterbury have access to fluoridated water.*

Data sourced from Ministry of Health.[21]

The percentage of Canterbury children caries free (no holes or fillings) at age 5.

	Actual 2009	Target 11/12	Target 12/13	Target 13/14
Māori	37.6%	46%	47%	48%
Pacific	26.8%	30%	31%	32%
Total	65.0%	67%	68%	69%



	2006	2007	2008	2009	2011/12 Target	2012/13 Target	2013/14 Target
Maori	29.1%	35.6%	42.8%	37.6%	46.0%	47.0%	48.0%
Pacific	26.4%	20.3%	26.6%	26.8%	30.0%	31.0%	32.0%
Total	56.0%	57.8%	64.3%	65.0%	67.0%	68.0%	69.0%
National Average	52.9%	51.4%	57.0%	55.6%			

[21] *Oral health data is reported annually for the school year (i.e. calendar year) and is based on the national DHB performance indicator PP11.*

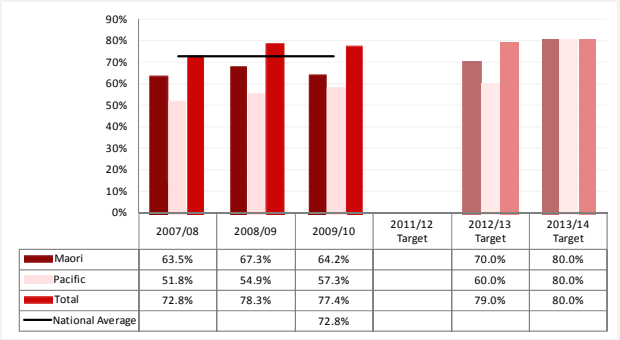
More people identified with diabetes have 'satisfactory' management of their diabetes.

- *Diabetes is a significant cause of ill health and premature death, and prevalence is increasing at an estimated 4-5% a year.*
- *Improving the management of diabetes will reduce avoidable complications that require hospital-level intervention, such as amputation, kidney failure and blindness, and will improve people's quality of life.*
- *Diabetes is also strongly associated with cardiovascular diseases (heart attacks and stroke) and respiratory disease. As such, it contributes significantly to the top causes of death in Canterbury and to the rate of acute admissions.*

Data sourced from Ministry of Health and Individual DHBs and is reported one quarter in arrears.[22]

The percentage of the Canterbury population receiving diabetes annual reviews who have HbA1c≤8%.

	Actual 09/10	Target 11/12	Target 12/13	Target 13/14
Māori	64.2%	n/a [23]	70%	80%
Pacific	57.3%	n/a	60%	80%
Total	77.4%	n/a	79%	80%



	2007/08	2008/09	2009/10	2011/12 Target	2012/13 Target	2013/14 Target
Maori	63.5%	67.3%	64.2%		70.0%	80.0%
Pacific	51.8%	54.9%	57.3%		60.0%	80.0%
Total	72.8%	78.3%	77.4%		79.0%	80.0%
National Average			72.8%			

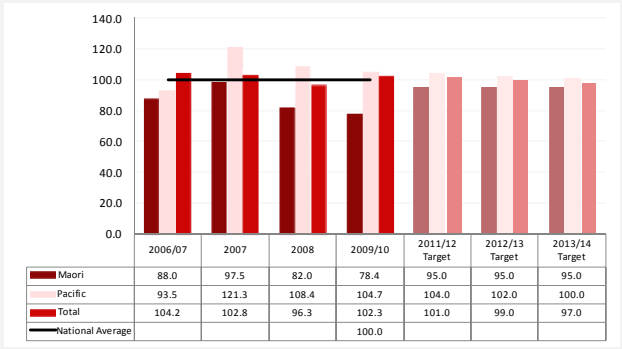
Fewer people are admitted to hospital with conditions considered 'avoidable' or 'preventable'.

- *There are a number of admissions to hospital for conditions which are seen as preventable through appropriate early intervention and a reduction in risk factors. As such, these admissions provide an indication of the access and effectiveness of screening, early intervention and community-based care.*
- *A reduction in these admissions will reflect better management and treatment of people across the whole system and will free up hospital resources for more complex and urgent cases. The expected rate is the national average, and a result greater than 100 indicates worse than average performance.*
- *The key factor in reducing avoidable hospital admissions is an improved interface between primary and secondary services. Achievement against this measure is seen as a proxy indicator of a more unified health system.*

Data sourced from the Ministry of Health. [24]

The standardised ratio of actual to expected avoidable hospital admissions for the Canterbury population (<75).

	Actual 09/10	Target 11/12	Target 12/13	Target 13/14
Māori	78.4	≤95	≤95	≤95
Pacific	104.7	≤104	≤102	≤100
Total	102.3	≤101	≤99	≤97



	2006/07	2007	2008	2009/10	2011/12 Target	2012/13 Target	2013/14 Target
Maori	88.0	97.5	82.0	78.4	95.0	95.0	95.0
Pacific	93.5	121.3	108.4	104.7	104.0	102.0	100.0
Total	104.2	102.8	96.3	102.3	101.0	99.0	97.0
National Average				100.0			

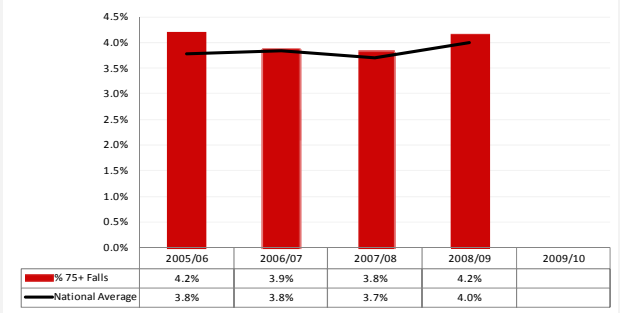
Older people (75+) are supported to maintain functional independence.

- *Around 12,000 New Zealanders (75+) are hospitalised annually as a result of injury due to falls. Compared to elderly people who do not fall, those who fall experience prolonged hospital stay, loss of confidence, restriction of social activities, loss of independence and an increased risk of institutional care.*
- *With a significantly increasing older population, a focus on reducing falls will help to reduce the relative demand on acute and residential services.*
- *A reduction in falls will indicate improved health service provision for older people, as the initiatives used to reduce falls address various health issues and associated risk factors including: medications use, lack of physical activity, poor nutrition, osteoporosis, impaired vision and environmental hazards.*

Data sourced from Ministry of Health.[25]

The percentage of the Canterbury population (75+) admitted to hospital as a result of a fall.

Actual 09/10	Target 11/12	Target 12/13	Target 13/14
n/a	n/a	n/a	n/a



	2005/06	2006/07	2007/08	2008/09	2009/10
% 75+ Falls	4.2%	3.9%	3.8%	4.2%	
National Average	3.8%	3.8%	3.7%	4.0%	

[22] *This measure is based on the national health target and 'satisfactory' is defined as having HbA1c≤8%.*

[23] *Following the February earthquake a significant number people are displaced from their homes and workplaces. While this group is being supported to attend primary care, this may not be at their usual general practice; hence explicit targets have not been set for 2011/12.*

[24] *Avoidable hospital admissions are based on 26 identified conditions including: asthma, diabetes, angina, vaccine-preventable diseases, dental conditions and gastroenteritis. The measure is based on the national DHB performance indicator SI1 and performance data is supplied to DHB by the Ministry of Health. The 09/10 baseline is for the 12 months to 30 Sept 2010.*

[25] *This is a new national DHB indicator (PP15) and data for 2009/10 has not been provided. The DHB will set targets in 2012/13.*

STRATEGIC OBJECTIVE

2.7 People Receive Timely and Appropriate Complex Care

Expectation

Secondary-level hospital and specialist services meet people's complex health needs, are responsive to episodic events and support community-based care providers. By providing appropriate and timely access to high quality complex services, health outcomes and quality of life are improved and untimely deaths reduced.

Why is this Outcome a Priority?

Timely access to high quality hospital and specialist services improves health outcomes, and shorter waiting lists and wait times are indicative of a well functioning system matching capacity with demand - managing the flow of patients through its services and addressing the needs of its population.

Our Government is concerned that patients wait too long for hospital diagnostic tests, for cancer treatment and for elective surgery. The expectations around reducing waiting times, coupled with the current fiscal situation, mean DHBs need to develop innovative ways of assisting more people and reducing waiting times with limited resources.

This outcome reflects the importance of ensuring that hospital and specialist services are sustainable and that the South Island has the capacity to provide for the complex needs of its population now and into the future. Typically, an organisation's capacity is considered to be the means through which an outcome is achieved and not an outcome itself. However, as providers of hospital and specialist services who are operating under increasing demand and workforce pressures, the South Island DHBs have included the provision of more timely and appropriate complex care as a Strategic Goal.

OUTCOMES MEASURES LONG TERM (5-10 YEARS)

Associated Regional Outcome Measures - We will know we are succeeding when there is:

A reduction in unplanned acute readmissions to hospital and specialist services.

- *Unplanned acute readmission rates are a measure of quality of care, efficiency and appropriateness of discharge for hospital patients. They are also a quality counter-measure to balance improvements in productivity and reduced lengths of stay, at the same time as our population is ageing and people are presenting with more complex conditions.*
- *Improved patient-focused and clinically driven pathways will support early intervention and planned readmission where clinically appropriate, and deliver improvements in care across the whole continuum. Responsive intervention will also enable people, their families and caregivers to maintain more stable lives.*

Data sourced from Ministry of Health.

Long-term Outcome Measure – The rate of acute readmissions to hospital within 28 days of discharge from hospital.

NOTE: The intention is to use the national DHB performance indicator (OS8), which was introduced for all DHBs in 2010/11. The data and definitions are still being tested, and the South Island DHBs will use this measure once data is stabilised.

A reduction in the rate of mortality within 30 days of discharge from hospital and specialist services.

- *Mortality rates are a measure of clinical outcomes for hospital patients and are related to the safety and efficacy of treatment. Maintaining or reducing our current mortality rates will demonstrate maintenance of clinical quality standards and a balance against productivity gains such as reduced length of stay.*
- *System and process changes being made to the way we deliver services to patients, such as changes intended to reduce the incidence of falls, pressure ulcers, pneumonia and hospital-acquired infections, will lead to a measurable change in patient mortality.*

Data sourced from Ministry of Health.

Long-term Outcome Measure – The rate of mortality within 30 days of discharge from hospital.

NOTE: The intention is to use the national DHB performance indicator (OS9), which was introduced for all DHBs in 2010/11. The data and definitions are still being tested, and the South Island DHBs will use this measure once data is stabilised.

IMPACT MEASURES MEDIUM TERM (3-5 YRS)

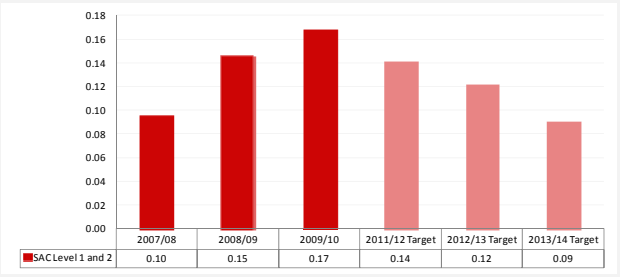
Over the next three years we seek to make a positive difference (impact) on the health and wellbeing of the Canterbury population by contributing to the longer-term outcomes. The effectiveness of the services the DHB funds and provides, and the contribution we make, will be evaluated using the following impact measures:

Fewer adverse events cause harm to patients in our hospital and specialist services.

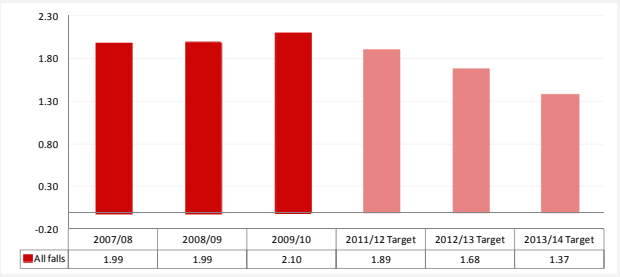
- *Quality improvements in service delivery, systems and processes will improve patient safety and reduce the number of serious incidents causing injury - providing better outcomes for patients in our services and reducing readmission and mortality rates, as well as unnecessary costs.*
- *Compared to elderly people who do not fall, those who fall experience prolonged hospital stay, loss of confidence, restriction of social activities, loss of independence and an increased risk of institutional care.*
- *Achievement against this measure will indicate improved quality processes and reduced harm in our hospital and specialist services.*

Data sourced from Individual DHBs.

The rate of SAC 1 and 2 level falls in Canterbury Hospitals (65+)[26]	Actual 09/10	Target 11/12	Target 12/13	Target 13/14
	0.17	0.14	0.12	0.09



The rate of all falls resulting in harm in Canterbury Hospitals.	Actual 09/10	Target 11/12	Target 12/13	Target 13/14
	2.10	1.89	1.68	1.37

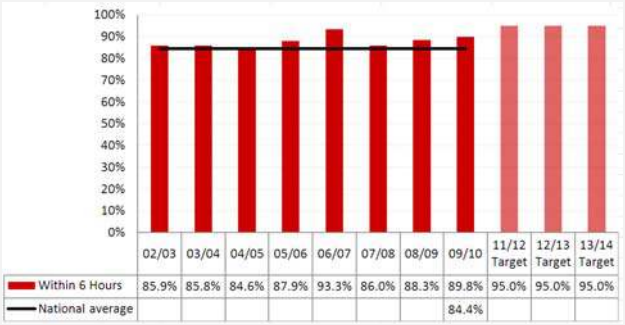


People receive timely access to urgent care services

- *Long stays in emergency departments (EDs) are linked to overcrowding of the ED, negative clinical outcomes and compromised standards of privacy and dignity for patients.*
- *The duration of stay in ED is influenced by services provided in the community to reduce inappropriate ED presentation, the effectiveness of the services provided in ED, and the hospital and community services provided following exit from ED. Therefore, reducing waiting times in ED is indicative of a coordinated 'whole of system' response to the urgent care needs of the population.*
- *Improved performance against this measure will not only improve outcomes for our population, but will improve the public's confidence in being able to access services when they need to and increase their level of trust in health services.*

Data sourced from the Ministry of Health.[27]

The percentage of patients presenting at Canterbury EDs who are admitted, discharged or transferred within six hours.	Actual 09/10	Target 11/12	Target 12/13	Target 13/14
	89.8%	95%	95%	95%



[26] *The Severity Assessment Code (SAC) is a numerical score given to an incident, based on the outcome of the incident and the likelihood that it will recur. Level 1 and 2 incidents are those with highest consequence and likelihood. Data reported is per 1,000 inpatient bed days*

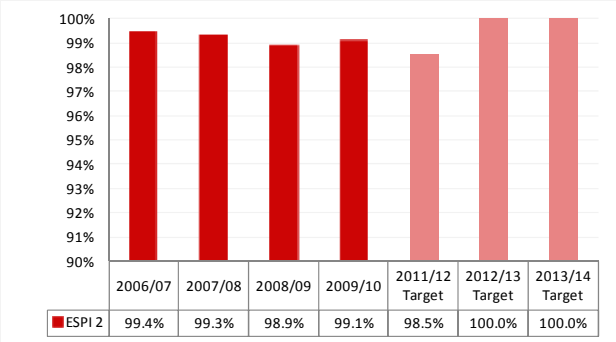
[27] *This measure is based on the national DHB Health Target 'Shorter stays in Emergency Departments'.*

People receive timely access to elective surgical services.

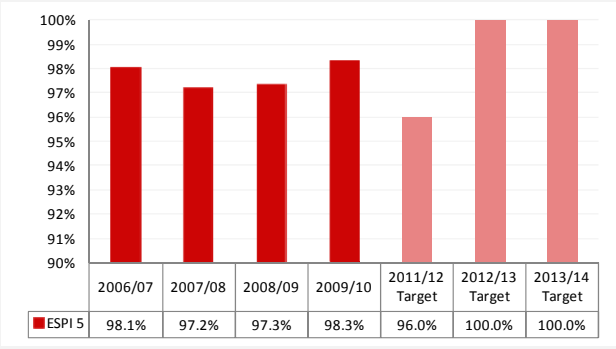
- *Elective (non-urgent) services are an important part of the health care system, as these services improve the patient's quality of life by reducing pain or discomfort and improving independence and wellbeing.*
- *The Government wants more New Zealanders to have access to elective surgical services. Improved performance against this measure is also indicative of the improved hospital productivity required to ensure the most effective use of resources so that wait times can be minimised whilst year-on-year growth in elective services is achieved.*
- *Timely access to elective services is considered a measure of the effectiveness of the health system and will not only improve health outcomes for our population, but will increase community confidence that the health system will meet their needs.*
- *National expectations have been set for a set of eight Elective Services Patient Flow Indicators (ESPIs), and Canterbury aims to continue to perform above these standards.*

Data sourced from individual DHBs.[28]

The percentage of people in Canterbury provided with a FSA within 6 months of referral (ESPI 2).	Actual 09/10	Target 11/12	Target 12/13	Target 13/14
	99.1%	98.5%[29]	100%	100%



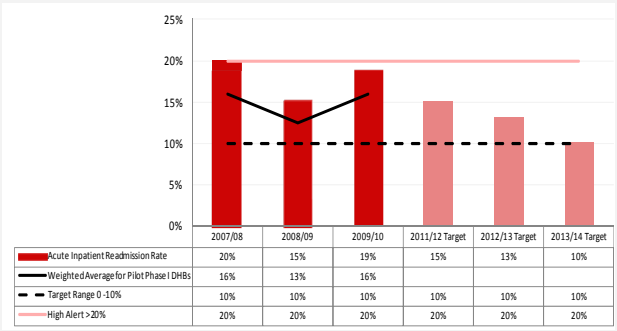
The percentage of people in Canterbury given a commitment to treat who are treated within 6 mths (ESPI 5).	Actual 09/10	Target 11/12	Target 12/13	Target 13/14
	98.4%	>96%	100%	100%



Fewer people have acute readmissions to specialist mental health services.

- *Acute readmission rates are a measure of quality of care, efficiency and appropriateness of discharge for hospital patients. They are also a quality counter-measure to balance improvements in productivity and reduced lengths of stay and for mental health services provide an indication of the integration between primary, community and secondary services in terms of supporting people in the community.*
- *Improved patient-focused and clinically driven pathways will support early intervention and planned readmission where clinically appropriate, and deliver improvements in care across the whole continuum. Responsive intervention will also enable people, their families and caregivers to maintain more stable lives.*

The rate of acute readmissions to Canterbury mental health services (within 28 days).	Actual 09/10	Target 11/12	Target 12/13	Target 13/14
	18.9%	15%	13%	10%



[28] *The Elective Services Patient Flow Indicators (ESPIs) are measures of system performance, for which DHBs receive summary reports from the Ministry of Health on a monthly basis. National average performance data is not made available for these measures.*

[29] *Canterbury's aim is to provide everyone with certainty, but due to the unknown factors around acute demand in the coming 12 months, the DHB has retained 2010/11 targets with the intention of achieving above this and reaching 100% in the out-years.*

GOVERNMENT EXPECTATIONS

Module 2

Health Targets - How Will We Contribute?

When planning investment and activity within the health sector, DHBs must consider their contribution and role in the achievement of the vision and goals of Government reflected through the expectations of the Minister of Health, the National Health Board and the Ministry of Health.

In setting expectations for 2011/12, a clear signal has been given that the public health system must deliver '*better, sooner, more convenient*' health care by focusing on enhancing performance, increasing outputs, improving quality and effectively managing resources. There is a strong focus on improving frontline services, operating within existing resources and working towards a more unified health system.

The Minister of Health continues to support strengthened clinical leadership and constructive staff engagement, and expects to see improvements in productivity, patient safety and the quality of services.

The Minister's specific priorities for DHBs in 2011/12 are:

- Improved service delivery and reducing waiting times - achievement of the national health targets and continued improvement in reducing waiting times;
- Improved clinical leadership - strengthened clinical engagement throughout the health system;
- Provision of services closer to home - further integration of services across the continuum of care to improve continuity and convenience for patients and reduce pressure on hospital services;
- Improved health service for older people - focusing on improving older people's underlying health and wellbeing and preparing to meet the impact of our ageing population;
- Regional cooperation - accelerated collaboration between neighbouring DHBs to maximise clinical and financial resources and evidence of real gains from these endeavours;
- More unified systems - working constructively with the National Health Board, National Health IT Board, Health Workforce NZ and Health Quality and Safety Commission to make gains in purchasing, productivity and quality; and
- Improved financial performance - taking ownership of financial performance and implementing specific actions to operating within budget.

To measure progress against the national priorities, a set of national health targets has been established by the Ministry of Health, with the anticipation that a collaborative DHB focus will drive performance improvement across the sector. The health targets are monitored quarterly by the National Health Board.

While the health targets capture only a small part of what is necessary and important to our community's health, they do provide a focus for action and improved performance across the continuum, from prevention and early intervention through to improved access to intensive assessment, treatment and support services. There is also clear alignment between regional and local priorities and the national health targets. In this sense, achievement of the national health targets is a reflection of how well the health system is improving the lives and wellbeing of our populations.[30]

Canterbury is committed to making continued progress towards achieving the national health targets, and our contribution (in terms of local targets) is set out in the following two pages. The activity planned to deliver on these health targets is summarised in the Service Performance section of this document.

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

Shorter Stays in EDs

Government Expectation

95% of patients presenting at an Emergency Department (ED) will be admitted, discharged or transferred within six hours.

Why is this target area important:

This target is reflective of a 'whole of system' approach to managing acute demand, strong clinical leadership and a commitment to improving the quality of care for patients across the whole continuum.

ED length of stay is also seen by the Government as an important measure of the quality of acute care in our public hospitals. Long stays in ED are reflective of overcrowding, which can lead to compromised standards of privacy and dignity for patients and are linked to negative clinical outcomes for patients, such as increased mortality and longer inpatient lengths of stay. The target is also reflective of the flow of patients through the hospital and how well different departments interact.

Our contribution:

95% of people presenting to a Canterbury ED will be admitted, discharged or transferred within six hours.

Improved Access to Elective Surgery

Government Expectation

More New Zealanders have access to elective surgical services, with an average of 4,000 additional discharges nationally every year.[31]

Why is this target area important:

The Government wants the public health system to *'deliver better, sooner, more convenient'* health care for all New Zealanders. In order to achieve this, the growth in elective surgical discharges must keep up with population growth. This in turn will increase access and achieve genuine reductions in waiting times for patients.

All patients also have the right to clarity about whether they will receive publicly funded treatment, timeliness in terms of those who are given a commitment to treatment receiving that treatment in a timely manner (a maximum of six months) and fairness in ensuring that prioritisation status is based on a patient's level of health need compared to other patients.

Our contribution:

16,110 elective surgical discharges will be delivered in 2011/12.

Shorter Waits for Cancer Treatment

Government Expectation

All New Zealanders requiring cancer radiation oncology treatment receive it within four weeks of their first specialist assessment.[32]

Why is this target area important:

Cancer is the leading cause of death and a major cause of hospitalisation in New Zealand. Timely cancer treatment is important to improve patient outcomes and provide a better quality of life. This target measures one part of a patient's journey with cancer and provides an indicator of how well the system is working.

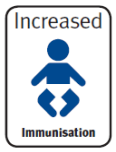
Māori and Pacific populations have proportionately higher cancer incidence compared to other populations. Providing support to improve access to treatment and ensure sufficient treatment capacity are both important factors in ensuring Māori and Pacific people have equitable outcomes.

Our contribution:

100% of people who need radiation oncology treatment will receive it within four weeks of the decision to treat.

[31] *The national health target definition of elective surgery excludes dental and cardiology services.*

[32] *The national health target definition excludes Category D patients, whose treatment is scheduled to ensure effective sequence of radiation treatment with chemotherapy or other anti-cancer drugs.*



Increased Immunisation Rates

Government Expectation

95% of two years olds in New Zealand are fully vaccinated against vaccine preventable diseases by July 2012.

Why is this target area important:

Immunisation can prevent a number of diseases and is a very cost-effective health intervention. Immunisation provides protection not only for individuals but for the whole population by reducing the incidence of diseases and preventing them from spreading to vulnerable people or population groups.

Population benefits only arise with high immunisation rates, and New Zealand's current rates are low by international standards and insufficient to prevent or reduce the impact of preventable diseases such as measles or pertussis (whooping cough). Coverage for two year olds demonstrates whether children have received the full series of infant immunisations, when they are most vulnerable.

Our contribution: [33]

Two year olds will be fully vaccinated.

Better Help For Smokers to Quit

Government Expectation

95% of all smokers presenting to ED, day stay and other hospital services and 90% of all smokers attending primary care are provided with help and advice to quit by July 2012.

Why is this target area important:

Smoking kills an estimated 5,000 people in New Zealand every year, and smoking-related diseases are a significant cost to the health sector. Smoking is also a major contributor to inequalities in health and to a number of long-term conditions, including heart disease, cancers and respiratory disease.

Most smokers want to quit, and there are simple, effective interventions that can be routinely provided in both primary and secondary care. This target is designed to prompt health professionals to routinely ask about smoking status and provide smokers with brief advice and support to prompt quit attempts and quit success.

Our contribution:

95% of smokers in Canterbury hospitals will be provided with advice and help to quit smoking by July 2012.

90% of smokers attending primary care will be provided with advice and help to quit smoking by July 2012.

Improved Diabetes and CVD Services

Government Expectation

People are supported to understand and identify the symptoms of long-term conditions and to better manage their condition.

Why is this target area important:

Long-term conditions comprise the major health burden for New Zealand now and in the foreseeable future. These conditions are a leading cause of morbidity and disproportionately affect Māori and Pacific people. As the population ages and lifestyles change, these conditions are likely to increase significantly.

Improving outcomes for people with diabetes and CVD requires a 'whole of system' approach that encourages healthier lifestyles and supports early diagnosis, management plans and access to treatment. These targets measure one part of the journey and can provide an indication of how well long-term conditions are being identified and managed in primary care.

Our contribution: [33]

The eligible adult population will have their CVD risk assessed once every five years.

The expected population with diabetes will receive a free diabetes annual review.

Those receiving a free annual diabetes review will have satisfactory or better diabetes management (HbA1c≤8%).

[33] *Following the February earthquake a significant number of people are displaced from their homes and workplaces. While this group is being supported to attend primary care, this may not be at their usual general practice; disrupting normal recall systems and processes. Hence, explicit targets have not been set for 2011/12 against the national Immunisation, Diabetes or CVD health targets. The DHB will continue to work towards regaining prior performance levels and will monitor and report performance against these indicators.*

SERVICE PERFORMANCE PRIORITIES 2011-2012

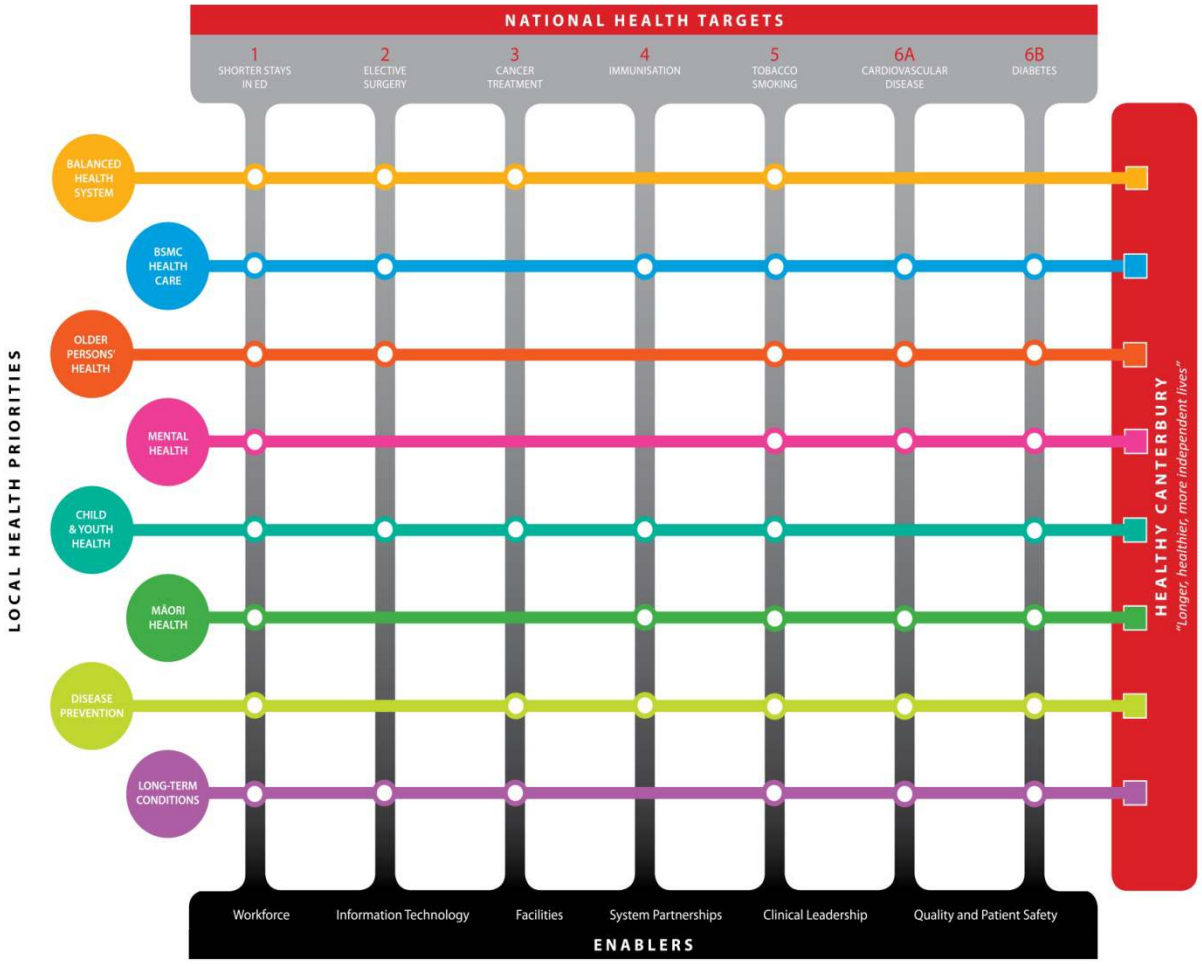
Module 3

Transforming the Canterbury Health System

The following section outlines our eight local priority areas and the key initiatives and activity we have planned to achieve improvements in each area. We have chosen our priorities based on our population's need, demand trends and the level of change needed to improve service delivery and health outcomes in our challenging environment. We have also aligned our priorities with the expectations of the Minister of Health, particular delivery of the national health targets.

The planned initiatives and actions reflect the local direction and approach we have built through our health services planning and reflect the implementation priorities of the CCN *Better, Sooner, More Convenient* Business Case. We have also incorporated the key elements of our Recovery Plan, which will guide our whole health system as we manage the ongoing seismic issues in Canterbury, and the collaborative regional direction established through the Regional South Island Health Services Plan.

The following diagram demonstrates the alignment between our local priorities (on the left) and the national health targets (across the top) and highlights the points at which activity will influence change.



3.1 Building a Balanced Health System – Maintaining Hospital Capacity

Why is this important?

> "We need the whole system to be working, for the whole system to work"
>
> *Dr Martin Seers, GP and Chair of Pegasus Health.*

Population growth, the increasing burden of long-term conditions and the changing demographics of our population all combine to increase the demand for secondary care services, and as our population ages, people are presenting with more complex health issues requiring higher levels of intervention. Canterbury was well prepared to respond to increased capacity constraints because we had planned for this eventuality; however, following the earthquakes, the system is now so constrained we will have to create new solutions to manage through the coming years.

We are the major provider of hospital and specialist services in Canterbury and across the South Island. Our recent experience has demonstrated that Canterbury is a key part of New Zealand's health system infrastructure at a national level, and that we need to remain clinically and financially sustainable, and continue to provide good quality health care, in order to help the whole of New Zealand's health system remain sustainable.

Canterbury is tantalisingly close to delivering an integrated health system where patients receive the right care and support at the right time, in the right place, from the right person.

Clinical leadership has been the key to making improvements in service quality and patient safety, and clinicians are actively engaged in service design and innovation. This experience stood the system in good stead when rapid re-planning was required to maintain services post-quake. Primary, secondary and community based health professionals worked together to create a system-wide Recovery Plan, the short-term elements of which have already been delivered.

> The Recovery Plan and implementation of new and accelerated initiatives is being progressed across the most impacted service areas: general medicine; older persons' health; primary care; community services; surgery; and mental health services.

Meeting the Minister's Expectations

- Improved service delivery, reduced waiting times and achievement of the national health targets;
- Improved clinical leadership and strengthened clinical engagement throughout the health system;
- Provision of services closer to home and further integration of services across the continuum of care to improve continuity for patients and reduce pressure on hospital services;
- Regional collaboration between neighbouring DHBs to maximise clinical and financial resources;
- Improved financial performance.

Where do we want to be?

Prior to the seismic events, Canterbury was already facing physical capacity as a key limiting factor. A number of changes in models of care consistent with Canterbury's overall strategic direction were in the planning, early implementation or expansion phases. In response to the earthquakes, some of these have been accelerated for earlier and more extended implementation, and new responses have been developed to meet the short-term need created by loss of physical capacity.

The new and expanded service models are designed to improve patient flow by:

- Reducing acute admissions;
- Reducing length of stay (acute, elective and Assessment, Treatment and Rehabilitation);
- Enhancing recovery and reducing rest home utilisation; and
- Functioning as an alternative to hospital and/or ARC admission when required.

These new models have enhanced the focus on a primary/community based response to health need and facilitated integration. The highest proportion of the coming year's additional funding has gone into community based services, but the teams delivering these services are drawn from right across the whole of the Canterbury health system - specialist services are working together with primary and community services to achieve shared goals.

In addition to the new services being implemented, Canterbury has re-commissioned three old wards (previously functioning as office space) to provide temporary capacity for the winter. These wards are based on The Princess Margaret Hospital site, and planning has involved relocating staff and developing new criteria, staffing and transport

processes with St John to manage the split of general medicine staff and patients between two sites. This is a short-term response, and planning is underway to create a more sustainable response for next winter.

Access to theatre time and beds has become a key constraint for surgery, and we have planned to significantly increase outsourcing to the private sector over the next two years. This is also a short-term response, as it is neither financially nor clinically sustainable and will undermine our workforce; further planning will address this issue.

Despite the circumstances, we are still working to deliver a system where the key measure of success at every point in the system will be reducing the time that patients waste waiting.

Our strategies are based on delivering a balanced, clinically and financially sustainable system:

- Increased responsiveness to primary care through the implementation/expansion of HealthPathways, our Electronic Referral Management System (ERMS) and new models of immediate access to consultant advice;
- Increased support to our partner DHBs through redesigned pathways and new models of care, developed by clinicians working in regional alliances;
- Increased acute assessment activity, which will reduce hospital admissions and time spent in emergency departments and provide more direct access into services from general practice;
- Increased surgical interventions, by using agreed pathways and referral guidelines to ensure that surgeon time is invested in the right patients and tight production planning with clinically led allocation of theatre time;
- Increased assessment, treatment and rehabilitation capacity to meet the needs of an ageing population, including more community based rehabilitation and the introduction of the Community Rehabilitation Enablement and Support Team (CREST);
- Reduced ARC admissions through ensuring that older people receive timely access to the right care closer to home and are better supported to remain safely in their own homes and communities; and
- Reduced patient harm through improved quality and patient safety initiatives, implementation of the national quality programme and the championing of quality by the DHB's Clinical Board.

It is accepted that the recovery of Canterbury as a district requires a minimum of a five year planning horizon. The Canterbury health system has adopted the same timetable; this does not change our deliverables, but will necessitate some compromises, some innovation and rapid cycle change to maintain momentum in difficult times.

HOW WE'RE GOING TO GET THERE – OUR PERFORMANCE STORY 2011/12

OBJECTIVE	ACTION	EVIDENCE
Reduce medical bed occupancy. *To manage our acute medical demand within the capacity available so that other hospital based services (e.g. surgery) are not compromised.*	Increase the use of community based interventions and responses to reduce acute medical admissions. Increase urgent general practice access to specialist assessment to reduce acute medical admissions. Introduce CREST services to reduce Average Length of Stay (ALOS)	Increased acute demand management and supported discharge activity. A reduction in acute medical admissions. Acute inpatient ALOS and Elective and arranged inpatient ALOS $\leq$4.00 days. Medical bed capacity meets demand.
Increase integration between secondary and primary care. *To support the provision of the right care in the right place at the right time by the right provider.*	Review the entire cardiac patient journey from beginning to end in order to expand the range of patient pathways agreed between general practise and hospital specialists. Establish clinically-led patient pathways for both cardiology and cardiothoracic services. Expand GP access to cardiac related diagnostics including Exercise Tolerance Testing (ETT) and Echocardiograms. Establish an Integrated Diabetes Service Development Group to expand the range of diabetes patient pathways agreed between general practise and hospital specialists. Support the design and implementation of clinical/patient education and tools for the self management of diabetes. Expand the range of Clinical Genetics pathways agreed between general practise and hospital specialists. Expand the range of Palliative Care patient pathways agreed between general practise and hospital specialists.	CVD pathways available online via the Health Pathways website. People receive ETT and Echocardiograms on direct GP referral from Q2 2011/12. Agreed Diabetes pathways online. Clinical Genetics pathways design beings Q1 2011/12. Palliative Care patient pathways design begins Q2 2011/12.

Improve organisational fitness. *To identify opportunities to centralise, consolidate or improve business practices and enable the DHB to meet future needs within available resources.*	Continue to support the Supply Chain Strategy to reduce stock holding, improve turnaround time from order to supply and reduce supply chain costs. Support national Shared Services Establishment Board initiatives to achieve efficiencies, economies of scale and standardisation across the health sector.	Further reduction in consumable costs across the DHB. 80% of all electronic purchasing through the Supply Chain Department catalogue.
Align strategic activity across the Southern region. *To make the most effective use of resources and workforce and ensure equity of access for our populations.*	Share the Canterbury Initiative process to support the development of clinically led patient pathways across the Southern Region. Formalise regional clinical service arrangements to allow for improved planning of capacity, workforce and infrastructure through active engagement and support of South Island regional alliances.	All five South Island DHBs implement HealthPathways for their district. An integrated neurosurgical service is established in accordance with the Governance's Board timeframes.

Urgent Care - A Whole of System Approach to Reducing ED Length of Stay

Why is this important?

In a constrained system with limited capacity, our approach to managing patient flow becomes even more important.

