CDHB

CANTERBURY DISTRICT HEALTH BOARD ANNUAL PLAN 2021/22

Incorporating the 2021/22 Statement of Performance Expectations

Statement of Joint Responsibility

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

This document is the DHB's Annual Plan which has been prepared to meet requirements under the New Zealand Public Health and Disability Act, Crown Entities Act, Public Finance Act, and expectations set by the Minister of Health.

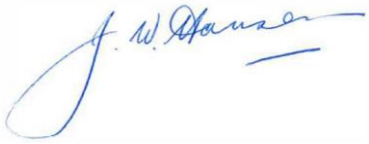
Linking with our Statement of Intent and System Level Measures Improvement Plan, the Annual Plan describes our strategic goals and objectives in terms of improving the health of our population and ensuring the sustainability of our health system. This Plan also highlights the actions we will take to deliver on national priorities and expectations in the coming year and presents our financial forecasts and our Statement of Performance Expectations for 2021/22.

The Statement of Performance Expectations is presented to Parliament and used at the end of the year to compare planned and actual performance. Audited results are presented in our Annual Report, published annually on our website.

The Canterbury DHB works collaboratively and in partnership with other service providers, agencies and community organisations to improve health outcomes for the Canterbury population. This includes participation in our large-scale Canterbury Clinical Network (CCN) District Alliance, with twelve local provider partners, the South Island Regional Alliance with our four South Island DHB partners and our transalpine partnership with the West Coast DHB.

We also recognise our role and responsibility in actively addressing disparities in health outcomes for Māori and we are committed to making a difference. We work closely with Manawhenua Ki Waitaha, our Kaupapa Māori service providers and our Māori communities, both directly and through the CCN Alliance, in a spirit of partnership and co-design that encompasses the principles of Te Tiriti o Waitangi and seeks to achieve health equity for Māori across Canterbury.

In signing this document, we are satisfied that it fairly represents our joint intentions and activity for the coming year and is in line with Government expectations for 2021/22.



Sir John Hansen
CHAIR | CANTERBURY DHB

Gabrielle Huria
DEPUTY CHAIR | CANTERBURY DHB

Dr Peter Bramley
CHIEF EXECUTIVE | CANTERBURY DHB

Honourable Andrew Little
MINISTER OF HEALTH

Honourable Grant Robertson
MINISTER OF FINANCE

17 November 2021

Letter of Approval from the Minister of Health

Hon Andrew Little
Minister of Health
Minister Responsible for the GCSB
Minister Responsible for the NZSIS
Minister for Treaty of Waitangi Negotiations
Minister Responsible for Pike River Re-entry

Sir John Hansen

17 November 2021

Tēnā koe Sir John

Canterbury District Health Board 2021/22 Annual Plan

This letter is to advise you that we have jointly approved and signed Canterbury District Health Board's (DHB's) 2021/22 annual plan (Plan) for one year.

When setting expectations for 2021/22 it was acknowledged that your Plan would be developed in a period where our COVID-19 response, recovery and immunisation programmes remained a key focus and therefore planning requirements were streamlined towards your DHB's work to improve equity and to embed lessons and innovations from COVID-19. Thank you for providing a strong plan for these areas.

Your Plan for 2021/22 will be delivered in an environment where this work continues to be of critical importance and where our system transition process is underway. We acknowledge that providing clarity on the critical areas for improvement through transition is helpful and, on that basis, we are confirming the top challenges that will be of focus for us through 2021/22:

- Supporting readiness and management of COVID-19.
- Supporting the mental wellbeing of people, particularly of youth and young people.
- Ensuring child wellbeing, particularly through increased immunisation.
- Managing acute demand.
- Managing planned care.

More broadly, we also confirm the importance of your Board delivering on the Plan in a fiscally prudent way and acknowledge that an intensive support programme will remain in place for Canterbury DHB.

We invite you to work closely with your regional Chair colleagues to share your skills, expertise, and problem-solving efforts to ensure progress is achieved in these top challenges. As performance progress is discussed through the year, we will look forward to hearing about your joint efforts and progress.

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

Your 2021/22 Plan provides an important foundation to ensure our health system delivers for New Zealanders during the period of system transition and we expect all DHBs will be disciplined in delivery of their plans.

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+64 4 817 8707 | a.little@ministers.govt.nz | beehive.govt.nz

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

Nāku noa, nā

Hon Andrew Little
Minister of Health

Hon Grant Robertson
Minister of Finance

Cc Dr Peter Bramley
Chief Executive of Canterbury DHB

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Foreword from the Chairs and Chief Executive

Tēnā Koutou Katoa

We'd like to begin by thanking everyone who works across the Canterbury health system for their continued commitment to supporting the national response to the COVID-19 pandemic. Our public health teams, laboratory and testing staff and those working at our borders and in managed isolation facilities, your professionalism and dedication are valued and appreciated by us all.

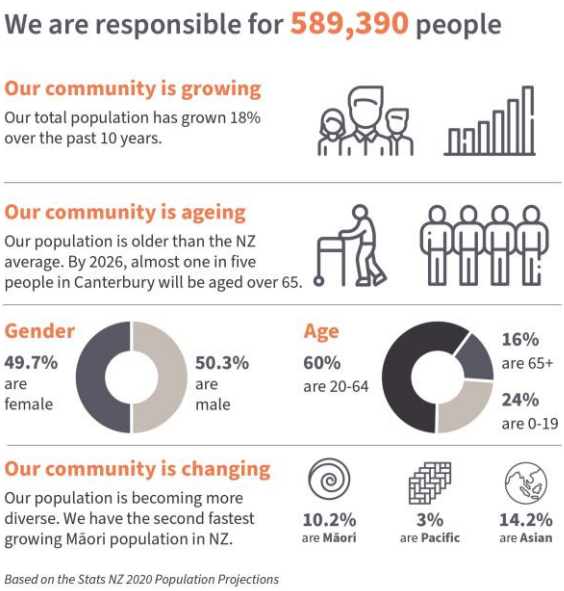
We would particularly like to acknowledge all those working with us to deliver the most ambitious vaccination campaign this country has ever seen. We continue to be impressed by the innovative vaccination models established across the region including Māori and Pasifika community clinics, primary care clinics, mobile clinics, pop-up and DHB-run mass vaccination clinics and the response led by Ngāi Tahu and the Māori/Indigenous Health Institute, from the Otago University, to ensure that we are reaching our most vulnerable populations.

This important work could not be achieved without our primary and community partners including general practice and pharmacy who, with their extensive vaccination experience and close links to our community, will play an increasingly critical role in the COVID-19 vaccination programme as it rolls out to the wider population in 2021/22.

The Coming Year

Our population continues to grow, age and become increasingly more diverse. In the coming year we will be responsible for an estimated 589,390 people across the Canterbury region.

Our challenges are not small but our Annual Plan for 2021/22 highlights our ongoing commitment to our community and to the expectations of Government, including our commitment to supporting the bold changes proposed for our health sector.



Focus on Equity

Improving equity of access and outcomes remains a high priority for this Board and Equity Outcome Actions (EOA) are highlighted throughout this Plan.

We will continue to partner with iwi, Manawhenua Ki Waitaha (our Iwi Advisory Board), Māori providers and our Māori community to meet our obligations as a treaty partner. Over the past year our teams have focused their collective effort on supporting increased access to kaupapa Māori and whānau ora services, have supported a Kahukura Kaumātua programme help improve engagement with older rural-based Māori and developed a Hauora Māori Equity Toolkit for our clinical staff to improve people's understanding and awareness of barriers to access and what we can do differently to better meet people's needs.

With support and input from Manawhenua Ki Waitaha we have developed a clear plan for implementing Whakamaua (the national Māori Health Action Plan), expanding on the work above and using the learnings to improve service access in other areas.

Our strategic partnership with Pasifika Futures will support the delivery of our Pacific Health Action Plan and improved outcomes for Pacific people in our region. We will also be engaging through our Disability Steering Group to launch our refreshed Disability Action Plan in the coming year. Both Plans will support increased consumer engagement in the design and development of services and improve our health systems' response to the needs of our increasingly diverse population.

Wellbeing and Prevention

Improving the uptake of screening programmes and smoking cessation programmes is a strong focus for the coming year along with continued investment in improving the mental wellbeing of our population. This will include partnering with iwi to undertake a redesign process to better tailor mental health and addiction services to meet the needs of our local population, completing the rollout of the Te Tumu Waiora service in general practice and fostering community-led solutions to improve access to mental health support for rangatahi.

We are also working with general practice and pharmacy to better support people with long-term conditions including respiratory disease, cardiovascular disease and diabetes. This will include a strong focus on engaging with our Māori and Pacific populations and a refocus of our investment in lifestyle programmes to better support our more vulnerable populations and improve the health and wellbeing of our community.

Improving Patient Flow

The opening of Waipapa and the positive reception it has received from our clinical teams and community has been a major achievement of the past year. However, the opening of Waipapa has coincided with a surge in demand for acute and emergency services that is being felt across the country. We are actively promoting the range of urgent and non-urgent services available in our community, to keep the Emergency Department for emergencies, and we are working collectively with our partners across the system to shift demand, so people can get the right care at the right time and in the right place.

As part of our continuous improvement programme 'Making the System Flow', we are identifying key opportunities to improve the way people move through our system, so that people spend less time waiting in our services, are treated faster, discharged earlier and supported to recover well. Our improvement focus for 2021/22 also includes improved clinical services planning, cancer services, older person's health services and rural health services.

Our Workforce and Infrastructure

A diverse workforce that reflects the make-up of our community helps provide the knowledge and lived experience to support the delivery of equitable care across our system. We are investing in several key equity roles and evolving our recruitment strategies as we find better ways of proactively encouraging and supporting applicants from a range of backgrounds to join our workforce. To make sure we continue to look after the wellbeing of our workforce and support the culture of our organisation, we will also take what we have learned from our recently completed People Survey (Tāngata Ora) to identify where we can better support and enable our people to do their best work.

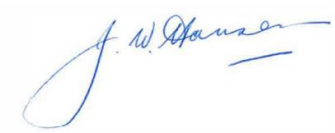
Our Accelerating Our Future programme continues to deliver efficiencies and is supporting the DHB to embrace digital and process improvements that will ensure a more sustainable financial future for our health system. Several initiatives are highlighted in our Plan that will support us to prioritise investment, enhance our productivity and capture efficiencies across our services, including several sustainability projects funded by the Ministry of Health.

With regards to facilities development, we eagerly anticipate the opening of a health hub in Selwyn providing a greater range of services in the heart of Canterbury's fastest-growing rural community. The development of our new Energy Centre for the Christchurch Campus is making great progress. With the decommissioning of our older boilers we will be better placed to meet our commitment to making our heating systems carbon-neutral. The build and upgrading of facilities at Hillmorton will support the last remaining mental health services at The Princess Margaret Hospital to move to new, fit-for-purpose facilities alongside other complementary services on the Hillmorton Campus.

Our Future

Only by working together in an integrated way can we meet the challenges facing our health system and achieve our collective goal of keeping people healthy and well in their own homes and communities. We will look to our partner organisations and communities as we embark on several co-design programmes in the coming year, and as we prepare for the transition to the new health system.

The creation of Health NZ and the Māori Health Authority presents a huge opportunity for our communities and whānau to influence and shape the future look and feel of health services in our region. We are fully committed to taking up the challenge and we encourage you to get involved to help to design a healthy future for our mokopuna.



Sir John Hansen
DHB Board Chair

Michelle Turrall
Manawhenua Ki Waitaha Chair

Peter Bramley
DHB Chief Executive

OVERVIEW

Who are we and what do we do?

Introducing the Canterbury DHB

1.1 Who are we

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

The Canterbury DHB has the third largest population of any DHB in the country. In 2021/22 we will be responsible for 589,390 people, 11.5% of the total New Zealand population.

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

In 2021/22, we will receive approximately $2.232 billion dollars to meet the needs of our population. In accordance with legislation, and consistent with Government objectives, we will use that funding to:

Plan and, in collaboration with clinical leads, alliance partners, and iwi, develop demand strategies and determine the services we need in place to improve the health and wellbeing our population.

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

Provide health services for our population, through our hospital and specialist services.

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

1.2 What makes us different?

As well as having the third largest population, we are also the second largest DHB by geographical area. Two of our rural districts (Selwyn and Waimakariri) are amongst the fastest growing territorial authorities in the country.

As the second largest tertiary service provider in the country, we own and operate six major hospital facilities across the Canterbury region, (the Christchurch, Christchurch Women's, Hillmorton, Burwood, Princess Margaret and Ashburton hospitals).

We operate the largest trauma centre in New Zealand and the fifth largest in Australasia and deliver the second largest number of elective (planned) surgeries in the country and half of all the elective surgery provided in the South Island.

We also own and operate ten smaller rural health facilities and several sector bases across the region.

To deliver healthcare to our population, we employ just over 11,000 people. We also hold and monitor approximately 1,000 service contracts and agreements with other organisations and individuals who provide services for our population. These include: general practice; pharmacy; laboratory; maternity; child health; diagnostic; personal health; mental health; dental; aged care; and community nursing services.

Since 2010, Canterbury DHB has shared operational resources with the West Coast DHB, including a joint chief executive, executive management leads, clinical leads and corporate service teams.

A formal service partnership means Canterbury specialists provide regular surgical lists and outpatient clinics on the West Coast. This arrangement provides more equitable access to specialist services for the West Coast population and supports improved service and workforce planning between both DHBs to reduce the unplanned acute load on Canterbury services.

1.3 Our regional role

As the second largest tertiary service provider in the country, we provide an extensive range of highly specialised services to people from other DHB regions where those services or treatments are not available.

This regional demand is complex in nature and growing steadily. In the five years to June 2019, there was a 7% increase in hospital admissions and a 13% increase in demand for outpatient appointments from people coming from regions outside of Canterbury.[1]

In 2018/19, almost 7,000 people from outside of Canterbury were discharged from one of our hospitals and close to 55,000 outpatient appointments were provided by Canterbury staff to people referred from other DHBs.

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

At a national level, we are one of only two DHBs in the country providing paediatric oncology, acute spinal cord impairment surgery, hyperbaric oxygen therapy and specialist burns treatment. Our laboratory service is also one of only two tertiary level laboratories in New Zealand and typically delivers over four million diagnostic laboratory tests a year.

[1] This reference is the five years to June 2019, excluding the impact of COVID on the 2019/20 year.

1.4 Our population profile

In the ten years since the earthquakes our population growth has been strong and steady, with an 18% increase in our total population and a 42% increase in our Māori population. Latest population estimates signal that Canterbury's population will reach 600,000 in the next three years.

Our population is spread out geographically across the region, with Selwyn and Waimakariri being two of the fastest growing districts in the country. Our population growth has been well beyond previous projections and is a major challenge for our health system.

Our population is slightly older than the average New Zealand population, and Canterbury has the largest population of people aged over 65 in the country. Latest population figures show 16% of our population are aged over 65, a total of 94,690 people. Our 65+ population will reach 100,000+ in the next three years.

Many long-term conditions become more common with age, including heart disease, stroke, cancer and dementia. As people age they develop more complex health needs and are more likely to need specialist services. We need to consider the growing burden of long-term conditions and the needs of our ageing population in our future planning.

Deprivation is also a strong predictor of the need for health services and a key driver of health inequities. The 2018 Census recorded one in every ten residents living in Canterbury were living in areas classified as socio-economically deprived.

Ethnicity, like age and deprivation, is also a strong predictor of the need for health services and some population groups have less opportunity and are more vulnerable to poor health outcomes than others.

Canterbury has the sixth largest and second fastest growing Māori population in the country. There are currently 59,860 Māori living in Canterbury, a 42% increase in population over the past ten years. In the next three years, our Māori population is expected to increase to over 65,000 people.

While our Pacific population is smaller, it is the fifth largest Pacific population in the country and like our Māori population is growing rapidly. There are currently 17,650 Pacific people living in Canterbury and this population is expected to grow to over 19,000 people in the next three years.

Latest population statistics show 10.2% of our Māori population and 9.9% of our Pacific population are aged under five, compared to 5.6% of our non-Māori population. There is a growing body of evidence that children's experiences during the first 1,000 days of life have far-reaching impacts on their health, educational and social outcomes. In supporting our population to thrive, it will be important for the health system to focus on meeting the health needs of our younger Māori and Pacific populations.

1.5 Our population's health

Canterbury's population has very similar life expectancy (81.5 years) to the New Zealand average (81.4 years).

Inequities continue to exist for Māori compared to non-Māori with Māori experiencing poorer overall health and a lower life expectancy (79.1 years). However, the equity gap for life expectancy is closing at a faster rate in Canterbury. At 2.4 years the gap is considerably smaller than nationally, where Māori life expectancy is almost 6.3 years lower than the total population.

The increasing prevalence of long-term physical and mental health conditions is one of the major drivers of demand for health services and the main cause of health loss amongst adults. This is true for Canterbury where an increasing number of people are living with long-term conditions such as cancer, heart disease, respiratory disease, diabetes and depression.

The most recent regional results from the New Zealand (NZ) Health Survey (2014-2017) found that:

- 15% of our total population, 40% of our Māori population and 37% of our Pacific population are current smokers.
- More than a quarter (28%) of our total population, 46% of our Māori population and over half (59%) of our Pacific population are classified as obese.
- 11% of our total population identified as inactive (having little or no physical activity). Rates for Māori and Pacific were similar (12%) and (15%).
- 20% of our adult population (one in five) are likely to drink in a hazardous manner, reflecting hazardous drinking habits in one in every five adults in Canterbury.
- 23% of our population have been diagnosed with a mood or anxiety disorder.

A reduction of known risk factors could dramatically reduce pressure on our health system and greatly improve health outcomes for our population. These risk factors also have strong socio-economic gradients, so population health interventions that reduce these risk factors will also contribute to reducing health inequities between population groups.

ONGOING HEALTH IMPACTS OF MAJOR EVENTS

The Canterbury population has experienced several major traumatic events over the last decade and, like other DHBs, we are now dealing with the impact of COVID-19 on people's mental health and wellbeing.

While some sections of our population are thriving in their lives, there is clear divergence in our community with a marked increase in demand for specialist mental health support. The proportion of Māori accessing services in Canterbury suggests a greater burden of mental disorder compared to the total population; while this pattern is also seen nationally, it indicates an area where we need increased focus.

1.6 Our operating challenges

While Canterbury has made real inroads in achieving an integrated health system, meeting the health needs of a large and growing population is complex.

Persistent inequities in health outcomes tell us that we need to do things differently. We cannot address the wider determinants of health inequity on our own. We need to partner with iwi, other government agencies and service providers to increasingly address socio-economic factors that impact significantly on health status, access and outcomes. We need to rise to the challenge of implementing a whole of system culture shift, to work as a wider, multi-cultural, multi-disciplinary, multi-agency team in response to the needs of our increasingly diverse population.

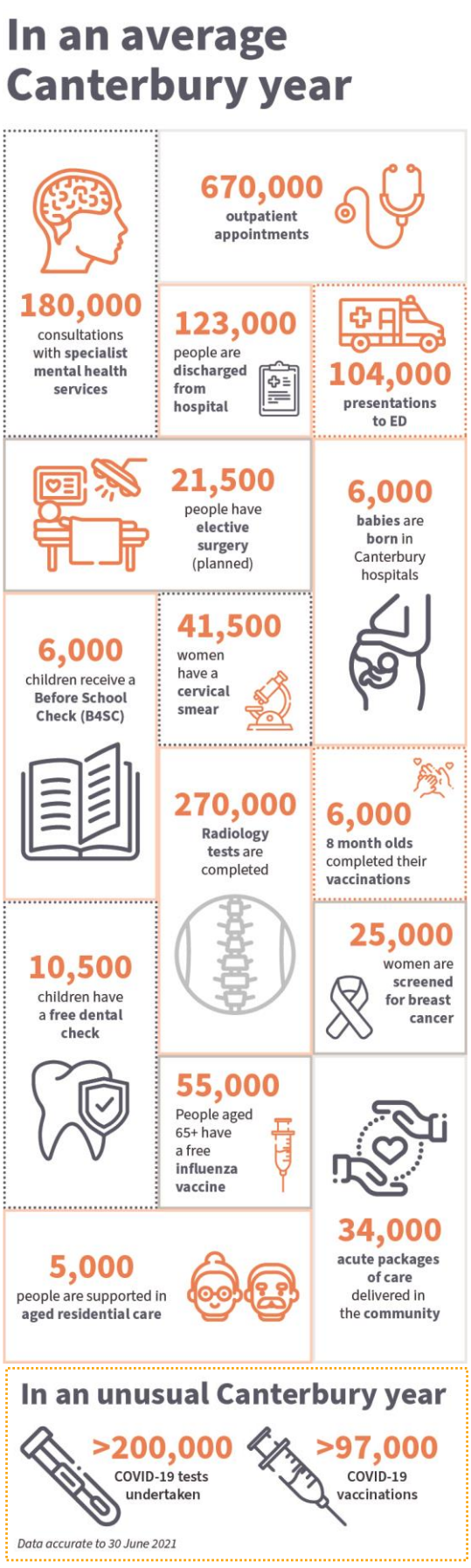
Like the rest of the health sector, we are experiencing growing demand pressures as our population ages and increasing fiscal pressures as treatment, infrastructure and wage costs rise. In the coming year we will continue to support Managed Isolation and Quarantine facilities and COVID-19 testing at our borders and in our community. We will also rollout the COVID-19 vaccination programme on an epic scale.

The system is likely to be put under pressure by the redeployment of staff to support the COVID-19 vaccination programme. It is expected that primary, community and public health services will be impacted as they work to deliver vaccinations to our population. Impacts are most likely to be felt across other immunisation programmes, school-based programmes and primary care screening programmes where the workforce will be most stretched.

We also face several unique capacity challenges related to our role as a tertiary provider, continued facilities constraints and expectations related to the demand for highly-complex and resource-intensive services from neighbouring DHBs. Our population has experienced several major traumatic events over the last decade with a marked increase in demand for mental health support.

The Canterbury DHB has a significant financial deficit exacerbated by the steady growth in treatment, infrastructure and wage costs. As part of our focus in the coming year we need to work hard to capture operational efficiencies, make the best use of the resources we have available and ensure we are investing in services that provide the greatest return in terms of health gain to bring our operating costs back into line with expectations.

As we face these challenges, we are also conscious of the pressure on our staff in relation to the increasing demand across the system, ongoing capacity issues and the additional stress related to the COVID-19 pandemic, particularly for those working in managed isolation facilities. The DHB is working hard to maintain safe working environments and ensure the wellbeing and ongoing engagement of our people.



Our Strategic Direction

1.7 The Canterbury vision

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

Our vision is underpinned by three strategic objectives:

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

In working to deliver on our vision, we have reset our relationships with health providers, and with the people we care for. We've become more integrated and more connected as we work to reduce waste and duplication across our system and improve the health of our community.

Connecting information systems and sharing data continues to be a key enabler of change. Access to real-time information, at the point of care, will help us to improve the efficiency and quality of the care we provide and reduce the time people spend waiting.

Clinically-led service change and service design has also been a cornerstone of our success to date. In the coming year we will build on this work by introducing a Partnering in Design process to support increased engagement with priority populations and ensure a stronger Māori voice in the design and development of health strategies to support improved health equity. We will also look to clinical leads to drive the Making Our System Flow project to improve production planning across our hospital services and respond to increasing capacity pressures across our system.

1.8 Nationally consistent

Our vision is closely aligned to the Government's long-term vision for the health sector, as articulated through the New Zealand Health Strategy with its central theme 'live well, stay well, get well.'

Our vision also reflects alignment with the Government theme 'Improving the wellbeing of New Zealanders and their families' and the priority outcomes: Support healthier, safer, more connected communities; Make New Zealand the best place in the world to be a child; and Ensure everyone who is able to, is earning, learning, caring or volunteering.

The Minister of Health's annual Letter of Expectations signals priorities and expectations for DHBs. The expectations for the coming year signal a strong focus on wellness, equity and sustainability.