If we are to continue to deliver care, we will need to ensure that our capacity is matched to demand and the right care is delivered rapidly and responsively to reduce the risk of emergency department (ED) attendance and avoidable hospital admission. This will enable us to ensure that scarce secondary resources are available for the people who need a more complex level of care.

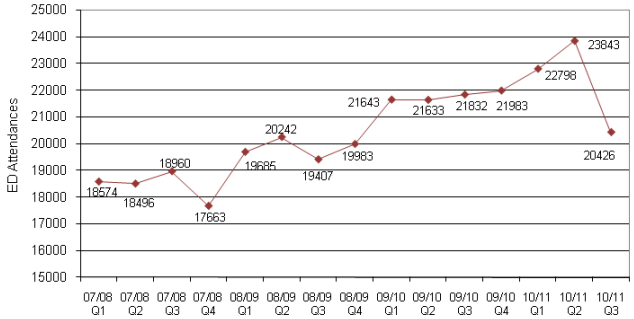
The patterns of use of services following the February quake have been particularly unusual, so it is even more important that our service response is flexible, as capacity and funding needs to move rapidly to meet changes in demand.

Increasing ED presentations and acute admissions to our hospitals consume resources and places pressure on clinical care, diminishing the effectiveness of hospital activity. Reducing the need for acute admissions by supporting people to stay well, to better manage their long-term conditions and to seek appropriate intervention early will also improve health outcomes for our population.

Meeting the Minister's Expectations

95% of patients will be admitted, discharged or transferred from ED within six hours.

CANTERBURY ED ATTENDANCES 2007/08 TO 2010/11

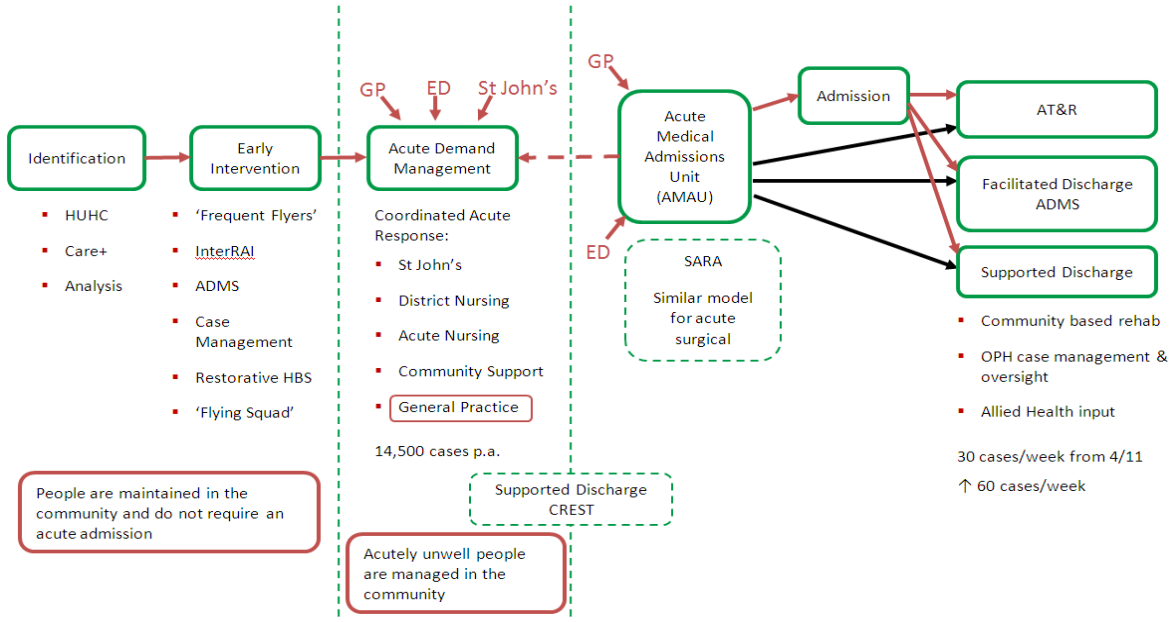


Where do we want to be?

The growth in acute demand can only be managed through initiatives focused across the whole of the health system. We will continue to take an integrated approach to managing acute demand by strengthening strategies to address *preload* (reducing acute demand, principally through primary care), *contractility* (ensuring effective ED functioning) and *afterload* (ensuring hospital flow, reducing gridlock and improving community based discharge services and rehabilitation). This approach requires effective and affordable access to urgent care, rapid access to advice and diagnostics and alternative models of care for ambulance call-outs.

The sustainability and effectiveness of after-hours services in Canterbury plays a key role in improving acute demand management. General practice after-hours care is designed to meet the needs of people who do not need acute hospital services but cannot be safely deferred until regular general practice services are next available. The affordability of these services requires attention, as there is evidence that when fully funded, post-quake access to urgent primary care during he regular working day and after hours increased and contributed to a decrease in self referrals to ED. This evidence will be tested in the coming year.

Figure 7: Improved Acute Patient Flow



HOW WE'RE GOING TO GET THERE – OUR PERFORMANCE STORY 2011/12		
OBJECTIVE	ACTION	EVIDENCE
Improve access to the most appropriate urgent care options to meet patient need at any given time. *To reduce ED presentations, especially in self and ambulance referrals, by ensuring appropriate referrals and access to urgent care in the community (preload).*	Reorient existing acute demand services to focus on patients with the greatest capacity to benefit and support people with a high level of need to access appropriate urgent care in the community rather than in hospitals. Expand nurse-led telephone triage and acute ambulance triage pathways for alternatives to hospital admission. Further develop and target flexible community based urgent care (admission avoidance) options and packages. Enable proactive management of vulnerable patients in the community including community observation and increased access to urgent diagnostics. Establish acute patient pathways to improve access to urgent clinical information and triage. Reduce after-hours care cost barriers for urban and rural high-needs people/populations.	>16,800 urgent care packages provided in the community. Public communication package encouraging people to phone their general practice for non-urgent care in place September 2011. Reduction in the growth rate of ED attendances. Reduction in the growth rate of medical admissions. Increase in access to general practice care (24/7) for people requiring urgent access to care. Increased ED ratio of triage 1 to 3 versus 4 and 5.
Deliver shorter stays in emergency departments. *To deliver ED services to patients in a timely manner that respects the patient's needs and values their time (contractility).*	Continue to utilise Project RED as the comprehensive, prioritised approach to contractility, employing lean thinking and similar methodologies to: Improve the flow of patients through ED, AMAU and SARA. Support ED, AMAU and SARA to access acute demand services in the community. Improve information systems to track the patient journey in ED and monitor time milestones for each patient. Support the clinical champions to provide leadership in improving acute care across the health system.	95% of people admitted, transferred or discharged within 6 hours of ED presentation. A reduction in the number of people acutely admitted from AMAU/SARA. A reduction in total case weights, but an increase in the average, reflecting complexity of acute admissions.
Improve supportive discharge process to provide people with appropriate care and support to return to their own homes. *To reduce time spent in ED, length of stay in hospital and reduce the likelihood of readmission (afterload).*	Implement the DHB recovery plan to support best use of available beds at both Christchurch Hospital and Princess Margaret Hospital through effective transfer processes. Establish the integrated District Nursing and Restorative Home Support model in order to better support older people in their own homes. Continue the development and expansion of CREST to ensure people are safely discharged home from hospital in a timely manner and avoid readmissions.	Phased roll-out of restorative model 75% complete by Q4 2011/12. 1,500 people access CREST services. 800 clients access a community based fall prevention programme. Reduction in readmission rates. Elective and arranged inpatient ALOS <4.00 days.

	Establish a new integrated community-based falls prevention programme including integrated care pathway and sector-wide training so that people are safer in their own homes and to reduce readmissions as a result of falls.	Acute inpatient ALOS <4.00 days.

Elective Services

Elective Services are non-urgent procedures and operations that improve people's quality of life. We will make the best use of the resources we have available, provide equity of access and certainty of care and keep waiting times under six months.

Why is this important?

The Canterbury DHB's population is growing and ageing, and the burden of long-term conditions is increasing. These trends result in increasing demand for elective services. It is important for the wellbeing of our population that we meet as much of this elective demand as possible, ensure our population receives equitable access to services and minimise the demand for acute services.

Meeting the Minister's Expectations

- 16,110 elective surgical discharges will be delivered - an increase of 632 on the 2010-11 targets.[34]

Where do we want to be?

To achieve our objective of increasing elective surgical discharges, we will continue to work collaboratively with our regional DHB colleagues through the South Island Regional Elective Services Plan. Taking a more collaborative approach will improve the delivery of elective services not only to our own population, but also that of the wider South Island. By making formal clinical arrangements around the delivery of services, we can better plan capacity and workforce needs and improve regional outcomes, without putting delivery of services to our own population at risk.

We are continuing a number of initiatives that have improved the delivery of elective services in Canterbury and enabled us to increase capacity - including full daily elective production plans for all surgical services. These initiatives aim to improve turnaround time for surgical patients, improve patient and staff safety and remove duplication and waste from theatre practice.

In response to capacity constraints, we have adopted a 'whole of system' production planning approach, incorporating private surgical capacity. We anticipate needing private capacity in some areas of elective surgical services, such as Ophthalmology, Orthopaedics, Cardiac Surgery, General Surgery and Urology, in order to support delivery of appropriate levels of service to our population over the next two years. However, we recognise this as a short-term solution, and we are taking an innovative and collaborative approach to planning and contracting for these services. We will reduce our reliance on private capacity to deliver electives as earthquake-compromised services are repaired or remodelled facilities are available within our hospitals.

We will also continue to deliver against the national Elective Services Patient Flow Indicators (ESPIs) which measure clarity, timeliness and fairness. Canterbury is committed to achieving the national targets for ESPI 2 and ESPI 5, and will continue working toward reductions in waiting times for our population, including a focus on managing long-wait patients and working toward 100% by 2012-13.

HOW WE'RE GOING TO GET THERE – OUR PERFORMANCE STORY 2011/12		
OBJECTIVE	ACTION	EVIDENCE
Increase production capability. *To deliver the elective surgical discharges planned in 2011/12.*	Engage services in production planning and development of 'whole of DHB' production plans that provide a clear operational basis for delivery (including private capacity). Support weekly production planning to deliver to capacity and respond to changes in demand. Maintain a pool of low complexity 'list fillers' who can come earlier for surgery at short notice. Deliver clinically appropriate elective procedures in acute settings where outcomes are more beneficial for patients.	Hospital outputs delivered to within 3% of overall plan. 16,110 elective services discharges delivered in Canterbury facilities. Elective Services Standardised Intervention Rates ≥308. Improved utilisation of theatre sessions to ≥85%. Continued compliance with ESPIs.

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

	Work in partnership with other South Island DHBs to agree a regional production plan and action plan to identify capacity available in the region and collectively ensure equitable access to elective services. Redirect appropriate IDF inflows, to increase the capacity available to our residents in our facilities. Utilise other DHBs' facilities to deliver care to our residents where possible and appropriate. Utilise other DHB staff resources to deliver planned additional sessions in our facilities. Formalise agreements with private providers to ensure service delivery occurs within national pricing framework. Increase uptake of the Electronic Referral Management Service (ERMS) to ensure the right patients are referred for surgery.	Increases in elective surgical delivery are able to be matched to the unmet need in our community. Uptake of ERMS by general practice will increase to 30%
Continually improve performance. *To improve service quality and capacity within our hospital and specialist services and reduce waiting times for our population.*	Ongoing implementation of lean thinking principles and processes, including production planning, to identify and remove the bottlenecks in current capacity, improve patient flow and reduce waiting times. Support surgical teams to establish performance benchmarks to improve start times and patient turnaround and increase available theatre time for additional elective procedures. Develop improved clinical frameworks for managing ICU beds to enable a greater flexibility to match the supply of ICU beds to demand. Post-quake, refine acute theatre models of care to reduce the impact of variation in acute demand on the delivery of elective surgery and support a culture that ensures, wherever clinically appropriate, day surgery and day of surgery admissions (DOSA) are normal practice, including: ▪ Additional consultant-led orthopaedic lists; ▪ Additional acute plastics (hand) lists; ▪ 23 hour ward for post-surgery patients; and ▪ Redesigned model to manage colonoscopy (surveillance) waiting list.	Hospital outputs are delivered to within 3% of plan. Utilisation of theatres increases to ≥85%. >85% of acute patients receive surgery within 24 hours. 60% of elective and arranged surgeries are day surgeries. 90% of elective and arranged day surgeries are day of surgery admissions. Elective and arranged inpatient ALOS ≤4.00 days. Acute inpatient ALOS ≤4.00 days. 30 day mortality rates maintained ≤1.67.

3.2 Better, Sooner, More Convenient Healthcare

We will ensure access to a wider range of integrated services, in more convenient locations, to further improve the overall health status of our population.

Why is this important?

Primary care is most people's first point of contact with health services and is also the point of continuity in health - providing services from disease prevention and management through to palliative care. Population growth, the increasing burden of long-term conditions and the changing demographics of our population all combine to increase the demand for health services, and as our population gets older, people develop more complex health issues that require higher levels of intervention. To free up our secondary care services to cope with increasingly complex demand, we are supporting the integration of health and social services across the whole of the system and building capacity in our primary and community services to support this direction and to improve health outcomes for our population.

While this direction of travel was in place before the recent series of earthquakes in Canterbury, the loss of capacity and damage to health and social services infrastructure and to private homes and businesses makes accelerated development even more important.

Meeting the Minister's Expectations

- *'Better, sooner, more convenient'* health care for all New Zealanders, including improved frontline services, integrated hospital and community services and services provided closer to people's own homes.
- 95% of two years olds are fully vaccinated
- 90% of the eligible adult population have their CVD risk assessed once every five years.
- An increased proportion of the expected population with diabetes will receive a free diabetes annual review and those receiving a free annual diabetes review will have satisfactory or better diabetes management (HbA1c≤8%).

NOTABLE SUCCESS

Canterbury's fist Integrated Family Health Centre opened in Rakaia in June 2010.

300 HealthPathways have assisted health professionals to provide consistent and integrated care to their patients.

10,000+ procedures have been delivered in the community instead of in hospital since December 2008 – closer to people's own homes and without the need for a hospital visit.

2,000 direct referrals are made every month by Canterbury GPs to community based radiology services, ensuring prompt care for their patients.

14,500 patients were provided with acute packages of care in 2009/10, reflecting the extensive community based activity focused on keeping people out of hospital.

91% of two year olds were fully vaccinated in the third quarter of 2010/11, despite the earthquake's adverse impact on patient behaviour and service delivery.

The Canterbury earthquakes have disrupted the provision of primary care services with many families having shifted from their usual homes and disconnected from their usual primary care networks. Others who have stayed in their homes are facing different challenges that have interrupted their usual routines and health seeking behaviours.

While we remain committed to achieving the Minister's health targets relating to long-term conditions (diabetes and cardiovascular disease) and immunisation - the population shifts being experienced have shifted the baseline assumptions and make prediction of targets against the normal systematic measures challenging. Accordingly Canterbury has not set formal targets against these three health targets but primary care teams will continue to engage with their population about these matters and measures will continue to be reported as we work to regain capacity.

Where We Want to Be

The Canterbury Clinical Network (CCN) was formed as a response to opportunities provided by the Government to transform health systems across New Zealand and was established with the explicit inclusion of the DHB as a key partner to enable a collaborative planning approach across the whole of the Canterbury health system. The CCN's work focuses on delivery of Canterbury's *'Better, Sooner, More Convenient'* Business Case (submitted in 2010), including the establishment of Integrated Family Health Centres and Networks and the strengthening of clinical leadership as a fundamental driver of improved patient care.

The focus across Canterbury will continue to be enabling clinical leadership over the range of areas that must be improved within the health system and, as a result of the earthquakes, re-establishing people's connection with

primary care and their general practice team. People utilising hospital EDs when hospital level treatment is not required will be supported to reconnect with general practice teams, in order to support their ability to live healthy lives in the community and free up specialist staff to provide timely service to those that need it the most.

Improvements will continue to be made at the interface between primary and secondary sectors. A significant number of the initiatives established across the interface in the past three years have been driven through our unique Canterbury Initiative. This model works by bringing together clinical representatives from general practice, hospital specialties and the community to identify and address challenges and design new pathways and models of care to improve the patient journey and support integrated service delivery. HealthPathway help to improve the referral of patients to secondary services, thus improving waiting times and ensuring that patients are referred to the most appropriate services. Towards the same end, efforts will continue to ensure that more diagnostic procedures are available on direct referral from GPs and to increase the number of procedures and follow-up work that is carried out in primary care – closer to peoples own homes and without the need for hospital appointments.

Integrated Family Health Centres (IFHCs) will be developed across rural Canterbury, as well as to replace damaged primary care infrastructure within Christchurch - particularly in the eastern suburbs. This will help to rebuild primary care services in a way that supports ongoing improvement in the integration between these services. Hubs will be developed as a basis for the provision of secondary and specialist services in the community – closer to patients. We expect to develop between 7 and 10 IFHC/Community Hub business cases, including new models of care and business models, by December 2011.

As part of our 'whole of system' approach to improving the continuity of care teams across the sector will be provided with tools to work within a restorative model and help frail elderly people avoid falls, thus enabling older people to live healthy lives in their own homes for longer. A range of initiatives is planned with the input of health and social service professionals from a range of disciplines. More rehabilitation services will be provided in people's' own homes. Patients will benefit from increased engagement with pharmacists to review the type of support they require and reduce the risks associated with their medication.

The focus on shared care, structured around the patient, is helping to minimise waits and unnecessary hospital visits. Like the shift of appropriate services out of hospital-based settings it is consistent with international research, evidence and experience on improving patient outcomes by providing the right service, at the right time and in the right place. It also meets the clear expectations of the Minister of Health for DHBs to provide *'Better, Sooner, More Convenient'* healthcare for their populations.

Two other key projects underway include the development of an electronic shared care system, which will provide electronic access to care plans and key clinical information for health professionals across the system involved in the care of people with complex sets of problems. Consideration of the best way to provide community laboratory services will also be deliberated and will include engagement with leadership in other districts within the South Island in order to determine the best way forward.

HOW WE'RE GOING TO GET THERE – OUR PERFORMANCE STORY 2011/12		
OBJECTIVE	ACTION	EVIDENCE
Implement the urgent care workstream. *To provide the most appropriate urgent care options to meet patient need at any given time, and ensure that only people who need hospital services present at ED and that others receive timely care in the community.* *Post February 22nd and subsequent engagement with General Practice it has been noted that this programme has experienced a 20% increase in uptake. The planned delivery is based on this increase continuing.*	Ensure that patients with acute conditions are provided with the most appropriate treatment by the most appropriate provider.	95% of patients admitted, discharged of transferred from an ED within six hours
	Continue to provide appropriate episodes of urgent care in the community to ensure that hospital services are reserved for conditions that are best managed by them.	>16,800 Acute Demand Packages of Care managed in a primary care setting during the 2011/12 year.
	Further develop community based Acute Demand Management Services (ADMS) to support people with a high level of need to connect with primary care for care that is best provided outside of a hospital rather than this care being provided within the ED. These services include: ▪ Community observation units; ▪ Packages of care; ▪ Acute nursing teams; ▪ Access to urgent diagnostics; and ▪ Service coordination.	A new framework for ADMS service provision, with strengthened clinical leadership, agreed and put in place before 30th Sept 2011 based on a Service Level Alliance. >2 improved practices or pathways reported on each quarter.
	Encourage patients to phone their general practice for	Public communications package in

	non-emergency care and relevant guidance on a 24 hour a day, 7 days a week basis in order to assist patients to seek care from the appropriate provider.	place by 30 September 2011.
		95% of general practices utilise the telephone triage system outside of business hours by June 2012.
Implement the aged care workstream. *To enable older people to live well at home and in their community and reduce demand on acute hospital and aged residential care services.*	Establish the integrated District Nursing and restorative home support model in order to support older people to continue living healthy lives in their own homes.	Phased rollout of restorative model 75% complete by Q4 2011/12.
	Fund appointments in primary care for medication review to ensure that medication associated adverse events are minimised and that patient outcomes are maximised.	2,000 targeted medication reviews provided to people 65+ with complex medication and support needs.
	Continue the implementation of CREST to ensure people are safely discharged home from hospital in a timely manner and avoid admission to hospital for people that can be rehabilitated in their homes. ▪ Stage 2 CREST entries from surgery and AT&R. ▪ Stage 3 CREST entries from general practice and ED. ▪ Stage 4 CREST intake service complete.	900 people (65+) supported upon hospital discharge by CREST services. 600 people (65+) supported upon direct GP referral by CREST services. A 10% reduction in acute hospital readmissions for people supported by CREST.
	Pass on the innovations developed as a part of the Gerontology Nurse Practitioner initiative in the Papanui area to other areas.	Further Gerontology Nurse Practitioner Service explored, with a decision made by 31 March 2012.
	Establish a new, integrated community-based falls prevention programme, including an integrated care pathway and training across the sector by Q1 2011/12. Ensure that older people that are especially vulnerable as a result of earthquake damage have priority access to falls assessments.	800 clients access a community based falls programme. A reduction in the proportion of the population (75+) admitted to hospital as a result of a fall.
	Engage ARC facilities in quality improvement work with other significant components of the system to ensure that optimal care is provided.	Evidence provided to show that planning towards these goals has occurred and is being implemented.
Implement the Primary Secondary Integration Workstream. *To support the provision of the right care in the right place at the right time by the right provider.*	Continue to expand the range of patient pathways between primary and secondary care to ensure patients receive the right care from the right provider, support the reduction in waiting times and maximise the value provided by clinicians right across the health sector.	350 HealthPathways available for use within Canterbury.
Implement the urban Integrated Family Health and Social Service Network System. *To support health and social service providers coming together to work in a defined community to operate as an integrated team.*	Implement Integrated Family Health Centres and Networks within Christchurch.	5 – 6 IFHCs developed or under development to replace damaged infrastructure.
	Develop community hubs to provide a range of outpatient and community specialist activity alongside extended primary care.	Plans developed for up to four hubs within the region.
Implement the Rural Health Workstream. *To ensure health services in the rural parts of Canterbury deliver comprehensive, integrated family health services equitably, efficiently and sustainably.*	Continue to expand the development of Integrated Family Health Centres (IFHCs) in rural Canterbury.	Construction of an IFHC occurs in Kaiapoi before October 2011.
		Construction of an IFHC begins in Darfield before 30 June 2012.
		Final design completed for an IFHC in Kaikoura before 31st December 2011.
Implement the Long Term Conditions Workstream. *To reduce the growth in the number of people with, and improve the outcomes of those who have, long term conditions, including diabetes, cardiovascular disease and respiratory disease.*	Mitigate the impact of long term conditions by supporting those who are at risk or have identified disease to live healthier lives through provision of relevant investigations and provision of agreed care plans. With a particular focus on achievement of the national Health Targets. Reprioritise the flexible funding pool to support a sharper focus on these areas and ensure that approaches are made more consistent across Canterbury.	Feedback on the level of achievement provided to primary care providers. 90% of identified smokers provided with advice and help to quit smoking.
		An increased number of patients receive CVD assessments.
		An increased number of patients

	Implement the Collaborative Care Management System to provide integrated information and care planning for people with complex needs. Continue the new Māori/Pacific Diabetes/CVD screening programme for early detection of at risk urban and rural Māori and Pacific people.	receive diabetes annual reviews.
		1,042 Māori/Pacific Diabetes/CVD screening consultation subsidies provided.
	Encourage all patients to enrol with and engage with general practice as their single point of ongoing continuity for healthcare.	Narrative provided showing how this message is being supported.
	Provide Canterbury Initiative clinical training to support new pathways.	Training plan developed before 30th September 2011.
Implement the Referred Services Management Workstream. *To enable transformation activities across Canterbury and support Business Case initiatives.*	Ensure that the use of community referred radiology continues to maximise value to the people of Canterbury.	>30,000 Community Referred Radiology referrals submitted. 90% of referrals submitted during the year are accepted. 30% of referrals submitted are provided electronically.
Implement the Pharmacy Workstream. *To enable transformation activities across Canterbury and support Business Case initiatives.*	Implement new dispensing arrangements to support effective and efficient use of subsidised medicines by providing expert medicines advice to prescribers and patients.	Six demonstration sites involving pharmacy and general practice operating under the revised multidisciplinary model before 30 June 2012.
Implement the recommendations of the Leadership and Support Service Level Alliance (SLA). *To enable transformation activities across Canterbury and support Business Case initiatives.*	Implement the functional and structural changes recommended by the Leadership and Support SLA showing how they ensure the following outcomes are achieved: ▪ Reduction of duplication; ▪ Reduction in bureaucracy; ▪ Financially sustainable solutions; and ▪ Leadership and support adding value.	Transitional steps planned by 31st December 2011.
		Activity occurs according to the transition plan.

3.3 Older Persons' Health Services

We will support older people to stay healthy and well and in their own homes for as long as possible, and establish a sustainable level of service provision for the future.

Why is this important?

Canterbury's population is ageing, and as older people experience more illness and disability than other population groups, this is driving an increasing demand for health and disability services and aged residential care services. We estimate that approximately half our resources are engaged in providing health services for people over 65.

The February earthquake has impacted considerably on inpatient and residential care capacity. Canterbury has lost 635 Aged Residential Care (ARC) beds, with seven facilities evacuated and nine other facilities deemed vulnerable. There is concern about exacerbated health issues over winter, the impact of damaged housing, increased anxiety and stress and access difficulties in some parts of the city. The Canterbury health system has accelerated many initiatives planned for the future to help address the pressure on reduced inpatient and ARC capacity, secure system sustainability, deliver appropriate services to our older population and retain the available workforce.

Meeting the Minister's Expectations

- Improved service delivery and reducing waiting times;
- Provision of services closer to home and further integration of services to improve continuity of care and reduce pressure on hospital services;
- Improved health service for older people - focusing on improving older people's underlying health and wellbeing and preparing to meet the impact of our ageing population; and
- Regional cooperation between neighbouring DHBs to maximise clinical and financial resources.

Where We Want to Be

While older people's health issues are likely to be more complicated, they can be supported to rebuild and even improve their functioning after illness. Provided people have adequate supports and have a manageable level of need, ageing in place will likely result in a much higher quality of life, and people may remain healthier for longer as a result of staying active and positively connected to their communities.

Our priorities and planned activity in relation to older people are aligned with our vision of integrated continuums of care and patient pathways across the whole of health system to enable better management of long-term conditions and a reduction in acute and unnecessary hospital admissions. The emphasis is on flexible, responsive, needs-based care, provided in the community to assist older people to stay well and in their own homes.

This work will be further enhanced through the 'whole of system' approach driven through the Aged Care Work Stream of the Canterbury Clinical Network and the activities arising from implementation of Canterbury's *Better, Sooner, More Convenient* Business Case, which includes a focus on age-related care.

Following the February 22nd earthquake, ARC capacity was reduced by 635 beds. Beds had been lost in September, but because of reducing admission rates there was spare capacity to absorb the loss. This is no longer the case, and Canterbury sits on a knife-edge of greater than 98% bed occupancy. To address this issue, a number of strategies have been established to reduce our reliance on ARC and guide the redevelopment of ARC capacity to make sure it is consistent with Canterbury's future vision. It is important to note that the lack of beds has also reduced access to respite and alternatives to ARC based respite care are in development.

HOW WE'RE GOING TO GET THERE – OUR PERFORMANCE STORY 2011/12

OBJECTIVE	ACTION	EVIDENCE
Implement the ARC Recovery Residential Plan and ARC components of the Canterbury Recovery Plan. *To support people post-quake, restore capacity in the short to medium term and take a more strategic approach to meeting future demand for services.*	Support the Single Point of Entry created post-quake. Support older people, their families and ARC repatriate into Canterbury through the Vulnerable Persons' Team. Continue to support ARC providers to focus on clinical safety within environmental challenges. Provide nursing and supervision support through the Clinical Nurse Specialist Team to improve quality in ARC. Support ARC providers with clear direction around new builds and repairs to best meet future demand levels. Explore alternative service models that include a focus on	ARC facilities contracted to accept residents from SPOE only. All residents who wish to return are repatriated by Q3 2011/12. A reduction in issues based comprehensive services assessments of ARC. Continuation of ARC InterRAI pilot. ARC Recovery Plan adopted by ARC.

	supporting carers and improving workforce satisfaction.	
Continue to establish the restorative services model across Canterbury services. *To provide more responsive and targeted services to better meet the needs of older people and enable them to maintain and regain independence.*	Oversee the transition of home based support service providers to the restorative model, to better support older people to maintain and regain their independence. Ensure restorative home support providers have training for and access to the InterRAI contact assessment for non-complex clients by Q1 2011/12. Support a redeveloped approach to assisted day care, respite services and ED services for older people to better identify and refer people at risk of deteriorating health.	InterRAI training undertaken by 3 providers by Q2 2011/12. Phased rollout of restorative model 75% complete by Q4 2011/12. Day care and respite services improvement plan delivered by Q3 2011/12.
Provide a timely and coordinated discharge and rehabilitation services for older people who require ongoing support after discharge from hospital or to avoid hospital admission. *To enable people to return home with the necessary treatment and support to restore functioning and maintain independence.*	Implement the CREST (Community Rehabilitation Enablement and Support Team) service for medically stable older people who are discharged from hospitals throughout Canterbury. Expand the service by facilitating direct referrals into CREST from primary care and ED to reduce the need for a hospital admission by Q1 2011/12. Support the CNN to champion and monitor the CREST programmes with regular reporting on referrals and outcomes for people referred into the service. Establish a means to measure improved functional independence of older adults in CREST by Q2 2011/12.	900 people (65+) supported upon hospital discharge by CREST services. 600 people (65+) supported upon direct GP referral by CREST services. A 10% reduction in acute hospital readmissions for people supported by CREST services. Reduction in ARC admissions for people supported by CREST.
Provide a structured, systematic and consultation-based medication management service in the community. *Improve patient understanding of their medicines-related health outcomes and support patients to improve self management of their medications.*	Develop and implement a clinically led Medication Management Service (MMS) through the Medication Management Service Level Alliance. Develop and implement a complementary MMS Pharmacist Service to increase the coverage of the service across the Canterbury region. Provide an education rollout for the MMS to GPs, PHOs, pharmacists and other community health providers to improve understanding of the service & referral pathways.	Medication Management System implemented by Q1 2011/12. Education sessions running by Q1 2011/12. 2,000 medication reviews provided for people (65+) on multiple medications.
Implement a 'whole of system' approach to falls prevention with provision of community-based falls prevention programmes to older adults (65+) across Canterbury *To supports older adults to maintain independence and live safely in their own homes and communities, reduce harm and hospitalisation as a result of falls and reduce acute demand and early entry into ARC.*	Develop a clinically led 'whole of system' falls prevention strategy that includes complimentary and aligned falls prevention activities across secondary, primary, community and aged residential care. Develop and implement education sessions for physiotherapists, GPs, Nurses and Pharmacists that complementary to the falls prevention programme. Provide a complementary Vitamin D Supplementation Programme in ARC to further reduce hospitalisations and harm as a result of falls. Support the Clinical Board and CCN to champion and monitor the falls prevention programmes with regular reporting on outcomes and milestones of the programme. Monitor fall rates across Canterbury and set targets for improvement from 2012/13 onwards.	Integrated community-based falls prevention programmes in place and providing services across Canterbury by Q1 2011/12. A reduction in the proportion of the population (75+) admitted to hospital as a result of a fall from 4.2% A 20% reduction in the rate of falls resulting in harm in Canterbury hospitals to 1.68 by 2012/13. An increase in the number of residents prescribed Vitamin D supplements in Canterbury ARC facilities from 47%.
Align strategic activity across the South Island. *To make the most effective use of resources and workforce and ensure equity of access for our populations.*	Participate in the South Island Regional Alliance for Older Persons' Health and support the Regional Work Plan. As 'regional provider', lead the rollout of InterRAI across the South Island to reduce variation of assessments and service access/provision Implement the South Island Dementia Initiatives to improve the skill sets of those working with older people who have dementia. Engage in the next steps of the ARC review.	InterRAI incorporated into assessment processes of all 5 South Island DHBs. An increase in the number of Canterbury ARC facilities using InterRAI from 11 to >25. Tailored programmes established for dementia training for South Island DHBs by Q3 2011/12.

3.4 Mental Health Services

We will provide an integrated, responsive system of mental health care that provides timely access to services for people with mental illness and alcohol and other drug problems.

Why is this important?

It is estimated that at any one time, 20% of the New Zealand population have a mental illness or addiction and 3% are severely affected by mental illness. While suicide rates have been reducing overall, this is still a key focus for the DHB and certain groups within our population continue to be at high risk. WHO Burden of Disease forecasted that depression will be the second leading cause of disability by 2020.

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

The February earthquake and ongoing aftershocks will have a significant psychological impact on the Canterbury population, and addressing this impact is a key component of the recovery effort. This requires an innovative 'whole of system' response that addresses mental health issues in the immediate, medium and longer term. Specific programmes have already been established in response to the earthquake and will continue to develop as community need becomes more apparent. A four-tiered response that spans primary, community and secondary services is being implemented, which will incorporate dedicated individual and group programmes for children and youth, adults and older people.

Meeting the Minster's expectations

- Improved service delivery and shorter waiting times;
- Improved clinical leadership and strengthened clinical engagement;
- Provision of services closer to home - further integration of services across the continuum of care to improve continuity and convenience for patients and reduce pressure on hospital services; and
- Regional cooperation between neighbouring DHBs to maximise clinical resources.

Where do we want to be?

Our system of mental health is based on a recovery approach. We are continuing to develop our community-based options, which provide services closer to people's own homes, and we are experiencing the benefits of increased collaboration among providers, service users and their families/whānau.

Partnerships among mental health service providers have continued to evolve and strengthen to support the recovery approach, and commitment to integration of services across the sector is evident in the willingness of all parties to work closely together. Canterbury's Mental Health Leadership Group is now well established and ensures the ongoing development and refinement of our mental health system is led by clinicians, consumers and consumers' families. Through this group, we identify service improvement opportunities across the whole of our health system and strengthen clinical engagement in service development.

Simplifying access pathways and improving access to specialist clinical resources are a major focus. We have established single points of entry for child and youth services and for adult services, which receive referrals and enable GPs and Non-Government Organisations (NGOs) to telephone a consultant psychiatrist for treatment advice for people who do not require case management within specialist services. This provides the benefit of timely specialist advice without the need for a specialist appointment or disruption of the primary or community care relationship.

Integration within our own specialist mental health services has been improved with a closer working relationship between community and inpatient services. A planned realignment of these services will increase community-based service options, ensuring people with complex and non-complex mental health needs are well supported by flexible clinical and support services. Implementation will be progressed by reconfiguring current resources from across the mental health system.

Our Alcohol and Other Drug (AOD) Plan was developed to streamline our AOD system and support collaboration across AOD services. The plan sits within the wider scope of best practice and focuses on local solutions for Canterbury by using the extensive experience of local consumers, families, clinicians and other stakeholders. The changes made to date have enabled earlier access to assessments, increased the numbers of people accessing AOD services, and led to numerous service improvements within AOD organisations across Canterbury.

Suicide prevention continues to be a priority, and our Suicide Prevention Initiative has resulted in improved screening in primary care. Thorough post-attempt planning has occurred, with the expectation that this service will commence in 2011. It will be introduced across primary and secondary services with a particular focus on the Christchurch Hospital Emergency Department for a 24 month pilot period.

In the coming year, we will continue to examine the range of mental health services in Canterbury and critically evaluate whether this meets the needs of service users and will enable us to meet future demand. This work will include a regional focus on alignment and integration and on implementation of the Regional Mental Health Plan (refer to Appendix 7).

HOW WE'RE GOING TO GET THERE – OUR PERFORMANCE STORY 2011/12

OBJECTIVE	ACTION	EVIDENCE
Establish earthquake-related mental health services. *To support people post-quake and meet expected increased demand.*	Provide increased resources to primary and secondary services to expand their workforce and implement trauma cognitive behavioural therapy based programmes. Provide clinical support and expertise to non-health community providers that contribute to the four-tiered mental health earthquake response.	> 1,300 additional services are made available for people suffering anxiety and trauma as a result of the earthquake including assessments, individual treatments and extended consultations.
Reorient the mental health system to reflect current needs. *To improve access and service responsiveness for people with mental illness, reduce acute readmissions to specialist mental health services and enable the DHB to meet future needs within available resources.*	Provide an expanded range of community services, supported through reconfiguration of resources consistent with the clinically led Adult Services Plan (and according to the direction of the rehabilitation systems framework). Provide long-term clients with management plans to better enable coordinated care between providers and support self management. Support the clinically led realignment of DHB community and inpatient adult specialist mental health service teams to deliver a shared care response. Increase the range of consult liaison and acute community services available and expand the service hours.	An increased number of people access complex mental health services: ▪ ≥2% for people aged 0-19 ▪ ≥2.5% for people aged 20-64. >95% of all long-term clients have current relapse prevention plans in place. >3,500 people access Brief Intervention Counselling in primary care. 60% of people are seen by specialist services within 7 days of pre-admission. 65% people receive post-discharge community care within 7 days of discharge.
Implement the AOD Plan. *To improve responsiveness for people with addictions and enable the DHB to meet future needs within available resources.*	Realign existing services to ensure consistency with the AOD Framework. Provide an increased range of flexible community AOD support options to enable more people to access AOD services in the community and closer to their own homes.	An increased number of people access AOD services. Wait times for AOD services are minimised.
Implement the Suicide Prevention Initiative. *To improve service quality and better support people at risk.*	Implement consistent assessment and management processes for suicide risk across primary and secondary settings and in our ED services. Implement a consistent response to post-attempt care with an initial pilot in our ED services.	At the completion of the 24 month pilot period, the evidence base provides an evaluation of the initiative. Ongoing outcome measures are developed.
Align strategic activity across the South Island. *To make the most effective use of resources and workforce and ensure equity of access for our populations.*	Participate in the South Island Regional Alliance and support the implementation of the Regional Mental Health Plan. As 'regional provider', take the lead in workforce education and supervision to build capacity and capability across South Island services and better support the continuum of care for patients, particularly when they are transferring between regional and district provider services.	A better regional perspective on mental health planning and funding improves effectiveness and ensures equity. Service Provision Framework (clinical pathways) in place for Child & Youth AOD services by Q2 2011/12.

3.4 Child and Youth Health Services

We will promote and improve the health of children and young people to enable them to make healthier choices and become healthier adults.

Why is this important?

A focus on child and youth health is seen as an investment in the future health and wellbeing of the population of Canterbury. Poor health in childhood can lead to poorer health outcomes into adulthood. Risk and protective factors and social patterns established in childhood and adolescence have a significant impact on health long-term.

Thankfully, the earthquakes did not result in many casualties among children and young people; however, they had a discernable effect on clinical services. With the damage to homes and infrastructure in Christchurch, some important interventions have been initiated. Free influenza vaccination has been extended to children from 6 months to 17 years of age to protect this population group. Home heating initiatives have been prioritised to where houses are damaged and to those with the greatest vulnerability to cold-related illness. Mental health initiatives in primary care and specialist mental health services have been designed to meet the anticipated needs among children, young people and their whānau/families as a result of the stress of the major events and the ongoing aftershocks.

International literature on disaster recovery indicates that those who were vulnerable prior to the disaster have an increased risk of poor health.[35] To compensate, we will place additional focus on interventions that will help identify those more vulnerable children and young people and support them to access services that will improve their health outcomes in the immediate and longer term.

Meeting the Minister's Expectations

- Improved service delivery and reduced waiting times;
- Improved clinical leadership and strengthened clinical engagement;
- Provision of services closer to home and further integration of services to improve continuity of care and reduce pressure on hospital services; and
- Regional collaboration between neighbouring DHBs to maximise clinical resources.

How are we improving outcomes for our population?

A number of our clinical services were affected by the earthquakes: neonatal intensive care saw a surge in the number of pre-term births at a time when capacity was stretched and, along with the Children's Haematology Oncology Centre (CHOC), temporarily transferred care of some patients to other DHBs around the country after the February earthquake. Community oral health facilities have been relocated to the HIllmorton Hospital site after their building was damaged in the February quake. We will consider workforce uncertainties and unknown demand factors in the coming 12 months, and initiatives are in place as part of the Canterbury Recovery Plan to address the effects of the earthquakes on our clinical services.

Our 'single point of entry' that enhances access to mental health services for children and young people has been reinforced to manage the expected increase in demand. We will continue to develop the Youth Brief Intervention Service that provides assistance in schools, communities and through mobile services in rural areas to support young people with mild to moderate mental health and alcohol and drug issues. The service has been reinforced to allow greater access for young people whose mental health has been affected by earthquake stresses. We will also develop an integrated response to reduce alcohol-related harm in young people, beginning with an assessment of the number of young people presenting for medical care for alcohol-related services (including injuries).

Fewer than 5% of children in Canterbury have access to fluoridated water, and therefore enrolments in dental programmes will be a key focus in 2011/12, combined with good oral health promotion. Clinical training will be provided for health professionals in Well Child, Tamariki Ora and general practice services to improve the delivery of oral health promotion. The redevelopment of our community dental facilities is substantially complete, with the opening of the Lincoln clinic scheduled for August 2011. All 18 mobile units have digital imaging equipment, and the implementation of a dental imaging server in July 2011 will further improve diagnostic services.

We will investigate delivery models for child health services to combine and streamline similar services, better support providers and improve data management. This will include developing community paediatrics as a health-promoting service.[36] This service will be at the interface of primary and secondary care and will focus on: leading

[35] *Bidwell, S (2011), 'Long term planning for recovery after disasters: ensuring health in all policies – a literature review', CDHB-Community and Public Health*

[36] *Services for Children and Young People - General and Community Paediatric Services Tier Two Service Specification January 2011.*

evaluation of clinical services for children and young people; development of good systems of care for health to facilitate prevention; and ensuring assessment and response to community needs in child and youth health.

To address the needs of vulnerable children and young people, we will continue to consolidate the 'B4 School Check' programme in Canterbury. Although we aim to reach all four year olds, we will prioritise children with the highest need to strengthen the relationship between high-need families and their general practice team and reduce the number of unnecessary hospital admissions for younger population groups.

We will also continue to focus on creating supportive environments for our younger population groups and work collaboratively with other government agencies to strengthen our approach to family violence. We will prioritise the prevention and management of child abuse and neglect and support government promotions including the 'Protecting our Most Vulnerable Infants' initiative and the national Child and Partner Abuse programme. We will also implement the new 'comprehensive gateway assessments' for children and young people in care.

HOW WE'RE GOING TO GET THERE – OUR PERFORMANCE STORY 2011/12

OBJECTIVE	ACTION	EVIDENCE
Implement immediate and medium-term recovery solutions to address earthquake-related issues and further improve integration between primary and secondary care. *To restore capacity in the short to medium term, reduce risk of unknown demand and meet future demand for services.*	Implement the Child and Youth Health work stream of the Canterbury Recovery Plan. Develop and implement an enhanced recruitment strategy for nursing staff in neonatal and child health services. Restrict the age group referred to the CHOC service to 0-15 years to reduce risk around over-capacity as a result of the lower North Island additional workload and post-quake uncertainty, until completion of enhanced facility.	Reduction in DNA rates for outpatient appointments.
	Increase the coordination of child and youth services available in Canterbury between primary and secondary care, including development of the community paediatrics services. Ensure any dedicated child health facility incorporates the objectives of the Charter on the Rights of Children & Young People in Healthcare Services in Aotearoa NZ[37] and the Facilities Business Case identifies facility requirements to meet population, physical, cultural and developmental needs.	100% of children requiring a paediatric FSA receive one within 6 months of referral (ESPI 2). 100% of children given a commitment for paediatric treatment are treated within 6 months (ESPI 5).
Better support oral health providers to improve oral health outcomes *To identify those children most at risk of tooth decay and implement effective preventive care.*	Ensure services for children requiring complex treatment are maintained post-quake. Work with Well Child, Tamariki Ora providers and general practice to implement a risk-based, targeted preventive care programme for children aged 9 months to 12 years. Continue the implementation of the Oral Health Business Case and redevelopment of community dental facilities: ▪ Open the Lincoln Clinic in August 2011. ▪ Implement the dental imaging server in July 2011.	≥90% of children enrolled in school and community dental services are examined according to planned recall. 67% of children are carries-free (no holes or fillings) at age five. A decrease in the number of children (<13 years) requiring general anaesthetic for dental treatment <692.
Identify and support those more vulnerable children and young people with the highest health needs. *To ensure early intervention in problems that affect children's wellbeing and development and ready access to services to minimise the long-term impact of the Canterbury earthquakes.*	Invest in primary and secondary mental health services to meet the anticipated needs among children, young people and their whānau/families as a result of the stress of the major earthquake events and the ongoing aftershocks. Develop an integrated response to reduce alcohol-related harm in young people initially in ED and after-hours services.	>2% young people (0-19) access specialist mental health services. An increased number of young people access Brief Intervention Counselling in primary care.
	Closely monitor access to B4 School Checks, referral patterns, growth and development. Support PHO mobile engagement teams to improve the uptake of B4 School Checks amongst Māori, Pacific and Quintile 5 children.	80% of all children (aged 4) receive a B4 School Check. 80% of Māori and Pacific children and children in deprivation Quintile 5 receive a B4 School Check.

[37] *Children's Hospitals Australasia / Paediatric Society of New Zealand (2011) Charter of Tamariki/Children's & Rangatahi/Young People's Rights in Healthcare Services in Aotearoa New Zealand.*

	Establish and arrange 'gateway assessments' for children and young people entering Child, Youth and Family (CYF) care and those residing in CYF residential facilities.	Gateway assessment processes established.
Promote family violence intervention and prevention programmes *To identify and reduce violence against children and young people and enhance the wellbeing of children in and out of home and CYF residential care.*	Train staff in the identification of child maltreatment and the impact and importance of screening for family violence. Ensure the CDHB Child and Family Safety Service and Child Health Service have adequate resources to undertake timely multidisciplinary assessments of children at risk. Participate in the development of the national Child Protection Clinical Network.	All recommendations from the Auckland University of Technology audit of the CDHB Violence Intervention Programme (VIP) are implemented. Combined audit of child an partner abuse components of the VIP ≥140/200.
Align strategic activity across the South Island. *To make the most effective use of resources and workforce and ensure equity of access for our populations*	Assist the progression of the regional child health alliance network in developing quality tools and identifying the best location for child health services from both a district and regional perspective. Develop regional clinical pathways for children transferring between district and regional services. Support the development of a regional paediatric early warning score protocol to improve assessment of unwell children and ensure the right care and support is provided. Review admission trends for respiratory and skin infections locally and regionally.	South Island regional clinical pathway for paediatric surgery established by August 2011. Shared paediatric early warning score protocol trialled from September 2011.

Immunisation

Why is this important?

The recent earthquakes will have a flow-on impact on immunisation rates in Canterbury. Canterbury rates were high prior to the February earthquake, with 92% of all children, 90% of Māori and 93% of Pacific children fully immunised by their second birthday. The earthquakes have interrupted general practices' systematic pre-planning and recalls for immunisations.

The dislocation of families has made tracing children and encouraging timely immunisations much more difficult in post-earthquake conditions. There will be a significant number of children having 'late' immunisations and children missing events who will have to be located and immunised by outreach services. There are also a number of relocated families who are living outside of Canterbury who need to be traced. The HPV programme will be likewise affected by the earthquake, with likely delays to immunisation.

Meeting the Minister's Expectations

95% percent of all two year olds are fully vaccinated.

Canterbury is unlikely to reach this target due to the significant disruption and dislocation of general practices and Christchurch families. However we will aim high and exercise our best endeavours to bring our immunisation rates back up to pre-quake levels and to meet the Minister's expectations. The coming year will be devoted to supporting general practice to re-establish their enrolled populations, which will allow systematic recall and follow-up of target populations. While we re-establish systems and regain capacity over the coming year, we will continue to monitor and report performance.

Where do we want to be?

An Immunisation Service Level Alliance (ISLA) was established in June 2010, and an integrated service model for immunisation was developed in August 2010. The ISLA has identified four key actions that need to occur to increase immunisation rates: development of an immunisation promotion plan; appointment of a missed events coordination role; development of an immunisation reporting programme; and the developed of an outcome framework and key performance indicators for service providers. These actions will support all immunisation events, including childhood, 11 year old, HPV and seasonal influenza immunisation programmes – they will also support us to bring immunisation rates back to pre-quake levels and to re-establishing general practice contact with enrolled populations.

It is anticipated that Canterbury immunisation rates may drop as much as 20%, and additional targeted support to catch up includes: targeted recall at general practice; increased resources into missed events and outreach services;

and a Canterbury-wide promotion programme to encourage families who have missed an event to come in and remember the importance of timely vaccination.

The Ministry have provided an immunisation support package to assist Canterbury to boost outreach and follow-up services in order to track and immunise children that have been dislocated from their normal general practice as a result of the earthquakes. The focus in the first half of 2011/12 will be on improving childhood immunisation rates and influenza vaccination rates, to improve the likelihood of reaching 'herd immunity' status in the community. We will then turn increased focus onto bringing HPV immunisation rates back up, to improve individual immunity for young women in Canterbury. We will also expand access to immunisation for children in health care settings such as hospital clinics and inpatients wards with opportunistic immunisation.

HOW WE'RE GOING TO GET THERE – OUR PERFORMANCE STORY 2011/12		
OBJECTIVE	ACTION	EVIDENCE
Integrate and continue to improve the quality of immunisation services across the system *To increase immunisation coverage in Canterbury and reduce hospital admissions and illness due to vaccine-preventable diseases*	With the assistance of the Ministry support package: Develop and implement a Canterbury wide Immunisation Promotion Plan. Appoint a childhood immunisation missed events administrator to support general practice and outreach providers to track, find, recall and immunise hard to reach referrals and children dislocated from their usual general practice. Temporarily expand outreach services to support additional work in locating Christchurch children. Resolve data and system issues that will improve the accurate reporting of fully immunised children and assist in locating those who have not been fully immunised. Support the ISLA to develop new promotion strategies, monitor key performance indicators for service providers and improve the quality of immunisation services in Canterbury. Expand access to immunisation for children in secondary health care settings.	Missed events and extended outreach in place by Q1 2011/12. Regular reporting on rates of Canterbury children fully vaccinated at age two. Immunisation rates for children aged two return to pre-quake levels (91%) HPV immunisation rates for young women return to pre-quake levels (average of 44.6% Dose 1).[38]

Maternity

Our mission is to support women to be well mentally, physically and spiritually during their maternity journey: through preconception and very early pregnancy, antenatal, labour and birth as well as after birth and moving into parenthood.

Why is this important?

We believe that we need to align our maternity model of care with that introduced as part of Canterbury's Health Services Planning and our 'whole of system' vision. This takes a whole population approach to all of the health issues that impact on the health of mothers and babies. The maternity journey requires all health providers right across the system to work together to ensure that women are healthy, prepared and supported.

The February 22 earthquake has meant that we need to reconsider where we deliver maternity services in Canterbury. The closure of the St George's Maternity Unit due to earthquake damage has reduced birthing options for Christchurch women. While we made some immediate provision to provide maternity services through the greater use of primary birthing units this will not be sustainable over the longer term.

Where do we want to be?

We conducted a workshop, using a participatory model, to obtain and understand the perspective of women and family/whānau, maternity providers, other health professionals and non government organisations in regards to all stages of the maternity journey. Over 120 people attended and identified what works well, where there are gaps and the key areas where we could improve our service. We will work to progress actions and activity from this work in the coming year.

[38] *The measure is based on young women 12-18 who have been provided with Dose 1 of HPV. The national average is based on the 'major' six DHBs and pre-quake levels taken from February 2011. Like childhood immunisation rates, HPV immunisation rates will be negatively affected by displacement in Christchurch.*

In essence we want women to consider pregnancy as a normal life event.

- To be well and prepared for pregnancy;
- To receive early and consistent care during pregnancy;
- To have a safe and satisfying birth experience; and
- To be healthy and confident post birth to care for their healthy breastfed baby.

We plan to work with the Ministry of Health to implement key priority areas that support national consistency in the coming year, including work on national quality and safety standards and national clinical indicators. We will also take part in revising referral guidelines, service specifications and maternity standards. As part of this national work we will also look at improving maternity information systems and analysis and the introduction of national standardised, electronically transferrable maternity notes.

The DHB does not employ the significant majority of Lead Maternity Carers (LMCs) providing maternity services in Canterbury, and a partnership based around the clinical needs of women and their babies is vital to improving the maternity journey for women. Part of our focus over the past year has been the implementation of a national demonstration project linking pregnant women (who need additional medical support), their LMCs and their GP to improve continuity of care throughout the pregnancy. Canterbury has been one of two pilot sites in the country and the evaluation of this pilot is currently underway. We will make a decision on the direction we will take around this programme on release of the national evaluation.

In the short term we intend extending the capacity of two of our primary birthing units. This will provide us with time to better analyse and consider the primary birthing needs for Canterbury in the longer term, in the aftermath of this past year's seismic events. In the medium term our experience at Kaikoura with the integration of LMCs and primary care has been very positive for the community and we are exploring the opportunities around incorporating primary birthing facilities into IFHC and Community Hubs as part of our business case development.

HOW WE'RE GOING TO GET THERE – OUR PERFORMANCE STORY 2011/12		
OBJECTIVE	ACTION	EVIDENCE
Establish future infrastructure and workforce requirements and provide services that recognise the whole maternity journey. *To provide women with access to maternity care that meets their needs and expectations and enables the DHB to meet future needs within available resources.*	Analyse data pre and post earthquake in order to determine the most appropriate structure and location for primary birthing facilities in Canterbury. Consider the development of primary birthing facilities as part of the IFHC and Community Hub business case development.	Decision regarding future birthing units is made Q4 2011/12.
	Progress themes identified at the maternity journey workshop that have been on hold since the earthquakes. Develop and deliver a publicity campaign to increase awareness of birthing options and use of primary units. Review the maternity model of care for Ashburton. Develop a process for women and providers to identify a Lead Maternity Carer (LMC) which best meet their needs.	An increased number of women are birthing in community primary birthing facilities >13%.
	Take appropriate steps on release of the national evaluation of the demonstration project related to improving the continuity of care for pregnant.	Actions are taken in line with Ministry evaluation recommendation.
	Provide education and breastfeeding development opportunities for LMCs, practitioners and social service providers to help them support new mothers to develop confidence in breastfeeding. Provide lactation classes for pregnant women to promote and teach the art of breastfeeding and support environments that encourage breastfeeding. Identify women, particularly new mothers who smoke and offer then advice and support to quit smoking.	>85% of women have established breastfeeding on discharge from hospital. >95% of hospitalised smokers are offered advice and support to stop smoking.

3.6 Māori Health Services

We will work closely with stakeholders and providers to ensure that Māori and their whānau have access to services that best meet their needs to achieve Whānau Ora.

Why is this important?

The Canterbury population generally has better access to health services and better health status than the average New Zealander. This is true for all ethnicities living in Canterbury, but nonetheless, there are still real disparities between Māori and the rest of the Canterbury population in relation to health outcomes and life expectancy.

Canterbury's Māori population is growing and is a more youthful population; they have higher rates of diabetes, cardiovascular disease and respiratory disease and are over-represented in terms of risk factors, particularly smoking, where two in every five Māori women are regular smokers.

We have particular concerns with regard to the health of our Māori population after the recent earthquakes. Many of our worst-affected communities have proportionately higher Māori populations. These populations face colder homes, increased stress and overcrowding in homes and schools - all factors which increase their vulnerability to both physical and mental illness. Many whānau have shifted from their homes and are effectively disconnected from their usual primary care networks. Whānau who have stayed in their homes face different challenges that have interrupted their usual routines and health-seeking behaviours. Loss of personal income and interruption of transport links will present further barriers in accessing health care.

Meeting the Minister's Expectations

An amendment to the NZPHD Act in June of 2010 requires DHBs to develop Māori Health Plans. Canterbury's Māori Health Plan is available on our website and will be reported against quarterly to Manawhenua ki Waitaha, our Community and Public Health Committee and the Ministry of Health. A large section of this plan involves regional collaboration across the South Island to improve outcomes for our Māori populations.

ACHIEVEMENTS FOR MĀORI IN CANTERBURY

192 Māori enrolled with the Aukati Kaipaipa smoking cessation programme in 2009/10.

82% of Māori women were screened through the BreastScreen Aotearoa Programme.

90% of Māori two years olds were fully vaccinated in the first six months of 2010/11.

631 Māori participated in the new PHO Māori Diabetes/CVD screening programme to ensure early detection for at-risk Māori.

Where We Want to Be

In line with our 'whole of system' vision, we recognise that Māori participation in service development needs to be fostered to improve outcomes for our Māori population. This includes active participation at governance and advisory levels and a focus on Māori-led service provision and service development to ensure Māori received the right care and support, from the right person, at the right time, and in the right place.

Our success in establishing good foundations for our younger populations will assist in improving Māori health outcomes, including engagement in immunisation, B4 School Checks and free oral health services. Māori will also benefit from our investment in clinically led patient pathways and continuums of care across the Canterbury health system, including the development of targeted long-term conditions programmes and the provision of services closer to people's own homes and in the community.

A key focus will be our support of the transformation in primary care and the engagement streams initiated by the Canterbury Clinical Network to ensure Whānau Ora is central in the development of patient pathways and models of care for long-term conditions management. There is a national expectation that DHBs will focus on improving Whānau Ora, and we will work collaboratively across the Canterbury health system and the wider South Island region to combine resources to improve outcomes for our Māori population.

The number of appropriately skilled Māori staff employed in the health sector is also a factor in ensuring we have the right people with the right skills to provide the care and support needed. Canterbury will take the lead in the South Island for Kia Ora Hauora, a national initiative aimed at increasing the number of Māori studying towards health careers and working in health fields. We will continue our commitment to our local provider forums, which will help to build the capability and capacity of Māori service providers and the responsiveness of our own services.

These key areas are recognised in our Māori Health Plan for 2011/12.

HOW WE'RE GOING TO GET THERE – OUR PERFORMANCE STORY 2011/12		
OBJECTIVE	ACTION	EVIDENCE
Raise awareness of risk factors and the determinants of health. *To create environments that support Māori to take more responsibility for their own health and wellbeing and reduce inequalities in health status.*	Work with Tamariki Ora providers to identify and invest in strategies to support Māori mothers to breastfeed, including peer support programmes and lactation services. Temporarily expand immunisation outreach services to support additional work in locating Māori children dislocated from their usual general practice. Support PHO mobile engagement teams to improve the uptake of B4 School Checks amongst Māori children. Work with Tamariki Ora providers and general practice to implement a risk-based, targeted preventive oral health care program for children aged 9 months to 12 years. Invest in community based promotion to educate, recruit and retain women into the cervical screening programme. Support ABC Smoking Cessation Programmes in hospital and primary care settings to provide advice and support for people wanting to stop smoking.	64% of Māori children are fully or exclusively breastfed at 6 weeks and >18% at 6 months. Immunisation rates for Māori children (aged two) return to pre-quake levels. HPV immunisation rates for young Māori women return to pre-quake levels. 80% of Māori children (aged 4) have had a B4 School Check. 90% of Māori children enrolled in school and community dental services are examined according to planned recall. 75% of Māori women (20-69) are screening under the National Cervical Screening Programme. 95% of hospitalised smokers and 90% of smokers identified in primary care are provided with advice and help to quit.
Improve the management of long-term conditions. *To support Māori to stay well in their own homes and communities and reduce the demand for complex care and hospital and specialist services.*	Support the development of responsive programmes to better meet the needs of Māori through the CCN Māori Health and Long Term Conditions work streams: ▪ A Diabetes/CVD screening programme with a target of 1,042 consultations for early detection of at-risk Māori. ▪ Workshops that support primary care to provide care consistent with the emerging direction on Whānau Ora. ▪ Patient pathways to improve health outcomes for Māori, including the development of a cardiology pathway. ▪ Tailored respiratory programmes for Māori. ▪ An integrated diabetes service, promoting diabetes management guidelines, referrals pathways and education for those newly diagnosed with diabetes.	Increased numbers of Māori with diabetes have their diabetes systemically monitored. Increased numbers of eligible Māori have a CVD risk assessment every five years. An increase in Māori access rates to community based sleep assessments and community pulmonary rehabilitation programmes. Preventable hospital admissions rates for Māori across all age groups remain <95.
Reorient health services to reflect the needs of Māori. *To identify opportunities to reduce inequalities of access or health status between population groups, support Māori participation in the development of services and enable the DHB to meet future needs within available resources.*	Support Canterbury's Māori and Pacific Provider Forum to raise awareness amongst mainstream providers of the capacity and capability of Māori and Pacific health providers. Support the development of patient pathways to increase access to culturally appropriate options for Māori. Monitor performance against the Canterbury Māori Health Plan to help establish clear areas of priority and inequity. Work regionally to develop a process that better supports patients and whānau when they are transferring between services and between DHBs.	Māori whānau are supported to access health services and to navigate through and utilise health services. Increased referrals to and by Māori service providers in the community. Māori Health Plan progress reported quarterly. Improved long-term health outcomes for Māori in line with improvements for other population groups.
Support Māori workforce development. *To increase the number of Māori working in health fields and improve the cultural responsiveness of mainstream services.*	Engage Māori in health as a career option and provide up to 10 scholarships for study in primary health care fields. Lead the delivery of the national Kia Ora Hauora Māori Workforce Development Service in the South Island. Support Canterbury's Māori and Pacific Provider Forum to develop a clinical leadership team as a collaborative partnership across all services. Support the engagement of Māori and Pacific providers' clinical workforce with the Canterbury DHB's Medical Education and Training Unit.	Increased numbers of Māori choose health as career – nationally, 1,000 Māori enrolled and studying towards careers in health within 3 years. >50 Treaty and Tikanga Māori training programmes delivered across Canterbury health services.

3.7 Disease Prevention

By promoting healthy lifestyles and creating healthy environments, we will support people to take more responsibility for their own health and reduce the prevalence and impact of long-term conditions.

Why is this important?

Long-term conditions account for a significant number of potentially preventable presentations at emergency departments and admissions to hospital and specialist services. With an ageing population, this burden will increase. The World Health Organisation estimates that more than 70% of health care funds are currently spent on long-term conditions. Long-term conditions are also a barrier to independence and participation in the workforce and in society. Reducing risk factors will help mitigate the predicted increase in rates of long-term conditions, reduce demand for more complex intervention and enable people to attain the highest possible quality of life.

The February earthquake has impacted considerably on Canterbury residents. Many families have shifted from their homes and are effectively disconnected from their usual community and primary care networks, especially in the hardest hit areas. International literature on disaster recovery indicates that those who were vulnerable prior to the disaster have an increased risk of poor health, and those people already affected by long-term conditions are at risk of exacerbations of their conditions.[39]

An increase in risk behaviours such as tobacco smoking, alcohol consumption, poor nutrition, and decreased physical activity is typical in response to stressful events, and has been evident following the earthquakes. The concern is that while additional levels of stress continue, without interventions and support, inappropriate lifestyle behaviours are even more likely to develop for the longer term.

Meeting the Minister's Expectations by July 2012

- 95% of hospitalised smokers will be provided with advice and help to quit smoking; and
- 90% of enrolled patients who smoke and are seen in general practice will be provided with advice and help to quit smoking.

Where We Want to Be

The continued provision of community-based services and the facilitation of community action projects are central to rebuilding communities and promoting positive lifestyle behaviours.

Our Tobacco Control Plan identifies priority populations and environments where we will focus our efforts to reduce the harm caused by tobacco smoking, reduce the uptake of smoking and increase quit levels, particularly amongst identified high-risk groups. We have embedded the 'Ask, Brief advice, Cessation support' (ABC) programme in our services, and although in February, we were on track to reach the target, the earthquakes interceded and the overall rate has reduced slightly.

There is strong clinical leadership for smokefree in our hospital and specialist services. Our directors of nursing have taken responsibility for the smoking cessation health target, and a new clinical lead for smokefree in secondary care has been appointed. This senior clinical leadership is supported by a group of champions at ward level who are kept updated and provide smokefree support to their peers. Training in ABC is made available in a range of settings and can be provided formally or informally. ABC is becoming part of routine care.

Work is proceeding with the PHOs in developing systems for documenting smoking status and provision of brief advice and cessation support. Robust internal structures have been developed, including strong clinical representation, and a plan for training staff at practice level is being implemented. Efforts are being made to have consistent identification and delivery across general practice and resources are being shared to enable this.

2010 HEALTH NEEDS QUESTIONNAIRE

We asked residents what the important health issues facing our population are…

- 16% indicated they were frequent users of the health system.
- 56% described their health as excellent or very good.
- 29% stated they had good health.
- Only 2% described their health as poor.
- 86% identified drugs & alcohol as a risk factor affecting the health of our community, and 65% identified poor nutrition as a risk factor.
- Exercise/nutrition classes were identified by the majority of people as a factor that would help them improve their own health.
- Promoting healthy lifestyles was rated as the greatest action we could do to improve the health of the community.

Source: HealthFirst survey June 2010. 839 people responded, with 76% of respondents being female and 80% over 45 years of age.

[39] *Bidwell, S (2011), 'Long term planning for recovery after disasters: ensuring health in all policies – a literature review', CDHB-Community and Public Health*

The focus to date has been on documentation of smoking status, and good gains have been achieved.

Our Canterbury and West Coast Nutrition and Physical Activity Plan 2010-2012 and public health promotion programmes are focused on reducing risk factors through population and personal health initiatives that target improved nutrition and physical activity. We are committed to our leadership role and will continue to ensure a collaborative approach to improving health and lifestyles, with further emphasis on sharing resources across the whole of the system, reducing duplication and waste and supporting community groups to develop and implement projects that support healthy lifestyles and environments.

We will also continue to promote and extend the breastfeeding services available across Canterbury, provide breastfeeding education and support the development of environments that encourage breastfeeding as a positive foundation for good health - in order to turn-around currently trends in Canterbury and increase breastfeeding rates.

HOW WE'RE GOING TO GET THERE – OUR PERFORMANCE STORY 2011/12

OBJECTIVE	ACTION	EVIDENCE
Implement smoking cessation programmes. *To reduce the major risk factor of long-term conditions and reduce inequalities in health outcomes particularly for Māori who have disproportionately higher smoking rates.*	Provide and promote smokefree environments to support those making cessation attempts and reduce exposure to second-hand smoke. Ensure tobacco retailers comply with legislation. Further support the implementation of the ABC Strategy in hospitals and improve the identification of people who smoke and the provision of cessation advice and support by: ▪ Enhancing ABC documentation and data collection processes and systems; ▪ Supporting training for staff in informal settings and through formal training programmes, including a train the trainer approach; ▪ Developing and supporting clinical leadership through the clinical leader for smokefree, directors of nursing and a range of smokefree champions at ward level; ▪ Exploring ways to support Maori patients who smoke to successfully transition into a primary or community provided cessation programme. Support primary care to implement systems to provide and record the provision of smoking cessation advice by: ▪ Developing resources and provide training on how to document smoking status and the provision of advice or cessation support to GP practices; ▪ Establishing clinical leaders in each PHO; ▪ Ensuring feedback of performance to each practice including the potential use of dashboards or similar equivalents as used in hospital settings; ▪ Providing training and support to pharmacists to ask, provide brief advice and refer to cessation support. Promote the use of NRT and other medications to support effective cessation. Enhance referral pathways to ensure smooth transition from hospital to primary care cessation support or community cessation support (including Quitline). Ensure that at-risk communities in the east of Christchurch have access to cessation support and NRT. Support Māori smoking cessation services and work with statutory and community organisations who deal with large numbers of low-income, Maori and Pacific clients to develop a model of delivery of ABC in the community.	>90% of tobacco retailers identified from controlled purchase operations are compliant with legislation. 95% of hospitalised smokers are provided with advice and help to quit. 90% of enrolled patient who smoke and are seen in general practise will be provided with advice and help to quit. >200 people enrol with the Aukati Kaipaipa smoking cessation programme. >7,000 calls made to Quitline by Cantabrians seeking additional cessation support.

Implement the Nutrition and Physical Activity Plan 2010-2012. *To create environments that support healthy eating, physical activity and weight reduction and empower communities to take positive action to improve health and wellbeing.*	Facilitate community action to empower and enable Māori and Pacific people to achieve HEHA (Healthy Eating Health Action) goals, increase HEHA capability and rebuild communities post-earthquake. Provide programmes that enable older people to improve their cooking skills, nutrition knowledge and physical activity behaviours with a focus on supporting the 'Healthy Eating Healthy Ageing' programme. Develop and implement an integrated community-based falls prevention programme for Canterbury. Engage with CERA and other interagency strategies to support individual recovery and community wellbeing.	Delivery of Māori and Pacific Community Action projects that promote good health and wellbeing. >70% of priority schools are supported by the Health Promoting Schools framework. 80 'Appetite for Life' courses are provided in the community. >1,900 people needing additional physical activity support access Green Prescriptions via their GP. 800 older people (65+) access community-based falls prevention programmes.
Implement our Breastfeeding Action Plan. *To improve breastfeeding confidence and support mothers to care for themselves and their babies.*	Invest in services to support mothers to breastfeed, particularly in rural areas, including peer support programmes and lactation services. Support increased Lead Maternity Carer and Tamariki Ora input into educating, encouraging and supporting women to breastfeed. Strengthen stakeholder alliances and joint planning and coordination via the Canterbury Breastfeeding Steering Group and through joint strategies, projects and promotion of available services. Provide and promote supportive environments that encourage women to breastfeed.	>85% of new mothers have established breastfeeding on hospital discharge. 65 volunteer mothers are engaged in Mum 4 Mum peer support training. 67% of all infants, 64% of Māori and 67% of Pacific infants are fully or exclusively breastfed at 6 weeks. 28% of all infants and 18% of Māori infants are fully or exclusively breastfed at 6 months.
Reduce the harm caused by alcohol. *To reduce a major risk factor of harm and long-term conditions.*	Deliver host responsibility training to duty managers' courses to ensure licensed premises comply with legislation. Carry out evidenced-based promotional activities to improve people's drinking behaviour and reduce the amount of alcohol-related harm. Investigate ways to reduce the harm caused by alcohol, particularly alcohol consumption by pregnant women. Support alcohol screening and educational intervention programmes in hospital and community health systems.	95% of duty managers trained complete Host Responsibility courses. >90% of alcohol retailers are identified from controlled purchase operations as compliant with legislation. Programmes to reduce the harm caused by alcohol are identified in the hospital and community health settings.

3.8 The Management of Long-term Conditions

The outcomes of long-term conditions will be improved for our population by working collectively to reduce risk behaviours and improving consistent access to quality services across the whole system.

Why is this important?

Long term conditions are the leading cause of death and a major cause of hospitalisation in New Zealand. It is estimated that the most common long term conditions (cardiovascular disease, diabetes, respiratory disease and cancer) consume approximately 70% of health resources. They result from common preventable environmental factors and lifestyle choices, such as smoking, poor nutrition, lack of physical activity, excessive alcohol, poor housing, inadequate heating and poor air quality. Systematic management reduces the impact and mortality rate of these diseases through early treatment.

The impact of long term conditions disproportionately affects Māori, and improved screening, detection, management and treatment provides a major opportunity to improve Māori health outcomes and health status.

Meeting the Minister's Expectations

- 90% of the eligible adult population have their CVD risk assessed once every five years.
- An increased percentage of the expected population with diabetes receive a free diabetes annual review.
- Those receiving a free annual diabetes review have satisfactory or better diabetes management (HbA1c≤8%).
- 100% of people who need radiation oncology treatment receive it within four weeks of the decision to treat.

Canterbury will not be able to reach the first three of these health targets due to the significant disruption and dislocation of general practices and Christchurch families. The coming year will be devoted to supporting general practice to re-establish their enrolled populations, which will enable the systematic recall and follow-up of target populations to resume. While we re-establish systems and regain capacity, we will continue to monitor and report performance.

Where We Want to Be

The management of long term conditions is reliant on a systematic primary care response supported by reactive secondary care support. To achieve good management, there must be systematic processes in place for identifying, monitoring and regularly following up patients. Following the recent earthquakes, the population of Canterbury has undergone (and continues to undergo) significant changes and shifts in location, making systemic approaches difficult. Many families have shifted from their homes and are effectively disconnected from their usual general practices (although they have been supported to attend other general practices post-quake). Others who have stayed in their homes are facing different challenges that have interrupted their usual routines and health seeking behaviours. Future progress is reliant on re-establishing contact with and developing new enrolled populations.

Enabling clinical leadership is central to Canterbury's approach to managing long term conditions. The Integrated Respiratory Service Development Group has provided clinical governance for our system-wide respiratory services, including a community respiratory physician, community respiratory nurses and community pulmonary rehabilitation classes. This model will be replicated in diabetes, with the Integrated Diabetes Service Development Group soon to be established. This group will provide clinical leadership for new resources such as diabetes nurse specialists, who will be targeting low-recording practices to assist them with recalls and conducting quality diabetes annual reviews.

Cardiovascular Disease

Why is this important?

Cardiovascular Disease (CVD) includes coronary heart disease, circulation, stroke and other diseases of the heart. It is the main cause of death in Canterbury and the leading cause of hospitalisation (excluding pregnancy and childbirth). Older people, Māori and Pacific people have higher rates of CVD, which will increase as our population ages. CVD is also strongly influenced by environmental and lifestyle influences, including risk behaviours such as poor nutrition, lack of physical activity and tobacco smoking. Increasing rates of CVD will result in greater demand for more specialised care and treatment for heart attack, stroke, heart failure and other circulatory diseases.

Where do we want to be?

Addressing CVD is reliant on systematic measures to prevent and address risk factors and the systemic identification and management of people who have CVD. The participation of our largest PHO (Partnership Health Canterbury) in the PHO Performance Programme (PPP) and a clinically supported organisational shift has occurred with regard to systematic data collection for CVD, diabetes and smoking cessation. This will result in reduced variability in the use of patient management systems and better data extraction, management and reporting.

HOW WE'RE GOING TO GET THERE – OUR PERFORMANCE STORY 2011/12		
OBJECTIVE	ACTION	EVIDENCE
Improve the identification of people 'at risk' of CVD. *To improve access to appropriate intervention and support improved self management of CVD.*	Re-establish enrolled populations and implement systematic recall and follow-up. Continue implementation of the Diabetes/CVD screening programme to improve early detection of at-risk urban and rural Māori. Support implementation of a Diabetes/CVD screening programme to improve early detection of at-risk urban and rural Pacific people.	An increased percentage of the eligible population have had their CVD risk assessed every five years (fasting lipid/glucose test). An increased percentage of the eligible Māori and Pacific populations have their CVD risk assessed every five years (fasting lipid/glucose test). 1,042 Māori/Pacific Diabetes/CVD screening consultations provided.
Ensure people receive the right care in the right setting. *To support improved access to resources, information and support to enable people to modify lifestyles, self-manage their condition and stay well.*	Expand the range of patient pathways agreed between general practice and hospital specialists to include cardiology to support integrated CVD management. Reconnect with enrolled populations, and identify and engage those eligible with a CVD risk assessment in primary care. Develop access to exercise tolerance testing in the community.	CVD pathways available online via the Health Pathways website. An increased percentage of the eligible population receive CVD risk assessments in primary care.[40] People receive exercise tolerance testing from direct referral in the community from Q2 2011/12.
Support rehabilitation programmes. *To reduce the likelihood of a subsequent CVD event and to support people to optimise recovery.*	Continue to support referral of people to cardiac and stroke rehabilitation programmes after acute events. Provide a broader range of specialised rehabilitation and support services for people who need more advanced care.	30% of people access cardiac rehabilitation after an acute event. 69% of people access stroke rehabilitation after an acute event.

Diabetes

Why is this important?

Diabetes is estimated to cause around 1,200 deaths per year in New Zealand and can lead to blindness, amputation, heart disease and kidney failure. The impact of diabetes in terms of illness and the cost to the health sector is significant, and the prevalence of diabetes is increasing at an estimated 4-5% each year, particularly among Māori and Pacific people, with diabetes rates around three times higher than other New Zealanders.

Type II diabetes, most frequently diagnosed in adults and now being diagnosed in Canterbury's young people, is strongly linked to poor nutrition and other lifestyle factors and is therefore amenable to prevention. Good management of the disease results in better outcomes.

Where do we want to be?

The development of the Integrated Diabetes Service Development Group (IDSDG) will provide us with greater clinical leadership to develop a single seamless system for diabetes care. The appointment and training of two additional diabetes nurse specialists will assist in implementing IDSDG recommendations, in particular providing support to general practice to ensure systemic identification and management of people with diabetes.

[40] *This reference refers to the CVD Risk Assessments undertaken in primary care in line with the expectations of the national PHO performance programme.*

In Canterbury, we have worked closely as a system to improve performance and to make processes transparent. For diabetes, this involved establishing consensus around a long-term goal: *"that every patient with diabetes is known to their practice and can be shown to be receiving good regular care"*. An electronic diabetes annual review form, with several fields populated automatically from the practice patient record, has been developed. This will be implemented through the '*Better, Sooner, More Convenient'* Business Case and can also be used for the management of other long term conditions.