The priorities emphasised for 2021/22 are:

- Giving practical effect to Whakamaua (the national Māori Health Action Plan);
- Improving sustainability;
- Improving child wellbeing;
- Improving mental wellbeing;
- Improving wellbeing through prevention;
- Better population health outcomes, supported by a strong, equitable public health & disability system;
- Better population health outcomes supported by primary health care.

The Minister's letter also signals expectations for DHBs to continue to support the COVID-19 response, and to maintain their focus as the national Health & Disability System Review recommendations are implemented.

The Delivering on Government Priorities section of this Plan outlines how we will deliver on the Minister's expectations in the coming year. The Minister's Letter of Expectation for 2021/22 is attached as Appendix 2.

1.9 Regionally responsive

There are five DHBs in the South Island (Nelson Marlborough, Canterbury, West Coast, South Canterbury and Southern) and together we provide services for almost 1.2 million people, 23.3% of the total New Zealand population.

While each DHB is individually responsible for the provision of services to its own population, we work collaboratively through the South Island Regional Alliance to develop more innovative and efficient health services and improve health outcomes for the collective population of the South Island.

The five DHBs are currently working on a refocus and reset of priorities for the Regional Alliance to better support vulnerable service areas, address the inequities evident across our health system and respond to the recommendations of the National Health and Disability System Review.

The Canterbury DHB has made a strong commitment to this regional work and takes the lead in the development of Information Services regionally, including: HealthOne, HealthPathways, the Electronic Request Management System and the rollout of the South Island Patient Information Care System (PICS).

Activity from the current regional work programme is reflected through our Annual Plan and further information on the Regional Alliance can be found on the Alliance website: www.sialliance.health.nz.

Our Immediate Focus

Our resources are limited and the multi-faceted pressures and challenges facing our health system mean that services cannot continue to be provided in the same way.

Significant change is coming for our health sector and the DHB is committed to supporting the national direction. We are also taking a fresh approach locally to address our key challenges over the coming year. The following themes have been identified as critical to our success and actions aligned with these themes are reflected throughout the Plan.

A GREATER FOCUS ON EQUITY

We use service metrics and population data to identify disparities and target investment and action to deliver health equity for our population. Collective action will support change in areas that have been harder to tackle, and we will enhance our partnerships with iwi over the coming year and engage with Māori and Pacific communities, Manawhenua Ki Waitaha, Pasifika Futures and our Māori and Pacific health providers to create an environment where people can thrive. This will include actions to give effect to Whakamaua (the national Māori Health Action Plan) and our local Pacific Health Action Plan.

Rural populations can also experience inequitable access to health services and over the coming year we will engage more directly with our rural communities and rural service providers. This includes support for the development of the Selwyn Health Hub and an Integrated Family Health Centre on the Rangiora Health Hub site to improve access for these growing rural communities. We will also work closely with the three Canterbury PHOs to support sustainable after-hours solutions in our rural districts.

A STRONGER, MORE RESPONSIVE SYSTEM

There is overwhelming evidence and agreement that investment in equity, disease prevention and early intervention across the life course will reduce the burden of preventable disease and poor health and improve the health of our population. This is partnered with an expectation that through this focus acute care demand will be mitigated and the sustainability of our health system will be improved.

We will continue to work collaboratively, across the health and disability system and between DHBs, to ensure our investment is directed into activity and services that will provide the greatest impact and reduce acute service demand. This will include embedding the national Te Tumu Waiora initiative, Cancer Action Plan and National Bowel Screening Programme, the DHB's Maternity Strategy and our System Level Measures Improvement Plan.

Cross-sector investment and integration will also continue to be a key focus with ongoing partnerships with Education to support strong developmental pathways for children, and with ACC to reduce harm and enhance recovery following injury for our older population.

ENHANCED EFFICIENCY AND EFFECTIVENESS

We will implement the Making the System Flow Project with a focus on service efficiency and effectiveness to improve the flow of patients across the system and reduce the increasing demand pressure on our hospital services. This will include an emphasis on reducing acute admissions, long-stays for patients and hospital acquired conditions that have a negative impact on people's health outcomes and increase our treatment costs.

We will also place an increased focus on production planning to better match capacity with demand and will review our service delivery and workforce models to improve our capacity to sustainably respond to the evolving needs of our population. This includes implementation of our three year Planned Care Improvement Plan and the Care Capacity Demand Management Programme.

INCREASING VALUE FROM TECHNOLOGY

Continued implementation of our digital transformation is a critical factor in improving access to information, decision making, and workforce planning that will improve health outcomes for our population, support more efficient ways of working and reduce duplication and waste across our system.

Key focus areas for the coming year include the expansion of virtual networks and telehealth technology to improve access to care, device and infrastructure replacement to ensure business compliance, and the implementation of e-orders and e-referrals to streamline processes across our system.

CREATING A SUSTAINABLE FUTURE

Faced with an ageing and increasingly diverse population, changing patterns of demand, and limited resources, we need to establish a pathway forward that gives us the flexibility to respond to our population's need but also supports the system in a more financially sustainable way.

We are rolling out a significant sustainability programme, Accelerating Our Future, focused on capturing efficiencies through the transformation of service delivery and workforce models, and the introduction of process and procurement improvements to address growing cost pressures and reduce operating costs.

The DHB is also committed to supporting the national changes in response to the National Health System Review, implementing the national COVID-19 Vaccination Programme and ensuring preparedness in the event of a COVID-19 resurgence or outbreak.

THE YEAR AHEAD

What can you expect from us?

Delivering on Government Priorities

The following section highlights the activity the DHB will undertake in 2021/22 to deliver on national priorities and expectations and improve the health and wellbeing of our population.

It is important to note that this does not reflect all the activity happening across our health system. Our System Level Measures (SLM) Improvement Plan is developed in collaboration with our Alliance partners and is attached as an appendix to this Plan, as is the DHB's Statement of Service Performance for 2021/22. These documents sit alongside this Annual Plan to provide a broader picture of where we will be focusing our effort and investment over the coming year.

The activity highlighted through the Plans is reflected in the workplans of our local and regional alliances and our operational and corporate services teams. Delivery against the actions and performance measures in the Plan is publicly reported to our Board every quarter.

2.1 Commitment to Māori health

The values of our organisation, the way we work, and the way in which we interact with each other are all key factors in achieving health equity for Māori.

As a Crown agency, we recognise our responsibilities to uphold our obligations under the Te Tiriti o Waitangi and we work to improve the quality of care and equity of health outcomes for Māori and to address any systemic inequity, consistent with the recognised Tiriti principles of partnership, participation and protection.

The relationships and partnerships we build with Māori are fundamental to this work and in the coming year we will be partnering with iwi to support the redesign of mental health and addiction services.

We have a memorandum of understanding with Manawhenua Ki Waitaha (our Iwi Advisory Board), where we engage in the design and development of health strategies to support Māori aspirations for health and achieve equity of access and health outcomes. Members of the Māori Caucus within our District Alliance and Te Matau a Māui (our collective of Māori & Pacific Providers) also bring Māori perspectives to the redesign of services, the building of capacity across community services and support workforce development across our system.

We are developing a culture that addresses inequitable health outcomes through open discussion, use of the health equity assessment tools, universal performance targets and professional development and mentoring. In the coming year we will work with our partners to improve Māori health outcomes in Canterbury by giving effect to He Korowai Oranga and Whakamaua the national Māori Health Strategy and Action Health.

We have made an increased commitment to achieving greater Māori participation in our health workforce. Māori make up 10.2% of the Canterbury population but just 4.6% of the DHB workforce. We are participating in the national Kia Ora Hauora programme to increase the number of Māori working in health, by supporting pathways into tertiary education, local Māori health scholarships and work placements. We are also reviewing and revising recruitment practices that may be unintentionally limiting job placements for Māori applicants and supporting professional development and pathways into leadership roles for Māori staff.

In supporting our people to develop their understanding of te ao Māori and their ability to meaningfully engage with Māori stakeholders, consumers and whānau, we will also be building on current supports and competency frameworks, to influence and shape practice and support improved cultural competency.

2.2 Commitment to health equity

In Canterbury, as in the rest of New Zealand, people have differences in health outcomes and experience that are not only avoidable but unfair and unjust.

Social determinants such as education, employment, housing and geographical location can impact on opportunity, as can aspects of a person's identity including age, gender, ethnicity, social class, sexual orientation, ability and religion. Equity is about fairness and we are committed to reducing disparities and achieving equity for our population.

In acknowledging and taking steps to address inequities in our system we will need to evolve our workforce, build our cultural capability and work in partnership with our community to co-design service delivery models to better meet their needs. We also need to recognise that people with different levels of advantage require different service approaches and resources to achieve equitable outcomes.

The DHB is guided in this space by a range of national strategies, including: He Korowai Oranga (the Māori Health Strategy), Ola Manuia 2020-2025 (Pacific Health and Wellbeing Action Plan), Healthy Ageing Strategy, New Zealand Disability Strategy and the UN Convention on the Rights of Persons with Disabilities.

Actions and activity aimed at improving health equity are indicated throughout the following section by the Equity Outcome Action code (EOA).

2.3 Give Practical effect to Whakamaua - Māori Health Action Plan 2020-25

Planning Priority: Engagement and Obligations as a Treaty Partner	
Action to Improve Performance	**Milestone**
Partner with iwi to undertake a collective redesign process to better tailor mental health and addiction services to local population characteristics and needs, and foster community-led solutions to prioritise health equity for Māori. (EOA)	Q1: Partnership Group established. Q2: Process agreed and documented. Q3: Co-design underway.
Work in partnership with Manawhenua Ki Waitaha to support Māori representation on workstreams and governance groups across our system and cultural training for leadership Boards to raise their understanding and awareness of equity issues and obligations as a treaty partner. (EOA)	Q1: Training agreed for the CCN Alliance Leadership Team (ALT). Q2 Training provided for ALT and Māori represented on all CCN leadership groups.
Work in partnership with Te Ohu Urupare, Ngai Tahu, the Māori/Indigenous Health Institute (MIHI) and local kaupapa Māori providers to ensure a Māori -led approach across a range of delivery models for the COVID-19 vaccination programme in Canterbury and support strong uptake by our Māori population. (EOA)	Q1: Report on provision of mobile marae-based and Māori led vaccination clinics. Q4: Māori population uptake of COVID-19 vaccinations.
Engage with the Ministry of Health to offer Manawhenua Ki Waitaha members, Board and CCN Māori caucus members the opportunity to participate in the governance and leadership workshops developed by the Ministry. (EOA)	Q1-Q4: Leaders and Board members participate in training workshops.
Engage with the Ministry of Health and Health NZ to support participation of members of the DHB Board, local iwi and Manawhenua Ki Waitaha in national hui in relation to the development of the national Māori Health Authority. (EOA)	Q1-Q4: Opportunities identified and members participating in national hui.

Planning Priority: Whakamaua Objective: Accelerate and spread the delivery of kaupapa Māori and whānau-centred services	
Action to Improve Performance	**Milestone**
Collaborate with training bodies, service providers and Manawhenua Ki Waitaha to build on existing workforce scholarship initiatives to promote health careers and engage young Māori in roles in our health system. (EOA)	Q3: Review 2020/21 demand and confirm investment for coming year. Q4: Number of scholarships allocated.
Engage with Kia Ora Hauora to promote and support employment pathways and opportunities with the DHB and other health service providers in Canterbury. (EOA)	Q1-Q4: Progress against regional and national targets.
Progress the implementation of Te Tumu Waiora across general practice to support earlier intervention and improved outcomes for our population. (EOA) Ensure strong Māori workforce and provider representation in the provision of the programme to support the delivery of a culturally responsive service for Māori in need of mental health and wellbeing support. (EOA)	Q1: Two Māori providers engaged in the network. Q2: Proportion of Health Coaches that are Māori. Q4: Proportion of Māori accessing the service.
Collaborate with our community-based kaupapa Māori youth mental health and addiction providers, through the CYMHS and Manu Ka Rere networks, to develop an integrated response to addressing the rapid growth in demand for Child and Adolescent Mental Health Services. (EOA)	Q1: Youth capacity expanded. Q3: Centralised referral pathway agreed.
Continue to invest in Whaiora Online with He Waka Tapu to support people to access online support to improve their health and wellbeing. (EOA)	Q4: Report on number of people engaged with the online service.
Collaborate with Stop Smoking Practitioners from primary care and Māori and Pacific provider organisations to embed remote smoking cessation support (including telehealth, telephone and including home delivery of NRT), to improve continuity of support for people who are not able to access face-to-face services. (EOA)	Q4: Remote cessation service options are embedded as part of the wrap-around service.
Work with Te Matau a Māui and Pegasus Health PHO, to support Māori providers to access HealthOne, as members of the integrated multi-disciplinary team, to improve the delivery of care and support to Māori in Canterbury. (EOA)	Q1-Q4: Report on expanded access.

Planning Priority: Whakamaua Objective: Shift cultural and social norms	
Action to Improve Performance	**Milestone**
Embed the recruitment strategy introduced in 2020/21, to support Māori job applicants, who meet the minimum requirements for positions, to advance to the interview stage, to promote the diversification of our workforce. (EOA)	Q1: Pool of Māori to support interviews identified. Q3: Impact of policy reviewed.
Invest in the development of three new Equity and Diversity focused roles to support the DHB to attract, retain, develop and better utilise our Māori health workforce. (EOA)	Q1: Three new roles in place. Q2-Q4: Monitoring of recruitment/retention. Q4: Increase in the proportion of Māori in the DHB workforce.
Working with the Executive Director of Māori and Pacific Health, undertake an evaluation of leadership roles across the DHB to identify opportunities to improve the diversity of representation in decision-making positions. (EOA)	Q1: Evaluation completed. Q2: Actions to support increase diversity in leadership roles identified.
Deliver equity and outcomes training for all new nursing graduates at each Nursing Entry to Practice intake to raise awareness of the differences in health outcomes and ways to improve care for Māori patients and their whānau. (EOA) Introduce a requirement for all nursing graduates to complete the Understanding Bias in Health Care module by the end of their first year of practice. (EOA)	Q1-Q2: Equity and outcomes training delivered. Q4: All new graduates complete the Understanding Bias in Health Care module.
Build on the collaboration with the University of Otago's Māori/Indigenous Health Institute (MIHI) to rollout the locally designed Hauora Māori Equity Toolkit to departments across the Christchurch campus, as a means of advancing the thinking and skill sets of our staff in responding to the needs of Māori and their whānau in hospital settings and reduce institution barriers to equity. (EOA)	Q1: Use of toolkit in Urology evaluated. Q4: Number of departments engaged in the use of the toolkit.

Planning Priority: Whakamaua Objective: Reduce health inequities and health loss for Māori	
Action to Improve Performance	**Milestone**
Engage a summer student to evaluate the uptake of the Te Hā - Waitaha's Pregnancy Incentive Programme to identify barriers and strategies to further engage and retain young Māori women in the programme. (EOA)	Q1: Student engaged. Q3: Report delivered, and strategies identified.
Develop an Immunisation Engagement and Communication Plan, in partnership with Māori, Pacific and other consumer voices in our communities, to help promote and increase education around the importance of immunisation, particularly amongst high need and hard to reach populations. (EOA)	Q1: Hui to develop and agree key messages. Q2: Engagement and Communication Plan developed.
Introduce a pre-assessment process for all colonoscopy patients to identify and mitigate barriers to attendance, and work in partnership with Māori and Pacific support workers to increase appointment attendance. (EOA)	Q2: Process in place. Q3: Attendance report identifies areas for system improvement.
Track and monitor engagement with the National Bowel Screening Programme (NBSP) to identify areas where participation is low and work with the NBSP Steering Group to recalibrate strategies to meet targets. (EOA)	Q1: Monitoring in place. Q4: 60% of priority populations engaged in the NBSP.
Refresh the DHB's Māori Health Performance Dashboard in line with the Whakamaua indicators set, the DHB's Māori Profile and the national System Level Measures, to increase access to performance results and encourage conversations about equity. (EOA)	Q1: Refreshed dashboard presented at public Board meetings quarterly. Q2: Online view developed.
Produce and publish a quarterly progress report against the key Equity Outcome Actions in the Annual Plan. (EOA) Share the progress reports with Manawhenua Ki Waitaha and the DHB's Board to identify further opportunities to accelerate Māori health improvement and equity. (EOA)	Q1: Equity focused report developed. Q2: Quarterly reporting underway.

Planning Priority: Whakamaua Objective: Strengthen system accountability settings	
Action to Improve Performance	**Milestone**
Engage Manawhenua Ki Waitaha, in the completion and circulation of our Māori Health Snapshot, to inform strategic thinking and identify opportunities to accelerate Māori health improvement. (EOA)[2]	Q1: Canterbury Māori Health Snapshot released.

[2] This work was delayed in 2020/21 due to resource constraints and redeployments and has been prioritised for 2021/22.

Engage with Manawhenua Ki Waitaha on facilities development including regular engagement with the sub-committee on facilities development and collaboration from design phase forward for all up-coming major capital build projects. (EOA)	Q1-Q4: Quarterly meetings of sub-committee to engage on design and development. Q3: Annual facilities progress update provided to Manawhenua Ki Waitaha.
Refresh our approach to providing Home and Community Support Services (HCSS) to better meet the needs of older Māori and their whānau. (EOA) In doing so: Facilitate the engagement of Kaupapa Māori service providers as a connected part of the HCSS network to increase the uptake of services by older Māori and their whānau. (EOA) Support mana motuhake by partnering with Māori to enable the development and utilisation of community-based support services for older Māori and their whānau. (EOA)	Q1: Funding mechanism agreed/approved to enable investment in a new approach. Q2: Number of Kaupapa Māori providers engaged in the delivery of HCSS. Q4: Increased proportion of HCSS client base are Māori.
Engage disabled Māori in the refresh of the DHB's Disability Action Plan to promote alignment with Whāia Te Ao Mārama the national Māori Disability Action Plan. (EOA)	Q2: Alignment of plans completed.
In line with the regional Child Development Service work, enable the new Kaitautoko Māori role to support whānau to access Child Development Services and improve cultural competency within the existing workforce. (EOA)	Q2: Update on actions and activity.
Engage a Māori Clinical Lead to support an equity focus across HealthPathways to highlight areas of inequity and unmet need to general practice, alongside treatment and referral pathways. (EOA)	Q1: Active review of HealthPathways content underway.
Continue to track appointment attendance rates to identify system barriers and unmet need for Māori. (EOA) Support services with the lowest rates of attendance to consider learnings from previous reviews to support improved service access for Māori. (EOA)	Q1: Reporting is on the Executive and Operational leadership agenda. Q2: Services identified for further support. Q4: Increase in Māori attendance rates for outpatient clinics – baseline 93% (2019/20).
Increase emphasis on the use of performance and population health data to support external service provider reviews and realign resources and funding to support increased/equitable access to services for Māori. (EOA)	Q1: Refreshed contract review process in place. Q4: Investment reviews indicate refocus of resource to improve equity.

2.4 Improving sustainability (confirming the path to breakeven)

Planning Priority: Short term focus 2021/22	
Action to Improve Performance	**Milestone**
Implement the Kowhai Programme (funded by national sustainability funding) to improve the physical and cognitive functioning and wellbeing of older adults and reduce and/or mitigate the impacts of hospital acquired delirium.[3] Focus on implementing a trained volunteer programme and providing meaningful engagement and a person-centred approach, to improve health outcomes and support the financial sustainability of our health system. Engage with Manawhenua Ki Waitaha to determine an appropriate pathway for seeking expressions of interest in participation in the programme to increase the diversity of our volunteer workforce. (EOA)	Q1: Volunteer recruitment and training complete. Q2: Feedback and review processes in place tracking patient, whānau and staff experience. Q4: Reduction in adverse outcomes associated with hospitalisation - pressure injuries and patient falls. Q4: Reduction in the use of pool and agency staff for close observation - avoided costs anticipated at $100k.
As part of the Accelerating our Future programme, use local and national service analytics to identify opportunities for prioritising investment, enhancing productivity, and capturing workforce, information technology and operational efficiencies to support a pathway to financial sustainability for the DHB and the wider Canterbury health system.[4]	Q1: Progress on delivery of the Improvement Plan agreed in 2021/22. Q2: Impact of the DHB's refreshed Delegations Policy reviewed. Q4: Reduction in operating costs anticipated at $1-3m.
As part of the DHB's focus on strengthening production planning, enhance production planning for endoscopy services to ensure we have the capacity required to sustainably meet the growing demand associated with implementation of the National Bowel Screening Programme. Focus on reducing long waits for colonoscopies, ensuring equity of access for our population and reducing dependency on private providers to improve health outcomes and support the financial sustainability of our health system.	Q1: First of the new procedure rooms operational, expanding internal capacity. Q2: Pre-assessment process in place to reduce cancelled and missed appointments. Q3: Second procedure room operational. Q4: Reduction in outplacing/outsourcing costs anticipated at $600k.

[3] The DHB secured national sustainability funding for six projects in 2020/21 and this action reflects one of those six initiatives.

[4] This programme is also reflected in the Medium-Term Focus table following.

Planning Priority: Medium term focus (three years)	
Action to Improve Performance	**Milestone**
Capture opportunities provided through the national digital enablement funding and COVID-19 learnings to build on and increase the uptake of telehealth and virtual services across primary, community and secondary care settings. Focus on increased consumer engagement, access to earlier intervention to reduce acute presentations and admissions, and shared learning opportunities for service providers to support the sustainability of our system and improve equity of access across the region.	Q2: Increased utilisation of the MHERC online platform to support virtual service delivery by primary and community mental health service providers. Q2: Two secondary services engaged in the Planned Care Enhanced Telehealth Reach programme with locations scoped. Q3: Feasibility of virtual ward concept considered, and areas of focus confirmed. Q4: Remote smoking cessation service options are embedded as part of the wrap-around Stop Smoking service.
In partnership with clinical leads, develop and implement a clinical service planning process, for each of our major clinical service areas, that integrates a ten-year forward look with annual production planning to bring activity, workforce, facilities and financial management together into an integrated forward focused plan.	Q1: Framework, model and prioritised plan agreed. Q2: Approach tested on two service areas in rapid 30 days PDSA cycle. Q3: Planning partnership and tools in place to support adoption of clinical planning process across all major clinical areas.
Continue to implement the DHB's Accelerating our Future programme to support a pathway to financial sustainability including delivery of the following three workstreams:	
Clinical Procurement: Using local and national data and analytics, identify opportunities to reduce clinical consumable expenditure by 5%. Focus on consolidating suppliers, and rationalising and standardising equipment and delivery models, without impacting on patient care.	Year 1: Top 20 clinical consumables identified in terms of costs and focus underway to reduce costs in these areas - anticipated savings $2-5m. Year 2: Ongoing consumable and procurement focus identifies $2m savings. Year 3: Ongoing consumable and procurement focus identifies $2m savings.
Out-sourced and Outplaced Activity: Using local and national service data and analytics, identify opportunities to increase internal theatre efficiencies and improve the flow of patients through our system to support system sustainability and reduce operating costs by minimising outsourcing and outplaced activity. Focus on increasing the capacity of our anaesthesia resource to utilise internal theatre sessions fully and increase capacity across Waipapa through internal efficiency gains.	Year 1: Capacity efficiencies reflected in increased internal theatre use, maximum out-sourced and outplaced activity spend of $37m. Year 2: Ongoing data driven efficiency focus reduces maximum spend to $27m. Year 3: Ongoing data driven focus reduces maximum spend to $17m.
Information Support Services: Identify opportunities to improve governance and administrative processes, integrate application services and moderate service growth to support the sustainability of services and reduce operating costs. Focus on activity to capitalise labour rate savings while targeting vacancies, leave accrual and consumption-based commodity Information Technology.	Year 1: Streamlined governance and administration processes in place, reduction in external contractors and total Information Technology spend of $2m. Year 2: Ongoing reductions in the total Information Technology spend $2m. Year 3: Ongoing reductions in the total Information Technology spend $2m.