HOW WE'RE GOING TO GET THERE – OUR PERFORMANCE STORY 2011/12		
OBJECTIVE	ACTION	EVIDENCE
Improve the identification of people 'at risk' of diabetes. *To improve access to appropriate intervention and support improved self management of diabetes.*	Re-establish enrolled populations and implement systematic recall and follow-up. Identify enrolled population who have diabetes. Support primary care to further develop Māori diabetes project to engage target population. Support primary care to provide education and training to improve diabetes management in practices where additional support is needed. Continue implementation of the Diabetes/CVD screening programme to improve early detection of at-risk urban and rural Māori. Support implementation of a Diabetes/CVD screening programme to improve early detection of at-risk urban and rural Pacific people.	An increased percentage of the expected population with diabetes receives a diabetes annual review and has satisfactory or better diabetes management. An increased percentage of the expected Māori and Pacific populations with diabetes receives a diabetes annual review and has satisfactory or better diabetes management. 1,042 Māori and Pacific people supported through Diabetes/CVD screening programme.
Ensure people receive the right care in the right setting. *To support improved access to resources, information and support to enable people to modify lifestyles, self-manage their condition and stay well.*	Expand the range of diabetes patient pathways agreed between general practice and hospital specialists. Support primary care to manage people newly diagnosed with Type 2 diabetes, and people with diabetes who are starting insulin treatment. Support the design and implementation of clinical/patient education and tools for self management of diabetes.	Agreed diabetes pathways available online through Health Pathways. 206 newly diagnosed patients supported. 94 patients starting insulin treatment supported.

Respiratory Disease

Why is this important?

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

The impact of respiratory disease in terms of illness and the cost to the health sector is significant, with Māori having disproportionately higher rates of respiratory disease. Improved respiratory services provide a major opportunity to improve Māori health outcomes and health status.

Where do we want to be?

We are committed to a clinically led integrated respiratory service and ensuring services continue to be available in the community, so that respiratory disease is identified and treated early and preventable hospital admissions are avoided. Canterbury people have individualised respiratory management plans that promote self management, with support and services located closer to their home.

The range of clinically led services available includes spirometry, sleep assessment and pulmonary rehabilitation in a variety of community and general practice settings, both rural and urban. Respiratory patients receive quality education material and clinical input to support self management. The management of respiratory patients via the respiratory pathways and the community respiratory physician continues to develop, along with cross-referrals for diagnostic services; 81 general practices have referred to other practices for spirometry, and 66 practices for sleep.

Patients can be assured of consistent quality of care across secondary and primary care through the development of IT and quality systems, education programmes and an outcomes framework. Sharing of workforce and other resources across the system continues to ensure high productivity, sustainable development, value for money and improved access for patients.

HOW WE'RE GOING TO GET THERE – OUR PERFORMANCE STORY 2011/12		
OBJECTIVE	ACTION	EVIDENCE
Improve the identification of people 'at risk' of respiratory disease. *To improve access to appropriate respiratory interventions to prevent admissions and to ensure that people with respiratory disease are managed under a structured LTC programme or care plan.*	Consolidate and refine the identification of COPD and OSA by screening alongside other long-term conditions. Formalise and implement the pathway to support case finding for OSA (hip or knee arthroplasty with a BMI > 35) and COPD in primary care. Enhance appropriate access to community pulmonary rehabilitation programmes. Collaborate with Māori Health providers and deliver within the resources available tailored respiratory programmes for Māori. Enhance linkages with public health programmes that encompass warmer homes and smoking cessation.	>1,320 people access assessment for COPD and >1,020 access assessment for OSA (without the need for a hospital appointment). People with OSA are identified via the hip and knee pathway. A reduction in hospital follow-up for COPD patients. A reduction in acute respiratory admissions and a 10% reduction in respiratory readmission rate.
'Better, sooner, more convenient' management for people with respiratory disease *Ensure people receive the right care in the right setting and support people to modify lifestyles, self-manage their conditions and stay well.*	Support seamless patient care and improved access and coordination by enhancing services for patients in remote and rural communities. Introduce a transparent single gateway and triage of specialist referrals to ensure equity of access. Implement the CPAP Model of Care that promotes and supports an annual patient review in the community. Explore combined rehabilitation programmes for people with long-term conditions. Increase access to diagnostics and rehabilitation for Māori and Pacific people with respiratory disease.	Equitable access to respiratory services across urban and rural communities. A reduction in the proportion of people on CPAP who are reviewed annually in the hospital setting. A reduction in the proportion of hospital respiratory outpatient appointments that are follow-ups.
Apply the available Canterbury health workforce in different ways. *To support a rehabilitation focus, meet future needs within available resources and identify sub-regional strategies for sharing resources and managing respiratory patients.*	Provide support and training to local clinicians to enable them to deliver pulmonary rehabilitation in their local communities. Formally combine the Christchurch Hospital and CISO pulmonary rehabilitation programmes. Extend the respiratory education focus to support GP teams to provide care in the community.	180 people access pulmonary rehabilitation programmes delivered within current funding levels (15 programmes). Evidence of a more streamlined process for patients and improved productivity within current FTE.
Enhance secondary care activity for complex respiratory diseases, including lung cancer, cystic fibrosis, tuberculosis and respiratory failure. *To provide disease-specific care across inpatient, outpatient and community settings.*	The Cardio-Respiratory Integrated Specialist Service will work to improve management of complex respiratory diseases. Enhance and support the knowledge base of complex respiratory disease in community settings. Enhance timely provision of tuberculosis care, including appropriate links with Public Health. Enhance the role of lung cancer clinical nurse specialists, reducing time to diagnosis and treatment for lung cancer.	Increased community CPAP support results in reduced in-hospital support for long-term CPAP provision. Reduced hospital length of stay for patients with pulmonary tuberculosis. Reduced hospital length of stay for patients with cystic fibrosis. Lung cancer management meets Ministry targets for time from diagnosis to definitive treatment.

Cancer

Why is this important?

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

Meeting the Minister's Expectations

- 100% of people who need radiation oncology treatment will receive it within four weeks of first specialist assessment.

Where do we want to be?

We aim to enhance capacity and reduce waiting times for cancer treatment to continue to meet the health target. In line with this commitment, a fourth linear accelerator is scheduled to be operational at the end of October 2011, with planning underway for an additional radiation therapist and three additional student medical radiation therapists each year to ensure that future staffing needs are met. Additional radiation oncologist, medical oncologist and radiation oncology medical physicist positions have already been filled. To monitor health target compliance, the DHB will report to the Ministry of Health weekly on the waitlist and plan four weeks ahead for bookings.

Supporting the work of the Southern Cancer Network to develop standardised care across the region is an important focus for our clinicians. Canterbury will lead the extension of Telehealth videoconferencing to the West Coast and South Canterbury DHBs to support cancer services within these DHBs. The Oncology, Haematology and Palliative Care departments have come together to form the Canterbury Regional Cancer and Blood Service to enhance the integration of cancer services.

HOW WE'RE GOING TO GET THERE – OUR PERFORMANCE STORY 2011/12

OBJECTIVE	ACTION	EVIDENCE
Meet clinical guidelines and reduce waiting times for radiation treatment. *To improve access to timely treatment for patients.*	Install the fourth linear accelerator. Expand radiation treatment workforce. Ensure weekly prospective monitoring of radiation treatment waiting list.	The fourth linear accelerator is operational by end of October 2011. 100% of patients needing radiation treatment receive it within 4 weeks of first specialist assessment.
Support palliative care services. *To provide flexible, consistent care to meet the needs of palliative patients.*	Establish a Specialist Palliative Care Governance Group to facilitate sharing of information and other resources between the Canterbury DHB and Nurse Maude Specialist Palliative Care services. Improve patient information flows between the CDHB and Nurse Maude Specialist Palliative Care services.	Evaluation of the 2 year Liverpool Care Pathway pilot by August 2011. >20 ARC facilities trained to provide the Liverpool Care Pathway.
Align strategic activity across the South Island. *To make the most effective use of resources and workforce and ensure equity of access for our populations.*	Participate in the South Island Regional Alliance and support the implementation of the Southern Regional Cancer Network Work Plan. Implement the South Island Clinical Cancer Information System to share data on outcomes and service utilisation to improve service provision and enable informed service planning and development.	A better regional perspective on cancer services improves effectiveness and ensures equity. Clinical Cancer Information System in place Q4 2011/12.

FORECAST OF SERVICE PERFORMANCE

Module 4

Measuring Our Performance

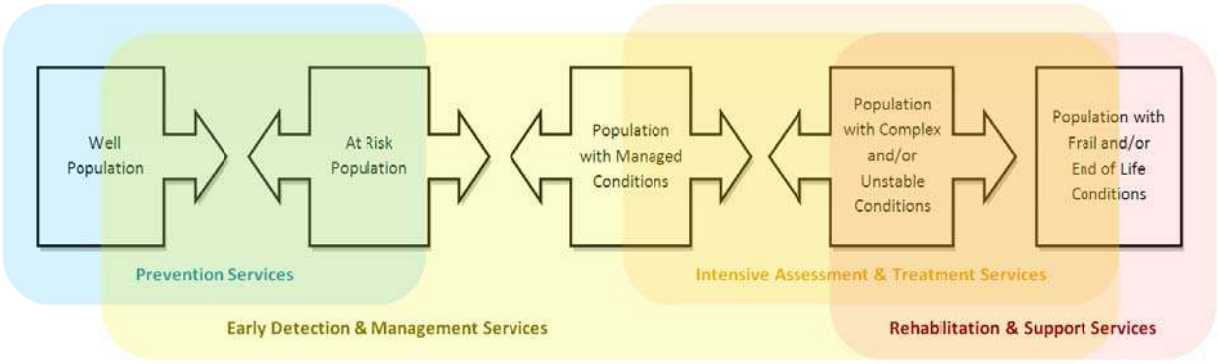
Over the long term, a key role of the health sector is to make positive changes in the health status of the population. Many of the determinants of health are beyond the DHB's influence; Government priorities and national policy and decision-making have a part to play in making health gains. However, as the major funder and provider of health and disability services in Canterbury, the decisions we make have a significant impact on our population and, if coordinated and planned correctly, will improve the efficiency and effectiveness of the whole Canterbury health system.

Understanding the dynamics of our population and the drivers of demand is fundamental when determining which services will be delivered to our population and at which level. Just as fundamental is our ability to assess whether the services we are purchasing and providing are making a measureable difference in the health and wellbeing of our population.

One of the functions of this document is to show how the DHB will evaluate the effectiveness of the decisions we make on behalf of our population. We do this by providing a forecast of the services (outputs) that we will fund and provide in 2011/12 (using associated performance measures and targets) and then reporting against these in our end-of-year Annual Report.[1]

In order to present a representative picture of performance, outputs have been aggregated into four '*output classes*' that are applicable to all DHBs, and are a logical fit with the stages of the continuum care. The contribution (or impact) of each output class on the strategic goals of the DHB are highlighted in the intervention logic diagram on page 32 of this document.

Figure 8: Scope of DHB Operations – Output Classes against the Continuum of Care



Over time, we anticipate it will be possible to use this output class framework to demonstrate changes in allocation of resources and activity from one end of the continuum of care to the other, and our progress in achieving the desired health outcomes for our populations.

Identifying appropriate output measures for each output class is difficult. The DHB also cannot simply measure '*volumes*'; the number of services delivered or the number of people who receive a service is often less important than whether '*the right person*' or '*enough*' of the right people received the service, or whether the service was delivered '*at the right time*'.

[1] *DHB performance is also measured by the Ministry of Health through quarterly reporting against the Performance Monitoring Framework (refer to Appendix 5). Annual Reports can be found on the DHB website www.cdhb.govt.nz.*

We have chosen to present a mix of measures focused on four key elements of performance: *Quantity or 'Volume'* (to demonstrate capacity), *Quality* (to demonstrate effectiveness) and *Timeliness* and *Coverage* (to demonstrate reach and access). Wherever possible, we have included a past year's baseline data to support evaluation of our performance at the end of the year, and national averages to give context in terms of what we are trying to achieve.

The set of output measures we have used reflect a reasonable picture of activity across the whole of the Canterbury health system. They measure those activities with the potential to make the greatest contribution to health and wellbeing in the shorter term, and to the health outcomes we are seeking over the longer term. They also include some specific volume measures which indicate the level of 'demand driven' services to which the DHB has to respond and our estimates (est.) of demand for the coming year rather than a target.

In setting performance targets, we have considered the changing demographics of our population, increasing demand for health services and the assumption that funding growth will be limited. Targets tend to reflect the objective of maintaining performance levels against increasing demand growth to demonstrate increased productivity and capacity.

With capacity severely restricted across Canterbury after the February earthquake, we are focusing new investment on services and programmes that reduce hospital admissions and the demand for aged residential care beds, such as acute demand package and restorative models of care that support people to stay well in their own homes and communities. Performance targets that demonstrate growth in service activity or the establishment of new services therefore tend to be based in primary and community settings and are programmes that will support our recovery and achievement of our vision in the longer term.

Measures that do relate to new services have no baseline data. A number also relate to Canterbury-specific services for which there is no national comparison or national average available. These instances have been noted. Some data is also provided to the DHB on calendar not financial year and rather than footnote every instance a symbol has been added to indicate where this is relevant (†).

Finally, our targets also reflect our commitment to reducing inequalities between population groups, and hence some measures appropriately reflect a specific focus on high need groups.

Where Does the Money Go?

The table below presents a summary of the 2010/11 budgeted financial performance by output class.

Revenue	**Total**
Prevention	$32,343,264
Early detection and management	$417,695,617
Intensive assessment & treatment	$717,226,905
Support & rehabilitation	$264,611,213
Grand Total	**$1,431,877,000**

Expenditure	**Total**
Prevention	$32,343,264
Early detection and management	$430,519,617
Intensive assessment & treatment	$729,402,905
Support & rehabilitation	$264,611,213
Grand Total	**$1,456,877,000**

Deficit	**-$25,000,000**

4.1 Prevention Services

Output Class Description

Prevention health services promote and protect the health of the whole population, or identifiable sub-populations, and address individual behaviours by targeting population-wide changes to physical and social environments to engage, influence and support people to make healthier choices. These services include education programmes and services to raise awareness of risk behaviours and healthy choices, the use of legislation and policy to protect the public from toxic environmental risks and communicable diseases, and individual health protection services such as immunisation and screening programmes that support early intervention to modify lifestyles and maintain good health.

These services are the domain of many organisations across the region including: the Ministry of Health; Community and Public Health (the public health unit of the Canterbury DHB, which also provides services for the West Coast and South Canterbury regions); primary care and general practice; a significant array of private and non-government organisations; and local and regional government. Services are provided with a mix of public and private funding.

Why is this Output Class significant for the DHB?

By improving environments and raising awareness, these services support people to make healthier choices, reducing the major risk factors that contribute to long-term conditions and delaying or reducing the impact of these conditions. Services are often designed to disseminate consistent messages to large numbers of people and can be cost-effective. High need and at risk population groups are also more likely to engage in risky behaviours and to live in environments less conducive to making healthier choices. Prevention services are therefore also our foremost opportunity to target improvements in the health of high need populations and to reduce inequalities in health status and health outcomes.

OUTPUTS SHORT-TERM PERFORMANCE MEASURES (2011/12)

Over the next three years we will fund and provide outputs (services) which will make a positive impact on the health and wellbeing of the Canterbury population. The Quantity (**V**olume), **T**imeliness, **C**overage and Service **Q**uality of those outputs will be measured using the following output performance measures:

Health Promotion and Education Services *These services inform people about risks and support them to be healthy. Success begins with awareness and engagement, reinforced by programmes that support people to maintain wellness or assist them to make healthier choices, change is indicated by rates of positive or negative behaviours (such as smoking rates).*	Notes	Actual 2009/10	Target 2011/12	Current National Average
Volunteer mothers are engaged in Mum 4 Mum peer support training	V [2]	new	>65	-
New mothers have established breastfeeding on discharge from hospital.	Q [3]	85%	>85%	-
Māori infants are exclusively and fully breastfed at 6 weeks.	Q [3]†	61%	64%	62%
Hospitalised smokers are provided with smoking cessation advice and support.	C	40%	95%	57%
Smokers identified in primary care receive smoking cessation advice and support.	C	new	90%	-
Māori smokers participate in the Aukati Kaipaipa smoking cessation programme.	V	192	>200	-
Calls from smokers seeking quit advice are responded to by Quitline services.	Q [4]	6,615	>7,000	-
Priority schools are supported by the Health Promoting Schools framework.	C [5]	74%	>70%	-
'Appetite for Life' courses are provided in the community.	V [6]	52	80	-
People needing additional physical activity support access Green Prescriptions.	V [7]	1,567	>1,900	-

[2] *Mum4Mum training supports social change by allowing the DHB to significantly increase its capacity to deliver key messages through informal contact facilitated by appropriately trained volunteer mothers. The measure is the number of mothers trained.*

[3] *The proportion of women breastfeeding is seen as a measure of service quality, demonstrating the effectiveness of consistent, collective health promotion messages delivered during the antenatal, birthing and early postnatal period.*

[4] *The number of calls made to Quitline reflects the volume of people taking self responsibility by seeking further cessation advice and hence the effectiveness of the smoking cessation health promotion messages, advice and support being delivered.*

[5] *The Health Promoting Schools Framework is used to address health issues with an 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.*

[6] *AFL is a healthy lifestyle programme that helps participants make positive changes to the habits that have led to their weight gain.*

[7] *A Green Prescription is a health professional's written advice to a patient to be physically active, as part of their health management.*

Statutory and Regulatory Services *These services sustainably manage environments to support people and communities to make healthier choices and maintain health and safety. They include: compliance monitoring with liquor licensing and smoke environment legislation, assurance of safe drinking water, proper management of hazardous substances and effective quarantine and bio-security procedures.*	Notes	Actual 2009/10	Target 2011/12	Current National Average
Tobacco retailers are compliant with current legislation.	Q [8]	98%	>90%	-
Alcohol retailers are compliant with current legislation.	Q [8]	95%	>90%	-

Population Based Screening Services *These services are mostly funded and provided through the National Screening Unit and help to identify people at risk of illness and pick up conditions earlier. They include breast and cervical cancer screening and antenatal HIV screening. The DHB's role is to encourage uptake, as indicated by high coverage rates.*	Notes	Actual 2009/10	Target 2011/12	Current National Average
Women are screened for HIV as part of routine antenatal blood tests.	C	60.4%	>65%	-
Children (<5) are provided with B4 School Health Checks.	C [9]	75%	80%	65%
Children (<5) in Quintile 5 are provided with B4 School Health Checks.	Q	new	80%	-
Eligible women (20-69) have a cervical cancer screen every three years.	C [10]	78%	>75%	76%
Eligible women (45-69) have a breast screen examination every two years.	C [10]	85%	>70%	58%

Immunisation Services *These services reduce the transmission and impact of vaccine-preventable diseases. The DHB works with primary care and allied health professionals to improve the provision of immunisations across all age groups both routinely and in response to specific risk. A high coverage rate is indicative of a well-coordinated and successful service.*	Notes	Actual 2009/10	Target 2011/12	Current National Average
Children are fully immunised at age two.	C [11]	89%	n/a	87%
An increased proportion of children (<2) are 'reached' by immunisation services.	Q [12]	96%	n/a	93%
Eligible young women (12-18) are engaged in the HPV vaccination programme.	C [13]	46.2%	>45%	36.5%
Older people (65+) receive a free flu vaccination every year.	V [14] †	48,987	>51,000	-
An increased proportion of the population (65+) are vaccinated against the flu.	C [14] †	75%	>75%	66%

[8] *The proportion of compliant retailers identified through controlled purchase operations is seen as a measure of the quality of the information, training and advice services provided to retailers.*

[9] *The B4 School Check is the final core WellChild/Tamariki Ora check, which children receive at age four. It is free, and includes vision, hearing, oral health, height and weight. The check allows health concerns to be identified and addressed early in a child's development, giving him/her the best possible start for school and later life.*

[10] *The breast and cervical screening standards are based on national targets and Canterbury aims to continue to successfully deliver at a level above these national targets and the national average for all DHBs.*

[11] *Following the February earthquake a significant number of people are displaced from their homes and workplaces. While this group is being supported to attend primary care, this may not be at their usual general practice; disrupting normal recall systems and processes. Hence, explicit targets have not been set for 2011/12 against the Immunisation measures. The DHB will continue to work towards regaining prior performance levels and will monitor and report performance against these indicators.*

[12] *'Reached' is defined as those children fully immunised, as well as those who have declined immunisations, have opted off the National Immunisations Register (NIR) or are on catch-up schedules. This reflects the quality of immunisation services in 'reaching' the parents of eligible children and providing advice and support to enable parents to make informed choices for their children.*

[13] *The measure is based on young women 12-18 who have been provided with Dose 1. The national average is based on the 'major' six DHBs. Like childhood immunisation rates, HPV immunisation rates will be negatively affected by displacement in Christchurch. The lower target reflects the work that will need to be done to reconnect people with their general practice and re-establish immunisation rates.*

[14] *The volume target is based on the number of vaccinations required to achieve 75% coverage and assumes an enrolled population of 70,105 (April 2011). The volume is important, as significant population growth for this age group means an increased volume must be delivered year on year to maintain the same percentage coverage.*

4.2 Early Detection and Management Services

Output Class Description

Early detection and management services maintain, improve and restore people's health by ensuring that people at risk or with disease onset are recognised early, their need is identified, long-term conditions are managed more effectively and services are coordinated - particularly where people have multiple conditions requiring ongoing interventions or support.

These services are by nature more generalist, usually accessible from multiple providers and a number of different locations. They include general practice, primary and community services, personal and mental health services, Māori and Pacific health services, pharmacy services, community radiology and diagnostic services and child oral health and dental services.

Some of these services are demand driven, such as pharmaceuticals and laboratory tests, and services are provided with a mix of public and private funding and may include co-payments for general practice services and pharmaceuticals.

Why is this Output Class significant for the DHB?

New Zealand 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 the prevalence also increases with age. The associated increase in demand for services includes an increasing demand for acute and urgent care services that, in Canterbury, is growing at a faster rate than the growth in our population.

By promoting regular engagement with health services, we support people to maintain good health through earlier diagnosis and treatment, which provides an opportunity to intervene in less invasive and more cost-effective ways associated with better long-term outcomes. These services also help to reduce the burden of long-term conditions by supporting people to better manage their conditions and avoid complications, acute illness and crises. The integration of services to meet Government expectations for '*better, sooner, more convenient health services*' presents a unique opportunity to reduce inefficiencies across the health system and provide access to a wider range of publicly funded services closer to home.

Providing flexible and responsive services in the community, without the need for a hospital appointment, will reduce the overall rate of admissions, particularly acute admissions. Reducing the diversion of critical resources into managing acute demand will have a major impact in freeing up hospital and specialist services for more complex and planned interventions.

OUTPUTS SHORT-TERM PERFORMANCE MEASURES (2011/12)

Over the next three years we will fund and provide outputs (services) which will make a positive impact on the health and wellbeing of the Canterbury population. The Quantity (**V**olume), **T**imeliness, **C**overage and Service **Q**uality of those outputs will be measured using the following output performance measures:

Primary Health Care (GP) Services *These services are offered in local community settings by teams of general practitioners (GPs), registered nurses, nurse practitioners and other primary health care professionals, aimed at improving, maintaining or restoring people's health. High levels of enrolment with general practice are indicative of engagement, accessibility and responsiveness of primary care services.*	Notes	Actual 2009/10	Target 2011/12	Current National Average
The Canterbury population is enrolled with a Primary Health Organisation.	C [15]	97%	>95%	96%
Integrated patient pathways are established across primary/secondary care.	V [16]	189	350	-
People access Brief Intervention Counselling (BIC) in primary care.	V [17]	2,598	>3,500	-
Ambulatory Sensitive Hospital Admission rates for children (0-4) are reduced.	Q [18]	116	<113	100

[15] *The national target for PHO enrolments is 95%, and the aim is to continue to successfully achieve above this level in Canterbury.*

[16] *Integrated patient pathways are clinically designed pathways that inform new patient-centred models of care. The HealthPathways website available from GP desktops contains information and resources to help general practice navigate the established pathways, including information on referrals, specialist advice, diagnostic tools, GP to GP referral and GP procedure subsidies and patient handouts.*

[17] *The Brief Intervention Coordination Service provides people with mild to moderate mental health concerns up to 5 sessions of free 'early' psychological intervention from their general practice teams, with the possibility of onward referral to a related community agency if appropriate. The aim is to provide early intervention and help people to reduce the likelihood of developing enduring conditions.*

[18] *A number of admissions to hospital are seen as preventable through appropriate early intervention and these admissions provide an indication of the access and effectiveness of primary care and an improved interface between primary and secondary services. The expected rate is the national average, and a result greater than 100 indicates worse than average performance.*

Oral Health Services *These services are provided by registered oral health professionals to assist people in maintaining healthy teeth and gums. High enrolments are indicative of engagement, while more timely examination and treatment indicates a well-functioning and efficient service.*	Notes	Actual 2009/10	Target 2011/12	Current National Average
An increased proportion of children (<5) are enrolled in oral health services.	C †	59%	62%	-
Enrolled children (0-12) are examined according to planned recall.	T †	90%	≥90%	-
Children (<13 years) do not require hospital dental care with general anaesthetic.	Q [19]	692	<588	-

Long-term Conditions Programmes *These services are targeted at people with high health need due to long-term conditions and aim to reduce deterioration, crises and complications. Success is demonstrated through identification of need, regular monitoring and outcomes that demonstrate successful management of conditions. A focus on early intervention strategies and additional services available in the community will help to reduce the need for hospital appointments.*	Notes	Actual 2009/10	Target 2011/12	Current National Average
People with diabetes receive free diabetes annual reviews.	V [20]	9,166	n/a	-
An increased proportion of the expected population have free diabetes reviews.	C [21]	43%	n/a	55%
The eligible population (35-74) receives annual CVD risk assessments.	C [22]†	22%	45%	32%
The eligible population (35-79) receives fasting lipid/glucose tests every 5 years.	C [21]	71%	n/a	76%
Māori access GP-based Māori Diabetes/CVD Screening Programmes.	V	new	1,042	-
Skin lesions (skin growths, including cancer) are removed in primary care.	V	2,188	2,800	-
Spirometry Tests are delivered in community rather than hospital settings.	V [23]	859	1,320	-

Pharmacy Services *These services are include provision and dispensing of medicines and are demand-driven. As long-term conditions become more prevalent, we are likely to see an increased dispensing of pharmaceutical items. To improve service quality we will introduce medication management for people on multiple medications to reduce potential negative interactive effects.*	Notes	Actual 2009/10	Target 2011/12	Current National Average
Medication reviews are provided for older people (65+) on multiple medications.	V	new	2,000	-
Total number of pharmaceutical items dispensed in the community.	V	7.98M	Est. <9M	-

Community Referred and Delivered Services *These are services to which a health professional may refer a person to help diagnose a health condition, or as part of treatment. They are provided by personnel such as laboratory technicians, medical radiation technologists and nurses. To improve performance, we will target improved primary care access to diagnostics to improve clinical referral processes and decision making.*	Notes	Actual 2009/10	Target 2011/12	Current National Average
Total number of community-based laboratory tests completed.	V	2.439M	Est. <2.6M	-
Total number of community radiology tests completed on direct GP referral.	V	24,108	>30,000	-
A high proportion of Community Referred Radiology tests are accepted.	Q [24]	new	90%	-

[19] *A reduction in the number of young children requiring invasive complex oral health treatment (under general anaesthetic) is indicative of the quality of early intervention and of public health education and messages regarding the importance of good oral health.*

[20] *The volume target is based on actual number of diabetes reviews provided. The volume is important, as the expected number of people with diabetes within the population increases each year and so correspondingly an increased number of diabetes reviews must be delivered to maintain the same percentage coverage rates.*

[21] *Following the February earthquake a significant number of people are displaced from their homes and workplaces. While this group is being supported to attend primary care, this may not be at their usual general practice; disrupting normal recall systems and processes. Hence, explicit targets have not been set for 2011/12 against the Diabetes or CVD measures. The DHB will continue to work towards regaining prior performance levels and will monitor and report performance against these indicators.*

[22] *This reference refers to the CVD Risk Assessments undertaken in primary care in line with the expectations of the national PHO performance programme.*

[23] *Community respiratory volumes include delivery by both GPs and mobile community respiratory providers. Spirometry is a tool for measuring lung function, assisting in the assessment of a range of respiratory conditions.*

[24] *The acceptance rate of community referred radiology test is indicative of the quality and appropriateness of the referrals being received.*

4.3 Intensive Assessment and Treatment Services

Output Class Description

Intensive assessment and treatment services are usually complex services provided by specialists and other health care professionals working closely together. These services are therefore usually (but not always) provided in hospital settings, which enable the co-location of clinical expertise and specialist equipment. These services include ambulatory services, inpatient and outpatient services and emergency or urgent care services.

The Canterbury DHB provides an extensive range of intensive treatment and complex specialist services to its population – and to the populations of other DHBs that do not provide the most complex services in their own regions. The DHB also funds some intensive assessment and treatment services for its population that are provided by other DHBs, private hospitals or private providers. A proportion of these services are driven by demand which the DHB must meet, such as acute and maternity services. However, others are planned services for which provision and access are determined by capacity, clinical triage, national service coverage agreements and treatment thresholds.

Why is this Output Class significant for the DHB?

Equitable, timely access to intensive assessment and treatment can significantly improve people's quality of life either through early intervention (e.g. removal of an obstructed gallbladder so that the patient does not have repeat attacks of abdominal pain) or through corrective action (e.g. major joint replacements). Responsive services and timely treatment support improvements across the whole system and give people confidence that complex intervention is available when needed. People are then able to establish more stable lives, resulting in improved public confidence in the health system.

As an owner and provider of these services, the DHB is also concerned with the quality of the services being provided. Quality improvement in service delivery, systems and processes will improve patient safety, reduce the number of events causing injury or harm and provide improved outcomes for people in our services. Adverse events in hospital, as well as causing harm to patients, drive unnecessary costs and redirect resources away from other services.

Government has set clear expectations for the delivery of increased elective surgical volumes, a reduction in waiting times for treatments and increased clinical leadership to improve the quality of care being delivered. In meeting these expectations, we are introducing innovative clinically led service delivery models and improving productivity within our hospital services.

OUTPUTS SHORT-TERM PERFORMANCE MEASURES (2011/12)

Over the next three years we will fund and provide outputs (services) which will make a positive impact on the health and wellbeing of the Canterbury population. The Quantity (Volume), Timeliness, Coverage and Service Quality of those outputs will be measured using the following output performance measures:

Specialist Mental Health Services *These are services for people who are most severely affected by mental illness or addictions. They include assessment, diagnosis, treatment and rehabilitation, as well as crisis response when needed. Utilisation rates will be monitored across age groups and ethnicities to ensure service levels are maintained and to demonstrate responsiveness.*	Notes	Actual 2009/10	Target 2011/12	Current National Average
Proportion of young people (0-19) accessing specialist mental health services.	C [25]	2.3%	≥2%	-
Proportion of adults (20-64) accessing specialist mental health services.	C [25]	2.8%	≥2.5%	-
People are seen by specialist services within seven days of pre-admission.	T [26]	50%	60%	64%
People receive post-discharge community care within seven days of discharge.	Q [26]	58%	65%	59%
Acute inpatient mental health bed occupancy rate.	C [27]	94%	>85%	-
Psychiatric Services for the Elderly (PSE) inpatient bed occupancy rate.	C [27]	88%	>85%	-

[25] *This measure includes more complex and specialised services provided by DHB services and NGOs who submit NHI additional reporting. The expectation established in that DHBs will work towards providing access to specialist services to 3% of the population.*

[26] *These measures provide an indication of the responsiveness of services to acute need and the integration of services in ensuring a continuum of care for clients after discharge – together these elements will help to reduce acute readmissions to mental health services.*

[27] *Occupancy rates provide an indication of the service's 'capacity to treat. The aim is to maintain enough beds to meet demand requirements (with some space to flex) but not too many to imply that resources are underutilised and could be better directly to other areas. Rates above 85% are optimum – too close to 100% would raise issues of capacity.*

Elective Services *These are services for people who do not need immediate hospital treatment and are 'booked' or 'arranged' services. This includes elective surgery, but also non-surgical interventions (such as coronary angioplasty) and specialist assessments (either first assessments, follow-ups or preadmission assessments).*	Notes	Actual 2009/10	Target 2011/12	Current National Average
Total number of elective surgical discharges provided.	V [28]	15,636	16,110	-
Elective and arranged surgery is undertaken on a Day Case basis.	Q [29]	54%	60%	56%
People receive their elective and arranged surgery on the Day of Admission.	Q [29]	78%	90%	80%
Average elective and arranged inpatient length of stay (days) is maintained.	Q [29]	3.9	<4.0	4.9
Total number of Surgical First Specialist Assessments (FSA) provided.	V	38,111	Est. >38,000	-
An increasing proportion of Surgical FSAs are non-contact (virtual) FSAs.	Q [30]	4.2%	4.5%	-
Total number of outpatient attendances.	V	643,517	Est. >640,000	-
Outpatient 'Did Not Attend' (DNA) rates are reduced.	Q	4.9%	<5%	-
Reporting of the rate of pressure injuries improves.	Q [31]	0.25	0.30	-
Reporting of the rate of medication, IV & blood incidents improves.	Q [31]	1.66	1.99	-
Staph Aureus HABSIs infection rates decrease.	Q [32]	0.07	0.056	-

Acute Services *These are services for illnesses that have an abrupt onset, are often of short duration and rapidly progressive, for which the need for care is urgent (they may or may not lead to a hospital admission). Hospital-based acute services include emergency departments, short-stay acute assessments and intensive care services. There are also a number of community-based acute demand programmes and packages of care unique to Canterbury, established to reduce acute demand particularly in light of the loss of capacity after the earthquakes. Productivity measures such as length of stay rates are balanced with outcome measures such as readmission rates to indicate the quality of service provision*	Notes	Actual 2009/10	Target 2011/12	Current National Average
Total number of people presenting at hospital Emergency Departments (ED).	V	87,091	<94,000	-
People are assessed, treated or discharged from ED in under six hours.	T	90%	>95%	87%
GP practices provide patients access to telephone triage outside business hours.	C	59%	95%	-
Acute Demand Packages of Care are provided via general practice.	V [33]	14,513	>16,800	-
Total acute inpatient average length of stay (days) is maintained.	Q [34]	3.9	<4.0	4.09
People receive radiation oncology treatment within 4 weeks of decision to treat.	T	new	100%	-

[28] *These elective surgery volumes exclude elective cardiology and dental and are discharges based on the national health target definition.*

[29] *These measures are based on OS3, OS5, OS6 and OS7 measures from the national indicators of performance set for DHBs – Appendix 6. 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 homes and frees up hospital beds where capacity in tight due to the earthquake. Day case, day of surgery rates and average length of stay are balanced against readmissions rates to ensure service and quality is appropriate.*

[30] *Non-contact FSA are those where specialist advice and assessment is provided without the need for a hospital appointment, increasing capacity across the system, reducing wait times for patients and taking duplication and waste out of the system.*

[31] *The targets are set to increase the rate of reported incidents, in line with the DHB policy of open disclosure and the responsibility of staff to report all adverse events. Achievement will reflect transparency and willingness by our staff to learn from events and prevent them from happening again. Measure is per 1,000 inpatient bed days.*

[32] *Staphylococcus aureus is often found in the nose or on the skin of healthy people, causing them no harm. However, it is possible for Staph aureus to cause infection, and hospitalised patients are at greater risk because they are unwell and have lowered resistance to infection. It is transmitted via contact with people already carrying the bacteria, or through improperly washed hands, surfaces or equipment; therefore, rates of Staph aureus in hospital can reflect the effectiveness of infection control procedures. Measured per 1,000 inpatient bed days).*

[33] *Refers to acute admission avoidable packages of care that allow people who would otherwise require a hospital admission to be treated in their own homes or community through Canterbury's Acute Demand Management Service (ADMS).*

[34] *This measure is based on the national OS4 measure (refer Appendix 6) Productivity measures such as length of stay rates are balanced with outcome measures such as readmission rates to indicate the quality of service provision.*

Maternity Services *These services are provided to women and their families through pre-conception, pregnancy, childbirth and for the first months of a baby's life. These services are provided in home, community and hospital settings by a range of health professionals, including midwives, GPs and obstetricians and include: specialist obstetric, lactation, anaesthetic, paediatric and radiology services. We will monitor volumes in this area to determine access and responsiveness of services.*	Notes	Actual 2009/10	Target 2011/12	Current National Average
Total number of maternity deliveries in the Canterbury region.	V	6,493	Est. >6,000	-
Proportion of total deliveries, made in Primary Birthing Units.	Q [35]	13%	>13%	-
Average post natal length of stay (days) is maintained.	V [36]	2.8	>2.4	3.3

Assessment, Treatment and Rehabilitation Services (AT&R) *These are services provided to restore functional ability and enable people to live as independently as possible. Services are delivered in specialist inpatient units, outpatient clinics and also in home and work environments. Specialist geriatric and allied health expertise and advice is also provided to general practitioners, home and community care providers, residential care facilities and voluntary groups. An increase in the rate of people discharged home with support, rather than to residential care or hospital environments, (where appropriate) is indicative of the responsiveness of services.*	Notes	Actual 2009/10	Target 2011/12	Current National Average
Total number of people (65+) accessing inpatient AT&R services.	V	2,480	Est. >2,400	-
Proportion of admissions into AT&R (PMH) made by direct community referral	Q	23%	>20%	-
AT&R inpatients (65+) are discharged to their own homes (not into ARC).	Q	86%	>88%	-

[35] *The DHB aims to increase people acceptance and confidence in using primary birthing units rather than having women birth in secondary or tertiary facilities when it is not needed in order to make better use of resources and to ensure limited secondary services are more appropriately available for those women who need complex or specialist intervention.*

[36] *The DHB offers longer stays for women who have a clinical need. With tight capacity constraints after the loss of the St Georges primary birthing unit we will carefully monitor rates to ensure that we continue to identifying women with a clinical need and offering this service across the region.*

4.4 Rehabilitation and Support Services

Output Class Description

Rehabilitation and support services provide people with the support and assistance they need to maintain or regain maximum functional independence, either temporarily while they recover from illness or disability, or over the rest of their lives. These services are delivered following a clinical 'needs assessment' process and include: domestic support, personal care, community nursing, community services provided in people's own homes and places of residence, day care, respite and residential care services. Services are mostly for older people, mental health clients and for personal health clients with complex health conditions.