2.5 Improving Maternal, Child and Youth Wellbeing

Planning Priority: Maternity Care	
Action to Improve Performance	**Milestone**
Complete the transfer of the DHB's primary birthing unit from Lincoln Hospital to the Selwyn Health Hub to support improved service delivery to the growing population in the Selwyn district and ensure appropriate use of the tertiary level capacity at Christchurch Women's Hospital.	Q3: Selwyn Health Hub operational.
Utilise the findings of the Maternity Post-COVID lockdown survey to better inform future service planning. In doing so: Through our Consumer Council, establish closer links with community providers to support women and whānau to access necessities (i.e. food and housing). Further develop telehealth processes to better enable access to virtual maternity services across primary and secondary rural settings to support our primary birthing units and reduce the need for women to travel. (EOA)	Q1: Closer links with community providers established. Q4: Increased access to virtual services tracked.
Establish a community-led oversight group to determine the workplan priorities that will support implementation of Canterbury's Maternity Strategy – with strong Māori & Pacific leadership to ensure the equity focus on the Strategy is realised. (EOA)	Q1: Community-led oversight group established. Q2: Engagement underway. Q3: Maternity Strategy workplan complete.
Establish an oversight group to review registration rates with Lead Maternity Carers and core midwives within the first 12 weeks of pregnancy, by ethnicity and locality, to identify and address common barriers to access. (EOA).	Q1: Oversight group established. Q3: Opportunities identified.
Undertake a review of access to ultrasound services in rural locations and by ethnicity, with a focus on achieving equity of access across the Canterbury region. (EOA)	Q1: Access rates analysed. Q3: Pathway improvements implemented.
Bring Pacific and Pregnancy & Parenting education (PPE) providers together to develop a PPE programme aimed at Pacific women to improve engagement with services. (EOA)	Q1: Oversight group in place. Q3: Options considered and implemented.
Review and refine SUDI prevention activity and service engagement in Canterbury to ensure we continue to meet the needs of our priority populations. (EOA)	Q1: Distribution of safe sleep devices reviewed. Q2: SUDI Governance Group workplan updated.
Support the Canterbury Breastfeeding Steering Group to work in partnership with priority communities to implement the Breastfeeding Action Plan. Develop an electronic breastfeeding resource for LMCs which includes specifics for engaging with and supporting priority populations. (EOA) Review breastfeeding services and resources/communications with an equity lens, to improve engagement with priority populations and lift breastfeeding rates. (EOA)	Q1. LMC resource launched at World Breastfeeding Week. Q2. Equity lens review of services and communications underway. Q4. Increase in the proportion of babies exclusively or fully breastfed at three months – baseline Māori 50%, Pacific 54% (2019/20).
Work regionally to review referral process to Well Child Tamariki Ora services, as part of the South Island Alliance WCTO Quality Improvement initiative and implement the national Well Child Tamariki Ora review recommendations (expected Q2 2021/22). In doing so seek to improve the sustainability and flexibility of the service delivery model to support and enable a whānau ora approach. (EOA)	Q1: Current pathway reviewed. Q3: Service improvement opportunities implemented.
Identify opportunities to streamline processes for the Newborn Metabolic and Hearing screening programme, to ensure we are adhering to lead times and enabling earlier intervention and treatment.	Q1: Review of pathways across all birthing facilities. Q3: Introduction of a paper free system with LinKIDS to support enrolment.
Building on the CCDM implementation, use Trendcare data from maternity services to identify and respond to workforce gaps and ensure safe staffing levels.	Q2: Trendcare data reviewed. Q4: Workforce realigned.
In line with our Maternity Workforce Plan, develop key messaging and pipelines to promote career pathways into midwifery with a focus on Māori & Pacific students. (EOA) Connect in with the South Island Workforce Development Hub, the Kiaora Hauora programme, ARA and the national work on the development of a midwifery pipeline.	Q2: Maternity workforce ethnicity mapped to identify gaps and focus. Q4: Partner with relevant education and health providers to develop key messaging.
Review the current processes in place for Perinatal & Maternity Mortality Reviews to enhance performance, capture opportunities to strengthen and align transalpine processes with the West Coast DHB.	Q1: Review complete.
Develop more specific supports for pregnant Māori, Pacific and Indian women and their whānau, to promote engagement with maternity services for priority populations. (EOA)	Q3: Community consultation series undertaken to identify barriers for engagement.

Strengthen engagement between Maternity leadership and Canterbury's Suicide Prevention Governance Group to enhance our first 1,000 days response for women and whānau experiencing maternal mental health distress	Q2: Joint meeting held. Q3: Ongoing engagement opportunities identified.
Improve the Community Dental Service's recall system by confirming the criteria for clinical need, refining the processes which identify Māori and Pacific pre-school children who are not enrolled with the service and actively engaging with their whānau to link them in with the oral health service. (EOA) [5] Implement the Well Child Tamariki Ora project to improve oral health literacy for parents of 0-2year-olds, to strengthen caregivers' understanding of oral health and improve oral health outcomes for children. Advocate for policies that will improve oral health for our most vulnerable populations, including water fluoridation, healthy school lunches and policies that reduce poor oral health for children.	Q1: Process improvements identified. Q2: Improvement actioned. Q3: Oral Health Literacy Project underway. Q4: Improvement in pre-school enrolment rates: baseline –Māori 82%, Pacific 86% (2019/20). Q4: Reduction in the equity gap for Ambulatory Sensitive Hospital Admissions for children 0-4: baseline – Total Population 4,001 per 100,000, Māori 6,842 per 100,000.

Planning Priority: Immunisation	
Action to Improve Performance	**Milestone**
Undertake a quality improvement review of the current process undertaken by the National Immunisation Register team to identify children from infancy to age five who are overdue for immunisations to lift immunisation coverage rates. National Immunisation Register and National Enrolment Service ethnicity for children match and if not, the child's ethnicity is confirmed. (EOA) Māori and Pacific children overdue for vaccinations are referred to the Missed Events Service within the agreed timeframes. (EOA) Māori and Pacific families, who agree to be referred to Outreach Immunisation Services, are given a priority referral. (EOA)	Q1: Review complete. Q2: Processes confirmed and updated with the team. Q3: Improvement in Māori and Pacific coverage rates across all age milestones. Q4: National targets are met across all age milestones.
Hold a Hui to develop an Immunisation Engagement and Communication Plan, in partnership with Māori, Pacific and other consumer voices in our communities, to help promote immunisation and increase education around the importance of immunisation, particularly among high need and hard to reach populations. (EOA)	Q1: Hui on key messages. Q2: Plan developed.
Identify two priority actions from the Immunisation Engagement and Communications Plan to deliver in 2021/22.	Q2: Priorities identified Q4: Two priorities delivered.
Partner with the Māui Collective and Community & Public Health team to develop and deliver community-led education and awareness sessions for providers on the importance of immunisation for Māori. (EOA)	Q3: Annual sessions planned and delivered.
Develop a process to data match between general practice and National Immunisation Registers to improve the identification of Kaumātua Māori, to enable this group to be prioritised and followed-up for Influenza vaccinations. (EOA) Engage with Te Puawaitanga, as a Kaupapa Māori partner, to support the delivery of vaccinations to Kaumātua Māori. (EOA)	Q1: Data matching process agreed and underway. Q3: Increase in Māori influenza vaccination coverage: baseline 42% (2019).
Provide an updated process chart to general practice to raise awareness around the timeframes for the new 12-month immunisation event.	Q1. Updated process chart distributed.
Develop a pathway to identify children who are overdue for their 12- and 15-month immunisations to link them back to the general practice and support the practice to prioritise and reach the families of these children.	Q1: Pathway agreed and implemented.
Provide quarterly reports on performance to the CCN Immunisation Service Level Alliance to support conversations about equity and opportunities for improvement. (EOA)	Q1-Q4: Quarterly performance reports discussed.
Collaborate with general practice and the COVID-19 vaccination team to ensure that both programmes are well resourced and delivery of the COVID-19 programme does not negatively impact on the delivery of childhood vaccinations. Work with general practice to ensure ongoing visibility and delivery of the national childhood immunisation programme. Ensure that capacity is maintained across LinKIDS, Missed Events and Outreach Teams to support delivery of childhood immunisations, undertaking monthly meetings with service providers to identify staffing requirements and monitor coverage.	Q1: Recruitment of new vaccinators for the COVID-19 programme. Q1-Q4: Quarterly newsletters to general practice highlight the childhood programme. Q1-Q4: Monthly monitoring of overdue children, including outreach waitlists.

[5] Dental conditions are the fifth largest contributor to Canterbury's Ambulatory Sensitive Hospital Admission rates for children aged 0-4 years and this work is expected to help to reduce avoidable hospital admissions and improve long-term oral health outcomes.

Contributory Measure CW07: Proportion of newborn children enrolled with a PHO by three months of age.	Increase on 2019/20 baseline to >85% for all population groups: Māori: 80% Pacific 93% Total Population: 93%
Contributory Measure CW05: Proportion of eligible children fully immunised at eight months of age.	Increase on 2019/20 baseline to >95% for all population groups: Māori: 90% Pacific: 96% Total Population: 94%

Planning Priority: Youth Health and Wellbeing	
Action to Improve Performance	**Milestone**
Confirm membership of the Rangatahi Work Group of the Child and Youth workstream, with at least two regular members who bring a youth perspective, to ensure that the youth voice, especially that of Māori and Pacific, is well heard and influences system level planning and improvement approaches in Canterbury. (EOA) In partnership with rangatahi, identify and prioritise actions to address access challenges and improve the utilisation of youth appropriate health services in Canterbury.	Q1: Membership of Rangatahi Work Group confirmed. Q2: Workplan completed and approved. Q4: Minimum of two priorities from the Workplan actioned.
Engage with the findings from the Youth Oral Health Survey, presented to the Transalpine Oral Health Service Development Group (OHSDG) in 2020/21, to improve youth engagement with oral health services. Collaborate with the Community Dental Service, OHSDG, OHSDG Equity Sub-Group, Te Kāhui o Papaki Kā Tai and Pacific reference groups to complete a Health Promotion and Education Plan with practical actions to address the barriers identified in the following five key areas: education, relationships, communication, logistics, and apathy. (EOA)	Q1: Youth Oral Health Survey results revisited. Q2: Health Promotion and Education Plan completed. Q4: Minimum of two priorities from the Plan actioned.
Providers will incorporate the key feedback from the Youth Health Survey, undertaken in 2020/21, into their continuous improvement plan for each school to ensure young people's needs and aspirations are influencing service provision and delivery models, and to increase engagement with the School Based Health Service (SBHS).	Q1 Continuous Improvement Plans reviewed. Q4: Student Survey repeated.
Engage with DHB regions where telehealth options have been used for delivery of SBHS, to understand how Canterbury might introduce a similar service option for SBHS where face-to-face service delivery is not possible.	Q1/Q2: Learnings from other regions captured. Q3/Q4: Logistics investigated, and options put forward.
Use learnings from the 2020 lockdown to confirm a prioritisation process with providers and schools for the most at-risk individuals. This will ensure those who could not be physically seen in the event of a lockdown are still able to be supported in some capacity and/or seen in person first after a lockdown. (EOA)	Q2: Learnings captured, collated and reviewed. Q4: Prioritisation process drafted and tested

Planning Priority: Family Violence and Sexual Violence	
Action to Improve Performance	**Milestone**
Refine and embed the process of contributing to the Integrated Safety Response (ISR) Programme virtually, using a secure online platform, to ensure that staff can work remotely to address family violence in the event of further escalation of lockdown levels.	Q1: COVID-19 learnings refined, and process finalised. Q2: Systems in place to support continued remote work as required.
Provide staff in key areas with core, refresher or Violence Intervention Programme (VIP) training, to ensure staff understand and implement Child Protection and Partner Abuse & Neglect policies and contribute to reducing family violence by increasing screening rates and enabling faster access to Family Harm services for patients.	Q1-Q4: Audits undertaken to evidence increased delivery of training. Q4: Number of DHB staff attending training sessions: baseline 560 staff (2020).
Increase communication about processes for sexual abuse referrals and service provision with local stakeholders including general practice, schools, Police and Māori and Pacific services providers, to raise awareness of services for people working with our priority populations (EOA).	Q1-Q4: Korero with external stakeholders.
Establish regular meetings with other sexual assault service providers, including START Healing (sexual abuse early intervention and counselling) and SASSC (Sexual Assault Support Services Canterbury) to improve our integrated services response.	Q1: Demonstrated participation in upcoming SASSC Youth Project. Q4: A minimum of three Child & Family Safety Service, Oranga Tamariki and Policy inter agency meetings held.

Commit to participation at the National VIP Forum, sharing knowledge and learnings to better support staff to gain confidence in identifying and managing child protection issues and working across disciplines and DHBs.	Q3: Staff participate in National VIP Forum. Q1-Q3: Staff participation in Regional Forums.
Through the recently established Newborn Uplift Steering Group and in consultation with the NICU Steering Group and local Iwi, consider and incorporate the new national standards in the development of a DHB Newborn Uplift Policy that ensures mana stays intact and parental involvement is assured. (EOA)[6]	Q2: National Standards reviewed and considered. Q3: Newborn Uplift Policy drafted and circulated for feedback and approval. Q4: Policy implemented.

2.6 Improving Mental Wellbeing

Planning Priority: Improving Mental Wellbeing	
Action to Improve Performance	**Milestone**
Work with partner health and social service agencies to support individuals, whānau and communities to access the resources they need to live in healthy environments that support their mental health and wellbeing. Coordinate a multi-agency group to generate wrap around solutions for people with complex needs, with a community-based clinical role established to bridge the gap between agencies for priority populations. (EOA)	Q1: Routine multi-agency meetings underway. Q1: Clinical FTE in place.
Investigate opportunities to enhance primary and community providers' access to the MHERC online platform, to support increased virtual service delivery and enable access to mental wellbeing online resources.	Q1: Establish uptake baseline. Q4: Increased utilisation of the online platform.
Establish a cross-system mental health leadership group, to plan, monitor and review the psychosocial response and enable a rapid integrated response from mental health services in the event of any future pandemic outbreak. Ensure membership from Māori and Pacific as well as primary, community, NGO and specialist services and close links to district multi-agency psychosocial group coordinated by Community & Public Health. (EOA)	Q1-Q4: Routine meetings with demand and service utilisation data available to review.
Partner with iwi to undertake a collective redesign process to better tailor mental health and addiction service to local population characteristics and needs and foster community and kaupapa Māori-led solutions to prioritise health equity for Māori. (EOA)	Q1: Partnership Group established. Q2: Process agreed and documented. Q3: Co-design underway.
Progress the implementation of Te Tumu Waiora across general practice, embedding and strengthening the programme to support earlier intervention and improved outcomes for our population. Ensure strong Māori workforce and provider engagement in the programme to support service uptake by Māori in need of mental health and wellbeing support. (EOA) Ensure alignment across all newly funded mental health initiatives including Youth, kaupapa Māori and Pacific programmes, irrespective of funding source, to further expand primary mental health and addiction support in communities. (EOA)	Q2: A further 6 FTE Health Improvement Practitioners (HIPs) and 6 FTE Health Coaches/ Support Workers recruited. Q2: Increased proportion of Health Coaches are Māori. Q4: Total of 26.2 HIPs and 33.8 Health Coaches/Support Workers in place.
Work with the Ministries of Health and Education to determine the approach to transitioning mental health support in schools, in alignment with the national model, influenced by the experience gained through Mana Ake.	Q1: Clear transition plan agreed.
Collaborate with our community-based youth mental health and addiction providers, through the CYMHS and Manu Ka Rere networks, to develop an integrated response to addressing the rapid growth in demand for Child and Adolescent Mental Health Services.	Q1: Youth capacity expanded. Q3: Centralised referral pathway agreed.
As part of the regional hub and spoke model for community-based withdrawal services, fund a Kaupapa Māori withdrawal management nurse in He Waka Tapu to support increased engagement with Māori. (EOA)	Q1: Service operational. Q4: Progress report on service delivery.
Progress the change proposal for our Te Korowai service, completing the recruitment of Pukenga Atawhai and embedding the roles into clinical teams, to strengthen the cultural responsiveness of specialist service delivery. (EOA)	Q1: DHB recruitment and change process complete.
Establish a pathway to give Pacific people with serious mental illness the option to transition from specialist services to community care provided by the Etu Pasifika to expand primary mental health and addiction support in communities. (EOA)	Q3: Pathway developed. Q4: Pathway in place.

[6] National standards are being developed by the Ministry of Health in conjunction with Oranga Tamariki and Police, to inform regional frameworks and policies.

Undertake a mapping exercise to identify where people are not getting follow up care within seven days post-discharge from specialist services and develop communications to strengthen the links between specialist providers and address barriers to support.	Q1: Mapping completed. Q2: Communications implemented. Q4: Review of rates.
As part of continuous improvement, review discharge processes where no or inadequate discharge plans are documented and implement improvement processes to ensure all inpatients have discharge plans in place.	Q2: Results of review collated. Q4: Review impact of improvement process.
Develop a centralised referral pathway for youth referrals to ensure people are getting access to the level of intervention needed and wait times are minimised.	Q3: Process agreed and documented. Q4: Process implemented.
Contributory Measure MH03: Proportion of long-term clients discharged from adult specialist mental health services with a transition or wellness plan in place.	Increase on 2019/20 baseline to 95% of all clients: Total Population: 72%
Contributory Measure MH07: Proportion of people discharged from mental health and addiction inpatient services for whom a community service contact is recorded in the seven days immediately following that discharge.	Increase on 2019/20 baseline for all population groups: Māori: 83% Pacific 82% Total Population: 84%

2.7 Improving Wellbeing through prevention

Planning Priority: Communicable Diseases – Current Context – COVID-19	
Action to Improve Performance	**Milestone**
Implement the key actions in our COVID-19 Programme Plan, COVID-19 Response Plan, and COVID-19 Quality Plan developed by our Community & Public Health team to minimise COVID-19's impact on health, wellbeing and equity in our communities, and support a positive community response. (EOA)	Q2&Q4: COVID-19 status and response reported to the Ministry.
Monitor and report communicable disease trends and outbreaks.	Q2&Q4: Number of reports sent to health professionals.
Follow up communicable disease notifications to reduce disease spread, with a focus on culturally appropriate responses. (EOA)	Q2&Q4: Number of notifications completed.
Identify and control communicable disease outbreaks, with a focus on culturally appropriate responses. (EOA)	Q2&Q4: Number of outbreaks recorded.

Planning Priority: Environmental Sustainability	
Action to Improve Performance	**Milestone**
Update the Staff Vehicle Transport Policy with additional focus on environmental considerations, including guidance on use of multi-person public transport and alternative transport options for Essential Workers during escalated COVID-19 levels.	Q1: Draft finalised and circulated for review. Q2: Final Policy approved by Executive Management Team and implemented.
Investigate the reimbursement of employee costs for use of alternative forms of electric transport such as e-scooters or e-bikes in place of reimbursement for fossil fuel travel option such as taxis, improving our environmental footprint and reducing risks of multi-person transportation alternatives during COVID-19 alert levels.	Q1: Scoping complete. Q2: Recommendations put forward for approval. Q4: Policy implemented.
Partner with the Digital Wings Trust to refurbish the DHB's old IT equipment for reuse in the community, to reduce the impact of disposal on the environment and support increased access to digital tools by community groups, individuals and whānau who might not otherwise access digital health options. (EOA)	Q2&Q4: Report on use of DHB equipment in the community.
Partner with defence, probation, faith-based organisations and the NZ High Commission in Samoa to coordinate the redistribution of DHB clinical equipment no longer in use to the Pacific Islands, to reduce the impact of disposal on the environment and increase access to health treatment for individuals and families in the Pacific Islands. (EOA)	Q2: Opportunities identified. Q4: Clinical equipment re-homing completed.
Complete the replacement and decommissioning of the DHB's remaining coal boilers at Christchurch and Ashburton hospitals to further reduce total emissions and meet the DHBs obligations under the Carbon Neutral Government Programme. Measure verify and report emissions annually to support the setting of credible emissions reduction targets and plans for 2025 and 2030.	Q2: Commissioning of the Christchurch hospital biomass boilers. Q4: Commissioning of the Ashburton hospital biomass boilers. Q4: Report total tCO_2e emissions to establish baselines for reduction targets

Planning Priority: Antimicrobial Resistance	
Action to Improve Performance	**Milestone**
An interdisciplinary group of clinicians, engineers and Infection Prevention and Control (IPC) specialists collaborate to ensure IPC policy and practice for DHB facilities and Canterbury Managed Isolation & Quarantine Facilities remains fit for purpose and reflective of rapidly evolving evidence and new understandings about transmission of COVID-19 respiratory particles.	Q1-Q4: Ongoing monitoring of overseas developments and advice to IPC on implications for the Canterbury region.
Develop and implement IPC management plans for COVID-19 patient admissions, including a section on multi-drug resistant organism's admission risk assessment (international regions with high incidence).	Q1: Implementation phase. Q2-Q4: Monitoring and evaluation phase.
Evaluate outcomes from previous Antimicrobial Stewardship (AMS) interventions to inform ongoing quality improvement and review the use of specific antimicrobial agents/families against local resistance patterns to inform future activities and interventions. In doing so: Review the pharmacokinetic target attainment and clinical outcomes with once daily versus three times daily gentamicin for treatment of endocarditis before and after changing to once daily dosing in March 2014. Implement appropriate quality improvement initiatives if areas for improvement are identified. Review the pharmacokinetic target attainment after implementation of new vancomycin dosing and monitoring guidelines. Implement appropriate quality improvement initiatives if areas for improvement are identified. Review Canterbury (hospital and community) usage of quinolones (ciprofloxacin, levofloxacin, moxifloxacin, norfloxacin) for comparison against local E. coli resistance patterns. Implement appropriate quality improvement initiatives if areas for improvement are identified.	Q1: Projects commenced (protocols drafted, and data collection started). Q3: Data analysis and write-up completed. Interventions initiated as required.
Engage in a collaborative initiative between AMS and IPC to support Aged-Residential Care (ARC) providers with projects that can improve the quality of antimicrobial prescribing, such as improving documentation of meaningful indications on antimicrobial prescriptions, education on multi-drug resistant organisms and antimicrobial stewardship and audits of antimicrobial prescribing.[7]	Q1: Commence engagement with local ARC facilities. Q2: Initial project for AMS developed.
Engage with community prescribers (particularly general practitioners) to improve antimicrobial stewardship locally, through the Canterbury AMS Strategic Group.	Q1-Q4: Engagement with community prescribers and sharing of resources.

Planning Priority: Drinking Water	
Action to Improve Performance	**Milestone**
Until Taumata Arowai (the new national drinking water agency) is established: Continue to deliver and report on the drinking water activities and measures in the Ministry of Health Environmental Health exemplar to ensure high quality drinking water and continue to monitor compliance of networked drinking water supplies in accordance with the Health Act.	Q2&Q4: Report on the percentage of networked water supplies (by class) where timely response was provided by the PHU to transgressions, contamination or interruption in accordance with drinking water legislation and standards.
Highlight non-compliant supplies, water supplies which predominantly serve Māori or Pacific populations, or those which potentially pose a public health risk, to Taumata Arowai at handover. (EOA)	Q1: Handover to Taumata Arowai highlights key water supplies or water supply risks.

Planning Priority: Environmental and Border Health	
Action to Improve Performance	**Milestone**
Continue to effectively manage COVID-19 risk at the air and maritime borders. Offer and support the delivery of COVID-19 vaccinations for all Community & Public Health and DHB staff who have contact with the border and implement and maintain a staff COVID-19 vaccination register.	Q2&Q4: COVID-19 border management status and response reported. Q2&Q4: Number of fully-vaccinated DHB staff on register.
Maintain relationships with local rūnanga to support an ongoing partnership in addressing environmental health issues. (EOA).	Q2&Q4: Number of issues identified, addressed and/or under action.

[7] This work is reliant on ARC facility interest which will depend in part on their requirements in the new Health and Disability Services Standards.

Work with councils to provide public health advice on strategic long-term planning regarding urban development whilst ensuring our focus is aligned with the priorities of Māori and Pacific populations within our district. (EOA)	Q2&Q4: Report on advice provided to district and regional councils.
Deliver and report on the activities contained in the Ministry of Health Environmental and Border Health exemplar, including undertaking compliance and enforcement activities relating to the Health Act 1956 and other environmental and border health legislation, to improve the quality and safety of our physical environment.	Q2&Q4: All regulatory performance measures reported as required.

Planning Priority: Healthy Food and Drink Environments	
Action to Improve Performance	**Milestone**
Using the audit of DHB sites (completed in 2020/21) identify areas in need of support and engage with them to comply with the DHB's Healthy Food and Drink Policy. Share the success stories from exemplar DHB sites or organisations to inspire change.	Q2: Review of audit results and sharing of success stories. Q4: Support targeted to non-compliant DHB sites.
Collaborate with Sport Canterbury and other education providers in early learning settings, primary, intermediate and secondary schools to support the adoption of water-only (including plain milk) and healthy food policies in line with national Healthy Active Learning Initiative. Place emphasis on education providers with higher proportions of Māori, Pacific and/or low socio-economic status students. (EOA)	Q2&Q4: Report proportion of schools and ECECs with water-only and healthy food policies.

Planning Priority: Smokefree 2025	
Action to Improve Performance	**Milestone**
Building on the lessons learnt during the COVID-19 lockdown, collaborate with Stop Smoking Practitioners from primary care and Māori and Pacific provider organisations to embed remote smoking cessation support (including telehealth, telephone and including home delivery of NRT), to improve continuity for people who are not able to access face-to-face services. (EOA)	Q4: Remote cessation service options are embedded as part of the wrap-around service.
Upgrade and refresh the DHB Smokefree SharePoint site to include a direct link for referrals to the stop smoking support service and access to useful information and resources, to phase out the faxed referral forms.	Q2: Site updated, and all departments informed of change.
Provide two training sessions for Pacific provider and community groups to increase stop smoking referrals, using Motivating Conversations techniques. (EOA)	Q1: Training session held. Q3: Training session held.
Through Smokefree Canterbury, inform and prepare submissions on the proposed Smokefree 2025 plan, with a focus on reducing supply and the impact on Māori and Pacific as priority populations. (EOA)	Q2: Report on activity. Q4: Report on activity.
Undertake compliance activities relating to the Smokefree Environments Act 1990, including delivering and reporting on the activities relating to public health regulatory performance measures, to reduce uptake of smoking among young people. (EOA)	Q2: Report on activity. Q4: Report on activity.
Engage a summer student to evaluate the uptake of the Te Hā - Waitaha's Pregnancy Incentive Programme to identify barriers and strategies to further engage and retain young Māori women in the programme. (EOA)	Q3: Summer student report delivered, and strategies identified.
Track and monitor the delivery of ABC (Ask, give Brief advice and offer Cessation Advice) across primary and secondary care to ensure consistent messaging about Smokefree support and provide information on smoking cessation to ensure priority populations are being supported. (EOA) Encourage primary and secondary care providers to code ABC delivery so the PHOs can identify patients still to be offered support and monitor progress towards target.	Q1-Q4: Monitor ABC rates quarterly to ensure priority populations are being reached. Q2&Q4: Monitor Smoking Cessation referrals six monthly to identify areas needing support.

Planning Priority: Breast Screening	
Action to Improve Performance	**Milestone**
Monitor breast screening rates by ethnicity to highlight any widening equity gaps due to COVID-19 delays and support ScreenSouth to prioritise Māori and Pacific women when allocating routine screening appointments. (EOA)	Q1: Prioritisation process in place to review any women whose screens were delayed.

Support ScreenSouth to strengthen connections with He Waka Tapu and Pacific providers to offer supported attendance at clinics to encourage and engage hard-to-reach priority population women in breast screening. (EOA)	Q1: Current processes reviewed and strengthened. Q4: Reduction in the equity gaps for Māori and Pacific women 45-69 - baseline Māori 69%, Pacific 66%, Total 76% (Mar 2021).
Engage with ScreenSouth, Pasifika Futures, He Waka Tapu, and the three Canterbury PHOs to consider how the mobile screening unit might be used to offer breast screening in community settings to encourage uptake by Māori and Pacific women. (EOA)	Q2: New initiative considered. Q3: Plan initiated to increase scope of the mobile unit.
Collaborate with ScreenSouth, Ha O Te Ora Wharekauri Trust and the Chatham Island's Medical Centre, to provide biennial screening appointments for women living in the Chathams to support participation in the programme by this priority population. (EOA)	Q1: Screening appointments held in Christchurch.
Support ScreenSouth and the PHOs to use data matching monthly to identify overdue women and those not enrolled in the national screening programme and follow-up with unscreened women to encourage and enable participation in the programme.	Q1-Q4: Monthly data matching undertaken and follow up ongoing. Q3: Increase in screening attendance rates. Q4: Increased uptake of screening by Māori and Pacific women 45-69 - baseline Māori 69%, Pacific 66% (Mar 2021).
Facilitate quarterly meetings with ScreenSouth, Pasifika Futures, He Waka Tapu and the three Canterbury PHOs to identify joint strategies to support women who have missed appointments or who have declined screening, to reduce barriers to access and lift screening rates for priority women. (EOA)	Q1: Quarterly meetings set.
Promote mobile screening clinic dates to raise awareness among Māori and Pacific women of the importance and availability of screening. (EOA)	Q2-Q3: Targeted health promotion promotes mobile screening clinics.

Planning Priority: Cervical Screening	
Action to Improve Performance	**Milestone**
Monitor cervical screening rates against the national screening targets and facilitate discussions on performance with ScreenSouth, Pasifika Futures, He Waka Tapu and the three Canterbury PHOs, to identify joint strategies to increase participation in the programme by Māori and Pacific women. (EOA)	Q1: Current monitoring processes reviewed and strengthened. Q4: Increased uptake of screening by Māori and Pacific women 25-69 - baseline Māori 64%, Pacific 68% (Mar 2021).
Work with ScreenSouth and the PHOs to develop and implement a plan to use one-off national COVID-19 funding to enable 'catch up' of priority women where coverage rates have been impacted by the COVID-19 lockdown.	Q1: Implementation Plan completed. Q4: Actions completed.
In partnership with ScreenSouth, Waitaha PHO and He Waka Tapu, implement an equity focused initiative in Ashburton, using data-matching to identify Māori and Pacific women on the PHO register who are not on the screening registers and local health navigators to follow-up with women, to lift participation in the programme. (EOA)	Q1. Initiative implemented. Q2. Evaluation of initiative undertaken.
Work with ScreenSouth to support a review and update of the regional Equity and Improvement Plan, to reduce the equity gaps in screening participation rates for Māori and Pacific women. (EOA)	Q1. Review and update completed. Q4: Reduction in the equity gaps for Māori and Pacific women 25-69 - baseline Māori 64%, Pacific 68%, Total 72% (Mar 2021).
Collaborate with Ha O Te Ora Wharekauri Trust and the Chatham Islands Medical Centre, to deliver an annual cervical screening clinic to women living in the Chatham Islands to support participation in the programme by this priority population. (EOA)	Q3: Cervical screening clinic delivered.
Link in with ScreenSouth outreach services to prioritise contact for priority group women to ensure equity of access to colposcopy across all population groups. (EOA) Introduce a process to better identify and mitigate barriers to attendance, where priority women booked for colposcopy are missing appointments. (EOA)	Q1: Performance baselines established. Q4: Increased rate of attendance at appointments.

Planning Priority: Reducing Alcohol Related Harm	
Action to Improve Performance	**Milestone**
Deliver against the objectives of the Christchurch Alcohol Action Plan (in partnership with the Christchurch City Council and Christchurch Police), in line with the Canterbury DHB's Alcohol Harm Reduction Strategy.	Q2&Q4: Report against Alcohol Plan and Strategy objectives.

By sharing this commitment with other partners, work can continue when one or two organisations are redirected into other priorities ensuring resilience across the system.	
Undertake compliance activities relating to the Sale and Supply of Alcohol Act 2012, including delivering and reporting on the activities relating to the public health regulatory performance measures, to reduce alcohol-related harm in the Canterbury population.	Q2&Q4: All regulatory performance measures reported as required.
Partner with hapū Māori and Māori organisations to strengthen the Māori voice in alcohol licensing decisions in higher Māori population neighbourhoods. (EOA)	Q2&Q4: Number of engagements with local Māori communities.
Work in partnership with Pacific stakeholders to reduce alcohol-related harm in Pacific communities. (EQA)	Q2&Q4: Number of engagements with local Pacific communities.

Planning Priority: Sexual and Reproductive Health	
Action to Improve Performance	**Milestone**
Promote and provide regular public health promotion education sessions for staff from the DHB and other organisations who work with sexual health issues.	Q2&Q4: Number of sexual health education sessions provided, and number of participants reported.
Promote the availability of free sexual health and reproductive health consultations in general practice for young people under 17, and eligibility for access to low-cost Long-Acting Reversible Contraception (LARC) to reduce cost barriers for young people. (EOA)	Q2&Q4: Report on service utilisation and promotion activities.
Promote the availability of free sexual health services (assessment, diagnosis & treatment provision) available at the DHB's Sexual Health Clinic to reduce cost barriers for young people. (EOA)	Q2&Q4: Report on service utilisation and promotion activities.
Implement initiatives from the Canterbury & West Coast Syphilis Working Group action plan to prevent new syphilis cases and congenital syphilis across the two regions and support the National Syphilis Action Plan, with a focus on action to support young Māori and Pacific people. (EOA)	Q2&Q4: Working group initiatives implemented as agreed.

Planning Priority: Cross Sectoral Collaboration including Health in All Policies	
Action to Improve Performance	**Milestone**
Deliver Broadly Speaking training (including the use of HEAT and other equity tools) to staff from the DHB and other health and social service agencies, to support and grow Health in All Policies work in our region.	Q2&Q4: Number of Broadly Speaking training sessions held, and number of non-health agencies attending.
Refresh our Joint Work Plan with Environment Canterbury and the Christchurch City Council and review priorities to support collaborative work to improve health in our region.	Q2&Q4: Number of joint initiatives agreed.
Co-ordinate, develop and deliver submissions related to policies impacting on our community's health, with emphasis on priority population groups. (EOA)	Q2&Q4: Number of public health-related submissions made.
Maintain the Canterbury Wellbeing Index, including He Tohu Ora, to provide valuable wellbeing and population health information to the wide range of agencies, communities and individuals who are working to support the wellbeing of the people of greater Christchurch. (EOA)	Q2&Q4: Wellbeing Index maintained.
Work in partnership with Manawhenua Ki Waitaha, Māori service providers, Māori whānau, hapū, and other Māori organisations, agencies and communities to respond to COVID-19 and develop mana enhancing actions to support and protect Māori whānau and communities. (EOA)	Q2&Q4: Partnership activities reported.
Work in partnership with Pacific stakeholders to maximise Pacific communities' capability and capacity to respond to COVID-19. (EOA)	Q2&Q4: Partnership activities reported.
Through the Waka Toa Ora forum, and in partnership with key Māori and Pacific organisations, collaborate on implementing a Health in All Policies approach in their work with a strong focus on addressing health equity for Māori, Pacific and low decile communities.[8] (EOA)	Q2&Q4: HIAP partnership activities with Māori and Pacific organisations reported.

[8] Waka Toa Ora is a Canterbury DHB-led inter-sectoral collaborative partnership, based on the WHO Healthy Cities model, previously known as Healthy Christchurch. The key theme of this initiative is that all sectors and groups have a role to play in creating a healthy Canterbury, whatever their specific focus (recreation, employment, youth, environmental enhancement, transport, housing or another aspect of health or wellbeing). This inter-sectoral initiative fosters collaboration between organisations who have signed the Waka Toa Ora Charter and there are currently over 200 charter signatory organisations.

2.8 Better Population Health Outcomes Supported by Strong and Equitable Public Health and Disability System

Planning Priority: Delivery of Whānau Ora	
Action to Improve Performance	**Milestone**
Building on the learnings from the COVID response, support the Te Oho Urupare Group to oversee an equitable response to COVID-19 recovery going forward. (EOA)	Q1-Q4: Regular input sought to direct our COVID responses.
Re-engage with Te Putahitanga to focus on joint work and capture opportunities to support increased capacity to respond to Māori health need across our health and social system. (EOA)	Q1: Engagement and identification of joint priorities.
Capture opportunities to model a whānau ora approach to screening and immunisation programme delivery, to engage not just the individual but the wider whānau in improving health and wellbeing. (EOA)	Q1: Opportunities identified. Q4: Increased uptake of screening and immunisation programmes.
Engage with Māori providers to support the development of whānau ora general practice models for our community (such as the He Waka Tapu low-cost general practice), to support increased access and choice for Māori. (EOA)	Q1-Q4: Ongoing engagement in the development of new models.
Engage He Waka Tapu and Purapura Whetu staff as Health Coaches in the Te Tumu Waiora programme, to support access to their organisation's wider whānau ora services for Māori engaged in the programme. (EOA)	Q1: Health Coaches in place. Q4: Proportional uptake of Te Tumu Waiora by Māori.
Partner with Pasifika Futures to implement the Pacific Health Action Plan (approved in 2020/21), to improve the health and wellbeing of our Pacific population. (EOA) *See Ola Manuia section.*	Q1-Q4: Implementation actions delivered in line with the agreed plan.

Planning Priority: Ola Manuia: Pacific Health and Wellbeing Action Plan 2020-2025	
Action to Improve Performance	**Milestone**
Establish a pathway to ensure Pacific people identified as part of COVID-19 case investigation are offered a translator and/or pathway to contact by a Pacific provider organisation, via the pacific health promoter, to ensure contact tracing of Pacific cases is culturally appropriate and effective. (EOA)	Q1: Pathway established and operational.
Develop a Pacific public health communication campaign to enable families to improve their knowledge and skills to manage their own health and wellbeing. (EOA)	Q3: Pacific public health communication campaign developed.
Establish a Pacific community leadership forum to develop a strong sustainable partnership with Pacific community leaders in Canterbury. (EOA)	Q3: Pacific community leadership forum established.
Implement a Pacific health leader's pathway to support and improve our capability and capacity to response to Pacific health need. (EOA)	Q3: "Pacific space" is co-designed within CDHB. Q3: Pacific health leaders' pathway implemented.
Support the development of a Pacific centre of excellence and innovation where Pacific people can access integrated primary care, family support and mental health and addiction services. (EOA)	Q1: Integrated Pacific service established in Christchurch.
Complete a Pacific Health Workforce Plan (starting with a workforce census), to ensure our system is prepared for the reality of a diverse workforce. (EOA)	Q1: Census undertaken. Q2: Pacific Health Workforce Plan developed.
Implement a cultural capability / competency programme for Canterbury DHB to help prepare our health system for the reality of a diverse workforce and a more diverse population. (EOA)	Q4: Cultural capability programme developed.

Planning Priority: Care Capacity Demand Management (CCDM)	
Action to Improve Performance	**Milestone**
Monitor verify and report on core CCDM data to evaluate the effectiveness of the programme in the DHB and identify areas for improvement. Establish an integrated operations centre where hospital-wide care capacity and patient demand is visible in real time 24/7 to support variance response management. Embed the processes and systems needed to use the CCDM staffing methodology to establish staffing numbers and skill mix for each ward/unit (using a validated patient acuity system with 12 months of accurate data).	Q1: Core data set is monitored and reported on. Q1: First tranche of wards complete FTE calculations. Q2: All inpatient areas have a local data council utilising the core data set to support quality initiatives.

	Q2: Variance response management system demonstrates staffing resource is consistently matched with demand in all inpatient areas.
Commence FTE calculation for our first tranche wards with aim to have all wards completed by Q1, 2022. Provide quarterly updates to the Ministry of Health on the FTE calculation progress.	Q1: 12 wards completed. Q1 2022: All wards complete. Q1-Q4: Quarterly report on FTE calculation.
Implement Trendcare in remaining two day-units; completing the implementation of Trendcare in all inpatient areas, inclusive of mental health, maternity and emergency departments.	Q3: Trendcare implementation complete.
Investigate the value of establishing a fourth integrated operations centre.	Q3: Evaluation of Ashburton underway.
Facilitate a CCDM programme governance hui and workshop.	Q2: Partnership Workshop undertaken.

Planning Priority: Health outcomes for disabled people	
Action to Improve Performance	**Milestone**
Establish a Disability Network Advisory Group that has key connections to the disability community to ensure communication both out and into the Emergency Control Centre is inclusive of the disability sector. (EOA)	Q1: Disability Network Advisory Group in place.
In line with our commitment to the national Accessible Information Charter, deliver on actions within the Accessible Information Working Group workplan to promote accessible information, to improve the inclusivity of our health services for disabled people across Canterbury. (EOA)	Q1: Workplan signed off by the Disability Steering Group. Q2-Q4: Progress against priority actions.
Engage disabled Māori in the refresh of the DHB's Disability Action Plan 2020-2030 to promote alignment with Whāia Te Ao Mārama the national Māori Disability Action Plan. (EOA)	Q2: Alignment of plans completed.
Invite Pacific members of the Disability Steering Group to join the Pacific Reference Health Group to ensure implementation of the DHB's Pacific Health Strategy is inclusive to the needs of disabled Pacific people. (EOA)	Q1: Membership confirmed.

Planning Priority: Planned Care	
Action to Improve Performance	**Milestone**
Utilise the Planned Care Improvement funding provided by the Ministry of Health to implement the DHB's Planned Care Improvement Action Plan and reduce the backlog of events created by the COVID-19 lockdown. In doing so add and release capacity to support additional assessments, clinics, surgeries and minor procedures to reduce waiting lists for planned care and progressively achieve Elective Services Patient Flow Indicators (ESPI) compliance.	Q1-Q4: Deliver reduction in patients waiting over 120 days, in line with the compliance trajectories agreed in the Planned Care Improvement Action Plan.
Complete an unmet need gap analysis for Planned Care Interventions to identify three service areas where inequities for our priority populations are significant and amenable to change in the coming year. (EOA) Identify Equity Improvement Projects in three of the prioritised focus areas as part of the DHB's three-year Planned Care Plan. (EOA)	Q1: Analysis underway. Q2: Three priority areas agreed. Q3: Opportunities identified and Equity Improvement Projects underway. Q4: Report on improvements.
Pilot a new non-surgical intervention pathway with a different workforce model for Gynaecology, whereby physiotherapists and dietitians screen, see and treat non-urgent gynaecology patient referrals, including those that have been declined, to reduce unnecessary surgical interventions and reduce wait times for treatment.	Q1: Physiotherapist and dietitian in place and pilot running. Q3: Evaluation of pathway completed and circulated.
In line with the national Mobility Action Plan, provide training to community providers to deliver non-surgical interventions for people with musculoskeletal health conditions in the community, to reduce waiting time for treatment and release capacity in our specialist services.	Q3: Training rollout completed. Q4: Delivery of non-surgical intervention volumes meets or exceeds plan.
Pilot nurse-led pre-operative patient phone calls for major elective operations in General Surgery to better prepare patients for surgery and help them to navigate their health journey by alleviating concerns and addressing questions prior to surgery. This work will help to reduce the number of cancelled surgeries, improving outcomes for patients and introducing efficiencies for our system.	Q1: Pre-operative calls instigated for patients having colorectal operations. Q3: Calls expanded to all General Surgery patients having complex elective surgery.

	Q4: General Surgery attendance rates improved.
Collaborate with our South Island DHB partners to increase our collective capacity and capability to effectively manage Inter-District Flows, agree shared South-Island wide processes to reduce duplication and use demand and service utilisation data better identify future capacity requirements.	Q1: Identify Canterbury capacity required to support South Island demand. Q3: Input projections into 2022/23 Production Planning.
Using Planned Care Initiative funding, implement the Enhanced Telehealth Reach programme to enhance our infrastructure, equipment and processes to further support digital and virtual service delivery.	Q1: Project designed. Q2: Two services engaged with pilot and locations scoped. Q3: Operational test complete pilot underway. Q4: 50 virtual patient consults delivered.
Led by the Theatre Utilisation Group, as part of continuous improvement, measure, verify and monitor start times for theatre sessions and address barriers to starting on time to improve theatre utilisation and reduce wait times for patients.	Q1: Theatre start time tracking in place and visible. Q2: Best practice clinical champions identified to support change. Q3: Test of change to identify impact of improvements. Q4: Report on change.
Refresh staff training and education on the appropriate coding and categorising of waitlist data to ensure accurate capture of activity around specialist assessments, treatment and follow-ups to improve production planning and targeting of patients with the longest waits.	Q1: Key specialties identified for focus. Q2: Common errors and opportunities for improvement identified. Q3: Staff education and induction materials updated. Q4: Educational materials shared across all specialties.
Contributory Measure: Proportion of General Surgery theatre sessions that start 'on time' (within 20 minutes of plan).	Improvement on 2019/20 baseline to 80% of all General Surgery theatre sessions. Baseline 46%.
Contributory Measure: Proportion of Orthopaedic patients waiting over 120 days for their treatment.	Improvement on (March 2021) baseline to <0.4% waiting over 120 days. Baseline 14.8%

Planning Priority: Acute Demand	
Action to Improve Performance	**Milestone**
Analyse SNOMED data and use the findings to improve the investigation of patients with possible heart attack in emergency, urgent care and community settings. (EOA)[9]	Q1-Q3: Data capture. Q4: Opportunities identified.
Work with the Urgent Care Service Level Alliance (SLA), to investigate Emergency Department (ED) and urgent care data for people presenting with chronic obstructive pulmonary disease (COPD) and heart failure to identify further opportunities to better support people in the community and reduce unnecessary ED presentations and acute hospital admissions. (EOA)[9]	Q1: Review of data and priority actions identified. Q2: Monitoring of trends. Q3: Progress against the Alliance work plans. Q4: Data review indicates impact on acute admissions.
Work with the Community-based Acute Demand Management Service to review and refresh the post-discharge management of patients with Heart Failure to reduce readmissions. (EOA) Investigate the use of telehealth (phone and/or video calls, and remote monitoring) to support people in their own homes following discharge from hospital. Scope the feasibility of a specialist-led heart failure clinic based in the community and targeted to the needs of Māori and Pacific patients, to reduce unnecessary ED presentations and hospital admissions. (EOA)	Q1 Engagement with key partners. Q2: Post discharge telehealth contacts investigated. Q3: Specialist heart failure clinic options scoped and presented. Q4: Data review indicates impact on acute admissions.
Participate in the Trans-Tasman research using Emergency Department data to assess the impact of COVID-19 restrictions, to understand future demand growth, identify	Q1: Research commenced. Q3: Preliminary findings shared with the Urgent Care Service Level Alliance.

[9] COPD and Heart Failure are two of the top eight drivers of ambulatory sensitive (avoidable) hospital admissions for Māori and Pacific adults in Canterbury. By improving the management of these long-term conditions this work will improve the health and wellbeing of our population and reduce the increasing acute demand load on our system.

opportunities for the system to respond to changing demand and to anticipate the impact of future events.	
Refresh and relaunch a public communications plan to support people to present to the right place in our system and investigate current telephone and online information to ensure alignment of urgent care messages.	Q1: Campaign relaunched on when to use ED. Q3: Refresh of telephone and navigation services complete.
As part of our continuous improvement programme, Making the System Flow, identify key opportunities to improve patient flow and models of care across our health system to support: the timely transfer of patients between services, enhanced care of patients through practices to optimise patient mobilisation, nutrition, hydration and cognitive stimulation and improved transition of care both pre and post-hospital admission.	Q1: Reconfigure transit team members to support timely patient transfers. Q3: Enhanced mobilisation pilot underway, utilising allied health assistants to optimise patient care.
Through the Urgent Care SLA, work with ACC to capture opportunities to improve acute care flow associated with the national roll out of the GP-referred MRI programme, by improving the pathway content for uncomplicated fractures and other common injury related presentations and appropriately diverting ACC patients away from ED.	Q1&Q3: Report progress on activity.
Evaluate the impact of the Mental Health and Addictions Crisis Support Educator role, to understand how this engagement has impacted on ED staff confidence to assess and refer patients requiring mental health and addiction support who present to ED. Seek to understand and address any equity issues in accessing mental health and addictions support. (EOA)	Q2: Evaluation underway. Q4: Impact assessed.
Undertake a deep dive into ED and primary urgent care data, to understand how our emergency and urgent care services are responding to priority populations. (EOA) Identify and implement at least one opportunity to improve the urgent care response for Māori. (EOA)	Q2: Data analysis complete. Q3: Opportunity identified. Q4: Actions implemented.
Participate in the multi-centre, prospective cohort study by the NZ Emergency Medicine Network into ED and hospital adverse events, to identify opportunities to improve health outcomes in partnership with primary care.	Q2: Study complete. Q4: Findings reported to Urgent Care SLA.