Support services also include palliative care services for people who have end-stage conditions. It is important that they and their families are appropriately supported, so that the person is able to live comfortably, have their needs met in a holistic and respectful way and die without undue pain and suffering. Delivery of these services is likely to include coordination with many other organisations and agencies and may include public, private and part-funding arrangements.

Why is this Output Class significant for the DHB?

Services that support people to manage their needs and live well, safely and independently in their own homes are considered to provide a much higher quality of life, as a result of staying active and positively connected to their communities. This is evident by less dependence on hospital and residential services and a reduction in acute illness, crisis or deterioration leading to acute admissions or readmission into hospital services. Even when returning to full health is not possible, timely access to responsive support services enables people to maximise function with the greatest independence.

In preventing deterioration and acute illness or crisis, these services have a major impact on the sustainability of hospital and specialist services and on the wider health system in general by reducing acute demand, unnecessary ED presentation and the need for more complex intervention.

While living in Aged Residential Care (ARC) is appropriate for a small proportion of our population, Canterbury rates are above national averages. Living in ARC has also been associated with a more rapid functional decline than 'ageing in place' and is a more expensive option. Resources could be better spent providing appropriate levels of support to people to help them stay in their own homes and to moderate the need for residential care and hospital level services.

Canterbury has taken a 'restorative' approach and has introduced individual packages of care to better meet people's needs, including complex packages of care for people assessed as eligible for ARC who would rather remain in their own homes. With an ageing population, it is vital that we ascertain the effectiveness of services in this area, and the DHB uses the InterRAI (International Residential Assessment Instrument) tool to ensure people receive support services that best meet their needs.

OUTPUTS SHORT-TERM PERFORMANCE MEASURES (2011/12)

Over the next three years we will fund and provide outputs (services) which will make a positive impact on the health and wellbeing of the Canterbury population. The Quantity (Volume), Timeliness, Coverage and Service Quality of those outputs will be measured using the following output performance measures:

Needs Assessment and Services Coordination Services *These are services that determine a person's eligibility and need for publicly funded support services and then assist the person to determine the best mix of supports based on their strengths, resources and goals. The supports are delivered by an integrated team in the person's own home or community. The number of assessments completed is indicative of access and responsiveness.*	Notes	Actual 2009/10	Target 2011/12	Current National Average
Total number of people (65+) provided with a clinical assessment of need.	V	5,008	Est. >6,000	-
People entering ARC have received a clinical assessment of need using InterRAI.	Q [37]	86%	>90%	-

[37] *The International Resident Assessment Instrument (InterRAI) is a comprehensive geriatric assessment tool used to ensure consistency in assessing the needs of older people.*

Palliative Care Services *These are services that improve the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early intervention, assessment, treatment of pain and other supports.*	Notes	Actual 2009/10	Target 2011/12	Current National Average
Total number of people accessing hospice or home-based palliative services.	V	2,100	Est. >2,000	-
ARC facilities are trained to provide the Liverpool Care Pathway.	C [38]	14	>20 sites	-

Rehabilitation Services *These services restore or maximise people's health or functional ability following a health-related event. They include mental health community support, physical or occupation therapy, treatment of pain or inflammation and retraining to compensate for specific lost functions. Success is measured through increased referral of the right people to these services.*	Notes	Actual 2009/10	Target 2011/12	Current National Average
People are referred to stroke rehabilitation services after an acute event.	C	73%	69%	-
People are referred to cardiac rehabilitation services after an acute event.	C	27%	30%	-
People access pulmonary rehabilitation courses in the community.	V	85	180	-
Older people (65+) access community-based falls prevention programmes.	V [39]	new	800	-

Home-Based Support Services *These are services designed to support people to continue living in their own homes and to restore functional independence. They may be short or longer-term in nature. An increase in the number of people being supported is indicative of increased capacity in the system, and success is measured against a decreased or delayed entry into residential or hospital* services.	Notes	Actual 2009/10	Target 2011/12	Current National Average
Total number of people supported by home support services.	V	9,422	Est. >9,400	-
Total number of people supported by district nursing services.	V	4,255	Est. >4,200	-
Eligible people (65+) are supported upon direct GP referral by CREST services.	V [40]	new	600	-
Eligible people (65+) are supported upon hospital discharge by CREST services.	V	new	900	-
People accessing CREST are less likely to be acutely readmitted to hospital.	Q [41]	new	10% reduction	-

Residential Care Services *These services are provided to meet the needs of a person who has been assessed as requiring long-term residential care in a hospital or rest home indefinitely. With an ageing population, a decrease in the number of subsidised bed days is seen as indicative of more people being successfully supported to continue living in their own homes and is balanced against the level of home-based support.*	Notes	Actual 2009/10	Target 2011/12	Current National Average
Total number of (subsidised) ARC rest home beds provided (days).	V [42]	676,374	Est. <676,374	-
Total number of (subsidised) ARC hospital beds provided (days).	V	507,516	Est. <507,576	-
Total number of (subsidised) ARC dementia beds provided (days).	V	206,585	Est. >208,000	-
Total number of (subsidised) ARC psycho-geriatric beds provided (days).	V	58,293	Est. >68,000	-
Rate of acute admissions into hospital services from ARC facilities maintained.	Q	3.73%	≤3.73%	-

[38] The Liverpool Care Pathway is an international programme adopted nationally, and being run as a pilot programme in Canterbury from September 2009 to August 2011. The programme begins with training and is planned to run in 20 pilot sites targeting an increase in the number of people supported by the Liverpool Care Pathway, as this reflects best-practice care.

[39] This measure refers to an integrated falls prevention service which is currently under development and includes the Otago Exercise Programme, Stay On Your Feet Programme and also the modified Tai Chai which is funded by ACC.

[40] The Community Rehabilitation Enablement and Support Team (CREST) facilitates earlier discharge from hospital to appropriate home-based rehabilitation services and will be expanded to support people who can be rehabilitated in their homes to avoid hospital admission.

[41] This will be measured against the readmission rates for the population not receiving CREST services.

[42] These measures are based on estimates made prior to the earthquakes and loss of ARC capacity it is likely that they will drop against an increase in home based support, district nursing and CREST services as people are supported in their own homes..

Respite and Day Services *These services provide people with a break from a routine or regimented programme so that crisis can be averted or so that a specific health need can be addressed. Services are provided by specialised organisations and are usually short-term or temporary in nature. They may also include support and respite for families, caregivers and others affected. Services are expected to increase over time, as more people are supported to remain in their own homes.*	Notes	Actual 2009/10	Target 2011/12	Current National Average
Total number of people accessing day services.	V	580	Est.>550	-
Occupancy rate of mental health planned and crisis respite beds.	C [43]	89%	>85%	-
Long-term mental health clients (0 -19) have current relapse prevention plans.	Q [44]	92%	>95%	-
Long-term mental health clients (20-64) have current relapse prevention plans.	Q	97%	>95%	-

[43] *Occupancy rates provide an indication of the service's 'capacity to treat. The aim is to maintain enough beds to meet demand requirements (with some space to flex) but not too many to imply that resources are underutilised and could be better directly to other areas. Rates above 85% are optimum – too close to 100% would raise issues of capacity.*

[44] *Relapse prevention/resiliency planning has been shown to be a key component of service delivery that allows the medium to longer-term impacts of a serious mental illness to be minimised, improving outcomes for clients. Accordingly, all clients with enduring serious mental illness are expected to have an up-to-date relapse prevention plan identifying early warning signs for the services user and their families. It identifies what the service users can do for themselves and what the service will do to support the service users.*

STEWARDSHIP

Module 5

Supporting Our Future Direction

Organisational capability is defined as "what an organisation needs in terms of access to leadership, people, culture, relationships, processes, technology, physical assets and structures to efficiently deliver the outputs required to achieve its goals". [45]

Having already identified the challenges we face, the outcomes we seek and our immediate recovery needs, the following section highlights the capability we have within the Canterbury system and the capability we will develop in the coming year.

5.1 Organisational Strength

The planning, funding and delivery of health and disability services is a complex business, involving an annual spend of more than $1.3 billion health dollars in Canterbury. In undertaking our role as a DHB, we are required to deliver on a broad mandate to a diverse range of stakeholders. To be as effective as possible, we must have capable leadership, an engaged workforce, a healthy organisational culture, sound relationships, robust and rigorous systems and the right infrastructure and assets.

As the direct employer of over 9,000 people, we must also be a good employer, building a workforce capable of meeting the needs of Canterbury's increasing and diverse population and creating an environment where innovation and engagement can flourish.

Organisational Culture

We recognise that a strong and inclusive organisational culture best enables our strategic direction. We also recognise that an engaged workforce is more productive, committed and likely to deliver a better service to patients and clients. Our aim is to keep our workforce enthusiastic and committed to the work they do, thereby ensuring that we are better able to deliver on our strategic goals.

OUR WAY OF WORKING

We are committed to:

- Being people and community focused;
- Demonstrating innovation; and
- Engaging with stakeholders.

These are goals for the whole of the system, and in this sense we seek to engage and inspire not only our own workforce, but all the people who work in the Canterbury health system, making the most of their enthusiasm and capacity for innovation.

In 2007 began a new journey to engage our workforce and that of the wider health system in the 2020 challenge. The focus has been to encourage professional networks across Canterbury to 'make it better' for our patients and clients and to encourage initiatives to evolve organically from within. Over 2,000 people participated in our six week Vision 2020 showcase, with this base group taking the message out to the wider health workforce. At the same time, we have been investing in 'lean thinking' approaches to service and system design through programmes such as *'CollaboR8'* (a two day programme for frontline staff that has involved 1,200 people in three years), and through programmes such as *'Making Time for Caring'* (which has been introduced in our wards, theatres and laboratories).

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

Our unique leadership programme *'XcelR8'* also empowers staff to positively improve the effectiveness and efficiency of the system and their immediate workplace in line with Vision 2020. Over 450 doctors, nurses, allied health professionals and management staff have so far participated in the programme and subsequent work-based projects. All this work has been underpinned by encouraging innovation from all staff through initiatives such as *'GenR8',* which encourages online idea sharing and development, all with a focus on collaboration across the Canterbury health system to 'make it better' for our community.

We also engage our workforce through our Canterbury Quality and Innovation Awards, which recognise excellence in quality improvement. Over 144 projects have been recognised through this programme since it began in 2003. Many have gone on to experience success in national and international awards programmes.

We have built up considerable momentum and support for change and transformation in Canterbury, and we will continue to invest in the participatory approach that has enabled much of our success to date.

Good Governance

The Canterbury health system is governed and supported by various boards and committees, clinical networks, working groups and forums. To support this, we have a clear accountability framework that empowers our governors to provide direction and to monitor the performance of the organisation. This is underpinned by a shared and well articulated strategic agenda and a clear decision-making framework.

We are fortunate to have a well functioning Board whose members contribute a wide range of skills and expertise to their governance role. Governance capability is maintained through regular forums and training, and is supported by the selection of a mix of experts, professionals and consumers on the Board's advisory committees. [46]

While responsibility for the DHB's overall performance, operation and management rests with the Board and Chief Executive, both ensure that their strategic and operational decisions are fully informed, with appropriate support at all levels of the decision-making process, including the following formal governance and advisory committees.

SUPPORT FOR GOOD GOVERNANCE

A clear accountability and delegations framework and clear terms of reference for networks and working groups.

A robust induction programme for Board members and access to ongoing training programmes and forums testing and reiterating Canterbury's strategic direction to ensure a coherent strategic approach.

Regular performance monitoring reporting, against financial and non-financial targets and forecasts, health benchmarks, quality and service performance goals.

Regular Chief Executive updates, community newsletters, public meetings, online forums and media briefings that update our community and external stakeholders on the strategic direction, decisions and current performance of the DHB.

Clinical Leadership

Our commitment to quality and patient safety places responsibility on the DHB to have effective mechanisms in place for planning, monitoring and managing the quality of clinical care provided. Our Clinical Board is a multidisciplinary clinical forum, whose 28 members represent the primary, secondary and community sectors.

The Clinical Board oversees the DHB's clinical activity, provides advice to the Chief Executive on clinical issues and takes a proactive role in setting clinical policy and standards and encouraging best practice and innovation. Members support and influence the DHB's vision and values and play an important clinical leadership role, leading by example to raise the standard of patient care.

Clinical governance is further facilitated and supported by the DHB's Chief Medical Officer, Executive Director of Nursing and Director of Allied Health, who provide clinical leadership and input into the decision-making process at the executive level of the DHB.

Clinical input into decision-making is also embedded in our model of shared management and clinician leadership at all levels within the DHB. This model is replicated across the whole of the Canterbury health system, with a framework of primary/secondary clinical leadership helping to drive the transformation of our health system - supported by the Canterbury Clinical Network.

[46] *There are currently two Māori members on the Board and three practicing clinical members, as well as five clinical members on the Board's Hospital Advisory Committee and four clinical members on the Community and Public Health and Disability Advisory Committee.*

Māori Participation in Decision-Making

We engage informally at many levels with Māori providers and community groups to facilitate genuine participation in the planning and delivery of health and disability services, particularly as they affect Canterbury's Māori population. Our Board also has a formal Memorandum of Understanding with Manawhenua Ki Waitaha (representing the seven Ngāi Tahu Rūnanga*)* as a further step to enhance Māori participation in decision-making. We continue to explore mechanisms to facilitate these formal relationships and encourage greater participation of Māori in the development of plans and strategies to reduce inequalities in health status within our population.

Our Māori Health Action Plan, approved by the Board in 2011, brings together a snapshot of the activity and action happening across the Canterbury health system to improve health outcomes for Māori, and we will publicly monitor performance against this Plan.

Consumer and Community Input

We also have links with a number of consumer and community reference groups, advisory groups and working parties. Their advice and input assists in developing DHB plans and strategies to improve the delivery of health and disability services.

Our Consumer Council provides input into decision-making as a permanent advisory group for the Chief Executive and supports a partnership model that provides a strong and viable voice for the community and consumers in health service planning and delivery. The Council consists of 15 representatives nominated by consumers and consumer lobby and advocacy groups, and networks support each representative in their role and facilitate wider communication across the Canterbury community.

Clear Prioritisation and Decision-Making Principles

The environment in which we operate requires us to make some hard decisions around which competing services or interventions to fund with the limited resources available.

There is a need to protect vital services that are contributing to population health gain and ensure that key relationships endure and provider capacity is maintained. At the same time, we must be aware that demand for health services may shift towards the more acute end of the continuum as a result of any poor short-term prioritisation decisions.

Supported by the Clinical Board, Consumer Council and Executive Management Team, we have established a prioritisation framework and a set of prioritisation principles. Based on best practice and consistent with our strategic direction, these principles assist us in making the decision to develop or implement new services. Our prioritisation principles are also applied when we review existing health investments and provide the opportunity to reallocate funding, on the basis of evidence, to services that are more effective in improving health outcomes and reducing inequalities.

CANTERBURY DHB PRIORITISATION PRINCIPLES

- Effectiveness: Services should produce more of the outcomes desired, such as a reduction in pain, greater independence and improved quality of life.
- Equity: Services should reduce significant inequalities in the health and independence of our population.
- Value for Money: Our population should receive the greatest possible value (in terms of effectiveness and equity) from public spending on health and disability services.
- Whānau Ora: Services should have a positive impact on the holistic health and wellbeing of the person and their family/whānau. This has particular significance for Māori, but relevance for all cultures.
- Acceptability: Services should be consistent with community values. Consideration will be given as to whether consumers or the community have had involvement in the development of the service.
- Ability to Implement: Implementation of the service is carefully considered, including the impact on the whole system, workforce considerations and any risk and change management requirements.

Canterbury's Shared Decision-Making Approach

In adopting our prioritisation principles, we recognised that our goals will not be achieved through the services we provide alone, and our relationships with the organisations we fund need to be more than contractual relationships.

Alongside our prioritisation process, we are adopting new approaches that better support our partnerships and alliances and support the view of the Canterbury health system as one

system and one health budget. At the core of the new approach is a decision-making process that makes clear which decisions remain the role of the DHB, and which decisions should be devolved to clinicians and providers (and ultimately be made on the front line of service delivery - at the clinician/patient interface).

To support our approach we will seek permission to change the rules around the way we fund and contract for health services to better enable us to respond flexibly to opportunities and innovations as they present themselves, with the minimum of process constraint.

5.2 Our People

KEY WORKFORCE CHALLENGE

Our workforce has shown an admirable willingness to work in difficult conditions, but the quakes are impacting on sick leave, staff retention and overall efficiency as services are split apart. Uncertainty about the future and the stress of aftershocks is taking an inexorable toll. This is one of the most significant risks to our health services' future sustainability.

Global competition for clinically skilled people, the expectations of younger generations of employees, the impact of emerging technologies, and rapidly changing demographics in the workplace are all ongoing challenges for health services throughout New Zealand.

Workplace strategies to address these challenges must be considered and balanced. Our ability to transform the Canterbury health system relies on having the right people, with the right skills, in the right place. Strategies must attract, retain and motivate key performers and those with high potential or scarce skills – while still focusing on cost containment, performance improvement and risk management.

As a good employer, we promote equity, fairness and a safe and healthy workplace. We uphold high standards of governance and ethical business conduct through a clear set of organisational values and policies. These standards include an integrated code of conduct which prescribes behavioural expectations, as well as compliance with all applicable legal requirements. We expect our executives and clinical leaders to adopt high standards of professional conduct and to influence our workforce through active example and leadership. However, in our current context it is not sufficient just to be a good employer through the promotion of equity, fairness and a safe and healthy workplace. To attract and retain quality people, we aim to make or workplace more engaging through motivational leadership, challenging work and ongoing career development.

Strategic Direction

We have taken the initial steps to build an integrated workforce approach across the Canterbury health system by engaging with primary and community providers on common HR systems, leadership development and workforce planning.

Canterbury DHB Workforce 2011		
Total Female Headcount	*Total Male Headcount*	*Total DHB Headcount*
7,324	1,697	9,021
12.5% of NZ total	11.8% of NZ total	12.4% of NZ total
Average Age	*Largest Ethnic Group*	*Average Length of Service*
45.8 years	NZ European 57%	9-10 years
Largest Workforce Group	*Youngest Workforce Group*	*Oldest Workforce Group*
Nursing 2,370 FTE	Technical and Scientific	Care and Support
51.5% of South Island FTEs	DHB Av Age 42.8 years	DHB Av Age 50 years

Our capability framework has been selected as the national framework for people-based processes. This same framework will underpin the development of national curriculum for the NZ Healthcare Institute for Management and Leadership at the University of Auckland.

Working in collaboration with the Universities of Canterbury and Otago and the South Island Polytechnic Network, we have developed a tertiary alliance that will (in time) deliver a single core management and leadership curriculum for all health employees in the South Island. This approach will promote career enhancement, as well as the development of leadership potential in individuals system-wide.

We have partnered with providers and equipped ourselves with best practice systems to attract, select and retain high quality employees and to better motivate our workforce in performance improvement. Progressive adoption of these recruitment and performance development systems will avoid duplication and extra costs while allowing flexibility.

In 2010 the DHB undertook a staff survey to measure the engagement of our workforce. Employee engagement illustrates the commitment and energy that employees bring to work and is a key indicator of their involvement and dedication to the organisation. This survey was well represented by all demographics and professional groups. The results told us that 68% of our overall workforce is engaged with only 4% reported to be disengaged. International research suggests that highly engaged people put forth 57% more effort and are 87% less likely to leave an organisation.

Areas that people reported to be most happy with were:

- Empowerment - they value the work they do and have a high level of confidence;
- Commitment - they are committed to their colleagues and prepared to go the extra mile;
- Nature of the job - the work people do is mentally stimulating and challenging; and
- Patient Safety – they feel confident raising concerns.

The survey identified three priorities for initial focus - Performance Management, Career Development and Incident Reporting. Working groups have already been established for each of these and initiatives to address them are well underway. We are currently using our engagement results to inform our overarching HR Strategy but more specifically our retention initiatives.

WORKFORCE ENGAGEMENT

- 68% of our overall workforce.
- 67% of Doctors (RMO's, SMO's & Interns).
- 67% of Nursing.
- 68% of Allied Health.
- 74% of Support Services.

Operational Direction

We continue to support the training and development of junior doctors, nurses, midwives, allied health professionals and management. These arrangements include joint clinical appointments with the University of Otago, stipend arrangements, our Nursing Entry to Practice programmes, clinical placements, joint non-clinical appointments across the Canterbury and West Coast DHBs, secondments into and from the primary care sector and an active role in the establishment of regional training hubs.

We have extended our *'XcelR8'* programme to clinical and non-clinical West Coast DHB staff, supporting joint endeavours and clinical practice development.

We will continue to refine workplace support systems such as health and safety, training and development, industrial relations, HR administration and payroll to support ongoing organisational initiatives and reduce overheads and duplication between services and between DHBs. Canterbury is taking a lead on a number of workforce streams across the South Island, and we will continue to work closely with the West Coast and South Canterbury DHBs to streamline services and share resources.

HOW WE'RE GOING TO GET THERE – OUR PERFORMANCE STORY 2011/12

OBJECTIVE	ACTION	EVIDENCE
Implement the national leadership development direction. *To influence changes in behaviour that will positively impact on performance.*	Collaborate with NZ Centre of Excellence in Healthcare and Leadership via project planning to align our management and leadership curriculum with the national direction. Develop core curriculum at a local level, supported by a MoU between Canterbury DHB, University of Canterbury and Otago and the Christchurch Polytechnic Institute of Technology.	Joint appointment of a project manager for curriculum development by Q1 2011/12. Project plan for curriculum development underway by Q2 2011/12.
Regional alignment of recruitment activities, policies and procedures. *To positively improve the candidates experience with us, streamline recruitment processes and reduce the time taken to make appointments.*	Implement full centralisation of recruitment activities across the CDHB and WCDHB with recruitment specialists partnering with hiring managers to identify and share talent. Introduce value added services such as career guidance, resume preparation, interview coaching and settlement support to improve the ease of recruitment. Take a lead in aligning key HR policies, procedures and operations across the South Island. Develop and introduce a Canterbury wide Alumni and Employee Referral Programme.	25% reduction in time taken to fill vacancies. Hiring Managers time halved (currently averaging 8 days per annum). Alignment of approaches and outcomes evident by Q3 2011/12.

Implement Leadership Development Programmes *To support the South Island workforce to sustain itself from within and across its infrastructure, improving staff retention and recruitment rates.*	Establish a clearly defined strategy and a combination of approaches, including observational and electronic systems to facilitate the recognition of talent. Establish talent pools with identification of critical roles (e.g. those with skills in demand) across the DHB and the wider Canterbury workforce as well as the wider South Island region. Appropriately invest in the development of identified talent to ensure a foundation for succession management. Take a lead in supporting the adoption of leadership development practices across the South Island.	Initial cohort of staff identified from the pilot performance management group by Q2 2011/12. Critical local and regional positions filled with confidence and relative ease.
Implement Performance Development Programme *To support improved outcomes for patients by ensuring expectations around performance are clear and people have a greater understanding about how they contribute to the wider organisation (ultimately increasing their level of engagement).*	Provide further education and training in end to end performance management to ensure a consistent approach to managing performance across the DHB. Introduce online technology to significantly reduce the time to complete 'forms' and allow more time for the manager and employee to have quality conversations regarding performance expectations. Introduce performance measures that have a combination of what (technical) and how (behavioural) to increase satisfaction and engagement in workplace performance management. Take a lead in supporting the adoption of performance development practices across the South Island.	70% of DHB employees using the online performance system by Q4 2011/12. Managers and the organisation have greater visibility of their performers (both high and low). A ROI right down to an individual will be evident. 1% improvement in overall employee engagement results.
Promote Employee Engagement *To keep our workforce enthusiastic and committed to the work they do, thereby ensuring that we are better able to deliver on our strategic goals.*	Continue commitment to the working parties established for the organisations three priorities identified by the 2010 staff Engagement Survey (Performance Management, Career Development and Incident Reporting). Introduce online exit interviews with data being correlated with the Engagement Survey. Individual teams revisit and refresh their Engagement Action Plan regularly (minimum quarterly). Work with the West Coast DHB to introduce the Engagement Survey for their workforce.	1% improvement in overall employee engagement results. 95% of exit interviews completed. 85% people advising that they would consider returning to the Canterbury DHB.
Expand Core Learning and Development Models *To support changes in core and essential technical skills and behavioural requirements that will support improved outcomes for patients and job satisfaction for our workforce.*	Explore learning and developmental needs through robust conversations, training needs analysis and performance reviews to identify core developmental requirements. Support individuals to set specific goals and objectives in support of their core learning (with a potential view to long term career goals post the pilot of the performance management system). Construct a training portal to enable courses and training events to be advertised and explained so appropriate interventions are selected to meet developmental needs.	Goals embedded in individual development plans. Changes in behaviour measured through ongoing observation and conversations. Outcomes recorded against the performance measures.

5.3 Measuring Our Performance

In our role as planner and funder of services we hold over 1,000 contracts and service agreements with the organisations or individuals who provide the health services required to meet the needs of our population and we monitor these agreements through regular performance reports and data analysis. We also monitor and assess the quality of services provided through reporting of adverse incidents, routine quality audits, service reviews and issues-based audits.

In our role as provider of hospital and specialist services we have a set of annual volume and performance expectations which are monitored and reported monthly to the Hospital Advisory Committee (the Board's statutory advisory committee) alongside an agreed set of productivity and quality performance indicators. We also report quarterly to the National Health Board against a set of ownership indicators and regularly feed into health benchmark and quality indicator reporting to compare our performance with other providers.

For our Board, we provide monthly and quarterly performance monitoring against a mix of financial and non-financial indicators and targets. We provide and discuss this performance at public meetings and make this information available to the public on our website. We also support the Minister of Health's expectation that the public should be provided with better information on health system performance by publishing on our website and in local newspapers Canterbury's quarterly performance against the national health targets.

More recently, in light of the severely restricted capacity across the Canterbury health system, we have been publishing and circulating a system-wide dashboard which presents daily updates on service utilisation, demand trends and current capacity.

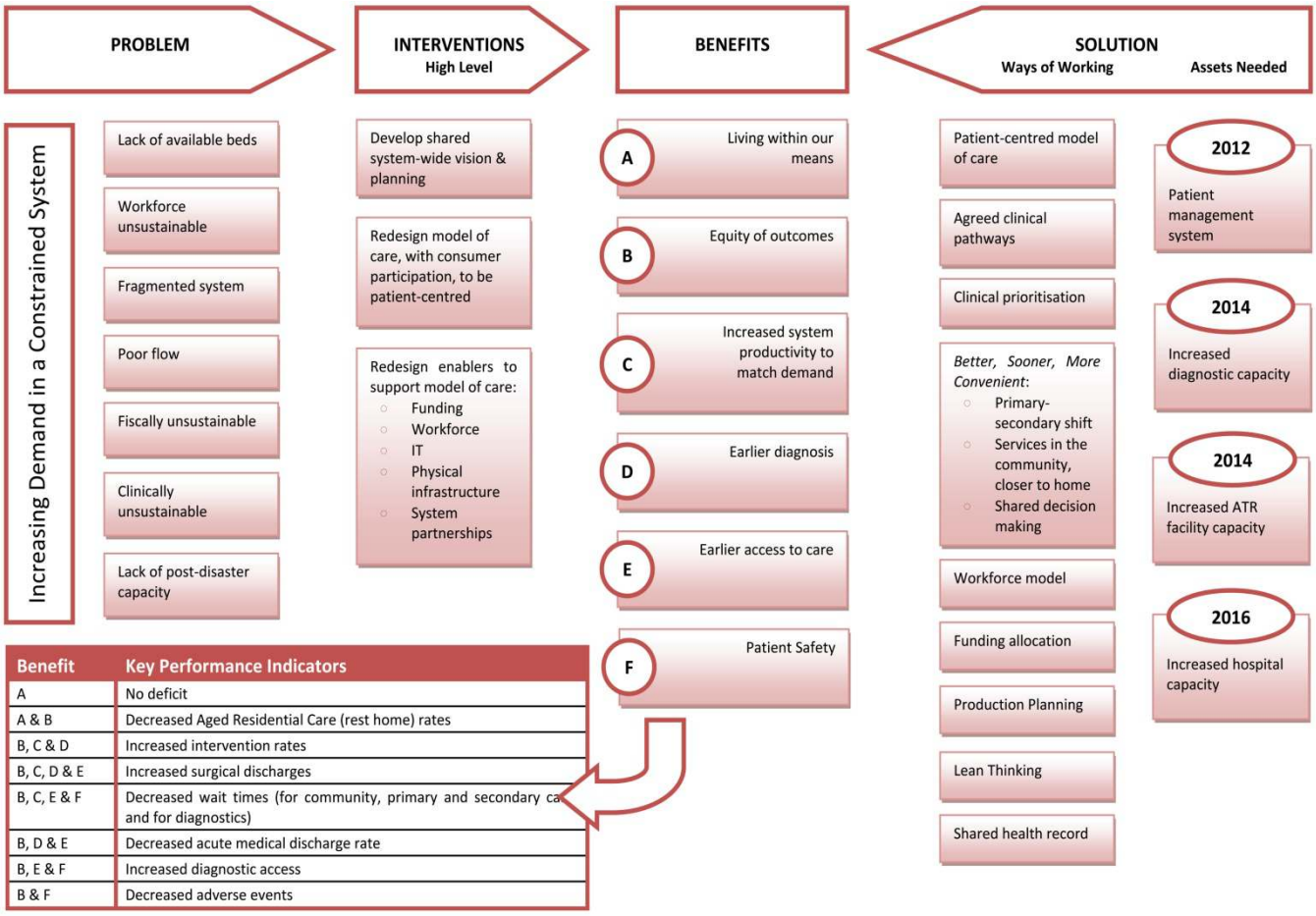
Our planned performance as a planner, funder and provider of services is outlined in our service performance plans and statement of service performance in this document.

Intervention Logic Map

Alongside these mechanisms, and in line with our whole of system approach, when we look to determine whether we are achieving value for our investment we also use an investment logic map that assists to clearly define and validate the identified system need (the problem) and the benefits that solutions are expected to offer to the system and more importantly to our population.

The investment logic map depicts the problems that an investment needs to address, the high level strategies that will be required to respond to the problem and the benefits that any investment must produce. It then helps us to define the likely best solution and includes a set of performance measures that we use both as a planner, funder and provider to measure whether we are achieving value from our investment.

Figure 9: Intervention Logic Map - A 'Whole of System' Approach



Benefit	Key Performance Indicators
A	No deficit
A & B	Decreased Aged Residential Care (rest home) rates
B, C & D	Increased intervention rates
B, C, D & E	Increased surgical discharges
B, C, E & F	Decreased wait times (for community, primary and secondary ca and for diagnostics)
B, D & E	Decreased acute medical discharge rate
B, E & F	Increased diagnostic access
B & F	Decreased adverse events

Building the Capability to Transform Our System

Canterbury is fortunate to have significant clinical and professional capability - with clinical leaders and health professionals from across the system stepping up to the challenge of transforming the way we work. However, there are still significant capability opportunities that have yet to be realised and will help us to deliver a fully interconnected and responsive health system. Quality improvement and patient safety processes, information and technology services, assets and infrastructure are all critical enablers to delivering our strategic goals and improving national and regional collaboration.

5.4 Our Commitment to Quality and Patient Safety

We are committed to a number of initiatives that encourage quality improvement and innovation to enhance service delivery and patient outcomes. We continue to embrace this momentum, support clinical leadership across the system and engage our workforce in these initiatives. Our Medical Director of Patient Safety works alongside our quality leaders and DHB staff to eliminate the harm that can occur to patients in hospital settings and to promote our focus on quality and patient safety.

COMMITMENT TO QUALITY

By improving the quality and safety of the care that patients receive, there is not only an enhancement of the service delivered, but also a financial gain through reduced wastage, targeted resource investment and removing the need for additional services as a result of adverse and unnecessary events.

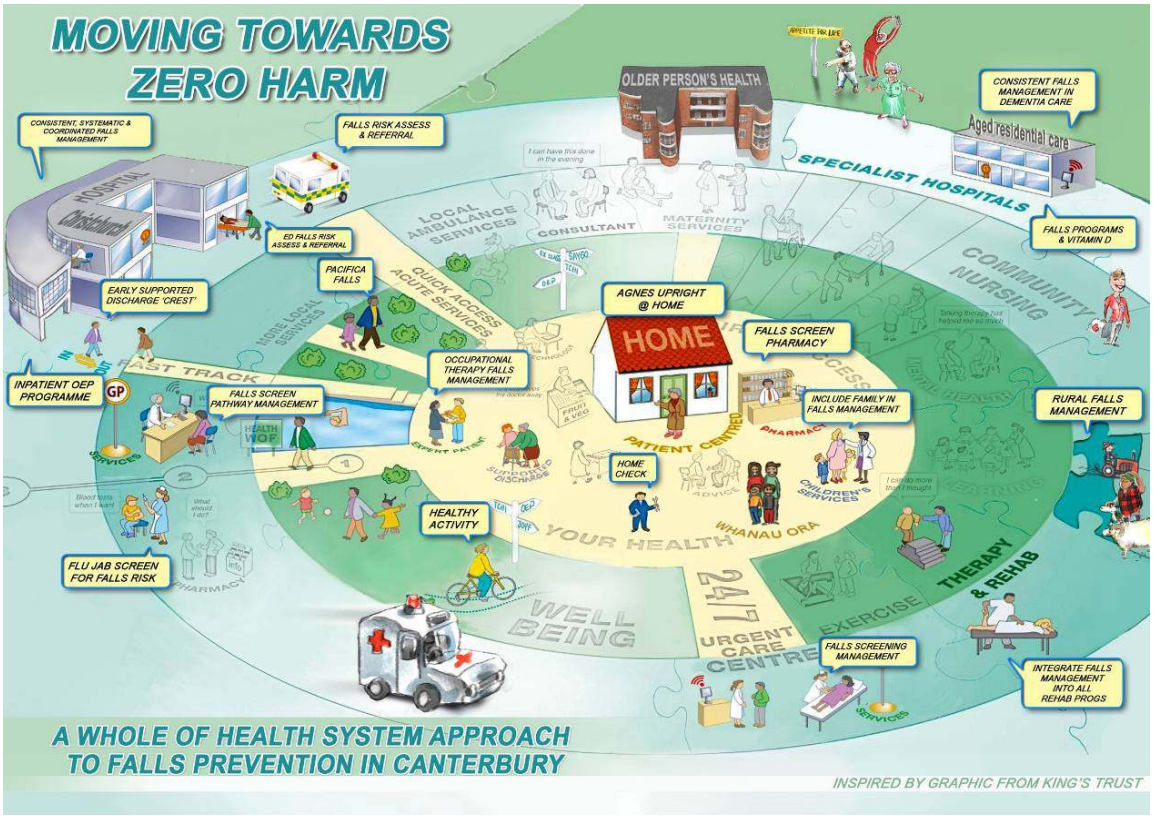
Our initiatives are aligned to the national health priority areas, the Health Quality and Safety Commission work programme and the quality goals of our Quality Strategic Plan. In addition to our commitment to national projects on Incident Management, Hand Hygiene and Safe Medicines, we are also focusing on:

- The *Safe Patient Journey* as an effective mechanism for systematically identifying and managing problems and failures in the system and for informing the development of preventive strategies and redesigned patient care processes to eliminate repeated harm.
- A '*Whole of System approach to Falls Prevention*' in Canterbury. This seeks to unify the Canterbury health system's approach to falls prevention so that we work as one system with one source of funding, support clinical leadership and assist in closing the gap between research and evidence-based practice in the area of falls prevention. The vision is to move towards 'zero harm' from falls in Canterbury. We are also working closely with ACC and the Ministry of Health on developing a consistent nation-wide approach to falls prevention. This approach will assist with implementing the National Falls Prevention Strategy for the elderly and meeting the national performance measure of reducing hospital admissions as a result of falls.
- The Clinical Board programme of *Patient Safety Walk Rounds*. We recognise that the views of frontline staff and patients enhance and improve services across the Canterbury health system. The Clinical Board Patient Safety Walk Rounds provide frontline staff with the opportunity to converse with Clinical Board members about their ideas for improvement and share their successes and concerns regarding patient safety. They also help us improve the visibility of our leaders and provide an opportunity to champion patient safety at grassroots level. Five walk rounds have been completed in our hospital and specialist services, and the first of the community based walk rounds will take place in mid-2011. We expect to complete another six walk rounds by the end of 2011.
- Setting up a *Health Innovation and Improvement Hub* in Canterbury. The Canterbury Health Innovation and Improvement Hub is part of a national initiative to facilitate the development of leading edge ideas within the health sector. Our Hub will specialise in the evaluation, management and commercialisation of intellectual property generated from across our health system. It will improve both patient outcomes and the productivity of our health system through the accelerated adoption of proven service improvements and medical technology and through the improved attraction and retention of valuable staffing resource. With involvement from across the sector, the Canterbury Development Corporation, universities and other tertiary education providers, the Hub will harness our innovation and provide opportunities for clinicians to be at the front end of health development, without detracting from frontline care.
- Improving our *Emergency Response* by meeting the objectives of the Canterbury West Coast Emergency Care Coordination Team (ECCT), which are driven by the ECCT Annual Regional Emergency Services Plan

(*informed by the March 1999 Roadside to Bedside document*). The ECCT will be working with key stakeholders to progress the Automated External Defibrillators and Maternity Survey projects, as well as continuing to work on raising the profile of the regional ECCT.

Canterbury is also participating in some of the Australasian Health Round Table initiatives: Long Stay Patients, Trigger Tool Methodology, Standardised Hospital Mortality Ratio and an Adverse Drug Event Collaborative. These projects will help us to improve the quality of care we provide. In the coming year, the Clinical Board will review Canterbury's Quality Strategic Plan and champion quality projects including the development of a set of Quality Accounts to measure the quality of the services we provide and communication of the Zero Harm philosophy.

Figure 10: Moving Towards Zero Harm - A 'Whole of System' Approach to Falls Prevention in Canterbury



5.5 Information Services and Technology

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

Information Management is a national priority, with DHBs taking a collective approach to implementing the Government's National Health Information Technology Plan (NHITP) and ensuring quality standards are met. Regional DHB workshops have determined a collective view of the strategic actions necessary to deliver on the NHITP within the South Island, and the Canterbury DHB is committed to this collective approach, which addresses all nine work streams of the national plan.

One of the priorities of the national and regional plans is to enable seamless and transparent access to clinical patient information and data. This will benefit patients by enabling more effective clinical decision-making, improving standards of care and reducing the risk of missing important information hidden in other systems.