Planning Priority: Rural Health	
Action to Improve Performance	**Milestone**
Develop a guide to telehealth-based care for outpatients available to hospital clinicians and service managers (including information for patients) to support a consistent approach to the delivery of virtual services. Standardise telehealth service delivery for planned care across centralised specialist services, to provide telehealth as the preferred option when patient is confirmed as telehealth suitable.	Q2: Guide available and promoted to hospital departments. Q4 Demonstrated change in increase of telehealth delivery of planned follow up appointments.
Link in with national and international work in the rural care space to identify sustainable service delivery models for acute and after hours care in rural areas.	Q1: Ongoing engagement with Rural Hospital and Rural General practice Networks.
Engage with PHOs to assist rural practice teams to establish mutually beneficial response arrangements with St John and Fire and Emergency NZ volunteers, to strengthen emergency and urgent care access for rural communities. (EOA)	Q3. Coordinated emergency and urgent care response arrangements agreed in most rural localities.
Complete the modelling of increasing demand in acute and inpatient settings at Ashburton Hospital to support the alignment of capacity at the ward rostering level. Utilise the modelling to inform resource planning for longer-term sustainable service delivery and to respond to potential changes in local primary care capacity. (EOA)	Q1: Demand modelling, partnered with CCDM analysis contribute to improved production planning. Q3: Five-year-horizon resource planning informed.
Engage with PHOs and local service providers to support Pacific people in mid-Canterbury, including those presenting to the Acute Assessment Unit, to connect and enrol with a local general practice. (EOA)	Q1: Pegasus and Waitaha community health workers facilitate enrolment.
Work with Waitaha and Pegasus PHOs to complete a review of the rural general practice subsidy as part of a wider review of rural health services to enhance the quality and sustainability of rural health services.	Q2: GP subsidy review complete.
Facilitate the opening of the primary maternity birthing unit, dental service and community outpatient service in the Selwyn Health Hub, providing closer to home services to people living in the Selwyn area. (EOA)	Q3: Selwyn Health Hub operational.
Consider future models of care for the ageing population living rurally, to ensure sustainable and culturally appropriate aged and end-of-life care for rural people and their whānau in their homes and communities. (EOA)	Q1-Q4: Ongoing consideration of service models.

Provide packages of care to enable more Chatham Islanders, assessed as eligible for aged-residential care, to remain on the Island with their whānau if they wish to. (EOA)	Q1: Options in place.
Facilitate on-island access to dental care for Chatham Islanders to reduce barriers to access due to travel. (EOA)	Q2: On-island dental clinic sessions delivered.

Planning Priority: Implementation of the Healthy Ageing Strategy 2016 and Priority Actions 2019-2022	
Action to Improve Performance	**Milestone**
Plan and conduct Emergency Simulation Exercise (ESE) to test recently developed pandemic response planning in Aged Residential Care and identify gaps for improvement.	Q2: ESE completed. Q3: Proposed improvements advised.
Plan and conduct Emergency Simulation Exercise (ESE) to test recently developed pandemic response planning with Home and Community Support Service providers and identify gaps for improvement.	Q2: ESE completed. Q3: Proposed improvements advised.
Building on the frailty pathway work in 2020/21, regularise the use of the InterRAI Service Allocation Tool (SAT), to better identify Māori and Pacific clients with emerging signs of frailty. (EOA)	Q3: Cohort defined.
Develop a pathway for referrals to community strength and balance classes for the cohort identified by the SAT tool to and support earlier intervention.	Q4: Pathway developed.
Work with Sport Canterbury to promote accreditation for strength and balance classes with a dedicated Māori and Pacific focus. (EOA)	Q2: Māori and Pacific strength and balance classes available.
In consultation with key dementia stakeholders, scope a Dementia Nurse Specialist role to support early dementia diagnosis and care planning in general practice.	Q2: Role scoped.
Engage with our Community & Public Health team to develop dementia prevention "brain health" guidelines and promote these across the sector, to improve memory and thinking and reduce risk of dementia.	Q1: Guidelines finalised. Q3: Promotion underway.
Fully integrate ACC Non-Acute Rehabilitation (NAR) bundles of care into our early supported discharge model, including the use of standardised algorithms to ensure people have equitable access to services according to need. (EOA)	Q4: Community rehabilitation providers reporting on ACC NAR bundles for all clients.
Deploy community rehabilitation and support services across rural areas, to ensure people can access the service irrespective of where they live in Canterbury. (EOA)	Q4: Pilot in Hurunui completed.

Planning Priority: Health quality & safety (quality improvement)	
Action to Improve Performance	**Milestone**
Build on the learnings from COVID-19 to improve staff hand hygiene related to glove use, and cleaning of hands pre and post glove use, from an average of 86% to 95% (Hand Hygiene Gold Auditing Programme). Access current practice, including staff perceptions and issues, to identify and address barriers and behaviours.	Q1: Current state assessed. Q2: Strategies developed and tested to address root causes. Q4: Strategies implemented.
Implement standard delivery of Hand Hygiene opportunities for those patients that are unable to walk independently to a hand basin, to lift patient responses from being provided with a suitable alternative from an average of 69% to 85% (Inpatient Experience Survey). Implement a trial in one inpatient ward and one acute service to agreed method and measures before rolling out to the wider organisation.	Q1: Method tested in one inpatient service. Q2: Method tested in one inpatient acute service. Q3: Learnings reviewed, and implementation plan developed.
Engage with clinical leads to align the Gout Health Pathway with best-practice prescribing of non-steroidal anti-inflammatory drugs (NSAIDs), to support improved health outcomes, particularly for Māori and Pacific populations with a higher risk of kidney disease. (EOA)	Q2: Community Health Pathway updated. Q2: HealthInfo Patient information updated.
Build on the Health Quality and Safety Commission Quality and Safety Marker (QSM) work in 2020/21. Develop a practical development pathway to increase meaningful consumer engagement in service activity and target support to increase maturity in priority engagement elements in lower rated services areas.	Q2: Maturity self-assessment completed. Q2: Leader's survey completed. Q4: Promotion of leaders and leadership in engagement in services with lower ratings.

Use information gathered from surveys of engagement leaders to plan and promote leaders and leadership in engagement in the organisation, prioritising those service areas with lower engagement ratings.	
Report against the Consumer Engagement QSM twice-yearly via the online form on the Commission's website.	Q1: Report delivered. Q3: Report delivered.
Implement the Te Pou six core strategies service review tool to identify further improvement opportunities to build on progress made as part of the HQSC Zero Seclusion programme. Engage with other major services that have made significant gains to identify process improvements that could be captured in our services.	Q2: Te Pou service review tool implemented. Q3: Improvement opportunities identified.
Develop and agree a workplan of activity for the Specialist Mental Health Service's Restraint Minimisation Committee, based on the outcome of the six strategies review (above).	Q3: Workplan developed.
Progress the change proposal for our Te Korowai service, completing the recruitment of Pukenga Atawhai and embedding the roles into clinical teams, to strengthen the cultural responsiveness of our inpatient units. (EOA)	Q1: DHB recruitment and change process complete.
Develop new online dashboards for Specialist Mental Health Service leadership and clinical teams to track key performance measures including outcome and balancing measures for seclusion reduction to support the use of key performance measures in daily operations and to inform improvement work. Display performance data on shared screens alongside CCDM measures with data at ward and service level to provide near real-time feedback to clinical teams.	Q1: Dashboards developed and in use. Q3-4: Seclusion information and outcome measures reported in monthly reports to the CEO, ensuring engagement and support from leadership.

Planning Priority: Te Aho o Te Kahu – Cancer Control Agency	
Action to Improve Performance	**Milestone**
New Zealanders have a system that delivers consistent and modern cancer care – He pūnaha atawahi	
Support the Te Aho o Te Kahu (Cancer Control Agency) ACT-NOW project by working towards the implementation of nationally agreed treatment regimens and associated data standards for medical oncology and malignant haematology. Ensure data standards in our oncology e-prescribing system are compliant. Implement processes to transfer local data into the national repository.	Q1: Stocktake and review of backlogged care plans and capacity required to alleviate constraints. Q2: Strategies and capacity plans identified. Q4: Collaboration underway to achieve alignment with the other four South Island DHBs.
Work with Te Aho o Te Kahu, the Southern Hub and the South Island Alliance to adopt and implement the national cancer-related Health Information Standards Organisation (HISO) standards. Demonstrate evidence of implementation and compliance with the HISO standards as they are rolled out in regional documentation and policies. Enhance Faster Cancer Treatment (FCT) reporting to include ethnicity data so reporting has ethnicity reporting fields to HISO standards. (EOA)	Q1: Confirm HISO standards and interoperability within regional and MDM platforms. Q2: Ethnicity Data included against all FCT performance data. Q3: Support expansion of SIPICS across the other South Island DHBs to support a single patient record.
Work with Te Aho o Te Kahu Southern Hub to develop and consider the recommendations of the national Radiation Oncology Service Plan and ensure that the model of service is fit to meet the current and future needs of the region. Support the Cancer and Regional Haematology Service (CRCHS) with staff workforce modelling for current linear accelerator (linac) capacity to ensure workforce capacity and capability aligns to current linac capacity. Participate in regional work on the location of additional linacs and facilities and future workforce forecasting for additional linac capacity to inform business case and recruitment scheduling.	Q1-Q4: Continued engagement with regional hub on national Radiation Oncology Service Plan. Q1: Workforce modelling confirmed at a national level. Q2: Forecast modelling for increased linac capacity complete.
Continue the planned linear accelerator replacement programme, consistent with the DHB's performance support and Infrastructure capital programme.	Q1: Lessons learnt review on completed 2 x linac replacement program of work. Q4: Begin to prepare business case for replacement linac - due 2023.
Support key work streams to strengthen sustainability of the Medical Oncology Service: ▪ Workforce and team development. ▪ Sustainable tumour stream focus.	Q1: Medical Oncology Service delivery improvement metrics confirmed. Q2: Revised multidisciplinary model of care finalised.

▪ Multidisciplinary model of care development.	
Manage the delivery of the National Endoscopy Quality Improvement Programme (NEQIP) for New Zealand.	Q1: NEQIP resource in place to support the Programme. Q1: COVID-19 contingency plans endorsed. Q4: Delivery targets achieved.
New Zealanders experience equitable cancer outcomes – He taurite ngā huanga	
Seek to improve access to and rates of radiation therapy, particularly for Māori who have a higher cancer mortality rate than non-Māori. Support the Cancer and Regional Haematology Service to use service and population data to understand and optimize treatment delivery within system capacity.	Q2: Workforce modelling integrated into planning framework. Q3: Facilities plan has inclusion of future Linac requirements.
Participate in the Te Aho o Te Kahu travel and accommodation project to improve equity of access and support to cancer services/treatment within Canterbury and across the South Island. (EOA) Work to implement the recommendations of this project, particularly those that ensure equity of access for Māori and rural communities who currently experience greater barriers to accessing cancer services. (EOA)	Q1-Q4: Participation as required.
Collaborate with the Southern Hub and regional DHB partners to agree an action plan to address equity of outcomes following release of the national actions report from the Te Aho o Te Kahu Māori community-based hui being held in 2021. (EOA) Maintain a focus on engaging Māori and Pacific communities in the rollout of the National Bowel Screening Programme (NBSP) to ensure equity of access to diagnosis for priority populations. (EOA) Work with service leaders to ensure staff receive appropriate cultural competency training and introduce basic Te Reo into patient waiting areas to ensure patients are welcomed and made to feel comfortable and respected. (EOA) Implement use of the Health Inequalities Assessment Tool (HEAT) into Cancer and Regional Haematology Service design and delivery to reduce inequities for Māori and Pacific patients. (EOA)	Q2: NBSP has engaged with all priority communities (including the Chatham Islands). Q3: Regional workplan agreed. Q4: Staff have received cultural competency training. Q4: Demonstrated use of HEAT tools in service design and planning.
New Zealanders have fewer cancers – He iti iho te mate pukupuku	
Collaborate with local providers, Māori and Pacific communities and other health agencies to undertake activities that address the modifiable risk factor for cancer and promote screening and earlier intervention as referenced in the following sections: ▪ Healthy Food & Drink Environments (page 19). ▪ Smokefree 2025 (page 19). ▪ Reducing Alcohol Related Harm (page 20-21). ▪ Breast Screening (page 19-20). ▪ Cervical Screening (page 20). ▪ Bowel Screening (page 29). ▪ Long Term Conditions Management (page 34).	Refer to relevant section in Annual plan for actions and milestones to improvement performance in these areas.
New Zealanders have better cancer survival, supportive care and end-of-life care- He hiki ake i te o ranga	
Continue to implement and report progress against our Bowel Cancer Service Improvement Plan to improve performance against national waiting time standards for endoscopy services.	Q1-Q4: Recruitment of key position to support the delivery of services. Q1-Q4: Two temporary endoscopy suites commissioned to increase current capacity.
Revise and update our Bowel Cancer Quality Service Improvement Plan following publication of the second national Bowel Cancer Quality Improvement Indicators Monitoring Report (expected in quarter three of 2020-21).	Q3: Sector workshop to agree on Improvement Plan revisions. Q4: Clinical leadership endorsement of refreshed Improvement Plan.
Develop a Lung Cancer Service Improvement Plan based on the results of the February 2021 Lung Cancer Quality Improvement Monitoring Report and the national Lung Cancer Quality Improvement Plan (expected in quarter four 2020/21). Select the QPIs where our DHB is outside the national average to drive improvements. Ensure a strong equity focus, with incidence rates for Māori being significantly higher than non-Māori and health outcomes for Māori being significantly poorer. (EOA) Establish an annual programme of work for the Improvement Plan and a monitoring framework to track progress locally.	Q2: Sector working group formed. Q2: Audit of QPIs completed to support selection of focus areas. Q4: Clinical leadership endorsement of solutions and work programme. Q1-Q4: Ongoing engagement with regional hub on national and regional actions.

Develop a Prostate Cancer Service Improvement Plan based on the results of the Prostate Cancer Quality Improvement Monitoring Report (expected to be released in quarter three 2020/21). Establish a Prostate Cancer Service Improvement clinical governance group to select the QPIs where our DHB is outside the national average and to drive improvements. Hold a stakeholder workshop to co-design solutions to underperforming QPIs.	Q2: Group formed, and clinical lead endorsed to support national work. Q4: Clinical leadership endorsement of solutions and work programme. Q1-Q4: Ongoing engagement with regional hub on national and regional actions.
Use data intelligence systems to monitor (monthly) the 62-day and 31-day wait times for access to cancer treatment and undertake a breach analysis for every patient who waits longer than target, to identify any emergent systems or data issues and capture opportunities to reduce process delays. Work in partnership with Te Aho o Te Kahu and the Ministry of Health to ensure business rule changes for Faster Cancer Treatment (FCT) data are made as required. Use of the Quality Performance Indicator reports to direct actions to determine equity gaps, make improvements in pathways, increase supportive care and improve cultural resources for Faster Cancer Treatment. (EOA) Work with the Te Aho o Te Kahu Regional Hub to expand improvement work across other priority patient groups. (EOA)	Q1-Q4: Monthly and quarterly qualitative reports monitored for any system or data issues. Q1-Q4: Business rules applied as required. Q2: Identify priority patient cohorts and implement pathway improvement. Q3: Tracking of FCT wait times by ethnicity is live and visible. Q1-Q4: Continued delivery against the 62-day and 31-day wait time targets for all population groups.
Following release of national guidelines, and in partnership with clinicians and priority populations, develop a plan and process to support the implementation of the End-of-Life Choice Act from 7 November 2021 and ensure a dignified process for individuals, whānau and clinician teams.	Q2: Stakeholder consultation and engagement. Q3: Advice to Board on service impact for new requirements. Q1-Q4: Ongoing feedback to national leadership on implications and impact on services.
Review the impact of the COVID-19 lockdown on cancer diagnostic and treatment wait times and use this information to plan and manage future service volumes. In the event of a COVID-19 resurgence, implement the COVID-19 guidance developed by Te Aho o Te Kahu to ensure minimal impact for cancer patients and their whānau.	Q1-Q4: Monitor the impact of COVID-19 on cancer diagnostic and treatment services and use the national guidance to respond to any further resurgence, as required.

Planning Priority: Bowel screening and colonoscopy wait times	
Action to Improve Performance	**Milestone**
Track and monitor colonoscopy service wait times to identify and respond to areas of pressure and reduce waiting times following lockdown, with a focus on reducing long-waits and ensuring equity for our population. (EOA)	Q1-Q4: Quarterly progress against waiting times in line with the DHB's recovery plan.
Complete recruitment of replacement and additional staff to ensure the service has capacity to meet current and growing demand associated with the National Bowel Screening Programme.	Q1: Two new Senior Medical Officers (SMOs) take up their agreed positions. Q2: Recruitment of additional staffing including Registered Nurses, SMOs, Healthcare Assistants and Technicians.
Enhance production and leave planning, to better match capacity with demand throughout the year.	Q1: Production plan for 2021/22 confirmed.
In line with the recently approved business case, expand the footprint of colonoscopy services (internally) by two additional procedural rooms, planned with a 12-month phased approach, to increase the capacity to deliver colonoscopies in response to current wait-time challenges and growing demand associated with the implementation of the National Bowel Screening Programme.	Q1: First additional in-house procedure room open. Q3: Second additional in-house procedure room opens.
Confirm the ongoing outsourcing and outplacing capacity required to achieve national targets for colonoscopies, once new staff and first procedure room are in place.	Q2: Capacity contract reviewed.
Introduce a pre-assessment process for all colonoscopy patients to identify and mitigate barriers to attendance, and work in partnership with Māori and Pacific support workers to increase appointment attendance. (EOA)	Q2: Process in place. Q3: Attendance report identifies areas for system improvement.
Promote participation in the National Bowel Screening Programme with marketing and advertising in general newsletters, newspapers and local magazines – focusing on suburbs where our priority populations live. (EOA)	Q1-Q4: Marketing programme in place.
Engage directly with general practice and pharmacy to provide education and resources to support them to encourage their eligible populations to participate in the National Bowel Screening Programme.	Q1: All general practices visited.

Through the Equity Advisory Group, engage with Māori, Pacific and quintile five populations with face-to-face interaction, at community meetings, marae, churches and other events to encourage participation. (EOA)	Q1-Q4: Calendar of events in place and delivered against.
Provide earlier access to FTE kits for priority populations, to encourage uptake of the programme. (EOA)	Q1: Process in place and advertised.
Engage with the Ministry of Health to access screening data from the National Bowel Screening Register to support the provision of an outreach programme to follow-up non-participants, prioritising priority populations. (EOA)	Q1: Agreement reached on access to data to support outreach.
Track and monitor engagement with the National Bowel Screening Programme (NBSP) to identify areas where participation is low and work with the Equity Advisory Group and NBSP Steering Group to review and recalibrate strategies to meet targets. (EOA)	Q1: Monitoring in place. Q4: 60% of priority populations engaged in the NBSP.

Planning Priority: Health Workforce	
Action to Improve Performance	**Milestone**
In an international context; review the utilisation of the undergraduate nursing workforce during the COVID-19 response to inform the potential roles they might have in the continued response and any future events.	Q1: Literature review of nursing student's role during pandemic/disaster response circulated for consideration.
Recognise the vital role allied health assistants and dental therapists played in adopting PPE champion roles as part of the COVID-19 response and identify the role this workforce group can play in future resurgence planning.	Q1: Resurgence planning incorporates wider roles of allied health workforce.
Complete the trial of Blue Mirror Artificial Intelligence programme for donning and doffing PPE, to reduce healthcare worker supervision and exposure through a virtual buddy system.	Q3 Report on trial findings presented for consideration.
Work in partnership with our unions through our local Bipartite Action Group (BAG), to support the principles of constructive engagement, linking into local resurgence planning and when considering or developing any new initiatives to increase workforce flexibility and mobility.	Q1-Q4: Regular monthly updates presented to BAG meetings.
Collaborate with local health provider partners, the Ministry of Health and the national Immunisation Advisory Centre (IMAC) to assure and achieve: ▪ Increased visibility of the full vaccinator work force. ▪ Access to peer support and assessment. ▪ Clear pathways to becoming a vaccinator. ▪ Education on the cultural significance of vaccination. ▪ Cross fertilization of skills.	Q1: IMAC and DHB joint developed peer assessment vaccination simulation / CPR training in place. Q1-Q4: Comprehensive list of all vaccinators registered within Canterbury maintained.
Embed the recruitment diversity strategy introduced in 2020/21, by supporting Māori and Pacific job applicants, who meet the minimum requirements for positions, to advance to the interview stage, to promote and increase the diversification of our workforce. (EOA)	Q1: Strategy communicated to hiring managers. Q4: Impact of policy change reviewed.
Invest in the development of three new Equity and Diversity focused roles to support the DHB to attract, retain and develop our Māori health workforce and lift the cultural competency and equity focus across the DHB. (EOA)	Q1: Three new roles in place. Q4: Increase in the proportion of Māori in the DHB workforce. Q4: Cultural competency workshops underway
Engage our leaders in Te Huarahi Hautu, a comprehensive training programme for DHB people leaders, to equip them with the tools to reach their full potential, ensure they model behaviour that reflects our values and vison and build organisational competency in management. Key components are the Health Equity and How We Hire Around Here modules, aimed at upskilling hiring managers in recognising and responding to equity issues and in the technical aspects of the recruitment process to improve diversity in line with the policy above. (EOA)	Q1: Te Huarahi Hautu underway. Q3: Review of DHB leaders completing the Health Equity and How We Hire modules.
Working with the Executive Director of Māori Health, undertake an evaluation of leadership roles across the DHB to identify opportunities to improve the diversity of representation in decision-making positions. (EOA)	Q1: Evaluation completed. Q2: Actions to support increase diversity in leadership roles identified.
Deliver equity and outcomes training for all new nursing graduates at each Nursing Entry to Practice intake to raise awareness of the differences in health outcomes and ways to improve care for Māori patients and their whānau. (EOA)	Q1-Q2: Equity and outcomes training delivered. Q4: All new graduates complete the Understanding Bias in Health Care module.

Introduce a requirement for all nursing graduates to complete the Understanding Bias in Health Care module by the end of their first year of practice. (EOA)	
Relaunch the Code of Conduct to support professional behaviour and standards across the organisation, supported by training for staff and managers on bullying, harassment and restorative justice processes.	Q1: Refreshed Code of Conduct released. Q2: Training sessions and workshops underway.
Annual Staff Engagement Survey: Introduce regular staff engagement 'pulse' surveys to monitor and better understand the wellbeing, safety and motivation levels of our people and implement actions and strategies in response to the issues identified.	Q1: First baseline survey results released. Q2: Key actions identified and response strategies underway. Q3: Pulse survey completed to monitor impacts.
Partner with Wellbeing Health & Safety to assess the risk of workplace noise exposure and identify and implement strategies for mitigating/controlling this risk.	Q3: First noise surveys completed in Orthopaedics and Theatres. Q4. Key outcomes and recommendations of the review complete.
Implement workplace violence prevention and control strategies in line with national WorkSafe Guidance. The first stage of this programme is the trial of the Victorian 10-point plan within Adult Specialist Mental Health Services.	Q1: Strategies implemented in adult community SMHS. Q3: Strategies implemented in two further areas.
Develop and implement a DHB-wide Safe Moving and Handling Programme to reduce musculoskeletal injuries from moving and handling incidents, which make up half of all DHB ACC claims. Undertake a Hazardous Substances Review and prepare an Action Plan to reduce the risk to staff and patients.	Q3. Programme approved, and trainers employed. Q4. Training commenced in Older Person's Health and Rehabilitation Services. Q2: Hazardous Substances Review and Action Plan completed. Q4: Hazardous Substances Plan implemented.

Planning Priority: Data and digital enablement	
Action to Improve Performance	**Milestone**
Deploy the Virtual Private Network (AnyConnect) to laptops so DHB data can be securely accessed for remote working across different locations.	Q1: Roll-out complete.
Engage with service areas to increase adoption of Microsoft Teams technology, using Teams chat, task management and virtual meetings to support cross team engagement from different locations, reduce travel and support staff to work remotely in a major event.	Q4: Adoption of Microsoft Teams increases from 29%.
Deploy e-swab orders to Managed Isolation & Quarantine Facilities, Community Testing Stations and general practice, to ensure more rapid processing and traceability of COVID-19 samples and reporting to referrers and ESR and to lower the risk of transcription errors. Implement negative texting capability to report negative COVID-19 results and ensure timely reporting of negative results to patients during an outbreak.	Q1-Q4: Timely reporting of COVID-19 test results in line with national expectations.
Recommence the device replacement project for PCs, laptops and iPads and the conversion of some PCs to thin clients to ensure business compliance.	Q1-Q4: Deployment on target.
Recommence the rollout of the Citrix infrastructure to replace the legacy Virtual Desktop Infrastructure (VDI) environment to ensure business compliance. This includes increasing the number of VDI thin client hardware items to provide a more cost-effective solution for the DHB.	Q2: Balance of VDI infrastructure replaced. Q3: Terminal deployment completed.
Recommence planning to migrate the Regional Data Warehouse into the Cloud and introduce PowerBI as a data information solution for the organisation, to improve accessibility and interoperability of data across our wider health system.	Q4: Both systems in production.
Build on the work completed for e-referrals to refresh and confirm the system direction and continue to streamline the electronic referral of patients across our system.	Q1: Refreshed roadmap agreed.
Establish a single Microsoft tenancy between Canterbury and West Coast DHBs, to enable staff in both DHBs to work in either DHB location.	Q2: Tenancy established.
With the collaborative support of the Regional Chief Digital and Information Officer forum (South Island DHBs), investigate the development and delivery of a secondary care patient portal solution to support increased access for patients to their health information. (EOA)	Q2: Assess options. Q3: Business case presented.

Partner with Digital Wings to refurbish the DHB's old IT equipment for reuse in the community to support increased access to digital tools by community groups and people who might not otherwise have them. (EOA)	Q2&Q4: Report on use of DHB equipment in the community.
Utilise the national Digital Enablement funding for investment into the hardware required (computers, cameras, microphones) to support increased telehealth appointments so we provide greater access for people in locational disadvantaged communities and reduce travel for patients and clinical teams. (EOA)	Q2: Business case approved. Q3: Roll-out planned. Q4: Deployment of equipment to priority clinical areas.

Planning Priority: Implementing the New Zealand Health Research Strategy	
Action to Improve Performance	**Milestone**
Develop and launch a DHB research website (for internal and external users) with access to current research process and procedures, to ensure researchers can continue with research initiation and approval processes during periods of reduced access to the workplace.	Q2: Research website launched.
Actively engage in Ministry of Health and Health Research Council processes to strengthen capacity and capability for research across DHBs.	Q1: Participation in online information session.
Formalise the Transalpine Research Partnership with the West Coast DHB to create pathways for staff to engage in research and innovation and identify regional priorities for research activity.[10]	Q2: Partnership endorsed by Canterbury and West Coast Executive Teams.
Using the research activation grant, awarded by the Health Research Council in 2020/21, develop and establish the systems and frameworks needed to facilitate and grow future health delivery research. In doing so: Bring our health system and research partners, iwi, and Māori communities together to participate in a Collaboration Pilot to identify opportunities and pathways to support Hauora Māori health advancement through research. (EOA)	Q1: Individual meetings with research institutions in Canterbury underway.
Develop and implement a stratified approach to the approval of research that takes into consideration the size, scope and impact of applications, to free-up capacity to support those research projects or innovation initiatives that will have the greatest impact for our population.	Q2: Locality approval process available on CDHB research website.
Provide education sessions to potential researchers highlighting research funding opportunities and how to begin a research pathway.	Q3: Education session delivered.

2.9 Better Population Health Outcomes Supported by Primary Health Care

Planning Priority: Primary Care	
Action to Improve Performance	**Milestone**
Using the national digital enablement funding, to capture the momentum for change built up during the COVID-19 lockdown and support the increased uptake of telehealth and virtual services across primary care, through service and consumer engagement, transition to new tools, training and increased visibility of telehealth use and access. (EOA)	Q1: Update on application of funding. Q4: Report on uptake of telehealth and virtual services.
Continue to make available a range of COVID-19 testing options (e.g. general practice, testing sites, pop up clinics) to meet the needs of our population and ensure our system can cope with upsurges in demand for testing at times of elevated community anxiety.	Q1-Q4: Track demand and identify and response to pressure points as needed.
Collaborate with our primary and community partners to explore and implement clinically driven adjustments to the acute demand programme, aimed at addressing the growth in acute demand, and identifying and developing a sustainable and equitable service model to support our future population. *Refer also to the acute demand, rural health and long-term conditions sections of this plan for other key actions and changes in service and workforce models aimed at building capability and capacity in primary care over the coming year.*	Q1: Engagement with key partners and stakeholders. Q2: Priority areas of focus and strategies identified. Q4 Process of changes commenced/implemented.
Through the Canterbury Clinical Network, use the Manawhenua endorsed, Partnering in Design process to support stronger Māori input into the development of future strategies and service models. (EOA)	Q1-Q4: Use of the Partnering in Design process to support strategy and service design.

[10] This work was planned in 2020/21, but due to redeployment of staff to the COVID-19 response this was reprioritised to this year.

Through the Population Health & Access Service Level Alliance, complete the community engagement started in 2020/21, to support future investment in lifestyle services, to better support people to stay well and take greater responsibility for their own health and wellbeing. Focus on equity of access to services for Māori as a priority population in this space. (EOA)	Q1: Results of engagement considered, and principles developed for consideration. Q2: Future direction mapping underway.
Work in partnership with Pasifika Futures to build the capability and capacity to support our Pacific population including support for the Etu Pasifika healthcare clinic which provides integrated wrap around services for Pacific people and their families. (EOA)	Q1-4: Implementation of the Pacific Action Plan agreed in 2020/21.

Planning Priority: Pharmacy	
Action to Improve Performance	**Milestone**
In collaboration with primary health organisations, provide general practice with support and encouragement to connect to the NZ electronic Prescription Service (NZePS) and to implement systems for the secure transmission of digital scripts to pharmacies, minimising the inefficient handling of paper scripts and faxes, and improving access and experience for patients.	Q2: Messaging to motivate uptake of NZePS. Q4: 90% or more of practices have connected to NZePS.
Provide regular immunisation education to pharmacies to ensure authorised pharmacists are confident to vaccinate and understand the importance of reaching our priority populations. (EOA)	Q3: Education delivered to pharmacist vaccinators. Q4: Increase in the delivery of influenza vaccinations delivered by pharmacists.
Highlight pharmacy as an option in the newly developed Immunisation Engagement and Communications Plan, to help promote the delivery of immunisations by pharmacists and increase awareness of vaccination options for our priority and hard to reach populations. (EOA)	Q2: Communications Plan updated. Q4: Increase in the proportion of the population receiving an influenza vaccination – baseline Māori 54%, Total 66% (2020).
Engage with the Canterbury Community Pharmacy Group, to improve equity of access to Medicines Use Reviews (MURs) through the setting of a service level target for each pharmacy. (EOA) Report delivery against targets to the Pharmacy Service Level Alliance to identify equity gaps and opportunities for improvement.	Q1: MUR targets set. Q2-4: Delivery against targets reported quarterly to the Pharmacy Service Level Alliance.

Planning Priority: Reconfiguration of the National Air Ambulance Service Project – Phase Two	
Action to Improve Performance	**Milestone**
Maintain our commitment to the national plan to achieve a high functioning and integrated National Air Ambulance Service (NASO) and actively participate through the National Ambulance and Retrieval Quality and Safety Group (clinical governance) processes to achieve this. Support changed governance arrangements to improve the partnership with DHBs, MOH and ACC across all elements of the National Ambulance Sector Office (NASO) work programme and support the design and planning for tasking and coordination of aeromedical services.	Q1-Q4: Ongoing commitment maintained.
Work collaboratively to support the design of a flexible aero-medical workforce model that enables sustainable system improvements and supports service capacity in a COVID-19 impacted health system.	Q1-Q4: Ongoing commitment maintained.
As part of a national DHB working group, support the development of clinical and operational quality measures and KPIs for inter hospital transfers. Through the national DHB working group, endorse and implement the collection and reporting of the KPIs through the NASO performance monitoring and reporting system. Provide timely and accurate safety issue reporting to clinical and operational governance to support continuous quality improvement and inform national standard operational procedures.	Q1: KPI framework endorsed by DHBs. Q2: Data collection underway. Q4: National work programme delivering against KPIs.
Participate in a stocktake of clinical flight equipment and certifications to contribute to the development of inter-operability and compatibility recommendations for aircraft and stretcher systems.	Q4: National stocktake completed and recommendations agreed
Through the national DHB working group, seek to achieve health equity for rural and priority populations by undertaking a review to understand the challenges and improvements required. (EOA)	Q4: National review completed, and recommendations agreed.

Planning Priority: Long term conditions	
Action to Improve Performance	**Milestone**
Support Canterbury's three Primary Health Organisations (PHOs) to engage general practices in the Health Care Home (HCH) Programme to increase the number of practices implementing the core elements of the HCH model, improve outcomes for our population, and improve the sustainability of primary care business models.	Q1-Q4: Report cumulative growth in practices engaged.
Partner with Sport Canterbury to ensure Green Prescription (GRx) participants have a choice of activities that are relevant and appropriate for them, to increase engagement and the likelihood participants will maintain activities after discharge from the programme. (EOA) Reintroduce the follow-up survey to monitor engagement levels, particularly for priority populations. (EOA)	Q1: Participant survey reintroduced. Q4: Annual survey demonstrates GRx participants still undertaking physical activities 6 – 8 months after exiting the service.
PHOs will monitor page hits on web-based reporting tools, or alternative means, to connect with practices and understand and lift the level of engagement in using the dashboard viewers to identify patients requiring recall for smoking, healthy heart, diabetes or cervical screening monitoring or interventions.	Q1: Review underway. Q2: Data used to inform quality improvement and improve access to services. Q4: Lift in smoking, diabetes, and cervical screening rates across general practices.
Collaborate with Tangata Atumoto Trust, Sport Canterbury and Nurse Maude to develop and provide culturally appropriate education to a group of Pacific men who have a diagnosis of Type 2 Diabetes, as a priority population group. (EOA)	Q1: Education sessions delivered. Q3: Education sessions reviewed and expanded for the wider Pacific population.
In line with the regional Hepatitis C work plan, implement a pilot "test to treat" model utilising the point of care antibody test and portable rapid Polymerase Chain Reaction (PRC) testing, to enable earlier intervention and treatment.	Q4: Pilot underway.
Engage with PHOs and local service providers to support Pacific people in mid-Canterbury, including those presenting to the Acute Assessment Unit, to connect and enrol with a local general practice. (EOA)	Q1: Pegasus and Waitaha community health workers facilitate enrolment.
Through the Urgent Care Service Level Alliance, explore opportunities to reduce ambulatory sensitive (avoidable) hospital admissions by utilising a virtual ward concept in the community.	Q1: Feasibility of virtual ward concept considered. Q2-Q3: Areas of focus confirmed and explored. Q4: Proposal developed.
Contributory Measure PH03: Proportion of the population enrolled with a Primary Health Organisation.	Increase on 2019/20 baseline to >95% for all population groups: Māori: 91% Pacific 98% Total Population: 95%
Contributory Measure PH04: Proportion of the enrolled population who smoke who have been offered help to quit smoking by a health care practitioner in the past 15 months.	Increase on 2019/20 baseline to >90% for all population groups: Māori: 71% Pacific 70% Total Population: 73%

Managing Our Finances

The Canterbury DHB understands its fiscal responsibilities and we are committed to living within our means. Our projected statement of financial performance is shown below. Further detail on the DHB's financial outlook and assumptions for 2021/22 can be found in Appendix 5.

2.10 Prospective Statement of Financial Performance – to 30 June 2025

	2020/21 Unaudited Actual $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000	2024/25 Plan $'000
REVENUE					
Ministry of Health revenue (Note 1)	2,000,593	2,091,407	2,171,185	2,273,401	2,380,568
Other government revenue	61,022	65,127	66,624	68,165	69,753
Earthquake repair revenue redrawn	364	800	300	-	-
Other revenue	65,133	75,073	77,480	79,745	81,769
Total Revenue	**2,127,112**	**2,232,407**	**2,315,589**	**2,421,311**	**2,532,090**
EXPENSE					
Personnel	995,203	1,029,965	1,058,221	1,091,874	1,126,674
Outsourced personnel & clinical serrvices	35,597	57,640	47,743	42,877	39,060
Clinical supplies	170,704	172,737	176,032	181,070	186,609
Earthquake building repair costs	364	800	300	-	-
Infrastructure & non clinical	125,513	119,319	120,430	123,119	125,165
External service providers	844,188	851,785	854,613	875,976	897,875
Total Expense Before Depreciation & Capital Charge	**2,171,569**	**2,232,246**	**2,257,339**	**2,314,916**	**2,375,383**
Surplus/(Deficit) Before Depreciation & Capital Charge	**(44,457)**	**161**	**58,250**	**106,395**	**156,707**
Depreciation and amortisation	89,676	92,104	91,741	85,993	85,491
Capital charge and interest expense	42,080	57,064	63,471	69,188	70,296
Total Depreciation, Capital Charge & Interest Expense	**131,756**	**149,168**	**155,212**	**155,181**	**155,787**
Surplus/(Deficit)	**(176,213)**	**(149,007)**	**(96,962)**	**(48,786)**	**920**
OTHER COMPREHENSIVE REVENUE & EXPENSE					
Revaluation of property, plant & equipment	95,482	-	-	-	-
Total Comprehensive Income/(Deficit)	(80,731)	(149,007)	(96,962)	(48,786)	920

Note 1: Includes capital charge relief funding for Waipapa and asset revaluation, where applicable.

2.11 Prospective Financial Performance by Output Class – to 30 June 2025

	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000	2024/25 Plan $'000
Revenue				
Prevention	47,844	49,770	51,598	53,513
Early detection and management	463,728	466,730	482,645	499,365
Intensive assessment & treatment	1,399,537	1,464,996	1,541,285	1,621,139
Rehabilitation & Support	321,298	334,093	345,783	358,073
Total Revenue	**2,232,407**	**2,315,589**	**2,421,311**	**2,532,090**
Expenditure				
Prevention	49,927	51,139	52,277	53,497
Early detection and management	493,667	485,743	492,095	499,139
Intensive assessment & treatment	1,495,746	1,528,076	1,573,495	1,621,124
Rehabilitation & Support	342,074	347,593	352,230	357,410
Total Expenditure	**2,381,414**	**2,412,551**	**2,470,097**	**2,531,170**
Surplus/(Deficit)	(149,007)	(96,962)	(48,786)	920

Note: 'Early detection' changes in 2022/23 reflect completion of some planned Covid-19 services.

STEWARDSHIP

How are we managing our business to achieve our vision?

Managing Our Business

This section highlights how we will organise and manage our business to support the delivery of equitable, integrated, clinically sustainable and financially viable health services.

3.1 Partnering for better outcomes

Working collaboratively has enabled us to respond to the changing needs of our population and is a critical factor in achieving the goals and objectives in this Plan.

Recognising the wider influences that shape the health and wellbeing of our population, we partner with organisations and agencies from outside the health sector, investing in initiatives to improve outcomes for the most vulnerable in our community. This includes work with ACC, Corrections, Police, the Ministries of Social Development and Education, Oranga Tamariki, the national Whānau Ora Commissioning Agencies and local and regional councils.

In addition, the DHB's major strategic partnerships include:

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

Consumer Council: The DHB is committed to a culture that focuses on the patient and supports consumer participation in the design of services and strategies to improve health and wellbeing. This includes input into the work of our Alliance with consumers represented on work streams. The DHB also has a Consumer Council, where members ensure a strong and viable voice in health service planning and service redesign.

Clinical Partnerships: Clinical leadership is intrinsic to our success and a clinically-led management-enabled approach is embedded at all levels of our organisation, and across our local and regional alliances. The DHB also has a Clinical Board where members work together to influence the DHB's vision and play an important role in raising standards of patient care.

Manawhenua Ki Waitaha: We have a memorandum of understanding and strategic partnership with Manawhenua Ki Waitaha (as our Iwi Advisory Board), where we actively engage in the design and development of health strategies to support Māori aspirations for health and achieve equity of access and outcomes. Manawhenua Ki Waitaha members also bring a Māori perspective to the redesign of services and setting of strategic direction through participation in the Canterbury Clinical Network District Alliance.

Transalpine Partnership: Connecting the Canterbury and West Coast health systems is enabling more coordinated care and supporting more sustainable access to specialist services for our population. The two DHBs also share a Chief Executive, executive management team, clinical leads, corporate services teams and information systems.

Public Health Partnerships: Our Community & Public Health division takes the lead in the delivery of public health services for our population. Collective public health initiatives include: Waka Toa Ora, supporting community wellbeing and the Greater Christchurch Partnership, supporting, a 'health in all policies' approach.

South Island Regional Health Alliance: The Regional Alliance brings the region's five DHBs together to work collaboratively to develop more innovation and efficient health services. The South Island DHBs are currently working on a refocus and reset of priorities for the Regional Alliance to better support vulnerable services, address the inequities evident across our health system and respond to the recommendations of the National Health and Disability System Review.

3.2 Performance Management

To support good governance, we have an outcome-based decision-making and accountability framework that enables our stakeholders, Board and executive to monitor service performance and provide direction. We have also invested in the development of 'live data' systems where real-time operational information enables responsive decision making and planning.

At the broadest level, we monitor our health system performance against a core set of desired population outcomes, captured in our Statement of Intent and System Level Measures Improvement Plan. These frameworks define success from a population health perspective and are used as a means of evaluating the effectiveness of our investment decisions.

The DHB's service performance is monitored through quarterly and monthly reporting to our Board and to the Ministry of Health against key indicators aligned to the national DHB performance framework. This includes our quarterly Annual Plan and Māori and Pacific Health Dashboards reports.

Our service performance is also audited annually against our Statement of Performance Expectations (Appendix 4), the results of which are presented in our Annual Report available on our website.

3.3 Financial management

Canterbury DHB's key financial indicator is operating expenditure. This is monitored through quarterly and monthly reporting to our Executive Management Team, Chief Executive, Board and Ministry. The DHB's Board also has a Quality, Finance, Audit and Risk sub-

Committee which supports good financial governance and provides advice to the DHB's Board.

In common with DHBs across the country, the Canterbury DHB has found it increasingly difficult to achieve a breakeven position. However, we have made a strong commitment to reducing operating costs and living within our means.

Efficiencies are expected to be achieved through increased use of technology and automation, the transformation of our workforce and service delivery models and the delivery of process improvements. This includes process and procurement improvements and service changes delivered through our sustainability programme, Accelerating Our Future, to address growing cost pressures, reduce operating costs and prioritise investment.

Further information about the Canterbury DHB's planned financial position for 2021/22 and forecasts for out-years is contained in Appendix 5.

3.4 Continuous quality improvement

The Canterbury DHB is committed to health excellence, with a strong focus on service quality and system performance and using data and information to inform systematic improvement by teams and services. Working in partnership with patients and whānau is central to improved performance and we have made a commitment to using our inpatient experience survey results to improve the way we communicate with patients and their families.

The national Health Quality and Safety Commission (HQSC) Quality & Safety Markers supplement local performance framework and are used to monitor patient safety and track the effectiveness of improvement activity. We report results to our community in our Quality Accounts which can be found on our website.

Expectations for externally contracted services are aligned with national quality standards and auditing of contracted providers includes quality audits. We work with the other South Island DHBs, as a partner in the regional Quality & Safety Alliance, to implement quality and patient safety improvements.

3.5 Risk Management

The DHB has a formal risk management and reporting system which incorporates bi-monthly reporting of the high and extreme risks to the Executive Management Team. The high and extreme risks are also reported twice a year to the Board's Quality, Finance, Audit and Risk Committee and all risks are reported to the Committee once a year. The DHB is committed to managing risks in accordance with the latest in risk management standards with the DHB's Risk Management Policy and Framework being aligned with the components of the current ISO 31000:2018 Risk Management Standard.

3.6 Asset management

As at 30 June 2021 the total value of the DHB's asset portfolio, inclusive of capital work-in-progress (net accumulated depreciation and amortisation) was approximately $1.568 billion. We are accountable to Government for the financial and operational management of these assets and our capital intentions are updated annually to reflect changes in asset states and planned investment.

The DHB has developed and implemented an Asset Management Policy and Asset Management Strategy and has a five-year Asset Management Maturity Improvement Plan in place to embed a more strategic approach to asset maintenance, replacement and investment. We have also developed a Long Term Investment Plan with a ten-year outlook reflecting anticipated impact of changing patterns of demand and new models of care on future asset requirements.

A National Asset Management Plan is currently being developed by the Ministry of Health and this will help to inform our asset planning going forward.

3.7 Ownership interests

The Canterbury DHB has several ownership interests that support the delivery of health services including two operational subsidiaries, owned by the DHB.

Canterbury Linen Services Limited: provides laundry services to DHB hospitals and external commercial clients. The Canterbury DHB owns all shares.

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

South Island Shared Service Agency Limited: is an unlisted company, no longer trading or operating. The functions are conducted by the South Island Alliance Programme Office, via an agency agreement with the five South Island DHBs.

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

New Zealand Health Innovation Hub Limited: engages with clinicians and industry to develop, validate and commercialise health technologies and improvement initiatives that will deliver health and economic benefits to the system. Formerly a partnership between Canterbury, Counties Manukau, Waitemata and Auckland DHBs, Canterbury DHB now holds all the ownership interests.

Building Our Capability

3.8 Investing in our people

It has been a challenging ten years for our health system. The earthquakes have driven increased demand and the repair and redevelopment programme has been disruptive and stressful for many, with sick leave rates increasing markedly.

The DHB has committed to a People Strategy to positively motivate and support the health and wellbeing of our workforce. There is a strong commitment to making things better and, as a good employer, we promote equity, fairness and a safe, healthy workplace.

Workplace Health and Safety is integral to our organisation. We have strategic health and safety programmes and reviews underway to support the safety of our employees, including Safe Moving and Handling, Violence Prevention, Workplace Noise and Hazardous Substances reviews.

We also have a clear set of organisational values and operational policies to that effect, including our Equality, Diversity & Inclusion Policy and Wellbeing Policy. In the coming year we will relaunch our Code of Conduct and staff engagement survey and will implement the national Care Capacity Demand Management agreement by June 2021.

Future Health Workforce

In responding to our population challenges we recognise that our future workforce models will need to look different. We identify available talent and expand workforce capability through participation in the regional Workforce Development Hub, links with the education sector, support for scholarships, and clinical placements in our hospitals and participation in the national Kia Ora Hauora programme.

We have established a blended NetP Māori Initiative titled 'Korimako', in partnership with Pegasus Health and the Māui Collective. This includes annual funding for new graduate registered nurse positions as a sustainable pathway for building a Māori primary care registered nursing workforce. The DHB is also working on a long-term nursing workforce development plan, examining future nursing roles, pathways for advanced nursing, succession planning and increasing diversity.

In the past year we have released an Allied Health Strategy with a strong emphasis on a stepped model of care which supports a focus on wellbeing, prevention, early intervention and enablement. Workforce development is being supported through the evolution of our Calderdale Framework to enhance skill mix and opportunities for the development of sustainable interprofessional models of care. This will enable both Allied Health and Nursing Practitioners to work at top of scope and lead pathways where appropriate.

We also remain fully committed to providing a high standard of education and training for our Resident Medical Officers (RMOs) and meeting all our obligations and requirements for prevocational and vocational training. This includes establishment and ongoing support of clinical governance and operational structures and processes, such as the Medical Education and Training Unit, to support education and training for RMOs across the DHB.