This is particularly relevant in Canterbury, as the February earthquake has displaced many people from their health providers and their health records, and has highlighted weaknesses in our Clinical Information Systems where they are disparate and not technologically robust. There is an urgent need to move faster towards the

implementation of a more effective, well structured and integrated health information system. While the longer-term system architecture is yet to be defined, a number of short-term actions will be addressed in the coming year to deliver more immediate improvements.

Our local Information Services Strategic Plan (ISSP) re-enforces the objectives of the national strategy and supports the implementation of unified systems and shared care planning that is an essential component in our recovery and future transformation. The ISSP involves working closely with clinicians and stakeholders across Canterbury and the wider South Island region, to implement solutions that support effective and seamless care by providing clinicians with the right information, in the right place, at the right time.

ISSP actions that will be delivered in the coming year are aligned to the National Plan, but also to the South Island Regional IT Plan and Canterbury will take the lead in implementing and supporting a number of national and regional programmes. Major 2011/12 ISSP initiatives include:

- *Implementation of the Concerto Clinical Information System (CIS).* The CIS is a portal that brings all a patient's clinical information into one view, and allows the entry of new data in an organised and clinically effective way. Canterbury is taking the lead in the rollout of the CIS across the South Island. Whilst this project is ambitious, a single, patient-centric, integrated portal across all South Island hospital services will greatly improve clinical decision-making and networking across the South Island and provide integrated and timely information at the point of care.

  The CIS includes a focus on E-Discharges, which allow discharge summaries to be sent electronically to GPs, significantly assisting a 'whole of system' approach to patient care. In the coming year, we will take the next step in E-Referrals by supporting referral to private providers and inviting the West Coast DHB to adopt our Electronic Referrals Management System (ERMS).

  ELECTRONIC REFERRAL MANAGEMENT SYSTEM

  ERMS has been launched and currently allows GPs to send structured referrals to 60 hospital departments and to community based radiology providers for 30 investigation types.

  It is integrated with TestSafe South (a laboratory results repository that enables primary and secondary care clinicians to access the same lab results) and with our 'single point of entry' for radiology.

- *Implementation of a Single Patient Administration System*. Canterbury currently supports three different systems across our hospital services. One of these (*HOMER),* which is used in acute settings, is approaching 'end of life'. We will move to one single system, which is also aligned with the South Island's regional direction, where a regional business case is being proposed. This is a significant undertaking and will take several years to complete; however, implementation will focus on best practice processes and will enhance data quality locally, regionally and for national collection.

- *Implementation of Health Pathways region-wide*. Canterbury's HealthPathways website has been customised for West Coast DHB, Nelson/Marlborough DHB, South Canterbury DHB and discussions are underway with Southern DHB. To facilitate implementation the Canterbury Initiative way of working has been made available to each DHB with direct support from the Canterbury Initiative Development Team. It is anticipated that the Electronic Referral management System (ERMS) will be utilised in the West Coast and it is being considered by the other South island DHBs.

- *Implementation of HSA Global Coordinated Care Management System.* A cloud based integration of clinical information and shared planning targeted at supporting individuals with complex needs. It is being implemented in the first instance to support the new CREST programme.

HOW WE'RE GOING TO GET THERE – OUR PERFORMANCE STORY 2011/12		
OBJECTIVE	ACTION	EVIDENCE
Support closer alignment of clinical information across the Canterbury health system. *To improve access to secure and vital clinical information for clinical staff and to support timely clinical decision-making at*	Develop an Emergency Shared Care Record View (ESCRV) that will incorporate critical information from providers across Canterbury (secondary, primary and community services) and allow for the extract of information in case of emergency.	Key information available to clinical carers in all care settings by Q1.
	Work alongside primary care to accelerate the next steps in establishing a Shared Electronic Health Record through the HSA Global Collaborative Care Management System.	HSA Global implementation underway by Q2.
	Take the next step in the rollout of the Concerto Clinical Information System (CIS):	E-referral process within the CDHB is both safe and efficient.

the point of care.	Increase the use of E-Discharges, allowing summaries to be sent electronically to GPs, and the use of Éclair laboratory results reporting and electronic lab test sign-off. Complete the implementation of GP E-referrals into the Concerto framework, enabling ERMS/Concerto integration.	ERMS/Concerto integration is complete by Q3.
Implement the South Island Regional Health IT Plan. *To improve the integration of clinical information across the South Island and thus enable greater sharing of information across continuums, support clinical decision-making, improve regional networking and reduce unnecessary duplication.*	Complete implementation of the Concerto CIS for the South Canterbury DHB and implement the Concerto CIS for the West Coast DHB.	Single Concerto record across CDHB/SCDHB/WCDHB by Q3.
	Support the migration of West Coast DHB laboratory information to the Regional Solution (TestSafe South) as the next step in creating a single laboratory and pharmacy repository.	Single laboratory and pharmacy repository across CDHB/WCDHB by Q3.
	Complete the consolidation of South Canterbury DHB and West Coast DHB Imaging/Picture Archive System (PACS) into the Regional Solution.	Single PACS archive across CDHB/SCDHB/WCDHB by Q2.
	Take the next step in implementation of a single patient administration system (PAS). Support the development of a business case for a regional approach to PAS replacement to facilitate a single PAS for the South Island.	Business case submitted for approval Q2.
	Implement the South Island Clinical Cancer Information System to share data and information on outcomes and service utilisation to improve service provision and enable informed service planning and development.	Clinical Cancer Information System in place Q4.
	Continue to take the regional lead in the ongoing expansion of the InterRAI platform in the South Island.	InterRAI application software is hosted in Canterbury.
Improve the quality of data collection and storage. *To support clinical quality and efficiencies, and better inform service planning and development.*	Continue to take the regional lead in administration of the South Island Health Telecommunications Network (DHBOO). Move the DHBOO to a national health accredited network to support continual and sustained quality improvement. Issue an RFP for data centre facilities which will also support regional initiatives.	DHBOO successfully carrying increased traffic and connecting South Island DHBs and health care agencies together. Selection and implementation to new data centre complete Q2.
	Identify and pursue initiatives to improve the quality of data collection. Provide training that emphasises the need for National Health Index (NHI) recording and ethnicity data quality.	NHI duplications are $\leq$6%. Ethnicities set to 'Not stated' or 'Response Unidentifiable' in the NHI are $\leq$2%.

5.6 Our Facilities – Supporting Continued Service Delivery

The majority of existing Canterbury facilities have been identified as impeding the continuing transformation of our health system. Their current physical geometry provides no further opportunity for co-location of services and hampers further adaptation of service delivery models to improve the quality of care. The DHB has already exhausted other expansion and reconfiguration opportunities, and planning and forecasting have indicated severe constraints on physical capacity to provide patient care during 2011/12 and beyond.

The recent earthquakes in Canterbury have further highlighted facility inadequacies and constraints. Only dedicated work from our maintenance and engineering team kept Christchurch Hospital and other sites going in the face of damage to essential infrastructure. The quakes demonstrated quite clearly that these are not facilities that can be relied upon to continue to function post-disaster. Most of our facilities are damaged, and some have become unusable. A number of strategies have had to be implemented to maintain capacity this winter. Some of them are consistent with the future direction and have accelerated our progress, while others are expensive and complex alternatives required to maintain patient care.

The redesign of our health facilities is essential to support the ongoing implementation of our patient-centred models of care – models that are collaborative, integrated with primary care, interdisciplinary, anticipatory and focused on the patient journey through the whole of the system.

In transforming the way we work, our current facilities configuration has proven to be a barrier that has to be worked around. Our new patient pathways highlight the operational inefficiency of current and traditional service models that deal in terms of fragmented services stretched across multiple locations. It is imperative that the transformation we are delivering is underpinned by a hospital system that is responsive and supports flexibility of service provision.

We have reviewed the configuration of each key site, identified the best potential alignment of services and assets, and planned a progressive redevelopment of our facilities in line with our service transformation. We have completed a Strategic Stage Analysis, a Ministry of Health requirement to show what we plan to do and how we plan to do it, and an independent Ministry-commissioned review has endorsed our proposed direction of travel. The first two of a series of national 'gateway reviews' have been completed, and a business case for the first stage of development at Christchurch Hospital and the development of Health Services for Older People was submitted in November 2010 (following the September 4th quake) . We are now working with the Capital Investment Committee of the National Health Board to progress the business case.

The impact of the quakes has served to cement our direction; nothing substantive has changed in our base analysis that would provoke a reconsideration of the strategy or the business case. The only issues will be around finances and timing. The original business case was clearly affordable for the DHB, but other capital commitments post-quake will see us moving to a deficit situation as we recover. Timing has become critical, as decisions about short-term capital investment to fix existing infrastructure need to be made in the context of the longer-term direction or money will be wasted. This becomes particularly crucial with the imminent changes in Building Codes, which will change the extent, the cost and the timing of upgrades to buildings to meet more stringent earthquake standards. It is expected that CERA will require rapid upgrading of buildings identified as having structural weaknesses. Independent engineers are undertaking on our behalf extensive, invasive reviews of all DHB buildings, which will guide decisions regarding repairs and replacement.

Fortunately, the land that our main sites are built on has been cleared as stable and suitable for building. This is particularly important with regard to the Christchurch Hospital site, as the continuation of the main hospital at that site has been identified by the City Council as core to the recovery of Christchurch and integral to the central business district recovery plan they are required to prepare under CERA legislation. The old Christchurch Women's site on Colombo Street has also been identified as a possible location for future health services, and a business case is being developed in conjunction with the Canterbury Clinical Network for that site to become a community hub with extended services including 24/7 acute primary care.

5.7 National and Regional Collaboration

Working collaboratively with others, both across the sector and with other health and social services providers, is integral to increasing our capacity to respond to the changing needs of our population (particularly in response to the earthquakes), and to achieving the objectives set out in this plan.

We are committed to sharing resources with regional DHBs, as well as collaborating with other health and social service providers to build capacity in the health sector. We are also committed to working with external agencies and providers of other types of services to influence the social determinants that are external to the health system but contribute to improving health outcomes for our population.

National Collaboration

At a national level, we work with the education, social development and justice sectors to improve outcomes for the Canterbury population through training, health, nutrition, physical activity, alcohol and other drug and mental health initiatives – crossing sectors in an effort to meet shared goals.

Similarly, we are committed to implementing a number of national programmes which will improve the health of our community, including B4 School Checks, the Human Papillomavirus (HPV) Immunisation Programme and rollout of the InterRAI assessment tool for which Canterbury is taking a lead in the South Island.

Canterbury will also participate in the national work streams being developed and led by the National Health Board, National Health IT Board, Health Quality and Safety Commission and Health Workforce New Zealand. By clearly establishing strategic direction, these work streams will support common platforms, reduce duplication and variation and minimise inequalities between DHBs - all of which will free up resources and create additional capacity in the health sector.

Regional Collaboration

The five South Island DHBs have produced a South Island Regional Health Services Plan and agreed a process for collective decision-making that provides direction for the type and level of service that will be required to best meet the needs of the South Island population.

Canterbury will be working closely with the other South Island DHBs in an alliance framework which will change the dynamics of our DHB relationships. This structure will be further developed and embedded during 2011/12, as our regional planning processes mature.

A number of the regional clinical networks and work streams that already exist will be supported to move to alliance models in the coming year and extend membership across the sector, bringing in colleagues from primary and community services to further expand their experience and expertise. In particular, the Southern Cancer Network, Health of Older People, Mental Health and the Child Health work streams.

This step up to a regional alliance will better support clinical networks, provide clear long-term signals around regional service planning and capital investment and improve the use of shared resources - increasing service capacity across the South Island.

The Canterbury specific actions in relation to regional planning can be found throughout the Actions and Activity section of this document. The full work plan can be found in the South Island Health Services Plan and a summary of the priority areas for 2011/12 is attached to this document (Appendix 7).

5.8 Associate and Subsidiary Companies

The Canterbury DHB has two operational subsidiary companies, which as wholly owned subsidiaries have their own Board of Directors (appointed by the DHB). Both subsidiary companies report to Canterbury DHB, as their shareholder, on a regular basis.

- *Brackenridge Estate Limited* - Incorporated in 1998, Brackenridge Estate Limited provides residential care and respite services, together with day programmes for people with intellectual disability and high dependency needs. Brackenridge operates a range of houses on the Brackenridge site and in the community. Funding for Brackenridge comes from two sources: a contract directly with the Ministry of Health and contracts with the Ministry of Social Development. Brackenridge is currently working through a strategic planning process, including consideration of its future ownership – with the view to, at some stage, transition to non-DHB ownership.
- *Canterbury Laundry Service Limited* **-** Canterbury Laundry Service Limited was incorporated as a company in February 1993. The Canterbury DHB owns all shares and the land and buildings used by the Laundry Service (located at Sylvan Street in Christchurch). Plant and equipment, motor vehicles and the rental linen pool are now the major fixed assets of the Company. A rental is paid to the DHB for the use of the land and buildings. The company provides laundry services to Canterbury DHB hospitals and a range of external clients.

We are also a joint shareholder in the *South Island Shared Services Agency Limited* (SISSAL), which is wholly owned by the five South Island DHBs: Nelson Marlborough, West Coast, Southern, South Canterbury and Canterbury. SISSAL is funded to provide services such as contract and provider management, audit, analysis, service development and project management. SISSAL has an annual budget of around $2.8m and produces its own Statement of Intent.

We are continually assessing the role and efficiency of our subsidiaries to ensure efficiency of our core services.

5.9 Accountability and Consultation with the Minister

As a Crown entity, the DHB must have regard to Government legislation and to Government policy as directed by the Minister of Health. As appropriate, and required by legislation, we will engage the Minister in discussion about any proposals to significantly change the way we invest in, or deliver, health services in the Canterbury region, and seek prior approval before making any significant change. The DHB will also inform the Minister of

any proposals for significant capital investment or the disposal of Crown land. We will also comply with requirements in relation to any specific consultation expectations that the Minister communicates to us.

The Crown Entities Act requires the DHB to report annually to Parliament on our performance, as judged against our Statement of Intent, and to publish this account as our Annual Report.

In addition we must comply with reporting requirements and obligations in the Crown Entities Act and Operational Policy Framework and with specific expectations that the Minister communicates to us. This includes ad-hoc information reports as requested by the Minister, service agreement reporting (against service contracts) and the following regular formal reporting provided to the National Health Board:

- Annual Reports and Audited Financial Statements;
- Quarterly non-financial performance reports and health target reports;
- Quarterly hospital benchmark information reports;
- Quarterly reports on service delivery against plan;
- Bi-annual risk reports;
- Monthly financial reports; and
- Monthly waiting time and ESPI compliance reporting.

The DHB also meets requirements with respect to national health information reporting including: ethnicity reporting, national health index (NHI), national minimum dataset (NMDS), national booking reporting system (NBRS), mental health information national collection (MHINC), national immunisation register (NIR) and national non-admitted patient collection (NNPAC).

SERVICE CONFIGURATION

Module 6

A Balanced and Resilient Health System

As we move forward in our transformation and respond to the after-effects of the Canterbury earthquakes, it is critical that we continue to reorient and rebalance our system to make the most effective use of available resources and enable us to do more (and see more people) with the same resources.

6.2 Service Redesign and Reconfiguration

We have a clear set of prioritisation principles which guide our decision-making, and we have adopted a shared decision-making approach which better supports our partnerships and alliances and the view of the Canterbury health system as one system with one health budget.

At the core of Canterbury's approach is a decision-making process that makes clear which decisions remain the responsibility of the DHB, and which decisions should be devolved to clinicians and providers (and ultimately be made on the front line of service delivery - at the clinician/patient interface).

Traditional and current national policy and process barriers can delay decision-making and take it away from the front line of service provision. To support our approach, we will seek support to change the rules around the way we fund and contract for health services to better enable us to respond flexibly to opportunities and innovations as they present themselves with the minimum of process constraint. We expect to work through these changes with the National Health Board in the coming year.

Flexibility in our approach has enabled the Canterbury health system to continue to deliver core health services in the face of significant disruption. As we continue to respond to a challenging and dynamic environment this capability becomes even more crucial in order to continue to deliver effective health services.

Canterbury has a policy of ongoing participatory engagement and will keep a steady stream of information flowing across the sector on the direction and planned transformation of Canterbury health services.

Service Coverage

The service coverage schedule between the DHB and the Ministry is the translation of Government policy into the required minimum level and standard of service to be made available to the public. Canterbury will seek support for contracting outside of national process to allow for further innovation in areas such as pharmacy, laboratories and primary care. However, we do not seek any exceptions to the Service Coverage Schedule for the coming year and do not expect any exceptions to occur for the residents of Canterbury in 2011/12.

In a very small number of cases, some highly specialised services are not provided in Canterbury and are only available on a national basis (such as paediatric cardiac surgery and liver and lung transplants). For these services, we have funding arrangements with other DHBs that ensure services provided to Canterbury residents are appropriately funded by us.

We will monitor service issues and risks through analysis of trends and demand, risk reporting, formal audit outcomes and complaint mechanisms and will report to the National Health Board on resolution of any new service coverage gap that becomes apparent over the next year.

Service Change

Over the coming year, we will continue to transform the way the Canterbury health system works to 'make it better'. Alongside service transformation, we will continue to make efficiency gains by delivering the same service in more productive ways and by reducing duplication between services and providers. Quality improvements will standardise processes, reduce variation and waste and improve patient outcomes by freeing

up health professionals' time for more direct patient contact. Production planning will also improve the use of our workforce and resources, and reduce waste and duplication in our hospital and specialist services.

We will ensure value for our investment through the regular review and evaluation of current services and by using our prioritisation principles and new contracting frameworks to question whether we can improve outcomes by delivering services in different ways. We will also continue to implement national strategies and meet the expectations of the Minister of Health, particularly with regards to the delivery of national health targets and the implementation of the Canterbury Clinical Network's Business Case.

The DHB is required to notify the Minister of Health before making any significant service change. It is anticipated that new models of care and service delivery will emerge as our work progresses, and these are likely to result in service change or changes to service arrangements. Due to Canterbury's shared decision-making approach, we know where we are likely to make change and the outcomes we seek, but we cannot pre-empt the extent or detail of any service change before the clinical leaders, networks and alliances responsible for them make the relevant decisions.

In most instances, we anticipate that the changes will be in funding models, models of care or service delivery methods, aimed at ensuring that the right person receives the right care and support, at the right time, in the right place. Significant service changes anticipated over the coming year fit into four categories:

- ***Internal service shifts or reconfiguration*** to reduce bureaucracy or improve productivity, value for money, patient safety and clinical quality in line with Vision 2020, our 'Improving the Patient Journey' Programme and our Quality Strategic Plan:
- ***Redesign of service delivery models across hospital and specialist services*** to support more responsive service delivery and to ensure we can continue to provide services within available resources in line with Vision 2020, our 'Improving the Patient Journey Programme' and the Canterbury Recovery Plan:
- ***Redesign or reconfiguration of service delivery models across the whole system*** to build capacity to meet future population growth and improve service delivery and health outcomes in line with Vision 2020, the CCN '*Better, Sooner, More Convenient'* Business Case and the Canterbury Recovery Plan:
- ***Regional service shifts or reconfiguration of service delivery models*** as a result of regional review to ensure consistency across the South Island, provide equity of access to services and improve health outcomes for the South Island population in line with the Regional South Island Health Services Plan.

At the time of writing, we expect to consult the Minister regarding major capital expenditure, including the proposed facilities redevelopment on the Christchurch Hospital, Burwood Hospital and Kaikoura Hospital sites. We also expect to consult the Minister regarding the formal establishment of the Canterbury Innovation Hub.

Service Issues – Risks and Opportunities

The South Island DHBs are collaborating on the implementation of the Regional Health Services Plan, regional alliances and work stream action plans in 2011/12. This plan is in its infancy and will over the coming year be better defined, with managed clinical pathways being developed for service users. Any service changes that Canterbury makes will be carefully considered so as not to destabilise regional work or negatively affect our neighbouring DHBs.

Our greatest service risk going into the next 12 months is simply dealing with the unknown. There is no basis upon which to predict activity and demand after the Canterbury earthquakes and no comparable situation to draw upon. We will implement our Recovery Plan and have in place a contingency plan for dealing with any major increase in demand levels over the winter period. At the same time, we will closely monitor access, utilisation and trends across the whole of the Canterbury health system to identify where in the system support is required to meet patient need, gauge how the system is functioning as a whole and enable and encourage a system perspective to managing our recovery. We will continue our open dialogue with the National Health Board with regard to our recovery and any service issues and risk that become apparent.

PRODUCTION PLANNING

Module 7

Capacity in the Right Place and at the Right Time

Canterbury is focused on a direction that supports people to stay well, reduces the need for higher-level complex intervention by hospital services and reduces acute demand and demand for ARC services.

The summary table below is indicative only and has been included in the Annual Plan (on request of the Ministry) to formalise the link between the DHB's production plan and our planning documents.

The raw growth by output class has some value in highlighting significant increases and decreases in planned delivery, but doesn't represent anything at an aggregate level. This analysis doesn't include those outputs not allocated to any output class by the Ministry's costing system, nor does it allow for areas where Canterbury has already moved outputs from hospital settings to primary settings and where most DHBs have not. The costing system is not individualised or sensitive in this manner. It is expected that there will be further work undertaken in the coming year to allow DHBs to show output variance in a more accurate way that is sensitive to local change.

7.1 2011/12 Production Plan Summary

Annual Plan View
CANTERBURY DHB

RAW GROWTH BY OUTPUT CLASS [1]

	2009/10 actuals	2010/11 forecast		2011/12 planned	
Prevention	16	16	- -	16	- -
Early detection and treatment	-	-	- ▲	-	- ▲
Intensive assessment & treatment	581,466	566,799	-2.5% ▼	608,767	7.4% ▲
Rehabilitation & support	-	-	▲	-	▲

[1] Doesn't include outputs not allocated to any output class.

HOSPITAL OUTPUTS GROWTH

Inpatients	2009/10 actuals	2010/11 forecast		2011/12 planned	
Medical	32,520	34,013	4.6% ▲	35,031	3.0% ▲
Maternity	9,011	8,964	-0.5% ▼	8,854	-1.2% ▼
Surgical	43,460	42,311	-2.6% ▼	42,177	-0.3% ▼
Total Inpatient (CWDs)	***84,992***	***85,287***	**0.3% ▲**	***86,062***	**0.9% ▲**

Outpatients (expressed as cost weights)	2009/10 actuals	2010/11 forecast		2011/12 planned	
Emergency Department	3,616	3,664	1.3% ▲	3,981	8.6% ▲
Medical first	2,376	2,202	-7.3% ▼	2,302	4.5% ▲
Medical follow up	5,807	5,532	-4.7% ▼	5,684	2.7% ▲
Renal	1,035	937	-9.5% ▼	985	5.2% ▲
Scope	1,593	1,486	-6.7% ▼	1,561	5.0% ▲
Surgical first	2,328	2,144	-7.9% ▼	2,320	8.2% ▲
Surgical follow up	3,548	3,360	-5.3% ▼	3,458	2.9% ▲
Maternity	1,798	1,813	0.8% ▲	1,892	4.4% ▲
Total Outpatient events	***22,101***	***21,137***	**-4.4% ▼**	***22,183***	**4.9% ▲**
Total Additional Volumes	***25,482***	***24,724***	**-3.0% ▼**	***25,991***	**5.1% ▲**
TOTAL ACTIVITY EXPRESSED AS COST WEIGHTS	***132,575***	***131,149***	**-1.1% ▼**	***134,236***	**2.4% ▲**

FINANCIAL PERFORMANCE 2011-2014

Module 8

Fiscal Sustainability

Over the past ten years an increasing share of national expenditure has been devoted to health. While we continue to receive a large share of national funding, clear signals have been given that Government is looking to the whole of the health sector to rethink how we will meet the needs of our populations with a more moderate growth platform now and into the future. In setting expectations for 2011/12, the Minister expects DHBs to operate within existing resources and approved financial budgets and to work collaboratively to meet fiscal challenges and ensure services and service delivery models are clinically and financially sustainable.

The following section provides a summary of the Canterbury DHB's financial assumptions and projections over the next three years, in order to achieve the objectives and goals outlined in this Annual Plan.

8.1 Meeting Our Financial Challenges

Prior to the earthquakes Canterbury was on track to deliver a break even financial performance as the result of three years of sustained focus on delivering a balanced, clinically and financially sustainable system.

The unique situation of the Canterbury earthquakes aside; Canterbury faces the same fiscal pressures as other DHBs: demographically and technologically driven demand, increasing expectations, increasing cost growth and wage and salaries expectations. The element which is different in Canterbury is the scale on which these effects take place.

In addition to the usual fiscal pressures Canterbury also has to meet the significant costs of the earthquake in terms of infrastructure damage, treatment and additional personal health costs (such as the relocation of patients and services) and the predicted increase in demand and the costs of recovery over the next five years. The total cost of the earthquakes is an unknown factor; in particular we are unable to assess the interplay between the costs of repairs and insurance recovery. For the purposes of planning our operational expenditure we have assumed the impact from insurance revenue and cost is neutral. From a service perspective we have had to focus on ensuring services continue to be delivered during the quakes and in their aftermath. We have taken a long term view that the current system workforce and capacity will be needed in the future so we have sought to support and stabilise the sector with flexible use of funding.

There is no 'quick-fix' solution. To ensure our health system is financially sustainable we are focused on making the whole of the system work properly and achieving the best possible outcomes for our investment. This was work Canterbury was already investing in to meet the challenges faced across the

THE CANTERBURY FINANCIAL REALITY

We know that there will be significant costs associated with the Canterbury earthquakes.

There are the obvious costs in terms of damage to infrastructure and plant and equipment, treatment of injured people and transport of patients out of Christchurch.

There are also less obvious costs such as the relocation of services out of damaged facilities, rental and fitout of new premises, and the costs of outsourcing services as a result of lost capacity.

Increased investment will be needed in primary and community services to manage the pressure of acute demand and cope with lost capacity as a result of the earthquakes.

There are anticipated costs associated with a displaced population, with an increased level of deprivation, disassociation with primary care and a lost of continuity around the management of long-term conditions.

There are also anticipated costs such as changes to building and compliance codes, insurance cover and repair costs which cannot be quantified without further information.

All of these accumulate into a picture of the unknown in terms of our financial outlook. However, Canterbury's focus is on keeping our health system running and providing services for our population. Our recovery and our vision are on the same track and even though our health system now has a different horizon we will maintain our sense of direction and deliver our vision.

health sector, we will have to be even more focused on this direction to cope with the added pressure related to the earthquake recovery.

Constraining cost growth is critical to our success. If an increasing share of our funding continues to be directed into meeting the growing cost of providing services, our ability to maintain current levels of service delivery will be at risk. We will also be severely restricted in terms of our ability to invest in new equipment, technology and new initiatives that allow us to meet future demand levels.

It is also critical that we continue to reorient and rebalance our health system. By being more effective and improving the quality of the care we provide, we reduce rework and duplication, avoid unnecessary costs and expenditure and do more (and see more people) with our current resources. We are also able to better manage the pressure of acute demand growth, maintain the resilience and viability of services and build on productivity gains already achieved through increasing the integration of services across the system.

Canterbury has already committed to a number of mechanisms and strategies to constrain cost growth and rebalance our health system. We will continue to focus on these initiatives, which have contributed to our considerable past success and given us a level of resilience that will be vital in the coming year:

- Reducing variation, duplication and waste from the system;
- Doing the basics well and understanding our core business;
- Investing in clinical leadership and clinical input into operational processes and decision-making;
- Developing workforce capacity and supporting less traditional and integrated workforce models;
- Realigning service expenditure to better manage the pressure of demand growth; and
- Supporting unified systems to shared resources and systems.

8.2 Financial Outlook

Revenue from the Government (via the Ministry of Health) is the main source of funding for the Canterbury DHB. This is supplemented by additional funding from side agreements with organisations such as the Accident Compensation Corporation (ACC) and payments from other DHBs for services provided to their populations. For 2011/12 the DHB is forecasting revenue/funding, including non-Government-related revenue, will increase by approximately $52M.

With capacity severely restricted across Canterbury after the February earthquake, it is vital that we are able to focus our investment on services and programmes that reduce hospital admissions, the demand for aged residential care beds, and on restorative models of care that support people to stay well in their own homes and communities.

We have elected to apply new expenditure at a proportionally greater rate to primary and community services (including district nursing and home based support services) in order to support our recovery over the next year, manage predicted increases in demand pressures, and support people in their own homes and communities rather than in hospitals and aged residential care facilities.

Out-years Scenario

We have made a conservative assumption that funding increases in the out years (2012/13 and 2013/14) will be the same as national average increases.

8.3 Assumptions

As a result of the earthquake, we have made the assumption that Canterbury will run deficits for the 2011/12 and 2012/13 financial years to cover the cost of the recovery.

While we are aware that the costs around building and infrastructure repairs, insurance payments, the additional costs of compliance with new building codes, and the impact of impairment on our land, buildings,

and infrastructure will be significant; like the wider system impacts from the earthquakes and continuing aftershocks, these costs are yet unknown and have not been assumed in our forecasts.

In preparing our forecasts we have made the following assumptions:

- Revenue and expenditure have been budgeted on current Government policy settings and known health service initiatives.
- Population based funding will continue at levels prior to the earthquakes.
- We will receive fair prices for services provided on behalf of other DHBs and the Crown, including paediatric Oncology services.
- Early payment arrangements will be retained by the DHB.
- No additional compliance costs have been budgeted, as it is assumed these will be cost neutral or fully funded. It is also assumed that the impact of any legislative changes, sector reorganisation or service devolvement (during the term of this Plan) will be cost neutral or fully funded.
- Damage to our buildings, infrastructure, and equipment will be fully covered by insurance recoveries, and that expenditure and recoveries will be recognised within the same financial year.
- There will be minimal impact from any revaluation of land and buildings (We are currently reviewing the impairment on our land, buildings and infrastructure as a result of the earthquakes but the estimated impact has not been quantified).[47]
- 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 be made within available funding levels, after allowance for committed and demand-driven funding.
- Revenue and expenditure have been budgeted on the basis that transformation and earthquake recovery strategies and programmes will not be delayed due to sector or legislative changes. It is assumed that investment to meet increased demand will be prioritised and approved in line with our Board's strategy.
- It is assumed, particularly with the damage sustained by our facilities, work will continue on the Facilities Redevelopment Plan (for Christchurch Hospital and Older Persons' Health Specialist Services); however, no major facilities development or capital expenditure associated with the redevelopment will take place during the term of this Plan, unless specific prior approval has been given by the Minister of Health.
- Revenue and expenditure have been budgeted on normal operations with no assumption for costs or disruptions associated with any pandemic, or with a further natural disaster.
- Changes in expenditure in relation to KiwiSaver for outyears will be fully funded.

8.4 Asset Planning and Sustainable Investment

Business Cases

In 2010 the DHB supported the Canterbury Clinical Network's submission of the business case for 'Better, Sooner, More Convenient Health Care' in Canterbury. This was approved by the Minister of Health and 2011/12 will be year two of the implementation of this transformational plan. The initiatives and programmes planned for year two are outlined in Appendix 6 of this document, and will be funded within current allocations.

In 2010 the DHB also submitted a business case seeking approval for the Redevelopment of Christchurch Hospital and Older Persons' Health Specialist Services. Considering the significant damage our facilities sustained during the February earthquake, and the subsequent impairments to the provision of care we will progress with the next stage of this business case in the coming year. Subject to approval, the original timelines for the redevelopment are: Burwood (Older Persons' Health Services) site by 2014 and Christchurch site by 2016. These will need to be reconsidered in light of the seismic events.

[47] *The last revaluation occurred in June 2010.*

In the coming year the DHB will prepare a business case for the redevelopment of the Kaikoura Hospital site into an Integrated Family Health Centre, which is expected to be delivered by Quarter 3, 2011/12.

Capital Expenditure

Subject to approval of Canterbury's business case for the redevelopment of Christchurch Hospital and Older Persons' Health Services, the first phase of the plan would see the DHB substantially funding the capital expenditure. In order to achieve this, Canterbury's baseline capital expenditure budget will be set at $25M until completion of the facilities redevelopment programme.

Significant capital projects included within this budget are:

- Mental Health Adult Inpatient Facility redesign;
- Patient Management System – phase 1 of a 3 year project, to replace our existing system, which will become unsupported in 2014;
- Kaikoura Hospital detailed design, to support the preparation of the business case; and
- Upgrade of our Oracle Financial Management System (FMIS), which is nearing the end of its supported life. The upgrade will be a shared system in line with the national FMIS direction.

Other significant capital expenditure that has already been committed where the expenditure will be incurred in the 2011/12 financial year includes: the Christchurch Hospital campus boiler replacement, electricity network infrastructure, linear accelerators and the Children's Haematology Oncology Centre. With a tight capital expenditure budget, the DHB will continue to be disciplined and focus on the key priorities in determining capital expenditure spending.

Capital expenditure associated with immediate projects necessary to undertake as a result of damage to our infrastructure, and the infrastructure of providers we fund, have not been included within our capital plans. It is assumed that the capital required for these developments will be approved and/or funded via the National Health Board Capital Investment Committee.

8.5 Debt and Equity

The Canterbury DHB has a $129.650M total loan facility with the Crown Health Funding Agency. The DHB's estimated total term debt is expected to be $75M as at June 2012. The DHB is also repaying $1.861M of equity annually as part of the agreed FRS-3 funding.

The Crown Health Financing Agency term liabilities are secured by a negative pledge. Without the Crown Health Financing Agency's prior written consent the DHB cannot perform the following actions:

- Create any security over its assets, except in certain circumstances;
- Lend money to another person or entity (except in the ordinary course of business and then only on commercial terms) or give a guarantee;
- Make a substantial change in the nature or scope of its business as presently conducted, or undertake any business or activity unrelated to health; or
- Dispose of any of its assets except disposals at full value in the ordinary course of business.

8.6 Additional Information and Explanations

Disposal of Land

As part of the preparation required for the anticipated Christchurch Hospital redevelopment, a land exchange is planned between the Christchurch City Council and the Canterbury DHB. This was part of a significant public consultation in 2010, which received Christchurch City Council and widespread community support. The Christchurch City Council proposed to pass legislation through Parliament in 2011 to effect the land transfer.

Disposal of surplus assets over the next three years may include a house property in Hamner Springs. This property was previously approved for disposal, by the former Minister of Health but not purchased by the Crown as part of a larger holding.

Disposal over the next three years may also include (all or part of) the former Christchurch Women's Hospital site (Colombo/Durham Street, Christchurch). A formal decision has yet to be made as to whether or not the full parcel of this land is considered 'surplus' and this may now be delayed as the site has been identified as a possible location for future health services and a community hub.

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

The development of the CBD plan and the CERA Recovery Strategy may have an impact on decisions that can be taken in regard to land and facilities.

Activities for which Compensation is Sought

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

Acquisition of Shares

Before we or any of our associates or subsidiaries 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.

This is likely to include seeking approval for establishing the legal entities required to formal establish the 'Innovation Hub' in Canterbury.

Accounting Policies

The accounting policies adopted are consistent with those in the prior year. For a full statement of accounting policies, refer to Appendix 8.