In collaboration with the West Coast DHB, we are reviewing recruitment practices, particularly those that may unintentionally limit job placements for Māori applicants. The work of Te Tumu Whakarae (the National Māori GMs Group) will further inform our actions to improve equity and we will be evaluating the impact of this policy in 2021/22.

We are also working jointly to support the career aspirations of our people so that they can grow and develop. Te Huarahi Hautu is our new comprehensive training programme for DHB people leaders, to equip them with the tools to reach their full potential, ensure they model behaviour that reflects our values and vison and build organisational competency in management.

Key actions and activity to progress this work have been highlighted in Section 4 of this Annual Plan.

3.9 Investing in information systems

Connecting health information solutions is central to our vision of an integrated system and, by realising opportunities to improve clinical decision making and reduce waste and duplication, is a key factor in the future sustainability of our health system.

The South Island DHBs are working regionally to deliver on the national Digital Health Strategy and support the integration of patient information systems

and services across the South Island. The Canterbury DHB is committed to this approach and has taken a lead in rolling out regional information solutions that transform the way our people make requests, send referrals and share patient information including: HealthOne; Health Connect South; the Electronic Request Management System; and the South Island Patient Information Care System (SI PICS).

We are also leading the region in the development of a shared data warehouse that creates a platform for further developing 'big data' analytics to accurately predict and plan care at patient and system levels, resulting in better patient care and a more efficient system, maximising efficiency by supporting innovation in service and system redesign.

We continue to normalise the opportunities identified through our COVID-19 response to sustain and amplify positive changes to our work environment. Our focus areas include the deployment of Intune, wider adoption of collaboration tools such as Microsoft Teams and expanded use of Telehealth capability.

Further digital advancements will be pursued to improve patient care in the coming year including electronic orders and e-referrals. The DHB is also completing the upgrade of its digital hardware and legacy systems.

Key actions and activity to progress this work have been highlighted in Section 4 of this Annual Plan.

3.10 Investing in facilities

In the same way that workforce and information technology underpin and enable our transformation, health facilities can support or hamper the delivery and quality of the care we provide.

Our growing population, changing service demand patterns, and increasing regional service expectations mean capacity issues are an ongoing challenge and we are challenging ourselves to improve the flow of patients across our services and the wider system.

The completion of Waipapa (our acute services building) will allow us to capture efficiency savings by co-locating and consolidating services, integrating rosters and supporting more integrated service models. It will also enable the staged return of much of our outplaced and out-sourced services, considerably reducing our operating expenses in this regard.

Several other facilities related programmes of work are underway or awaiting approval to support the delivery of health care to our population.

Energy Centre Christchurch Hospital: The Boiler House servicing the Christchurch Hospital and Canterbury Health Laboratories is seismically compromised. Construction of the new Energy Centre is underway and practical completion is anticipated by mid-2022.

Mental Health Services Hillmorton Hospital: Construction is underway on the development of an Integrated Family Services Unit (incorporating Mothers and Babies, Eating Disorders, and Child and Adolescent inpatient services) and a separate High and Complex facility, both on the Hillmorton Hospital campus. This includes upgrading the facility development to a Green Star 4 rating, with the additional $2.8m from the New Zealand Upgrade Programme's clean powered public service funding. The DHB Board has also approved the repurposing the vacant ex-Canterbury Laundry building (owned by the DHB and adjacent to the Hillmorton Hospital campus) for the development of a Child and Adolescent Mental Health outpatient facility.

Planning to seismically strengthen and refurbish the building is underway. Both projects will support the migration of these mental health services from The Princess Margaret Hospital site, where they are currently located, and completion of all facilities is anticipated in late 2022.

A wider programme business case for Mental Health Services has been submitted to the Ministry of Health and the national Capital Investment Committee (CIC). The masterplan addresses the capacity and safety issues associated with the remainder of the service facilities, namely the Adult Inpatient Unit, and will enable a significant transformation in the service delivery model for mental health services.

Other Coordinated Campus Planning Works Christchurch Hospital: With the masterplan for the wider Christchurch Hospital Campus having been agreed with the Ministry of Health the DHB is also moving forward with the following:

Tower 3: In November 2020 the DHB received approval for the development of Tower 3, to be constructed on the Waipapa building, along with a series of enabling works to support continued service provision and support the future development of the wider campus. The construction of the Tower is being managed by the Ministry of Health and design is underway. Tower 3 is expected to be completed in 2023.

Building Compliance and Seismic Repairs: The relocation of services to Waipapa released space in other parts of Christchurch Hospital to enable us to move forward with outstanding building compliance requirements and seismic repairs. This is a longer-term programme of work and it is anticipated this will be completed in 2024.

Parkside: The compliance and seismic repairs do not include enhancement of clinical amenity in the Parkside facility, which has remained largely untouched since it was built in the late 1980s. A modest case for clinical enhancement of the Parkside facility wards has been submitted to CIC and we are working on a case for the renovation of the residual wards and Parkside theatres. As part of our future focus the DHB is also working on the development of a new facility for Canterbury's laboratory services and a new Cancer Centre.

Reconfiguring Services

3.11 Service coverage

Responsibility for ensuring service coverage is shared jointly between the DHB and the Ministry of Health and we are responsible for taking appropriate action to ensure that service coverage is delivered for our population, including those priority populations who may have high or differing needs.

In the current environment of increasing resource constraints and rising service demand, it is likely that service levels and access to services in some locations may have to be adjusted. The DHB identifies service coverage risk through the monitoring of performance indicators, risk reporting, formal audits, complaint mechanisms and the ongoing review of patient pathways and takes appropriate action to ensure service coverage is maintained.

We are not seeking any formal exemptions to the Service Coverage Schedule for 2021/22.

3.12 Service change

As we consolidate our new ways of working across new acute and outpatient facilities and embrace new virtual consultation, automation and clinical technologies, we expect that the configuration, scope, delivery model or location of some services will change.

We will be looking to ensure we are delivering service as effectively and efficiently as possible as part of our commitment to a more sustainable future and will seek to prioritise resources into the areas of greatest need, where we can make the biggest impact in terms of health outcomes for our population.

We also anticipate that new models of care will continue to emerge as we work with our primary and community partners and other South Island DHBs to enhance equity, improve the sustainability of our service models and address the evolving needs of our growing population.

Changes to services are always carefully considered, not only for the benefits they bring but also the impact they may have on other stakeholders. Consistent with our shared decision-making approach, we look to our clinically-led alliances, leadership groups and community for advice on the development of new services and service models and engage with the Ministry with regards to significant service change.

The DHB is permitted (pursuant to Section 24(1) and Section 25 of the NZPHD Act 2000), to negotiate, enter into or amend service agreements or arrangements to assist in meeting its objectives and goals. In doing so, we will seek to ensure any resulting agreements or arrangements do not jeopardise our ability to meet our statutory obligations or agreements with the Crown.

We will also manage our functions in a way that supports the intended direction and anticipated system change programme associated with the National Health and Disability System review.

Anticipated areas of service change, for the period of this Plan, are highlighted in the following table. The changes identified will require further consideration and discussion with staff, providers, the DHB's Board and the Ministry of Health as they are developed. Not all anticipated changes will progress.

Type of Change	Description of Anticipated Service Change and FTE impact	Anticipated Benefit	Driver
Establishment of a new service	COVID-19 Vaccination Services – The DHB will develop and support the development of new services for the provision of the COVID-19 vaccination programme in our region. These will have a fixed term focus and will impact on the DHB's FTE with additional people employed to support the programme and backfill staff seconded to the programme.	Protection of the population from the impacts of COVID-19.	National
Establishment of a new service	Rural Primary Care Services - The DHB will facilitate the construction and opening of an Integrated Family Health Centre on the Rangiora Health Hub site, to improve access to service for people living in North Canterbury.	Increased local capacity and service integration.	Local
Change in the model of service delivery and the location of services.	Maternity Services - The DHB will continue to implement the direction of travel outlined in its Maternity Strategy to better meet population needs through a more integrated and sustainable service model. This will result in the reconfiguration of maternity services to better meet demand, including the relocation of maternity services in Selwyn from Lincoln Hospital to the Selwyn Health and Social Services Hub in Rolleston.	Increased service integration and improved patient outcomes.	Local
Change in the model of service delivery.	Community Pharmacy Services - The DHB will continue to work with pharmacy providers to develop integrated, consumer-focused services in alignment with the national Pharmacy Action Plan, including the commissioning of pharmacies to provide influenza and MMR immunisations.	Increased service capacity, integration and improved patient outcomes.	National COVID

Type of Change	Description of Anticipated Service Change and FTE impact	Anticipated Benefit	Driver
Change in location and service provider.	Outplaced and Out-sourced Services - The DHB will seek to repatriate outplaced and out-sourced services back into our facilities as we bring our Waipapa services up to full capacity.	A reduction in outsourcing service costs.	Local
Change in location, service provider and potential reconfiguration of services.	Planned Care - In line with national direction the DHB will increase the focus on the provision of planned procedures in primary care settings. This may result in the reconfiguration of some services currently provided in hospital settings and alignment with intervention rates in other DHBs. The DHB will also pilot a non-surgical pathway for Gynaecology and, in line with the national Mobility Action Plan, support delivery of non-surgical interventions for people with musculoskeletal health conditions.	Improved access, earlier intervention and more sustainable service delivery.	National
Reconfiguration of the service delivery model.	Acute Demand Services - The DHB will support the development of new acute care guidance and a review of its investment in the Acute Demand Management Service, with a focus on optimising investment across urgent care services, targeting Māori, Pacific and populations of high need and reducing ED presentations and acute hospital admissions.	Increased equity, service sustainability and improved patient outcomes.	Local
Reconfiguration of the service delivery model.	Care Capacity Demand Management - The DHB will work towards full implementation of Care Capacity Demand Management, to better align workforce planning with service demand and patient acuity.	Consistent care and alignment of workforce with service demand.	National
Change in workforce and service delivery model.	Non-Clinical Support Services - As part of the Accelerating Our Future Programme, the DHB will capture opportunities to streamline and modernise clerical, administration and non-clinical systems and processes across the DHB including implementation of ServiceNow and robotics process automation proof of concepts in selected non-clinical support services areas to capture efficiencies and increase patient and employee value. This is likely to include a reconfiguration/reduction of FTE resources and/or a change in workforce mix in these areas.	Release of capacity, more cost effective and efficient service delivery and reduction in operating costs.	Local
Potential change in location, provider and service delivery model.	Home & Community Based Support Services – The DHB will complete the redesign of the model of care for home and community-based support services to respond to increasing demand and evolving need, including an increased focus of engagement with priority populations.	Increased service integration and more sustainable service delivery.	Local
Potential change in location, provider and service delivery model.	Hospital and Community Based Rehabilitation Services – The DHB will review the flow of patients across our hospital and community-based rehabilitation services and consider the reconfiguration of service models to meet increasing demand. This may result in a reduction in FTE and/or change in workforce mix in this area.	Increased service integration and more sustainable service delivery.	Local
Potential change in location, provider and service delivery model.	Primary, Community and Referred Services – The DHB will continue to review external service contracts and seek to prioritise resources into areas of greatest need and services that provide the greatest return on investment. This will include reduced investment in some service areas as the DHB seeks to reduce overall expenditure and reprioritise funding. The DHB will also be looking to improve service options and access for our priority populations including support for Kaupapa Māori service providers and actions in line with development of our Māori Health Improvement Plan.	Sustainable service delivery, increased equity of access and health outcomes and improved return on investment.	Local National
Potential change in location, provider and service delivery model.	Lifestyle Services – The DHB is considering its investment in lifestyle services to better understand the impact in this area and to improve engagement with priority populations. This is likely to involve investing differently and ceasing some investment in favour of different programmes and evidence-based initiatives that enhance equity of outcomes for our population.	Sustainable service delivery, increased equity of access and an improved return on investment.	Local
Potential change in location, provider and service delivery model.	Rural Health Services - The DHB will work with primary and community partners to review rural health service delivery to enhance the development of Hubs and afterhours service models, support capacity and capability across local service providers and make the best use of resources to ensure the long-term sustainability and service quality of services in rural areas. This may include service change consistent with contemporary models of care, alignment of resources with population demand and consideration of the future of the DHB's rural facilities.	Sustainable service delivery, increased equity of access and health outcomes and improved return on investment.	Local National

Potential change in the model of service delivery.	Outpatient, Primary Care and Public Health Services – The DHB will review traditional models of service based on face-to-face outpatient, general practice and health promotion activity and seek to support models that incorporate virtual and telehealth technologies. This will include capturing opportunities created through the national digital enablement and planned care improvement funding.	Increased flexibility and access and more cost effective, efficient service delivery.	Local COVID
Potential change in the model of service delivery.	Community Pharmacy Services – The DHB will engage with pharmacies to shift further prescription and pharmacy referral flows to digital transmission pathways, to enable timely low-contact healthcare.	Increased service flexibility and access and improved patient experience.	Local COVID
Potential change in the model of service delivery.	Pacific Health Services – The DHB will work in partnership with Etu Pasifika to provide community-based care for people with enduring mental health conditions. This will involve the design and implementation of a new mental health pathway for people on discharge from specialist services.	Improved service access, equity, patient experience and health outcomes.	Local
Potential change in location of services, and service delivery model.	Endoscopy Services - The DHB is considering options to support additional endoscopy capacity to meet future demand following implementation of the bowel screening programme in Canterbury. This may result in a change in location of services or a change in the model of service delivery.	Improved service access, shorter wait times and improved patient outcomes.	Local

Shifts or additions in workforce Full Time Equivalents (FTE)

Service	Description	FTE Increase	Driver
NICU	Increase in the NICU ward nursing roster to manage increased demand.	10	Local
Gastroenterology Oncology	Increase in FTE to manage increased impact of national bowel screening programme and growing oncology demand.	18	Local
Radiology	Increase in FTE to enable reduction of out-sourced services.	4	Local
Public Health	Increase in FTE to deliver new services funded by national funding stream.	4	National
Support Services and Facilities	Full Year FTE impact of in-sourcing cleaning services which occurred in 2020/21.	7	Local
Sustainability initiatives and Child Development	Increased fixed-term FTE to deliver new nationally funded initiatives.	10	National
Specialist Mental Health Services	Recruitment of existing vacant positions, as well as additional FTE to support new nationally funded services, including regional Hub and Spoke services.	20	National Regional Local
Laboratory Services	Increase in FTE to support demand for increased service provision.	10	Local
Acute Medical Overflow	Increase in FTE to manage the impact of increasing acute demand and acute medical admissions.	30	Local
Waipapa	Full-Year FTE impact of the move of services into Waipapa and the return of outplaced and out-sourced services.	81	Local
Subsidiaries	Net subsidiaries - includes new and additional service FTE.	20	Local
Organisational wide	Net CDHB Other – includes CCDM and recruitment of vacant positions across the DHB.	29	Local
Total BAU		243	
COVID-19	Fixed term and annualized FTE funded by the Ministry of Health to staff the Managed Isolation & Quarantine (MIQ) facilities and COVID-19 testing (excludes FTE movement associated with the delivery of the COVID-19 vaccination programme).	22	National
Total CDHB and Subsidiaries		265	

IMPROVING HEALTH OUTCOMES

Are we making a difference?

Monitoring Our Performance

4.1 Improving health outcomes

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

DHBs have several different roles and associated responsibilities. In our governance role we are concerned with health equity for our population and the sustainability of our health system. In our funder role, we strive to improve the effectiveness of the health system and the return on our investment. As an owner and provider of services, we are focused on the quality of the care we deliver, the efficiency with which it is delivered, the experience of the people we serve, and the safety and wellbeing of the people who work for us.

There is no single performance measure or indicator that can easily reflect the impact of our work and we cannot measure everything that matters for everyone. In line with our vision for the future of our health system, we have developed an overarching intervention logic and an outcomes framework which is highlighted in our Statement of Intent, available on our website.

The outcomes framework helps to illustrate our commitment to longer-term outcomes and our population health-based approach to performance improvement by highlighting the difference we want to make in the health and wellbeing of our population. It also encompasses national direction and expectations, through the inclusion of national targets and system level performance measures.

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

Aligned to each goal, we have identified several population health indicators which will provide insight into how well our system is performing over time. These indicators are also reflected in the DHB's System Level Measures Improvement Plan developed in partnership with our Alliance partners and available on our website.

4.2 Improving service performance

Over the shorter-term, we evaluate our service performance by monitoring ourselves against a forecast of the service we plan to deliver and the standards we expect to meet. This forecast is set out in our Statement of Performance Expectations (Appendix 4).

The DHB reports annually against the Statement of Performance Expectations, in our Annual Report which can be found on our website.

The DHB also reports quarterly against a set of key quality indicators and patient experience indicators established by the national Health Quality and Safety Commission. Some of these measures are reflected in the Statement of Service Performance, all can be found on the HQSC website www.hqsc.govt.nz.

The Intervention Logic Diagram (Appendix 3), illustrates how the services we fund or provide will impact on the health of our population. The diagram also demonstrates how our work contributes to the goals of the wider South Island region and delivers on expectations of Government.

4.3 Accountability to the Minister

The DHB's reporting obligations include quarterly service level performance reporting to the Ministry of Health, in line with the national non-financial performance monitoring framework.

This framework has been updated for 2021/22 to provide a line of sight between DHB activity and the health system priorities that support delivery of the Government's priority goals for New Zealand. The health and disability system has been asked to focus on the following health system priorities:

- Improving Child Wellbeing (CW)
- Improving Mental Wellbeing (MH)
- Improving Wellbeing through Prevention (PV)
- Better population health outcomes supported by a Strong and equitable public health System (SS)
- Better population health outcomes supported by Primary Health Care (PH).

The national framework and the standards expected for 2021/22 are set out on the following pages.

National DHB Performance Framework 2021/22

Performance Measure		Performance Expectation		
Improving Child Wellbeing				
CW01	Children caries free at 5 years of age		Year 1	67.4%
			Year 2	67.4%
CW02	Oral health: Mean DMFT score at school year 8		Year 1	<0.70
			Year 2	<0.70
CW03	Improving the number of children enrolled and accessing Community Oral Health services	Children Enrolled: ≥95% of pre-school children (aged 0-4) will be enrolled in the Community Oral Health Service	Year 1	>=95%
			Year 2	>=95%
		Children Examined According to Planned Recall: ≤10% of pre-school and primary school children enrolled with the Community Oral Health Service will be overdue for their scheduled examinations with the Community Oral Health Service.	Year 1	<=10%
			Year 2	<=10%
CW04	Utilisation of DHB funded dental services by adolescents from School Year 9 up to and including 17 years		Year 1	>=85%
			Year 2	>=85%
CW05	Immunisation coverage	95% of eight-month-olds fully immunised.		
		95% of five-year-olds have completed all age-appropriate immunisations due between birth and five years of age.		
		75% of girls and boys fully immunised – HPV vaccine.		
		75% of 65+ year olds immunised – Influenza vaccine.		
CW06	Child health (breastfeeding)	70% of infants are exclusively or fully breastfed at three months.		
CW07	Newborn enrolment with General practice	The DHB has reached the Total population target for children enrolled with a general practice by six weeks of age (55%) and by three months of age (85%), has delivered all the actions and milestones identified for the period in its annual plan and has achieved significant progress for its Māori population group, and (where relevant) the Pacific population group, for both targets.		
CW08	Increased immunisation at two-years	95% of two-year olds have completed all age-appropriate immunisations due between birth and age two years.		
CW09	Better help for smokers to quit (maternity)	90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.		
CW10	Raising healthy kids	95% of obese children identified in the Before School Check (B4SC) programme are offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions.		
CW12	Youth mental health initiatives	Focus Area 1: Youth Service Level Alliance Team – provide reports as required.		
		Focus Area 2: School Based Health Services – provide reports as required.		
		Focus Area 3: Youth Primary Mental Health Services – refer MH04		
Improving Mental Wellbeing				
MH01	Improving the health status of people with severe mental illness through improved access	Age (0-19) Māori, Other & Total	>3.1% access specialist services	
		Age (20-64) Māori, Other & Total	>3.1% access specialist services	
		Age (65+) Māori, Other & Total	>3.0% access specialist services	
MH02	Improving mental health services using wellness and transition (discharge) planning	95% of clients discharged will have a quality transition or wellness plan.		
		95% of audited files meet accepted good practice.		
MH03	Shorter waits for mental health services for under 25-year olds.	Provide reports as specified.		
MH04	Rising to the Challenge: The Mental Health and Addiction Service Development Plan	Provide reports as specified.		
MH05	Reduce the rate of Māori under the Mental Health Act: Section 29 Community Treatment Orders	Reduce the rate of Māori under the Mental Health Act (s29) by at least 10% by the end of the reporting year.		
MH06	Output delivery against plan	Volume delivery for specialist Mental Health and Addiction services is within 5% variance (+/-) of planned volumes for services measured by FTE; 5% variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day; actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan.		
MH07	Improving the health status of people with severe mental illness through improved acute inpatient post discharge community care.	Provide reports as specified.		