FORECASTS OF FINANCIAL PERFORMANCE

Module 8

8.7 Group Statement of Comprehensive Income

	2009/10 Actual $'000	2010/11 Forecast $'000	2011/12 Forecast $'000	2012/13 Forecast $'000	2013/14 Forecast $'000
Operating Revenue					
MoH Revenue	1,262,542	1,308,758	1,363,714	1,402,671	1,441,395
Patient Related Revenue	44,807	40,043	40,959	42,474	44,046
Other Revenue	24,459	31,042	27,204	27,977	28,779
Total Operating Revenue	1,331,808	1,379,843	1,431,877	1,473,122	1,514,220
Operating Expenditure					
Employee Costs	542,121	559,995	585,373	605,501	620,129
Treatment Related Costs	116,647	123,788	128,162	129,694	129,408
External Providers	508,377	535,573	565,481	576,300	580,320
IDFs	31,184	31,008	33,141	34,280	35,108
Non Treatment Related & Other Costs	77,683	77,063	76,384	79,011	80,919
Total Operating Expenditure	1,276,012	1,327,427	1,388,541	1,424,786	1,445,884
Result before Interest, Depn & Cap Chrge	55,796	52,416	43,336	48,336	68,336
Interest, Depreciation & Capital Charge					
Interest Expense	(4,662)	(4,674)	(4,700)	(4,700)	(4,700)
Depreciation	(42,497)	(47,330)	(47,036)	(47,036)	(47,036)
Capital Charge Expenditure	(17,447)	(16,412)	(16,600)	(16,600)	(16,600)
Total Interest, Depreciation & Capital Charge	(64,606)	(68,416)	(68,336)	(68,336)	(68,336)
Net Surplus/(Deficit)	**(8,810)**	**(16,000)**	**(25,000)**	**(20,000)**	-
Other Comprehensive Income					
Gains on property revaluations	**16,371**	-	-	-	-
Total Comprehensive Income	**7,561**	**(16,000)**	**(25,000)**	**(20,000)**	-

8.8 Group Statement of Financial Position

	30/06/10 Actual *$'000*	30/06/11 Forecast *$'000*	30/06/12 Forecast *$'000*	30/06/13 Forecast *$'000*	30/06/14 Forecast *$'000*
Public Equity					
Opening Equity	215,923	229,352	211,491	184,630	162,770
Revaluation	16,371				
Equity Repayment	5,868	(1,861)	(1,861)	(1,861)	(1,861)
Net Result for the period	(8,810)	(16,000)	(25,000)	(20,000)	-
Total Public Equity	**229,352**	**211,491**	**184,630**	**162,770**	**160,909**
Current Assets					
Cash & Bank (OD)	69,076	99,513	81,386	72,071	90,712
MoH Debtor	18,410	20,372	20,374	20,374	15,374
Other Debtors & Other Receivables	16,043	19,765	19,765	19,765	19,765
Prepayments	1,310	872	872	872	872
Stocks	8,644	9,641	9,641	9,641	9,641
Total Current Assets	113,483	150,163	132,038	122,723	136,364
Current Liabilities					
Creditors & Accruals	85,981	110,000	110,000	110,000	110,000
Capital charge payable	4,927	7,229	7,229	7,229	7,229
GST	5,455	5,770	5,770	5,770	5,770
Interest Accrual	810	800	800	800	800
Staff Entitlement	127,197	125,000	125,000	125,000	125,000
Total Current Liabilities	224,370	248,799	248,799	248,799	248,799
Working Capital	(110,887)	(98,636)	(116,761)	(126,076)	(112,435)
Investments	10,446	12,066	12,066	12,066	12,066
Restricted Assets - Trust Fund	12,626	12,483	12,483	12,483	12,483
Fixed Assets					
Land	103,682	94,543	94,543	94,543	94,543
Buildings	253,220	217,721	208,887	199,614	189,614
Plant & Equipment	49,785	35,697	28,795	20,523	10,021
Capital WIP	5,468	34,725	41,725	46,725	51,725
Fixed Assets	412,155	382,686	373,950	361,405	345,903
Total Non Current Assets	435,227	407,235	398,499	385,954	370,452
Term Staff Entitlement	(7,362)	(9,625)	(9,625)	(9,625)	(9,625)
Trust Funds Liabilities	(12,626)	(12,483)	(12,483)	(12,483)	(12,483)
Term Loans	(75,000)	(75,000)	(75,000)	(75,000)	(75,000)
Total Non Current Liabilities	(94,988)	(97,108)	(97,108)	(97,108)	(97,108)
Net Assets	**229,352**	**211,491**	**184,630**	**162,770**	**160,909**

8.9 Group Statement of Movements in Equity

	30/06/10 Forecast *$'000*	30/06/11 Forecast *$'000*	30/06/12 Forecast *$'000*	30/06/13 Forecast *$'000*	30/06/14 Forecast *$'000*
Total Equity at Beginning of the Period	215,923	229,352	211,491	184,630	162,770
Total Comprehensive Income	7,561	(16,000)	(25,000)	(20,000)	-
Amount recognised Directly in Equity					
Impairment of property					
Total Recognised Revenues and Expenses					
Other Movements					
Contribution back to Crown	5,868	(1,861)	(1,861)	(1,861)	(1,861)
Contribution from Crown					
Total Public Equity	**229,352**	**211,491**	**184,630**	**162,770**	**160,909**

8.10 Group Statement of Cashflow

	2009/10 Actual $'000	2010/11 Forecast $'000	2011/12 Forecast $'000	2012/13 Forecast $'000	2013/14 Forecast $'000
Cashflows from Operating Activities					
Cash provided from:					
MOH Receipts	1,274,881	1,306,796	1,363,712	1,402,671	1,446,395
Other Receipts	62,879	61,685	62,363	64,651	67,025
	1,337,760	1,368,481	1,426,075	1,467,322	1,513,420
Cash applied to:					
Employee Costs	533,154	559,929	585,373	605,501	620,129
Supplies & Expenses	736,178	743,972	803,168	819,285	825,755
Capital Charge Payments	13,551	14,110	16,600	16,600	16,600
Finance Costs	4,673	4,684	4,700	4,700	4,700
Taxes Paid	(457)	(315)	-	-	-
	1,287,099	1,322,380	1,409,841	1,446,086	1,467,184
Net Cashflow from Operating Activities	**50,661**	**46,101**	**16,234**	**21,236**	**46,236**
Cashflows from Investing Activities					
Cash provided from:					
Sale of Assets	56				
Interest Received	4,239	5,678	5,800	5,800	5,800
	4,295	5,678	5,800	5,800	5,800
Cash applied to:					
Advance to JV/Trust Investments	(1,620)	1,620	-	-	-
Purchase of Assets	40,865	17,861	38,300	34,491	31,534
	39,245	19,481	38,300	34,491	31,534
Net Cashflow from Investing Activities	**(34,950)**	**(13,803)**	**(32,500)**	**(28,691)**	**(25,734)**
Cashflows from Financing Activities					
Cash provide from:					
Equity Injection	7,729				
Loans Raised	-	-	-	-	-
	7,729	-	-	-	-
Cash applied to:					
Loan Repayment					
Equity Repayment re FRS-3	1,861	1,861	1,861	1,861	1,861
	1,861	1,861	1,861	1,861	1,861
Net Cashflow from Financing Activities	**5,868**	**(1,861)**	**(1,861)**	**(1,861)**	**(1,861)**
Overall Increase/(Decrease) in Cash Held	21,579	30,437	(18,127)	(9,316)	18,641
Add Opening Cash Balance	47,497	69,076	99,513	81,387	72,071
Closing Cash Balance	**69,076**	**99,513**	**81,387**	**72,071**	**90,712**

8.11 Summary of Revenue and Expenses by Arm

FUNDING ARM	2009/10 $'000 Actual	2010/11 $'000 Forecast	2011/12 $'000 Forecast	2012/13 $'000 Forecast	2013/14 $'000 Forecast
Revenue					
MoH revenue	1,220,392	1,263,189	1,315,916	1,354,505	1,393,195
Patient Related Revenue					
Other					
Total Revenue	1,220,392	1,263,189	1,315,916	1,354,505	1,393,195
Expenditure					
Personnel					
Depreciation					
Interest & Capital charge					
Other - Personal Health	876,216	914,695	966,864	991,133	1,003,272
Other - Mental Health	131,455	131,348	137,812	142,911	148,198
Other - Disability Support	212,928	215,772	220,560	228,144	233,666
Other - Public Health	816	1,354	1,680	1,738	1,780
Other - Maori Health	1,315	1,691	1,824	1,887	1,932
Other - Governance & Admin	-	-	-	-	-
Total Expenditure	1,222,730	1,264,860	1,328,740	1,365,813	1,388,848
Net Surplus/(Deficit)	**(2,338)**	**(1,671)**	**(12,824)**	**(11,308)**	**4,347**
Property Revaluation	-	-	-	-	-
Total Comprehensive Income	**(2,338)**	**(1,671)**	**(12,824)**	**(11,308)**	**4,347**

GOVERNANCE & FUNDER ADMIN	2009/10 $'000	2010/11 $'000	2011/12 $'000	2012/13 $'000	2013/14 $'000
Revenue					
MoH revenue	-	623	-	-	-
Patient Related Revenue					
Other					
Total Revenue	-	623	-	-	-
Expenditure					
Personnel	3,214	3,159	3,336	3,451	3,535
Depreciation	29	15	-	-	-
Interest & Capital charge					
Other	(3,241)	(2,551)	(3,336)	(3,451)	(3,535)
Total Expenditure	2	623	-	-	-
Net Surplus/(Deficit)	**(2)**	-	-	-	-
Property Revaluation	-	-	-	-	-
Total Comprehensive Income	**(2)**	-	-	-	-

PROVIDER ARM	2009/10 $'000	2010/11 $'000	2011/12 $'000	2012/13 $'000	2013/14 $'000
Revenue					
MoH revenue	738,070	751,789	788,034	813,098	832,039
Patient Related Revenue	34,112	40,685	37,648	39,391	40,919
Other	22,403	21,966	20,395	21,360	21,576
Total Revenue	794,585	814,440	846,077	873,849	894,534
Expenditure					
Personnel	525,372	544,435	569,413	589,001	603,230
Depreciation	42,468	47,972	47,036	47,036	47,036
Interest & Capital charge	22,109	21,086	21,300	21,300	21,300
Other	211,106	215,276	220,504	225,204	227,315
Total Expenditure	801,055	828,769	858,255	882,542	898,881
Net Surplus/(Deficit)	**(6,470)**	**(14,329)**	**(12,178)**	**(8,693)**	**(4,347)**
Property Revaluation	**16,371**	-	-	-	-
Total Comprehensive Income	**9,901**	**(14,329)**	**(12,178)**	**(8,693)**	**(4,347)**

IN HOUSE ELIMINATION	2009/10 $'000	2010/11 $'000	2011/12 $'000	2012/13 $'000	2013/14 $'000
Revenue					
MoH revenue	(683,169)	(698,278)	(730,116)	(755,232)	(773,509)
Patient Related Revenue					
Other					
Total Revenue	(683,169)	(698,278)	(730,116)	(755,232)	(773,509)
Expenditure					
Personnel					
Depreciation					
Interest & Capital charge					
Other	(683,169)	(698,278)	(730,116)	(755,232)	(773,509)
Total Expenditure	(683,169)	(698,278)	(730,116)	(755,232)	(773,509)
Net Surplus/(Deficit)	-	-	-	-	-
Property Revaluation	-	-	-	-	-
Total Comprehensive Income	-	-	-	-	-

CONSOLIDATED	2009/10 $'000	2010/11 $'000	2011/12 $'000	2012/13 $'000	2013/14 $'000
Revenue					
MoH revenue	1,275,293	1,317,323	1,373,834	1,412,371	1,451,725
Patient Related Revenue	34,112	40,685	37,648	39,391	40,919
Other	22,403	21,966	20,395	21,360	21,576
Total Revenue	1,331,808	1,379,974	1,431,877	1,473,122	1,514,220
Expenditure					
Personnel	528,586	547,594	572,749	592,452	606,765
Depreciation	42,497	47,987	47,036	47,036	47,036
Interest & Capital charge	22,109	21,086	21,300	21,300	21,300
Other	747,426	779,307	815,792	832,334	839,119
Total Expenditure	1,340,618	1,395,974	1,456,877	1,493,122	1,514,220
Net Surplus/(Deficit)	**(8,810)**	**(16,000)**	**(25,000)**	**(20,000)**	-
Property Revaluation	16,371	-	-	-	-
Total Comprehensive Income	**7,561**	**(16,000)**	**(25,000)**	**(20,000)**	-

APPENDICES

Module 9

Further Information for the Reader

Appendix 1: Glossary of Terms.

Appendix 2: Objectives of a DHB – New Zealand Public Health and Disability Act (2000).

Appendix 3: Canterbury DHB Structure and Organisational Chart.

Appendix 4: Hospital and Specialist Services Overview.

Appendix 5: Monitoring Framework Measures - Indicators of DHB Performance.

Appendix 6: Year II Work Plan - Canterbury Clinical Network BSMC Business Case.

Appendix 7: South Island Health Services Plan Summary Work Plan - 2011/12.

Appendix 8: Statement of Accounting Policies.

REFERENCES

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

All Ministry of Health or National Health Board documents referenced in this Statement of Intent are available either on the Ministry's website (www.moh.govt.nz) or the National Health Board's website (www.nationalhealthboard.govt.nz).

The Crown Entities Act 2004 and the Public Finance Act 1989, both referenced in this document are available on the Treasury website (www.treasury.govt.nz).

9.1 Glossary of Terms

GLOSSARY OF TERMS USED IN THIS DOCUMENT		
ACC	Accident Compensation Corporation	Crown Entity set up to provide comprehensive no-fault personal accident cover for New Zealanders.
	Acute Care	Management of conditions with sudden onset and rapid progression.
ASH	Ambulatory Sensitive Hospital Admissions	Hospitalisation for causes which could have been avoided by preventive or therapeutic programmes.
	Capability	What an organisation needs (in terms of access to people, resources, systems, structures, culture and relationships), to efficiently deliver outputs.
CVD	Cardiovascular Disease	Diseases affecting the heart and circulatory system, including: ischaemic heart disease, rheumatic heart disease, cerebrovascular disease and other forms of vascular and heart disease.
COPD	Chronic Obstructive Pulmonary Disease	A progressive disease process that most commonly results from smoking. Chronic obstructive pulmonary disease is characterised by difficulty breathing, wheezing and a chronic cough.
	Continuum of Care	Exists when a person can access responsive services matched to their level of need at any time throughout their illness or recovery.
	Crown agent	A Crown entity that must give effect to government policy when directed by the responsible Minister.
	Crown Entity	A generic term for a diverse range of entities referred to in the Crown Entities Act 2004. Crown Entities are legally separate from the Crown and operate at arm's length from the responsible or shareholding Minister, but are included in the annual financial statements of the Government.
CFA	Crown Funding Agreement	An agreement by the Crown to provide funding in return for the provision of, or arranging the provision of, specified services.
DOSA	Day of Surgery Admission	Admission of a patient on the same day on which they are scheduled to have their elective surgery. The admission can be as either a day case or an inpatient.
	Determinants of Health	The range of personal, social, economic and environmental factors that determine the health status of individuals or populations.
	Effectiveness	The extent to which objectives are being achieved. Effectiveness indicators relate outputs to impacts and to outcomes. They can measure the steps along the way to achieving an overall objective or an Outcome and test whether outputs have the characteristics required for achieving a desired objective or government outcome.
ESPIs	Elective Services Patient flow Indicators	A set of indicators developed by the Ministry to monitor how patients are managed while waiting for elective (non-urgent) services.
FSA	First Specialist Assessment	(Outpatients only) The first time a patient is seen by a doctor for a consultation in that speciality. This does not include procedures, nurse or diagnostic appointments or pre-admission visits.
HbA1c	Haemoglobin A1c	Also known as glycated haemoglobin, HbA1c reflects the average blood glucose level over the past 3 months.
HEHA	Healthy Eating Healthy Action	The Ministry of Health's strategic approach to improving nutrition, increasing physical activity and achieving healthy weight for all New Zealanders.
HSS	Hospital and Specialist Services	The Provider-arm Division of the Canterbury DHB.
	Impact	The contribution made to an outcome by a specified set of goods and services (outputs), or actions, or both. Normally describes results that are directly attributable to the activity of an agency. Impact measures should be attributed to DHB outputs in a credible way and represent near-terms results expected from the outputs delivered.
IPJ	Improving the Patient Journey	A programme established by the DHB to encourage frontline health professionals to improve patient outcomes by reducing unnecessary delays within the patient continuum of care and embedding innovation tools and techniques into services
	Input	The resources (e.g. labour, materials, money, people, information technology) an organisation uses to produce outputs.
IDFs	Inter District Flows	Services (outputs) provided by a DHB to a patient whose place of residence is in another DHB's region. Under PBF, each DHB is funded on the basis of its resident population; therefore, the DHB providing the IDF will recover the costs of that IDF from the DHB who was funded for that patient.
InterRAI	International Resident Assessment Instrument	A comprehensive geriatric assessment tool.
	Intervention	An action or activity intended to enhance outcomes or otherwise benefit an agency or group.

	Intervention logic model	A framework for describing the relationships between resources, activities and results, which provides a common approach for planning, implementation and evaluation. Intervention logic focuses on being accountable for what matters: impacts and outcomes.
MoU	Memorandum of Understanding	An agreement of cooperation between organisations defining the roles and responsibilities of each organisation in relation to the other(s) with respect to an issue over which the organisations have concurrent jurisdiction.
	Morbidity	Illness, sickness.
	Mortality	Death.
NHI	National Health Index	An NHI number is a unique identifier assigned to every person who uses health and disability services in NZ. A person's NHI number is stored on the NHI along with their demographic details. The NHI is used to help with the planning, coordination and provision of health and disability services across NZ.
NGO	Non-Government Organisations	In the context of the relationship between Health and Disability NGOs and the Canterbury DHB, NGOs include independent community and iwi/Māori organisations operating on a not-for-profit basis, which bring a value to society that is distinct from both Government and the market.
OPF	Operational Policy Framework	An annual document endorsed by the Minister of Health that sets out the operational level accountabilities that all DHBs must comply with, given effect through the Crown Funding Agreements between the Minister and the DHB.
	Outcome	A state or condition of society, the economy or the environment, including a change in that state or condition. Outcomes are the impacts on the community of the outputs or activities of Government (e.g. a change in the health status of a population).
	Output Class	An aggregation of outputs of a similar nature.
	Outputs	Final goods and services delivered to a third party outside of the DHB. Not to be confused with goods and services produced entirely for consumption within the DHB (internal outputs or inputs).
PBF	Population Based Funding	Involves using a formula to allocate each DHB a fair share of the available resources so that each Board has an equal opportunity to meet the health and disability needs of its population.
	Primary Care	Professional health care received in the community, usually from a general practice, covering a broad range of health and preventative services. The first level of contact with the health system.
PHO	Primary Health Organisation	PHOs encompass the range of primary care practitioners and are funded by DHBs to provide of a set of essential primary health care services to the people enrolled with that PHO.
	Public Health	The science and art of preventing disease, prolonging life and promoting health and efficiency through organised community effort.
	Purchase agreement	A documented arrangement between a Minister and a department or other organisation for the supply of outputs.
	Regional collaboration	Refers to DHBs across geographical 'regions' planning and delivering services (clinical and non-clinical) together. Four regions exist: Northern, Midland, Central and Southern. The Southern region includes all five South Island DHBs (Canterbury, Nelson Marlborough, South Canterbury, Southern and West Coast DHBs). Regional collaboration sometimes involves multiple regions, or may be 'sub-regional collaboration' (DHBs working together in a smaller grouping of two or three DHBs, e.g. Canterbury and West Coast).
	Secondary Care	Specialist care that is typically provided in a hospital setting.
SISSAL	South Island Shared Services Agency Ltd	An organisation funded by the South Island DHBs on an annual budget basis to provide consultancy and management services including contract and provider management, audit, strategy and service development, analysis, and project and change management.
SSP	Statement of Service Performance	Government departments, and Crown entities from which the Government purchases a significant quantity of goods and services, are required to include audited statements of service performance with their financial statements. These statements report whether the organisation has met its service objectives for the year.
	Tertiary Care	Very specialised care often only provided in a smaller number of locations

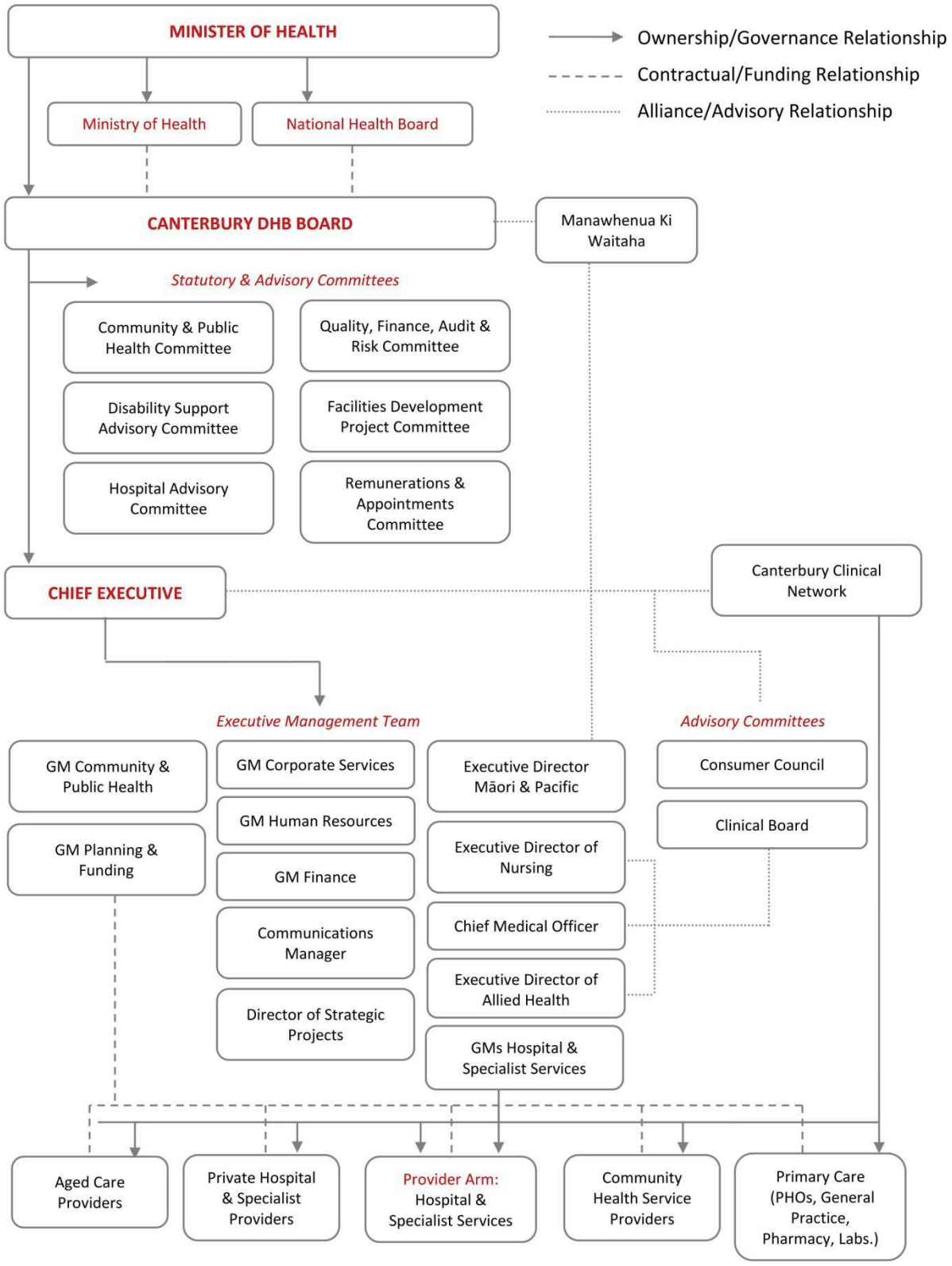
9.2 Objectives of a DHB – New Zealand Public Health and Disability Act (2000)

PART 3: SECTION 22:

The New Zealand Public Health and Disability Act outlines the following objectives for DHBs:

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

9.3 Canterbury DHB –Organisational Chart



9.4 Hospital and Specialist Services - Overview of Services

HOSPITAL SUPPORT AND LABORATORY SERVICES

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

MEDICAL AND SURGICAL SERVICES

Cover medical services: general medicine, cardiology/lipid disorders, endocrinology/diabetes, respiratory, rheumatology/immunology, infectious diseases, oncology, gastroenterology, clinical haematology, neurology, renal, palliative, hyperbaric medicine and sexual health. They also cover surgical services: general surgery, vascular, ENT, ophthalmology, cardiothoracic, orthopaedics, neurosurgery, urology, plastic, maxillofacial and cardiothoracic surgeries and the services of the day surgery unit. Medical and Surgical Services also covers: emergency investigations, outpatients, anaesthesia, intensive care, radiology, nuclear medicine, clinical pharmacology, pharmacy, medical physics and allied health services. The Christchurch Hospital has a busy Emergency Department, treating around 84,000 patients per annum.

SPECIALIST MENTAL HEALTH SERVICES

Cover specialist mental health services: adult community; adult acute; rehabilitation; child, adolescent and family (CAF); forensic; alcohol and drug; intellectually disabled persons' health; and other Specialty services. Services (including alcohol and drug services) are provided by a number of outpatient, inpatient, community-based and mobile services throughout Canterbury. Regional inpatient beds and consultation liaison are provided by the Forensic, Eating Disorders, Alcohol and Drug, and CAF Services. Rural Adult Community and CAF Services are provided to Kaikoura and Ashburton through outreach clinics.

OLDER PERSONS' SPECIALIST HEALTH AND REHABILITATION SERVICES

Cover assessment, treatment, rehabilitation and psychiatric services for the elderly in inpatient, outpatient and community settings; under 65 needs assessment service; generic geriatric outpatients; specialist osteoporosis clinics; and specialist under 65 assessment and treatment services for disability-funded clients. The Older Persons' Health Specialist Service also operates a psychogeriatric day hospital and provides inpatient and community stroke rehabilitation services. Rehabilitation services (provided at Burwood Hospital) include spinal, brain injury, orthopaedic and chronic pain management services. The majority of CDHB elective orthopaedic surgery is undertaken at Burwood Hospital, as well as some general Plastics lists. The Burwood Procedure Unit provides a 'see and treat' service for skin lesions in conjunction with primary care. A School and Community Child and Adolescent Dental Service is also provided by the DHB and managed through this service area.

ASHBURTON AND RURAL HEALTH SERVICES

Cover a wide range of services provided in rural areas, generally based out of Ashburton Hospital, but also covering services provided by the smaller rural hospitals of Akaroa, Darfield, Ellesmere, Kaikoura, Oxford and Waikari. Services include: general medicine and surgery; palliative care; maternity services; gynaecology services; assessment, treatment and rehabilitation services for the elderly; and long-term care for the elderly including specialised dementia care, diagnostic services and meals on wheels. Also offered in Ashburton are rural community services: day care, district nursing, home support and clinical nurse specialist outreach services including respiratory, cardiac, diabetes, wound care, urology, continence and stoma therapy. Within Ashburton the division also operates Tuarangi Home, which provides hospital level care for the elderly in Ashburton and is introducing, in 2011, rest home dementia care for the elderly.

WOMEN AND CHILDREN'S HEALTH SERVICES

Cover acute and elective gynaecology services; primary, secondary and tertiary obstetric services; neonatal intensive care services at Christchurch Women's Hospital; first trimester pregnancy terminations at Lyndhurst Hospital; and primary maternity services at Lincoln Maternity, Rangiora Hospital and the Burwood Birthing Unit. This Service also covers children's health: general paediatrics; paediatric oncology; paediatric surgery; child protection services; cot death/paediatric disordered breathing; community paediatrics and paediatric therapy; public health nursing services; and vision/hearing screening services. The Services' neonatal intensive care is involved in world-leading research investigating improved care for pre-term babies, and child health specialists provide a Paediatric Neurology, Oncology and Surgery Outreach Service to DHBs in the South Island and lower half of the North Island.

9.5 Monitoring Framework Measures - Indicators of DHB Performance

POLICY PRIORITIES DIMENSION

Performance Measure and Description			2011/12 Target	National Target	Timing
PP1 Clinical leadership self assessment					
Provide a qualitative report identifying progress achieved in fostering clinical leadership and the DHB engagement with it across their region.			N/A	N/A	Annual
PP2 Implementation of Better, Sooner, More Convenient primary health care					
Report progress on the implementation of changes to primary health care services that deliver *Better, Sooner, More Convenient* (BSMC) primary health care, particularly: the shifting of services from secondary care to primary care settings and the development of Integrated Family Health Centres. Include progress on the BSMC business case, including the operation and expenditure of the flexible funding pool. Provide resolution plans for problems identified.			N/A	N/A	Quarterly
PP3 Local Iwi/Māori engagement and participation in DHB decision-making, development of strategies and plans for Māori health gain					
Measure 1 - PHO Māori Health Plans Percentage of PHOs with MHPs that have been agreed to by the DHB.			**100%**	100%	
Measure 2 - PHO Māori Health Plans Report on how MHPs are being implemented by the PHOs and monitored by the DHB (include a list of the names of the PHOs with MHPs). **Measure 3 – DHB – Iwi/Māori relationships - (Memorandum of Understanding (MoU))** Provide a report demonstrating achievements against the MoU between the DHB and its local Iwi/Māori health relationship partner, and describe other initiatives achieved as an outcome of engagement between the parties. Provide a copy of the MoU. **Measure 4 – DHB – Iwi/Māori relationships** Report on how local Iwi/Māori are supported to participate in the development and implementation of the strategic agenda; service delivery planning, development, monitoring, and evaluation (include PHOs). **Measure 5 – DHB Māori Health Plan (MHP)** Provide a report by exception on national level priorities that have not been achieved in the DHB MHP, indicating why, what the DHB will do to rectify it, and by when.			N/A	N/A	Six-Monthly
PP4 Improving mainstream effectiveness DHB provider arms pathways of care of Māori					
Provide a report describing the reviews of pathways of care undertaken in the last 12 months that focused on improving health outcomes and reducing health inequalities for Māori. Report issues/opportunities brought to the DHB's attention as a result of the reviews in Measure 1; the follow-up actions the DHB intends to take/is taking as a result of the issues and opportunities identified; and the timeframes for implementing these actions.			N/A	N/A	Six-Monthly
PP5 Waiting times for chemotherapy treatment					
Provide monthly chemotherapy templates measuring the interval between the patient's first specialist assessment and the beginning of chemotherapy treatment and related measures. Provide a report outlining the resolution path where the monthly wait time data identifies: any patients domiciled in the DHB waiting more than four weeks due to capacity issues; and/or wait time standards were not met for patients in priority categories A and B.			**100% in 4 weeks**	100% in 4 weeks	Quarterly
PP6 Improving the health status of people with severe mental illness					
Report the average number of people domiciled in the DHB region, seen per year rolling every three months (the period is lagged by three months) for child and youth aged 0-19, adults aged 20-64 and older people aged 65+, each specified for each of the three categories Māori, Other, and in total.	**Age 0-19**	Māori	**2%**	N/A	Six-Monthly
		Other	**2%**		
		Total	**2%**		
	Age 20-64	Māori	**3.6%**		
		Other	**2.5%**		
		Total	**2.5%**		
	Age 65+	Total	**2.72%**		

PP7 Improving mental health services using crisis intervention planning					
1. Report the number of adults (20+ years) with enduring serious mental illness who have been in treatment for 2+ years since the first contact with any mental health service. Report the subset of alcohol and other drug only clients for the 20+ age group. 2. Report the number of children and youth (0-19 years) who have been in secondary care treatment for 1+ years. 3. Report the number and percentage of long-term clients with up to date relapse prevention/treatment plans. 4. Describe the methodology used to ensure adult long-term clients have up-to-date relapse prevention plans and that appropriate services are provided.	**Adult (20+)**	Māori	**95%**	95%	Six-Monthly
		Non-Māori	**95%**	95%	
	Child and Youth	Māori	**95%**	95%	
		Non Māori	**95%**	95%	
PP8 DHBs report alcohol and drug service waiting times and waiting lists					
For each service type, report (one month in arrears) the longest waiting time in days AND the number of people on the waiting list for treatment at the end of the month. Waiting times are measured from the time of referral for treatment to the first date the client is admitted to treatment, following assessment in any service (NGO or provider arm).			N/A	N/A	Six-Monthly
PP9 Delivery of Te Kokiri: the mental health and addiction action plan					
Provide a summary report on progress made towards implementation of Te Kōkiri: the Mental Health and Addiction Action Plan, using the Ministry template.			N/A	N/A	Annual
PP10 Oral Health DMFT Score at year 8					
Upon the commencement of dental care, at the last dental examination before the child leaves the DHB's Community Oral Health Service, the total number of: (i) permanent teeth of children in school Year 8 (12/13-year olds) that are – Decayed (D), Missing (due to caries, M), and Filled (F); and (ii) children who are caries-free (decay-free).		Māori	**1.90**	N/A	Annual
		Pacific	**1.95**		
		Other	**1.15**		
		Total	**1.25**		
PP11 Children caries free at 5 years of aged					
At the first examination after the child has turned five years, but before their sixth birthday, the total number of: (i) children who are caries-free (decay-free); and (ii) primary teeth of children that are – Decayed (d), Missing (due to caries, m), and Filled (f).		Māori	**46%**	N/A	Annual
		Pacific	**30%**		
		Other	**71%**		
		Total	**67%**		
PP12 Utilisation of DHB funded dental services by adolescents					
Report the total number of adolescents accessing DHB-funded adolescent oral health services.		Total	**75%**	85%	Annual
PP13 Improving the number of children enrolled in DHB funded dental services					
Measure 1 - Report the total number of children 0 to 4 years of age inclusive, who are enrolled with DHB-funded oral health services.		Children Enrolled **0-4 years**	**62%**	N/A	Annual
Measure 2 - Report:(i) the number of pre-school children and primary school children who have not been examined according to their planned recall; and (ii) the greatest length of time children have been waiting for their scheduled examination, and the number of children waiting for that period.		Children not examined **0-12 years**	**<10%**		
PP14 Family violence prevention					
Confirmation report based on audit scores for partner abuse and child abuse and neglect programme components.			**140/200**	140/200	Annual
PP15 Improving the safety of elderly: Reducing hospitalisation for falls					
Report the percentage of people 75 yrs and older domiciled in the DHB region hospitalised for falls, per year. (Data only for the first year of reporting).			N/A	N/A	Six-Monthly
PP16 Workforce - Career Planning					
Provide quantitative data to demonstrate progress achieved in career planning for the DHB's workforce.			N/A	N/A	Annual

SYSTEM INTEGRATION DIMENSION

Performance Measure and description			2011/12 Target	National Target	Frequency
SI1 Ambulatory sensitive (avoidable) hospital admissions					
Provide a commentary on the latest 12 month ASH data available via the nationwide service library. This commentary may include additional district level data not captured in the national data collection and also information about local initiatives that are intended to reduce ASH admissions. Provide information about how health inequalities are being addressed with respect to this health target, with a particular focus on ASH admissions for Pacific and Māori 45-64 year olds.	**Age 0-74**	Māori	**≤95**	N/A	Six-Monthly
		Pacific	**≤104**		
		Other	**≤105**		
	Age 0-4	Māori	**≤95**		
		Pacific	**≤116**		
		Other	**≤120**		
	Age 45-64	Māori	**≤95**		
		Pacific	**≤95**		
		Other	**≤95**		
SI2 Regional service planning					
Provide a single progress report on the implementation plan on behalf of the region. If actions, milestones, measures or financial performance are not tracking to plan, provide a resolution plan, commenting on the actions and regional decision-making processes being undertaken to agree to the resolution plan.			N/A	N/A	Quarterly
SI3 Service coverage					
Report progress achieved during the quarter 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 identified by the DHB or Ministry.			N/A	N/A	Six-Monthly
SI4 Elective services standardised intervention rates					
For any procedure where the standardised intervention rate in the 2011/12 financial year or 2011 calendar year is significantly below the target level, report: 1. what analysis the DHB has done to review the appropriateness of its rate **AND** 2. whether the DHB considers the rate to be appropriate for its population **OR** 3. the reasons for its relative under-delivery of that procedure **AND** 4. the actions being undertaken in the current year (2011/12) that will ensure the target rate is achieved.			**Per 10,000**	Per 10,000	Six-Monthly
	Intervention rate		**308**	308	
	Major joint replacements		**21**	21	
		Hip	**10.5**	10.5	
		Knee	**10.5**	10.5	
	Cataract Procedures		**27**	27	
	Cardiac procedures		**6.50**	6.5	
SI5 Expenditure on services provided by Māori Health providers					
Report actual expenditure (GST exclusive) on Māori providers by General Ledger (GL) code. Report actual reported expenditure for Māori providers in comparison to estimated expenditure in the Annual Plan for the same reporting period, with explanation of variances.			N/A	N/A	Annual
SI7 Improving breast-feeding rates					
Set breastfeeding targets with a focus on Māori, Pacific and the total population respectively to incrementally improve district breastfeeding rates to meet or exceed the National Indicator. Maintain and report on appropriate planning and implementation activity to improve the rates of breastfeeding in the district. This includes activity targeting Māori and Pacific communities. Provide local data from non-Plunket Well Child providers. (The Ministry will provide breastfeeding data sourced from Plunket.)	**6 weeks**	Māori	**64%**	74%	Annual
		Pacific	**67%**		
		Other	**70%**		
		Total	**67%**		
	3 Months	Māori	**46%**	57%	
		Pacific	**51%**		
		Other	**59%**		
		Total	**57%**		
	6 Months	Māori	**18%**	27%	
		Pacific	**26%**		
		Other	**29%**		
		Total	**28%**		

OWNERSHIP DIMENSION

Performance Measure and description	2011/12 Target	National Target	Frequency
OS3 Elective and arranged inpatient length of stay			
The standardised average length of stay (ALOS) for elective and arranged inpatients (excluding day patients).	**4.00 days**	N/A	Quarterly
OS4 Acute inpatient length of stay			
The standardised ALOS for acute inpatients (excluding day patients).	**4.00 days**	N/A	Quarterly
OS5 Theatre Utilisation			
Submit the following data elements, represented as a total of all theatres in each Provider Arm facility: Actual theatre utilisation; resourced theatre minutes; actual minutes used as a percentage of resourced utilisation.	**85%**	85%	Quarterly
OS6 Elective and arranged day surgery			
The standardised day surgery rate.	**60%**	60% Standardised	Quarterly
OS7 Elective and arranged day of surgery admissions			
The day of surgery admission rate.	**90%**	90% Standardised	Quarterly
OS8 Acute readmissions to hospital			
The standardised acute readmission rate (unplanned acute readmissions to hospital within 28 days).	**≤9.95%**	N/A	Quarterly
OS9 30 Day mortality			
The standardised mortality rate (within 30 days of admission, for all patient discharges, including day cases).	**≤1.67**	N/A	Annual
OS10 Improving the quality of data provided to national collection systems			
Measure 1: National Health Index (NHI) duplications	**≤6%**	3 - 6%	Quarterly
Measure 2: Ethnicity set to 'Not stated' or 'Response Unidentifiable' in the NHI	**≤2%**	0.5 - 2%	
Measure 3: Standard versus specific diagnosis code descriptors in the National Minimum Data Set (NMDS)	**≥55%**	55 - 65%	
Measure 4: Timeliness of NMDS data	**≤5%**	2 - 5%	
Measure 5: NNPAC Emergency Department admitted events have a matched NMDS event	**≥97%**	97 - 99.5%	
Measure 6: PRIMHD File Success Rate	**≥98%**	98 -99.5%	

OUTPUT DIMENSION

Performance Measure and description	2011/12 Target	National Target	Frequency
OP1 Output Delivery			
TO BE DEFINED			Quarterly

9.6 Year II Work Plan - Canterbury Clinical Network BSMC Business Case

ACTIONS 2011/12		
Objective	**Action**	**Evidence**
1. Implement the urgent care workstream. *To provide the most appropriate urgent care options to meet patient need at any given time, and ensure that only people who need hospital services present at ED and that others receive timely care in the community.* *Post February 22nd and subsequent engagement with General Practice it has been noted that this programme has experienced a 20% increase in uptake. The planned delivery is based on this increase continuing.*	1.1. Ensure that patients with acute conditions are provided with the most appropriate treatment by the most appropriate provider.	95% of patients will be admitted, discharged of transferred from an ED within six hours
	1.2. Continue to provide episodes of urgent care in the community where this is appropriate in order to ensure that hospital services are reserved for conditions that are best managed by them. Post February 22nd and subsequent engagement with General Practice it has been noted that this programme has experienced a 20% increase in uptake. The planned delivery is based on this increase continuing.	>16,800 urgent care episodes are managed in a primary care setting during the 2011/12 year.
	1.3. Further develop community based Acute Demand Management Services (ADMS) to support people with a high level of need to connect with primary care for care that is best provided outside of a hospital rather than this care being provided within the ED. These services include: ▪ Community observation units; ▪ Packages of care; ▪ Acute nursing teams; ▪ Access to urgent diagnostics; and ▪ Service coordination.	A new framework for ADMS service provision, with strengthened clinical leadership, is agreed and put in place before 30th Sept 2011. At least two improved practices or pathways are reported on each quarter. 2,000 episodes of subsidised community based care are provided, during 2011/12, to patients that may otherwise have sought this care from the ED (frequent attendees' and self referrers' projects).
	1.4. Encourage patients to phone their general practice for non-emergency care and relevant guidance on a 24 hour a day, 7 days a week basis in order to assist patients to seek care from the appropriate provider.	A communications package is put in place before 30 Sept 2011 to encourage patients to phone their general practice for non-emergency care. 95% of general practices across Canterbury utilise the telephone triage system outside of business hours by June 2012.
2. Implement the aged care workstream. *To enable older people to live well at home and in their community.* *This will reduce demand on acute hospital and aged residential care services.*	Age adjusted rates of acute hospital admissions and residential care admissions for elderly will be monitored and reported.	
	2.1. Phased rollout in Christchurch to establish restorative home support model in order to support older people to continue living healthy lives in their own homes.	Rollout will be 75% complete by June 2012.
	2.2. Fund appointment in primary care for medication review to ensure that medication associated adverse events are minimised and that patient outcomes are maximised.	2,000 targeted medication reviews provided to people 65+ with complex medication and support needs.
	2.3. Continue the implementation of CREST to ensure people are safely discharged home from hospital in a timely manner and avoid admission to hospital for people that can be rehabilitated in their homes. ▪ Stage 2 CREST entries from surgery and AT&R. ▪ Stage 3 CREST entries from general practice and ED. ▪ Stage 4 CREST intake service complete.	900 people (65+) supported upon hospital discharge by CREST. 600 people (65+) supported upon direct GP referral by CREST. A 10% reduction in acute hospital readmissions for people who are being supported by CREST services.
	2.4. Pass on the innovations developed as a part of the Gerontology Nurse Practitioner initiative in the	Further Gerontology Nurse Practitioner Service explored, with a decision made by

ACTIONS 2011/12		
Objective	Action	Evidence
	Papanui area to other areas.	31 March 2012
	2.5. Establish a new, integrated community-based falls prevention programme, including an integrated care pathway and training across the sector by Q1 2011/12. Ensure that older people that are especially vulnerable as a result of earthquake damage have priority access to falls assessments.	800 clients receive a community based falls programme. A reduction in the proportion of the population (75+) admitted to hospital as a result of a fall.
	2.6. Engage ARC facilities in quality improvement work with other significant components of the system to ensure that optimal care is provided.	Evidence is provided to show that planning towards these goals has occurred and is being implemented.
3. Implement the Primary Secondary Integration Workstream. *To support the provision of the right care in the right place at the right time by the right provider.*	3.1. Continue to expand the range of clinical pathways between primary and secondary care to ensure patients receive the right care at the right time from the right provider, support the reduction in waiting times and maximise the value provided by clinicians right across the health sector.	350 pathways will be available for use within Canterbury.
4. Implement the urban Integrated Family Health and Social Service Network System. *To support health and social service providers coming together to work in a defined community to operate as an integrated team.*	4.1. Implement Integrated Family Health Centres and networks within Christchurch.	5 – 6 IFHCs are developed or under development to replace damaged infrastructure.
	4.2. Community hubs are developed to provide a range of outpatient and community specialist activity alongside extended primary care.	Plans are developed for up to four hubs within the region
5. Implement the Rural Health Workstream. *To ensure health services in the rural parts of Canterbury deliver comprehensive, integrated family health services equitably, efficiently and sustainably.*	5.1. Continue to expand the development of Integrated Family Health Centres (IFHCs) in rural Canterbury.	Construction of an IFHC will occur in Kaiapoi before October 2011. Construction of an IFHC will begin in Darfield before 30 June 2012. Final design will be completed for an IFHC in Kaikoura before 31st December 2011.
6. Implement the Long Term Conditions Workstream. *To reduce the growth in the number of people with, and improve the outcomes of those who have, long term conditions, including diabetes, cardiovascular disease and respiratory disease.*	6.1. Mitigate the impact of long term conditions by supporting those who are at risk or have identified disease to live healthier lives through provision of relevant investigations and provision of agreed care plans. With a particular focus on achievement of the national Health Targets. Reprioritise the flexible funding pool to support a sharper focus on these areas and ensure that approaches are made more consistent across Canterbury. Implement the Collaborative Care Management System to provide integrated information and care planning for people with complex needs. Continue the new Māori/Pacific Diabetes/CVD screening programme for early detection of at risk urban and rural Māori and Pacific people.	Feedback on the level of achievement in these areas will be given to primary care providers. 90% of identified smokers will be provided with advice and help to quit smoking. The number of patients receiving cardiovascular risk and diabetes screening will be increased. The number of patients receiving diabetes annual review will be increased. 1,042 Māori/Pacific Diabetes/CVD screening consultation subsidies provided.
	6.2. Encourage all patients to enrol with and engage with general practice as their single point of ongoing continuity for healthcare.	Narrative will be provided showing how this message is being supported.
	6.3. Provide Canterbury Initiative clinical training to support new pathways.	Training plan developed before 30th September 2011.
7. Implement the Māori Health Workstream. *To promote Whānau Ora as the core*	7.1. Support primary healthcare teams to provide competent care to Māori whānau in a manner that is consistent with the emerging direction on whānau ora.	Review of existing workshop material is completed. First workshop with new material

ACTIONS 2011/12		
Objective	Action	Evidence
'future mindset' that allows us to change the way we think, plan and deliver our health services into the future.		delivered.
	7.2. Provide input to Māori Community Events which support whānau to live healthy lives within the community.	Five events will be supported during 2011/12
	7.3. Work with He Oranga Pounamou and its Canterbury Provider Network to progress the Kura Pounamou implementation of Whānau Ora.	Evidence is provided to show that the health sector in Canterbury is working with He Oranga Pounamu to maximise the impact of both programmes.
	7.4. Māori Diabetes/CVD screening programme continues.	1,042 Māori/Pacific Diabetes/CVD screening consultation subsidies provided.
8. Implement the Pacific Health Workstream. *To increase awareness and educate health professionals in best practice models of engagement with Pacific People.*	8.1. Support Pacific Health action plan to support Pacific peoples' access to primary health services and ensure that Pacific people experience good health outcomes. Pacific Health and primary health care in Canterbury report is completed and recommendations are provided about how to improve access of Pacific people to primary health care services.	Pacific 3 year plan completed by 30th September 2011. Implementation of the agreed actions occurs as scheduled.
	8.2. Pacific Scholarships offered to health students from Canterbury area.	5 Pacific scholarships are offered and awarded before 30th September 2011.
9. Implement the Engagement Workstream. *To enable the transformation activities across Canterbury and support the implementation of Business Case workstream initiatives.*	9.1. Engagement activities are spread across all workstream and alliance groups as wide clinical and community participation is facilitated.	Engagement plan is in place by 30th September 2012. Evidence is provided that implementation of plan is up to date.
	9.2. Development of the shared care model has involved many stakeholders in the process and piloting within the clusters has strengthened this engagement.	
	9.3. Sector wide communications have been developed and delivered, including internet.	
10. Implement the Information Technology Workstream. *To enable the transformation activities across Canterbury and support the implementation of Business Case workstream initiatives.*	10.1. Active involvement across the primary and secondary IT and analytical teams (as well as regional and national teams) is facilitated through supporting cluster development and the development of the Collaborative Care Management System. This will support the provision of complex care within the community and the sharing of relevant information for patients referred into this service.	CCMS interfaces with MedTech, Testsafe South and Concerto are in place before 30th September 2011. 50 patients are enrolled on the CCMS before 30th September 2011.
11. Implement the Alliance Framework Workstream. *To enable the transformation activities across Canterbury and support the implementation of Business Case workstream initiatives.*	11.1. Continue to expand the range of providers whose frameworks are developed within the alliance environment in order to ensure that the pool of those being invited to innovate continues to grow.	The Canterbury Pharmacy Alliance agreements will be implemented before 31st December 2011..
12. Implement the Referred Services Management Workstream. *To enable the transformation activities across Canterbury and support the implementation of Business Case workstream initiatives.*	12.1. Ensure that the use of community referred radiology continues to maximise value to the people of Canterbury.	30,000 Community Referred Radiology referrals submitted. 90% of referrals submitted during the year are accepted. 30% of referrals submitted will be provided electronically.
13. Implement the Pharmacy Workstream. *To enable the transformation activities across Canterbury and support the implementation of*	13.1. Implement new dispensing arrangements to support effective and efficient use of subsidised medicines by providing expert medicines advice to prescribers and patients.	Six demonstration sites involving pharmacy and general practice will be operating under the revised multidisciplinary model between 1 July 2011 and 30 June 2012.

ACTIONS 2011/12		
Objective	Action	Evidence
Business Case workstream initiatives.		
14. Implement the Workforce Development Workstream *To enable the transformation activities across Canterbury and support the implementation of Business Case workstream initiatives.*	*14.1.* Develop a workforce development plan to support the roles that are emerging through other work in the sector.	Plan developed by 31st March 2012.
15. Implement the recommendations of the Leadership and Support Service Level Alliance (SLA). *To enable the transformation activities across Canterbury and support the implementation of Business Case workstream initiatives.*	15.1. Implement the functional and structural changes recommended by the Leadership and Support SLA showing how they ensure the following outcomes are achieved: ▪ Reduction of duplication; and ▪ Reduction in bureaucracy; and ▪ Financially sustainable solutions; and ▪ Leadership and support adding value.	Transitional steps will be planned by 31st December 2011. Activity will occur according to the transition plan.
16. Implement the recommendations of the Flexible Funding Pool SLA. *To enable the transformation activities across Canterbury and support the implementation of Business Case workstream initiatives.*		From July 1st PHO's align appropriate funding streams based on principles set by the flexible funding pool service level alliance. By June 30th 2012 Canterbury wide service models are implemented to deliver consistent and appropriate services based on the flexible funding pool service level alliance.
17. Immunisation	17.1. Continue to improve immunisation outcomes for people in Canterbury. Streamline immunisation service.	Due to disruption to infrastructure and patient's health seeking behaviours Canterbury DHB has been allowed to not set targets for immunisation rates during 2011/12. This statistic will continue to be reported with the intention of having 95% of two year olds fully immunised. A missed events coordinator will be put in place before December 2011 to ensure that such events are followed up.

9.7 South Island Health Services Plan Summary Work Plan - 2011/12

CEO Sponsor: Brian Rousseau (SDHB)

Clinical Lead: Dr Shaun Costello

Regional structure: Southern Cancer Network

Regional Clinical Alliance

Cancer Services

The following actions will be implemented in 2011-12 to resolve issues of equity of access and clinical viability.

What actions are to be taken in 2011-12?	We expect these actions will…	To deliver	Measured by	In support of system outcomes
1. Development and implementation of a South Island Blood and Cancer Service Plan. 2. Implementation of the South Island Clinical Cancer Information System. 3. Share cancer control knowledge and information to enable informed decision making. 4. Efficiency gains and improvements to the patient journey are identified in the patient mapping reports (lung and bowel tumour streams), implemented and monitored. 5. Development of an (electronic) integrated referral system, South Island Medical Oncology Protocols, e-prescribing and an enhanced system (via SICCIS) for recording the medical oncology prioritisation wait times (pending the outcome of the funding bid for Medical Oncology Prioritisation Wait Time RFP). 6. Develop and support the implementation of a South Island 10-year plan for radiation oncology (including linear accelerator review). 7. Implement the South Island Multi-Disciplinary Meeting (MDM) project to improve the supporting infrastructure and increase access and utilisation of MDM. 8. Ongoing support and monitoring of the	• Facilitate regional collaboration and service quality improvement leading to better, sooner and more convenient cancer services. • Robust cancer data and information sources are developed and shared that describe outcomes, current service provision and enable informed service development & planning decision-making. • To share knowledge and information to inform and enable decision making for consumers and health professionals within the cancer continuum. • Efficiency gains and improvements to the patient journey are identified, implemented and monitored. • Improve access and wait times: for lung and colorectal cancer, to radiotherapy treatment, to medical oncology /chemotherapy, improve access to cancer diagnostics including PET scans. • Improve infrastructure and access to cancer multidisciplinary meetings. • Improve access and reduce inequalities to cancer services. • Workforce innovations are identified and	• The SCN Regional Strategic Plan. • The South Island Blood and Cancer Service Plan. • Cancer patients receive timely, high quality care, are supported across the cancer care continuum and have equitable access to services. • Cancer health targets are achieved in the South Island. • Cancer patients receive timely, high quality care, are supported across the cancer care continuum and have equitable access to services. • Cancer health targets are achieved in the South Island.	• Progress against the SCN Regional Strategic Plan. • South Island Blood and Cancer Service Plan complete and operational. • South Island Clinical Cancer Information System implemented and reporting South Island cancer information monthly[88]. • SCN website operational, Newsletters published quarterly. • Progress against the recommendations in the South Island Lung and Colorectal reports is monitored and achieved[2]. • Integrated referral system, e-prescribing implemented. South Island medical oncology protocols developed and implemented (pending successful bid)[2]. • South Island DHB's performances meet national cancer health target requirements. • 10% increase in the percentage of patients with Lung and Colorectal Cancer are discussed at Multidisciplinary meetings. • 10% increase in the number of patients with Lung or Colorectal cancer domiciled outside of Christchurch and Dunedin are discussed at Multidisciplinary meetings.	• Regional system and service efficiencies and quality improvement opportunities identified and implemented resulting in the meeting of national health targets, economies of scale, increased consistency of practice and increased equity of access. • Robust cancer data and information sources are developed and shared that enable informed service development & planning decision-making. • Innovation and infrastructure planning and development are supported to reduce inequalities and build regional capacity and capability. • Regional system and service efficiencies and quality improvement opportunities identified and implemented resulting in the meeting of national health targets, economies of scale, increased

[88] *References are to follow.*

What actions are to be taken in 2011-12?	We expect these actions will…	To deliver	Measured by	In support of system outcomes
utilisation of PET Scans and other diagnostics in the South Island 9. Reducing Inequalities projects are supported within the Local Cancer Networks 10. All SCN network groups are provided with ongoing support to progress actions in their respective work plans. 11. The advanced symptom management system (ASyMS©) bid (currently with Health Workforce NZ) will pilot an integrated cross tertiary and community technology based patient management system that will change current workforce and work flow while supporting a greater number of cancer patients self-manage (with support) while receiving chemotherapy in the community.	adapted to the South Island setting.		• South Island PET Scan utilisation (including variant requests) is collected via DHB of domicile and national clinical indication or variant and reported monthly[89]. • SCN work groups progress their respective work plans. • The internationally linked ASYMS pilot is funded and piloted in the South Island.	consistency of practice and increased equity of access. • Robust cancer data and information sources are developed and shared that enable informed service development & planning decision-making. • Innovation and infrastructure planning and development are supported to reduce inequalities and build regional capacity and capability.

CEO Sponsor: John Peters (NMDHB)

Clinical Lead: Nick Baker

Regional structure: SI Child Health Alliance

Child Health Services

Four actions will be implemented in 2011-12 to resolve issues of equity of access and clinical viability.

What actions are to be taken in 2011-12?	We expect these actions will…	To deliver	Measured by	In support of system outcomes
1. Child Health Alliance developed workplan focussed on priority areas across the continuum of Children's Health 2. Develop markers of processes of health care, (performance indicators) benchmark and work collaboratively to understand differences and identify opportunities for improvement.	• Ensure future development of Child Health Services across the SI is prioritised and focussed on meeting the needs of Children in a sustainable and equitable manner • Enhance collaboration and communication across SI child health services and enable consistency of clinical practices, efficiencies and improved	• Coordinated service development and provision across the continuum of services for Children • Clinically sustainable and affordable regional SI child health services that support clinicians to generate innovative changes to support holistic approaches across the network.	• Progress against agreed workplan Process markers (performance indicators) are developed and implemented to measure and compare systems supporting quality improvement and sharing of innovation. For example: • Reduction in did not attend (DNA) rates for outpatient appointments • Reduction in procedural waiting times • First specialist assessment (FSA) per capita for general and sub-specialty outpatient clinics (e.g. General paediatrics orthopaedics, ESPI compliance for paediatric surgery)	Strengthened regional collaboration and integration of child & youth health services. Strengthened regional collaboration and integration of child & youth health services. Improved health outcomes for target groups of children and

[89] *See South Island PET Scan utilisation report contained in Appendix 1 of the Southern Cancer Network Six Monthly Report July – December 2010*

What actions are to be taken in 2011-12?	We expect these actions will…	To deliver	Measured by	In support of system outcomes
3. Monitor and evaluate paediatric epidemiology data to assess the health status of the SI child and youth population 4. Develop and implement regional clinical pathways for children from secondary to tertiary care providers and where appropriate from secondary/tertiary to primary health care providers. 5. Develop a SI regional paediatric workforce development plan in conjunction with national workforce development and planning, including succession planning for regional paediatric multi-disciplinary teams. 6. Develop and implement regional early warning score protocol – a quality improvement tool to improve assessment of unwell children and ensure the right care, at the right time, by the right service is provided for all SI children.	access across health providers. • Support the implementation of an alliance framework and when appropriate alliance contracting. • Provide regional baseline data to improve service planning and reduce inequalities for this population group in the SI • Enhance collaboration and communication across SI child health services and enable consistency of clinical practices, efficiencies and improved access across health providers. • Improve service quality and viability. • Improve clinical assessment and early intervention of appropriate treatment	• South Island benchmarking and health status reports providing clarity around differences in care and outcomes with opportunities for improvement. • Clinically sustainable and affordable regional SI child health services that supports local child health services to provide safe and quality-focussed care with appropriate support from tertiary services and a multidirectional flow within the network. Maintenance of skills when workload alone is insufficient. Fewer isolated clinicians with better peer support. Linked services to achieve critical mass for viability Best practice clinical assessment and treatment of the unwell child / youth	Use of evidence about health status to focus service improvement and development. For example: • Chronic disease management in childhood and young people • Diabetes management Regional clinical pathways for gastroenterology and general surgery: • Are used by paediatricians in the 7 SI paediatric services for referral of children and young people from secondary to tertiary care • 85% gastroenterology and general surgery referrals will be assessed, have diagnostic investigations completed and treated within agreed national guideline timeframes (audit review) • Evaluate referrals to specialist services with a reduction of inappropriate clinical referrals SI regional paediatric workforce plan developed for: • Opportunities for paediatric training rotations across SI paediatric services • Shared clinical training/education opportunities • Shared recruitment and retention policies • Dual clinical appointments within DHB paediatric services • Fewer episodes of unexpected clinical deterioration and sentinel events • Improved staff awareness of normal physiological variation across the age span	families. Whole of systems approach to improve quality, access and sustainability of health services thereby increased sharing, reducing duplication and fragmentation of services. Sustainable workforce to ensure a viable child and youth health services in SI Improved health outcomes for at risk children and youth

Health of Older People

CEO Sponsor: Chris Fleming (SCDHB)

Clinical Lead: to be determined

Regional structure: SI Health of Older People Alliance

The following actions will be implemented in 2011-12 to resolve issues of equity of access and clinical viability.

What actions are to be taken in 2011-12?	We expect these actions will…	To deliver	Measured by	In support of system outcomes
1. Develop a common approach to restorative service delivery of community services 2. Roll out InterRAI across each of the South Island DHBs. 3. Standardize the eligibility criteria and processes for entry to services across the South Island. 4. Implement the South Island Dementia initiative. 5. Health of Older People Alliance developed workplan focussed on priority areas across the continuum of Older People's Services	• Ensure more consistent access to service provision, no matter which District users are domiciled in. • Improve a restorative focus for home-based support services across the region. • Improve the skill sets of those working with older people who have dementia. • Ensure future development of Older People's Services across the South Island is prioritised and focussed on meeting the needs of the Older Person in a sustainable and equitable manner	• Consistent approach to service allocation to ensure services are targeted appropriately to needs. • Coordinated service development and provision across the continuum of services for the Older Person	• Each DHBs service specifications reflect a common restorative approach • All 5 DHBs have incorporated InterRAI into needs assessment processes. • Each DHB has agreed the components and adopted a consistent approach to accessing support services for older people. • Each DHB has run a first round of the regional dementia training programme (Walking in other's shoes).	• Standard & objective access criteria for HOP services. • A restorative focus for home based support services. • More predictable access to specialist services and better use of scarce resources. • Reduced demand on residential services over time.

Mental Health

CEO Sponsor: John Peters (NMDHB)

Clinical Lead: to be determined

Regional structure: SI Mental Health Alliance

The following actions will be implemented in 2011-12 to resolve issues of equity of access and clinical viability[90][91].

What actions are to be taken in 2011-12?	We expect these actions will…	To deliver	Measured by	In support of system outcomes
1. Mental Health Alliance developed workplan focussed on priority areas across the continuum of Mental Health Services	• Collaborative planning and teamwork will enable the implementation of regional sustainable strategies to improve health outcomes	• Support to enable all people with experience of mental illness and addiction to fully participate in society and in the everyday life of their communities and whānau	Progress against agreed workplan	• Strengthened regional collaboration and integration of health services. • Whole of systems approach to improve quality, access and

[90] *Logan, F (2009), South Island Regional Mental Health Strategic Plan 2008- 2011. SISSAL, Christchurch, January 2009*

[91] *Minister of Health (2006). Te Kokiri: The Mental Health and Addiction Action Plan 2006-2015, Wellington, Ministry of Health*

What actions are to be taken in 2011-12?	We expect these actions will…	To deliver	Measured by	In support of system outcomes
				sustainability of health services thereby increased sharing, reducing duplication and fragmentation of services. • Improved health outcomes for service users, and family/ whānau. • The health and disability system outcome of 'New Zealanders living longer, healthier and more independent lives'. • An intermediate outcome is that people receive better health and disability services.
Mothers and babies[92]				
2. Regional provider expands the scope of regular education sessions beyond secondary care; tailoring specifically for individual districts and the needs of the wider health sector by utilising local/district expertise. 3. Regional service provides clinical supervision to District service staff. 4. The regional provider investigates a screening tool (peri natal and post partum) for use by service providers across the sector in the South Island.	• Support the Better, Sooner, More Convenient philosophy enabling primary care and NGOs to help people earlier rather than waiting to meet secondary service criteria. Education sessions will be tailored to meet the specific needs of the individual DHBs and providers. • Individual staff and cases will be supported and receive additional training/education which can then be shared with the local team. • Consistency and quality of care across the South Island.	• Regional provider delivers education sessions to the DHBs tailored to meet their needs, inclusive of the wider health sector. • Clinical supervision provided to District service staff by the regional provider. • Screening tool made available to service providers across the sector in the SI.	• Number of education sessions and number of people attending (primary, NGO, secondary). • Number of clinical supervision sessions provided. • Screening tool (peri natal and post partum) availability.	
Eating Disorders[93][94][95][96]				
5. The regional provider engages with DHBs to review the length of the weight recovery programme and trial utilisation of short stays. 6. Districts and the regional provider develop guidelines for a local "pre-admission programme", including medical stabilisation. The programme will provide active treatment at a District level for the consumer, while waiting for a tertiary level inpatient bed.	• Consumers beginning treatment more quickly. • Consumers beginning treatment more quickly.	• Short stays utilised. • Baseline measure: The median wait was 58 days (2009) and 32.5 days (2010). • Short stays utilised. • Baseline measure: The median wait was 58 days (2009) and 32.5 days (2010).	• Reduction in waiting list to regional weight recovery programme to be determined by the MH Alliance group. • Reduction in waiting list to regional weight recovery programme. • This will be determined by the MH Alliance group.	

[92] *Regional Models of Care Project: Identified Regional Model of Care; Mothers and Babies, SISSAL, Christchurch, December 2010*
[93] *Regional Models of Care Project: Identified Regional Model of Care; Eating Disorders, SISSAL, Christchurch, December 2010*
[94] *South Island Regional Eating Disorders Plan, SISSAL, Christchurch, 2009*
[95] *Regional Models of Care Project: Identified Regional Model of Care; Eating Disorders, SISSAL, Christchurch, December 2010*
[96] *South Island Regional Eating Disorders Plan, SISSAL, Christchurch, 2009*

What actions are to be taken in 2011-12?	We expect these actions will…	To deliver	Measured by	In support of system outcomes
Medical Detoxification[97]				
7. The regional provider to provide education and support for medical detoxification, keeping Districts up-to-date on treatment options. 8. Each District improves pre-admission medical detoxification support. Districts work closely with consumers to reduce the daily intake to an appropriate level for successful medical detoxification, and promote the use of Nicotine Replacement Therapy before entry to the programme.	• Consult liaison is currently provided to the wider health sector (primary, community and secondary services) in direct response to meeting Districts need for this type of service. Districts have identified a need for education and face to face consult liaison as provided by other regional mental health services. • All Districts will provide the intensive outpatient support required to increase the success of the medical detox programme.	• Regional provider delivers education sessions to the DHBs tailored to meet their needs. • Consumers on Nicotine Replacement Therapy on admission. Seen 48 hours before admission to confirm suitability for treatment and fitness to travel, and daily dosage reduced to required amount.	• Number of education sessions and number of people attending. • Number of people on NRT prior to admission.	
Child and Youth AOD Residential[98]				
9. The regional provider purchase technology (e.g. videoconference equipment) for enabling distance collaboration (co-working with the District service) and ongoing communication. 10. Odyssey House are supported to undertake a facilitated process to clearly define eligibility criteria and define roles and responsibilities of both the regional provider and the District services.	• Better distance collaboration, family involvement, on-going communication and consult liaison support and advice to improve communication between the Districts and the regional provider. • Increased engagement of young people in the service resulting in a higher completion rate.	• Better communication between Districts and the regional provider. • A regional access SPF is completed.	• Technology is made available and communication through this technology is improved. • Regional access SPF is completed; there is a higher completion rate as young people are more prepared for the programme.	
Inpatient Child and Youth Services[99]				
11. Regional provider improves the routine discharge planning process to facilitate a better transition process. 12. Include District staff as early as possible in discharge planning,	• Child/Youth and family are able to generalise the strategies learned in the regional service, to the local setting.	• Child/youth and family are more resilient at the vulnerable transition period.	• Child/youth able to generalise strategies	

[97] *Regional Models of Care Project: Identified Regional Model of Care; Medical Detoxification, SISSAL, Christchurch, December 2010*

[98] *Regional Models of Care Project: Identified Regional Model of Care; Child and Youth Alcohol and Other Drugs - Residential, SISSAL, Christchurch, December 2010*

[99] *Regional Models of Care Project: Identified Regional Model of Care; Inpatient Child, Adolescent and Family Mental Health Services, SISSAL, Christchurch, December 2010*

What actions are to be taken in 2011-12?	We expect these actions will…	To deliver	Measured by	In support of system outcomes
enabling District staff to work with the regional service prior to discharge if clinically indicated.				
Forensic[100]				
13. Develop business rules for the consistent and standardised collection of data relating to Forensic services across the SI. 14. Develop a South Island Forensic Outpatient service provision framework.	• Consistent understanding of Forensic activity across the SI to better undertake service development and planning. • Consistent access to services across the South Island.	• Consistent understanding of Forensic activity across the SI • South Island Forensic Outpatient Service Provision Framework completed.	• All activity is collected is consistent and standardised. • SI Forensic Outpatient Service Provision Framework completed.	

CEO Sponsor: Brian Rousseau (SDHB)

Clinical Lead: to be determined

Regional structure: SI Information Technology Alliance

Regional Business Alliance

Information Technology

The following actions will be implemented in 2011-12 to resolve issues of equity of access and clinical / financial viability. These actions are consistent with the roadmap set out in the South Island Regional IT Plan submitted to the National Health IT Board in September 2010 and aligned with the goals and aims set out in the National Health IT plan.

What actions are to be taken in 2011-12?	We expect these actions will…	To deliver	Measured by	In support of system outcomes
1. Establishment of a South Island (SI) IT Alliance with agreed Terms of Reference and a clinical component that will enable collaboration. 2. The following deliverables and actions are the focus: • Clinical information systems which includes clinical data repository, clinical workstation • Imaging/picture archive (PACS-Radiology and regional archive) • Clinical Support Systems (Laboratory	• Ensure IT developments appropriately link the South Island's DHBs and clinical networks. • Develop appropriate clinical pathways and administrative, IT and other support systems. • Enhance collaboration and communication across SI IT services to enable consistency of IT practices and clinical application, efficiencies and improve access across health service providers • Enable greater sharing of information across continuums of care including e-referrals/ e-discharges and clinical pathways • Robust cancer data and information sources are	• Sustainable technology and associate infrastructure • Regional access and consistent access to clinical information • Regional access and consistent access to clinical information	• Implementation of the SI Regional IT Plan • South Island Clinical Cancer Information System implemented and reporting South Island cancer information monthly.	• Strengthened regional collaboration and integration of health services across the continuum of care • Whole of systems approach to improve quality, access and sustainability of health services thereby increased sharing, reducing duplication and fragmentation of services. • Enhanced productivity and risk management

[100] *South Island Regional Forensic Plan, SISSAL, Christchurch 2007*

and Pharmacy) • Patient Administration System (PAS) 3. Implementation of the South Island Clinical Cancer Information System (including ASYMS).	developed and shared that describe outcomes, current service provision and enable informed service development & planning decision-making.			• Robust cancer data and information sources are developed and shared that enable informed service development & planning decision-making.

Information Technology, like health of older people, is being re-constituted to have a breadth of clinical membership to provide governance to the regional work programme. Once in place (end of April) an implementation plan will then be developed.

Since October 2010 SCDHB has begun to implement a number of CDHB information systems (CIS and RIS). West Coast DHB is next in line to follow SCDHB.

Resource is required however, to support the processes to develop business cases for larger regional information systems e.g. PMS. The alliance agreement approach is a vehicle to significantly enable the implementation the regional IS plan. As part of the upfront alliance agreement DHBs would identify and agree the contribution, risks and processes to clarify the parameters for the regional project; thus providing certainty and streamlining the project.

Procurement and Supply Chain

CEO Sponsor: David Meates (CDHB)

Regional structure: SI Procurement Alliance

The following actions will be implemented in 2011-12 to support financial viability and clinical safety and quality

What actions are to be taken in 2011-12?	We expect these actions will…	To deliver	Measured by	In support of system outcomes
Projects for the Procurement and Supply Chain Alliance have been identified as follows: 1. Processes and Documentation – building on work already done to enable SI DHBs to work together in this area. 2. Savings and general Reporting – a single SI savings report will be developed for DHBs, CEOs and HBL. 3. Planning – based on planning in the previous two years this will include consumables, services, and Capex. 4. Training and Development – to enable and grow the capability of supply and procurement staff in the SI. 5. Supply Chain – this will include warehousing, and place and chase of goods. 6. High Spend Commodity Groups – in the first instance short reports on key high spend groups will be developed to inform future decision making in these areas. These groups are likely to include fleet, vehicles, laundry, food, orderlies, cleaning, locums, temporary labour, radiology, laboratory, and coal. In addition to the above projects this alliance will continue to: 7. align contracts, overcoming the lead-in time to develop new contracts by using	• Enhance collaboration and communication across SI procurement functions. This will enable greater purchasing power and savings for SI DHBs. • Enable alignment of clinical material between CDHB and WCDHB in order to reduce clinical risk where clinicians are working between the two DHBs. • Provide stability and opportunities for procurement staff to improve and broaden their skill bases, which aid recruitment and retention of skilled staff in this sector. • Improve relationships with clinical staff will improve processes and ensure that the best decisions are made.	• Increased financial sustainability through cost savings in goods and services procured by SI DHBs. • Reduced repetition of competitive tendering' processes across the SI.	• Increased savings in SI procurement and supply chain to deliver to individual boards • Increased standardisation of processes and range of consumables • Increase in the number of collaborative projects • HBL are in agreement with the work plan • Standard reporting on procurement activity to all SI boards	Achievement of • Timely access to products and services required in the provision of health services • Less clinical variation to achieve safer and easier clinical exchanges

the opt-on clause on contracts as they expire. 8. Strengthen relationship with clinical staff, through promoting the work of this group to clinician leaders including goals and processes 9. Take advantage regionally of 'All of Government' contracts via MED.	• Alignment with the target of collective procurement driven by HBL and MED to take advantage of bulk purchasing savings.			

Other Service Areas

Chair: Professor Andrew Kaye

Regional Clinical Director: Mr Martin MacFarlane

Regional structure: SI Neurosurgery Governance Board

Neurosurgery

Neurosurgery has not been included as an area under the alliance model as there has been a separate governance structure reporting to the National Health Board has been established. The focus for 2011/12 however is:

What actions are to be taken in 2011-12?	We expect these actions will…	To deliver	Measured by	In support of system outcomes
1. Establishment of a South Island governance board to oversee the service, including a Clinical Director for the Service. 2. Development of vision and structure for the service 3. Development of a recruitment plan and pathway for all neurosurgeons and other key clinical staff in partnership with the University of Otago, RACS, DHBs and Neurosurgeons. 4. Review the funding of the service across the South Island DHBs; consider alternative funding models within the existing population share of Vote Health. 5. Development of a service delivery plan for the new South Island Neurosurgical Service. 6. Ensure the service is appropriately linked to the South Island's provincial hospitals and clinical networks. Development of appropriate clinical pathways and of administrative, IT and other support systems.	• Develop strong clinical leadership for neurosurgical services across the South Island. • Maintain stable staffing of neurosurgeons across both the Christchurch and Dunedin sites, deliver sustainable acute rosters and allow greater sub-specialisation and research across the entire service, as well as greater integration and co-operation with other specialties. • A service that is viewed as attractive in the long-term for the recruitment of the appropriate staff to make it a leader clinically and in research and teaching. • Sustainable funding model that supports the service's clinical goals • Equitable access to neurosurgery services across the whole of the South Island • Development of appropriate clinical pathways and of administrative, IT and other support systems	• One integrated neurosurgery service for the whole of the South Island, delivered from two sites – Christchurch Hospital and Dunedin Hospital. • The Service is clinically sustainable, high quality and financially viable.	• Establishment of a South Island governance board and its governing policies. • Staffing appointments made as per the Expert Panels recommendations • Revised Funding model presented. • Clinical indicator programme in place for whole service. Implementation of a South Island-wide service delivery plan that has: • Single points of access for consistent prioritisation, assessment and treatment processes • Clearly defined volumes for first specialist assessments and inpatient case loads • Equivalent access to diagnostics such as MRI, neurophysiology and interventional neuro-radiology. • Availability and pathways between associated services such as rehabilitation, intensive care and transport/ retrieval services, this will also include hospital beds. Community beds and other services.	Achievement of a single regional Neurosurgery Service across the South Island. Strengthened regional collaboration and integration of health services. Whole of systems approach to improve quality, access and sustainability of health services thereby increased sharing, reducing duplication and fragmentation of services. Improved health outcomes for service users, and family/whānau.

9.8 Statement of Accounting Policies

The prospective financial statements in this Statement of Intent for the year ended 30 June 2012 are prepared in accordance with Section 38 of the Public Finance Act 1989 and they comply with NZ IFRS, as appropriate for public benefit entities. FRS-42 states that the (prospective) forecast statements for an upcoming financial year should be prepared using the same standards as the statements at the end of that financial year. The following information is provided in respect of this Statement of Intent:

(i) Cautionary Note

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

(ii) Nature of Prospective Information

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

(iii) Assumptions

The main assumptions underlying the forecast are noted in Section 8 of the Statement of Intent.

REPORTING ENTITY AND STATUTORY BASE

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

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

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

The consolidated financial statements of Canterbury DHB consists of Canterbury DHB, its subsidiaries, Canterbury Laundry Service Ltd (100% owned) and Brackenridge Estate Ltd (100% owned), and associate entity South Island Shared Service Agency Ltd (47% owned).

The Canterbury DHB will adopt the following accounting policies consistently during the year and apply these policies for the Annual Accounts.

BASIS OF PREPARATION

Statement of compliance

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

Measurement basis

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

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

Functional and presentation currency

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

Changes in accounting policies

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

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

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

- NZ IFRS 9 *Financial Instruments* will eventually replace NZ IAS 39 *Financial Instruments: Recognition and Measurement*. NZ IAS 39 is being replaced through the following 3 main phases: Phase 1 Classification and Measurement, Phase 2 Impairment Methodology, and Phase 3 Hedge Accounting. Phase 1 on the classification and measurement of financial assets has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial instruments (its business model) and the contractual cash flow characteristics of the financial assets. The new standard also requires a single impairment method to be used, replacing the many different impairment methods in NZ IAS 39. The new standard is effective for reporting period beginning on or after 1 January 2013. Canterbury DHB has not yet assessed the impact of the new standard and expects it will not be early adopted.

- NZ IAS 23 *Borrowing Costs (revised 2007)* replaces NZ IAS 23 *Borrowing Costs (issued 2004)*. Canterbury DHB has elected to defer the adoption of NZ IAS 23 *Borrowing Costs (revised 2007)* in accordance with its transitional provisions that are applicable to public benefit entities. Consequently, all borrowing costs are recognised as an expense in the period in which they are incurred.

- NZ IAS 24 *Related Party Disclosure (Revised 2009)* replaces NZ IAS 24 *Related Party Disclosures (Issued 2004)* and is effective for reporting periods beginning on or after 1 January 2011. The revised standard:

  Removes the previous disclosure concessions applied by Canterbury DHB for arm-length transactions between Canterbury DHB and entities controlled or significantly influenced by the Crown. The effect of the revised standard is that more information is required to be disclosed about transactions between Canterbury DHB and

entities controlled or significantly influenced by the Crown. Clarifies that related party transactions include commitments with related parties.

SIGNIFICANT ACCOUNTING POLICIES

Basis for Consolidation

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

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

Subsidiaries

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

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

Associates

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

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

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

Transactions eliminated on consolidation

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

Foreign currency

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

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

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

Budget figures

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

Property, plant and equipment

Classes of property, plant and equipment

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

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

Owned assets

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

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

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

Fixed Assets Vested from the Hospital and Health Service

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

Additions

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

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

Subsequent costs

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

Disposal of Property, Plant and Equipment

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

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

Donated Assets

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

Depreciation

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

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

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

The residual value of assets is reassessed annually.

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

Intangible assets

Software development and acquisition

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

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

Amortisation

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

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

Investments

Financial assets held for trading are classified as current assets and are stated at fair value, with any resultant gain or loss recognised in other comprehensive income.

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

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

Trade and other receivables

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

Inventories

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

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

Cash and cash equivalents

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

Impairment

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

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

An impairment loss on property, plant and equipment revalued on a class of asset basis is recognised directly against any

revaluation reserve in respect of the same class of asset to the extent that the impairment loss does not exceed the amount in the revaluation reserve for the same class of asset, at which point it is recognised in the surplus or deficit.

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

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

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

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

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

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

Restricted assets and liabilities

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

Borrowings

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

Employee benefits

Defined contribution plans

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

Defined benefit plans

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

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

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

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

Annual leave, conference leave and medical education leave

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

Provisions

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

ACC Partnership Programme

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

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

Trade and other payables

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

Derivative financial instruments

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

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

Income tax

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

Goods and services tax

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

Revenue

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

Revenue relating to service contracts

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

Services rendered

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

Interest income

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

Operating lease payments

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

Non-current assets held for sale

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

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

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

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

Borrowing costs

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

Critical judgements in applying Canterbury DHB's accounting policies

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

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

Property, plant and equipment useful lives and residual value

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

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

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

Canterbury DHB has not made significant changes to past assumptions concerning useful lives and residual values other than aligning useful lives with the relvaluation performed as at 30 June 2010.

Retirement and long service leave

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

Leases classification

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

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

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

Non-government grants

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

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