Improving wellbeing through prevention				
PV01	Improving breast screening coverage and rescreening		70% coverage for all ethnic groups and overall.	
PV02	Improving cervical screening coverage		80% coverage for all ethnic groups and overall.	
Better population health outcomes supported by strong and equitable public health and disability system				
SS01	Faster cancer treatment -31-day indicator		85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.	
SS03	Ensuring delivery of Service Coverage		Provide reports as specified.	
SS04	Delivery of actions to improve Wrap Around Services for Older People		Provide reports as specified.	
SS05	Ambulatory Sensitive Hospitalisations (ASH adult)		<2,298 per 100,000 people (September 2020)	
SS07	Planned Care Measures	Planned Care Measure 1: Planned Care Interventions	TBC	
		Planned Care Measure 2: Elective Service Patient Flow Indicators	ESPI 1	100% (all) services report Yes (that more than 90% of referrals within the service are processed in 15 calendar days or less)
			ESPI 2	0% – no patients are waiting over four months for FSA
			ESPI 3	0% - zero patients in Active Review with a priority score above the actual Treatment Threshold
			ESPI 5	0% - zero patients are waiting over 120 days for treatment
			ESPI 8	100% - all patients were prioritised using an approved national or nationally recognised prioritisation tool
		Planned Care Measure 3: Diagnostic waiting times	Coronary Angiography	95% of patients with accepted referrals for elective coronary angiography receive their procedure within three months (90 days)
			Computed Tomography	95% of patients with accepted referrals for CT scans receive their scan, and scan results are reported, within six weeks (42 days).
			Magnetic Resonance Imaging	90% of patients with accepted referrals for MRI scans receive their scan, and scan results are reported, within six weeks (42 days).
		Planned Care Measure 4: Ophthalmology Follow-up Waiting Times	No patient will wait more than or equal to 50% longer than the intended time for their appointment. The 'intended time for their appointment' is the recommendation made by the responsible clinician of the timeframe in which the patient should next be reviewed by the ophthalmology service.	
		Planned Care Measure 5: Cardiac Urgency Waiting Times	All patients (both acute and elective) will receive their cardiac surgery within the urgency timeframe based on their clinical urgency.	
		Planned Care Measure 6: Acute Readmissions	The proportion of patients who were acutely readmitted post-discharge improves from base levels.	<=11.2 (September 2020)
		Planned Care Measure 7: Did Not Attend Rates for First Specialist Assessment by Ethnicity (Developmental)	Note: There will not be a Target Rate identified for this measure. It will be developmental for establishing baseline rates in the 2020/21 year.	
SS09	Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections	Focus Area 1: Improving the quality of data within the NHI	New NHI registration in error (causing duplication)	>2% to <=4%
			Recording of non-specific ethnicity in new NHI registration	>0.5% and < or equal to 2%
			Update of specific ethnicity value in existing NHI record with a non-specific value	>0.5% and < or equal to 2%
			Validated addresses excluding overseas, unknown and dot (.) in line 1	>76% and < or equal to 85%
			Invalid NHI data updates	Expectations TBC by MoH
		Focus Area 2: Improving the quality of data submitted to National Collections	NPF collection has accurate dates and links to NNPAC and NMDS for FSA and planned inpatient procedures.	Greater than or equal to 90% and less than 95 %
			National Collections completeness	Greater than or equal to 94.5% and less than 97.5%
			Assessment of data reported to the NMDS	Greater than or equal to 85% and less than 95%

		Focus Area 3: Improving the quality of the Programme for the Integration of MH data (PRIMHD)	Provide reports as specified
SS10	Shorter stays in Emergency Departments		95% of patients will be admitted, discharged or transferred from an emergency department (ED) within six hours.
SS11	Faster Cancer Treatment (62 days)		90% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.
SS12	Engagement/obligations as a Treaty partner		Reports provided and obligations met as specified.
SS13	Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)	Focus Area 1: Long term conditions	Report on actions, milestones and measures to support people with LTC to self-manage and build health literacy.
		Focus Area 2: Diabetes services	Report on the progress made in self-assessing diabetes services against the Quality Standards for Diabetes Care.
			Ascertainment: target 95-105% and no inequity
			HbA1c<64mmols: target 60% and no inequity
			No HbA1c result: target 7-8% and no inequity
		Focus Area 3: Cardiovascular health	Provide reports as specified
		Focus Area 4: Acute heart service	Indicator 1: Door to cath - Door to cath within three days for >70% of ACS patients undergoing coronary angiogram.
			Indicator 2a: Registry completion- >95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days of discharge and Indicator 2b: ≥ 99% within three months.
			Indicator 3: ACS LVEF assessment- ≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF (i.e. an echocardiogram or LVgram).
			Indicator 4: Composite Post ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication/intolerance >85% of ACS patients who undergo coronary angiogram should be prescribed, at discharge - Aspirin*, a 2nd anti-platelet agent*, and a statin (3 classes); ACEI/ARB if any of the following – LVEF ,50%, DM, HT, in-hospital HF (Killip Class II to IV) (4 classes), Beta-blocker if LVEF<40% (5-classes). *An anticoagulant can be substituted for one (but not both) of the two anti-platelet agents.
			Indicator 5: Device registry completion- ≥ 99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS QI Device forms within two months of the procedure.
			Indicator 6: Device registry completion- ≥ 99% of patients who have pacemaker or implantable cardiac defibrillator implantation/replacement have completion of ANZACS QI Device PPM (Indicator 5A) and ICD (Indicator 5B) forms within two months of the procedure.
		Focus Area 5: Stroke services	Indicator 1 ASU: 80% of stroke patients admitted to a stroke unit or organised stroke service, with a demonstrated stroke pathway within 24 hours of their presentation to hospital
			Indicator 2: Reperfusion Thrombolysis /Stroke Clot Retrieval 12% of patients with ischaemic stroke thrombolysed and/or treated with clot retrieval and counted by DHB of domicile, (Service provision 24/7)
			Indicator 3: In-patient rehabilitation: 80% of patients admitted with acute stroke who are transferred to in-patient rehabilitation services are transferred within 7 days of acute admission
			Indicator 4: Community rehabilitation: 60 % of patients referred for community rehabilitation are seen face-to-face by a member of the community rehabilitation team within 7 calendar days of hospital discharge.
SS15	Improving waiting times for Colonoscopy	90% of people accepted for an urgent diagnostic colonoscopy receive (or are waiting for) their procedure in 14 calendar days or less, 100% within 30 days or less.	
		70% of people accepted for a non-urgent diagnostic colonoscopy receive (or are waiting for) their procedure in 42 calendar days or less, 100% within 90 days or less.	
		70% of people waiting for a surveillance colonoscopy receive (or are waiting for) their procedure in 84 calendar days or less of the planned date, 100% within 120 days or less.	
		95% of participants who returned a positive FIT have a first offered diagnostic date that is within 45 calendar days of their FIT result being recorded in the NBSP IT system.	

SS17	Delivery of Whānau Ora	Appropriate progress identified in all areas of the measure deliverable.
Better Population Health Outcomes Supported by Primary Health Care		
PH01	Delivery of actions to improve system level measures (SLMs)	Provide reports as specified.
PH02	Improving the quality of ethnicity data collection in PHO and NHI registers	All PHOs in the region have implemented, trained staff and audited the quality of ethnicity data using EDAT within the past three-year period and the current results from Stage 3 EDAT show a level of match in ethnicity data of greater than 90%.
PH03	Access to Care (PHO Enrolments)	The DHB has an enrolled Māori population of 95% or above.
PH04	Primary health care: Better help for smokers to quit (primary care)	90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months
Other Requirements		
Annual plan actions – status update reports		Provide reports as specified.

APPENDICES

Further Information

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Appendices

Appendix 1	Glossary of Terms
Appendix 2	Minister of Health's Letter of Expectation 2021/22
Appendix 3	Overarching Intervention Logic Diagram
Appendix 4	Statement of Performance Expectations 2021/22
Appendix 5	Statement of Financial Performance 2021/22
Appendix 6	System Level Measures Improvement Plan 2021/22

Documents of interest

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

- Canterbury DHB Statement of Intent
- Canterbury System Level Measures Improvement Plan
- Canterbury Disability Action Plan

References

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

Appendix 1 Glossary of Terms

ADMS	Acute Demand Management Service	Refers to the service whereby general practice and acute community nursing deliver packages of care that enable people who would otherwise need an ED visit or hospital admission to be treated in the community or in their own homes.
	Baby Friendly Hospital Initiative	A worldwide programme led by the World Health Organization and UNICEF to encourage a high standard of care. An assessment/accreditation process recognises the standard.
CCN	The Canterbury Clinical Network District Alliance	The CCN is a collective alliance of healthcare leaders, professionals and providers from across the Canterbury Health System. The Alliance provides leadership to enable the transformation of the health system in collaboration with system partners and on behalf of the population.
CREST	Community Rehabilitation Enablement and Support Team	Community Rehabilitation Enablement and Support Team supports the frail elderly who would otherwise be re-admitted to hospital or residential care. The Team is a collaboration across primary and secondary services and has been instrumental in reducing acute demand for hospital services and rates of aged residential care.
ERMS	Electronic Referral Management System	ERMS is available from the GP desktop, and enables referrals to public hospitals and private providers to be sent and received electronically. Developed in Canterbury, it is now being rolled out South Island-wide and has streamlined the referral process by ensuring referrals are efficiently directed to the right place and receipt is acknowledged.
ESPIs	Elective Services Patient flow Indicators	The Elective Services Patient flow Indicators are a set of six indicators developed by the Ministry of Health to measure whether DHBs are meeting required performance standards in terms of the delivery of elective (non-urgent) services including wait times from referral to assessment and wait times from decision to treatment.
	Health Connect South	A shared regional clinical information system that provides a single repository for clinical records across the South Island. Already implemented in Canterbury, West Coast and South Canterbury, it is being rolled out across the rest of the South Island.
interRAI	International Resident Assessment Instrument	A suite of geriatric assessment tools that support clinical decision making and care planning by providing evidence-based practice guidelines and ensuring needs assessments are consistent and people are receiving equitable access to services. Aggregated data from the assessments is also used as a planning tool to improve the quality of health services and better target resources across the wider community according to need.
	Manawhenua Ki Waitaha	The Manawhenua Advisory Group made up of the manawhenua health advisors mandated by the Papatipu Rūnanga as the Te Tiriti o Waitangi partners to the Canterbury DHB. Manawhenua Ki Waitaha works independently and alongside the DHB to develop and implement strategies for Māori health gain, support the delivery of health and disability support services consistent with Māori cultural concepts, values, and practices, and support Māori aspirations for health, reducing inequalities between Māori and other New Zealanders.
NHI	National Health Index	An NHI number is a unique identifier assigned to every person who uses health and disability services in NZ.
PHO	Primary Health Organisation	Funded by DHBs, PHOs ensure the provision of essential primary health care services to people who are enrolled with them, either directly or through their provider members (general practice). The aim is to ensure general practice services are better linked with other health services to ensure a seamless continuum of care.
PRIMHD	Programme for the Integration of Mental Health Data	The Ministry of Health's national mental health and addiction information collection holding both activity and outcomes data collected from DHBs and non-governmental organisations. PRIMHD is part of the Ministry's national data warehouse.
	Public Health Services	The science and art of preventing disease, prolonging life and promoting health and efficiency through organised community effort.
SIAPO	South Island Alliance Programme Office	A project office that supports the five South Island DHBs to work together to support the delivery of clinically and financially sustainable service across the South Island.
	Tertiary Care	Very specialised care often only provided in a small number of locations.

Appendix 2 Minister of Health's Letter of Expectation

Hon Andrew Little

Minister of Health
Minister Responsible for the GCSB
Minister Responsible for the NZSIS
Minister for Treaty of Waitangi Negotiations
Minister Responsible for Pike River Re-entry

10 FEB 2021

Sir John Hansen
Chair
Canterbury District Health Board
John.Hansen@cdhb.health.nz

Tēnā koe Sir John

Letter of Expectations for district health boards and subsidiary entities for 2021/22

This letter sets out the Government's expectations for district health boards (DHBs) and their subsidiary entities for 2021/22. As a DHB Chair you are accountable to me for meeting these expectations.

This government acknowledges the progress made to rebuild our health system, but there is still more to do. It is clear that COVID-19 will be placing a range of pressures on our health system for some time. We are well placed to continue to respond to resurgence as needed and to lock-in new ways of operating based on our COVID-19 response so that we retain and embed new and innovative approaches where possible.

A safe and effective vaccine for COVID-19 is an essential part of how we protect our communities, and this will be a key piece of work for the health system during 2021/22. Additional information will be provided when it becomes available.

As you know the Government has accepted the high-level direction of travel of the Health and Disability System Review (HDSR) and during this next phase we will roll out our plan to improve the public health system to ensure it delivers high quality services, improved equity for our vulnerable populations and supports better outcomes for all New Zealanders.

There will be uncertainty ahead, but I expect that this will not stop you from driving forward and continuing to deliver the improvements already underway. It is important that the sector continues to function at its best to provide health and disability services for New Zealanders while system changes are being confirmed and implemented. I also expect that you will begin to work together on further enhancements. The work we do now will ensure we have the right models of care to support longer term sustainability and to maximise outcomes through robust investment in primary and community care.

The priorities this Government has previously outlined to guide DHB planning will remain of critical importance for the coming year. Our wellbeing and equity system priorities together with a focus on giving practical effect to Whakamaua: the Māori Health Action Plan 2020-2025 and improvements to DHB sustainability, continue to provide a solid framework for planning and articulating the work DHBs are doing:

- giving practical effect to Whakamaua: the Māori Health Action Plan 2020-2025
- improving sustainability
- improving child wellbeing
- improving mental wellbeing including a focus on the transformational direction for our approach to mental health and addiction through the agreed actions from the Mental Health and Addiction Inquiry

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- improving wellbeing through prevention;
- better population outcomes supported by a strong and equitable public health and disability system
- better population health and outcomes supported by primary health care.

I would like you to continue to build on these areas of focus, so we improve equity for our vulnerable populations while also ensuring COVID-19 lessons and innovations are captured.

I expect all DHBs to deliver breakeven results by the end of 2021/22 and your annual plan will not be supported without this commitment. Strong fiscal management is critical to support our collective ability to invest more in new models of care and in primary care and population prevention approaches.

It is also imperative that the health system maintains and continues to strengthen our health capital planning, investment and delivery and as Chair you must have clear oversight of the DHB's annual plan to ensure it is sustainable, person centred and reflects Government expectations, including breakeven financial targets.

As you will be aware the Government will be implementing recommendations from the Health and Disability system review. This work will be undertaken alongside the work laid out in this letter. I expect that all DHB's will continue to provide the highest quality services to their populations while any changes are implemented across the system.

A number of DHBs will benefit from expert support across a range of areas and I understand that Chairs are working on an exemplars group. I expect you to seek the support of your colleagues and the Ministry where you need a lift in capability or support to navigate specific challenges.

This Government has provided specific sustainability funding for DHB led improvement projects. I expect to see tangible outcomes being delivered and implemented with this funding and reports on the impact it is having.

You will be aware that pay parity for workforces in the DHB-funded sectors is an issue. This is also an issue in other parts of the State sector, and it is important that a whole-of-Government approach is taken. This Government's position will be developed at a central agency level and I expect you to contribute to and act consistently with this approach. There are complex matters that need careful consideration, including whether DHB funding has flowed equitably to employees in the past and how this would be protected in the future.

I expect all DHBs to increase the pace and scale of implementation of the Care Capacity Demand Management Programme (CCDM) in 2021 to meet the expectations outlined in the 2018 NZNO DHB MECA. I want to be clear that full implementation of CCDM includes annual FTE calculations and ensuring agreed budgeted nursing and midwifery FTE are in place.

DHBs are responsible for the health outcomes for your population and it is important that DHBs and the Ministry continue to work together, and with primary and community providers, to ensure we have a strong and equitable public health system delivering better health outcomes for our most vulnerable populations who have long-standing health inequities.

Please ensure any approaches to a service reconfiguration support improved access to care and equity, and are financially sound. As you are aware any shifts or additions in workforce / FTE must be considered as a service change and follow service change processes. DHBs

must remain focused and prepared for increased pressure and ensure systems are in place to ensure COVID-19 innovations are used to avoid pressure building up on existing services.

DHBs are expected to support and contribute to the Ministry's National Asset Management Programme (NAMP), which will be used to assist the Capital Investment Committee and Ministers to make more informed decision on DHB capital expenditure. I expect DHBs to develop their own Asset Management Policy and Strategy and align their asset management
istry of Health district health board sector Asset Management

Unlike previous years I have strong expectations that the annual planning process will be completed on time and as Chair it is your responsibility to meet all deadlines for this process. I expect a strong first draft annual plan will be provided to the Ministry for review in early March so that a robust final plan that meets all expectations will be able to be agreed with me as early as possible post Budget 21. If timelines are not met and robust and appropriate plans are not delivered I will not be able to sign them off for the year.

Please note that I do not require you to refresh your Statement of Intent for 2021/22.

We face complex challenges that require collective approaches and I am looking forward to working with you as we continue our efforts to improve outcomes for New Zealanders.

Thank you for the work you have been doing to provide strong governance within our health system. I remind you that in everything you do you are part of the system.

Ngā mihi nui

Hon Andrew Little
Minister of Health

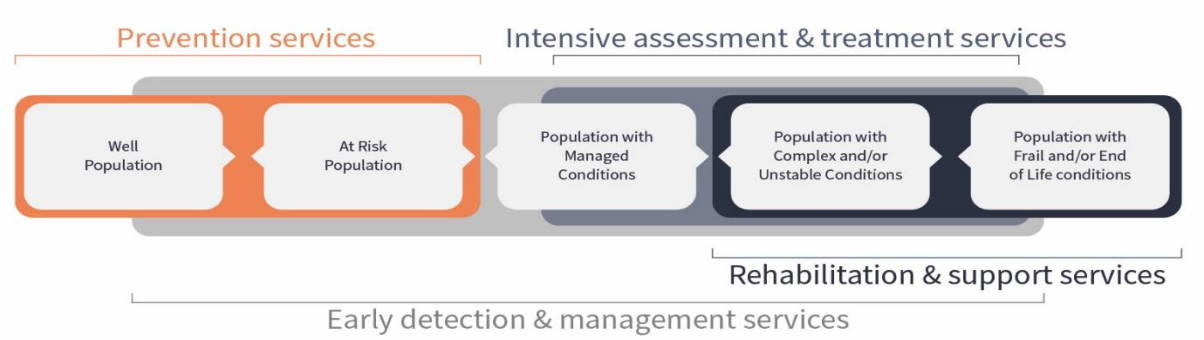
Cc Dr Andrew Brant
Chief Executive
Canterbury District Health Board

Appendix 3 Overarching Intervention Logic Diagram

Te Tiriti O Waitangi

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

Appendix 4 Statement of Performance Expectations



Evaluating our performance

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

Having a limited pool of resources and faced with growing demand for health services and increasing fiscal pressures, we are strongly motivated to ensure we are delivering effective and efficient services.

Over the longer term, we evaluate the effectiveness of our decisions by tracking the health of our population against a set of desired population health outcomes. These longer-term outcomes are highlighted in the DHB's Statement of Intent.

On an annual basis, we track our performance against an annual Statement of Performance Expectations, our forecast of the services we plan to deliver and the standards we expect to meet. The results are presented in our Annual Report at the end of the year.

The following section presents the Canterbury DHB's Statement of Performance Expectations for 2021/22.

IDENTIFYING PERFORMANCE MEASURES

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

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

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

It is important to include a mix of service measures under each service class to ensure a balanced, well-rounded picture and provide a fair indication of how well the DHB is performing.

The mix of measures identified in our Statement of Performance Expectations addresses the five key aspects of service performance we believe are most important to our community and stakeholders:

Access (A)
Are services accessible, is access equitable, are we engaging with our population?

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

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

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

SETTING STANDARDS

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

Targets reflect the strategic objectives of the DHB: increasing the reach of prevention programmes; reducing acute or avoidable hospital admissions; and maintaining access to services - while at the same time reducing waiting times and delays in treatment. We also seek to improve the experience of people in our care, increase equity of access and health outcomes and increase public confidence in our health system.

In considering our drive towards equity, performance targets are universal, set with the aim of reducing disparities between population groups. Key focus areas have been identified to improve Māori and Pacific health and breakdowns by ethnicity are aligned to each of these measures.

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

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

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

PERFORMANCE EXPECTATIONS

The pressures on our system in 2021/22 will be compounded by our ongoing response to the COVID-19 pandemic. Over the coming year we will have to engage our public health, general practice, vaccination teams and community providers in supporting the COVID-19 vaccination programme and the DHB will need to continue to support Managed Isolation and Quarantine Facilities and COVID-19.

There is a risk that the redeployment and shift of staff to support the COVID-19 vaccination programme will have some impact on the delivery of other prevention, immunisation and screening services. Depending on how the pandemic plays out in New Zealand we may have to respond to an escalation of events. If another lockdown is imposed, we will expect a far greater impact on service delivery right across our system.

NOTES FOR THE READER

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

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

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

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

Where does the money go?

In 2021/22 the DHB will receive approximately $2.232 billion dollars with which to purchase and provide the services required to meet the needs of our population.

The table below presents a summary of our anticipated financial position for 2021/22, split by service class.

	2021/22 $'000
Revenue	
Prevention	$47,844
Early detection & management	$463,728
Intensive assessment & treatment	$1,399,537
Rehabilitation & support	$321,298
Total Revenue	$2,232,407
Expenditure	
Prevention	$49,927
Early detection & management	$493,667
Intensive assessment & treatment	$1,495,746
Rehabilitation & support	$342,074
Total Expenditure	$2,381,414
Surplus/(Deficit)	($149,007)

Prevention services

WHY ARE THESE SERVICES SIGNIFICANT?

Preventative health services are those that promote and protect the health of the whole population, or targeted sub-groups, and influence individual behaviours by targeting changes to physical and social environments to engage, influence and support people to make healthier choices. These services include: the use of legislation and policy to protect the population from environmental risks and communicable disease; education programmes and services to raise awareness of risk behaviours and healthy choices; and health protection services such as immunisation and screening programmes that support people to modify lifestyles and maintain good health.

By supporting people to make healthier choices, we can reduce the major risk factors that contribute to poor health such as smoking, poor diet, obesity, lack of physical exercise and hazardous drinking. High-need population groups are more likely to engage in risky behaviours or live in environments less conducive to making healthier choices. Prevention services are therefore one of our foremost opportunities to target improvements in the health of high-need populations and reduce inequities in health status and health outcomes. Prevention services are also designed to spread consistent messages to large numbers of people and can therefore also be a very cost-effective health intervention.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Population Health Services – Healthy Environments					
These services address aspects of the physical, social and built environment to protect health and improve health outcomes.	Note	Target Group	2018/19 Results	2019/20 Results	2021/22 Target
Number of submissions providing strategic public health input and expert advice to inform policy in the region and/or nationally	Q [11]	Total	42	96	E.70
Licensed alcohol premises identified as compliant with legislation	Q [12]	Total	93%	100%	90%
Tobacco retailers identified as compliant with legislation	Q [12]	Total	96%	97%	90%

Health Promotion and Education Services					
These services inform people about risk factors and support them to make healthy choices. Success is evident through increased engagement and healthier choices.	Note	Target Group	2018/19 Results	2019/20 Results	2021/22 Target
Mothers receiving breastfeeding and lactation support in the community	A	Total	861	861	>600
Babies exclusively/fully breastfed at three months	Q[13]	Māori	50%	50%	70%
		Pacific	55%	54%	
		Total	62%	62%	
People provided with a Green Prescription for additional physical activity	A[14]	Total	4,818	5,158	>3,500
Green Prescription participants more active 6-8 months after referral	Q	Total	n.a	n.a	>50%
Smokers, enrolled with a PHO, receiving advice and support to quit smoking (ABC)	Q[15]	Māori	79%	71%	90%
		Pacific	77%	70%	
		Total	82%	73%	
Smokers, identified in hospital, receiving advice and support to quit smoking (ABC)	Q	Māori	92%	85%	95%
		Pacific	93%	88%	
		Total	92%	84%	
Pregnant women, identified as smokers at confirmation of pregnancy with an LMC, receiving advice and support to quit smoking (ABC)	Q[16]	Māori	78%	89%	90%
		Total	86%	93%	

[11] Submissions are made to influence policy in the interests of improving and protecting the health of the population and providing a healthy and safe environment for our population. The number of submissions varies in a given year and may be higher (for example) when Territorial Authorities are consulting on long-term plans.

[12] New Zealand law prevents retailers from selling alcohol or tobacco to young people aged under 18 years. The measure relates to Controlled Purchase Operations which involve sending supervised volunteers (under 18 years of age) into licensed premises or tobacco retailers. Compliance is seen as a proxy measure of the success of education and training for retailers and reflects a culture that encourages a responsible approach to alcohol and tobacco.

[13] Evidence shows that infants who are breastfed have a lower risk of developing chronic illnesses during their lifetimes. This measure is part of the national Well Child/Tamariki Ora Quality Framework, data from providers is not able to be combined so performance from the largest provider (Plunket) is presented.

[14] A Green Prescription is a health professional's written advice to a patient to be physically active, as part of their health management. Sport Canterbury has picked up and reintegrated the patient experience survey, previously undertaken by Research NZ on behalf of the Ministry of Health, this will be completed annually.

[15] The ABC programme has a cessation focus and refers to health professionals Asking about smoking status, providing Brief advice and providing Cessation support. The provision of professional advice and cessation support is shown to increase the likelihood of smokers making quit attempts and the success rate of those attempts.

[16] This data is sourced from the national Maternity Dataset which only covers approximately 80% of pregnancies nationally, as such, the results indicate trends rather than absolute performance Pacific results are not available for publication. Standards have been set nationally in line with other ABC programme targets.

Population-Based Screening Services					
These services help to identify people at risk and support earlier intervention and treatment. Success is evident through high levels of engagement with services.	Note	Target Group	2018/19 Results	2019/20 Results	2021/22 Target
Four-year-olds provided with a B4 School Check (B4SC)	A[17]	Māori	100%	91%	90%
		Pacific	92%	80%	
		Total	96%	90%	
Four-year-olds (identified as obese at their B4SC) offered a referral for clinical assessment and family-based nutrition, activity and lifestyle intervention	Q	Māori	100%	97%	95%
		Pacific	100%	100%	
		Total	100%	99%	
Women aged 25-69 having a cervical cancer screen in the last 3 years	A[18]	Māori	68%	63%	80%
		Pacific	78%	67%	
		Total	72%	70%	
Women aged 45-69 having a breast cancer screen in the last 2 years	A[19]	Māori	68%	68%	70%
		Pacific	62%	62%	
		Total	78%	73%	
People aged 60-74 participating in the national bowel screening programme	A	Māori	new	new	60%
		Pacific	new	new	
		Total	new	new	

Immunisation Services					
These services reduce the transmission and impact of vaccine-preventable diseases. High coverage rates are indicative of a well-coordinated, successful service.	Note	Target Group	2018/19 Results	2019/20 Results	2021/22 Target
Children fully immunised at eight months of age	A[20]	Māori	91%	90%	95%
		Pacific	96%	96%	
		Total	94%	94%	
Proportion of eight-month-olds 'reached' by immunisation services	Q	Total	98%	98%	95%
Children fully immunised at two years	A	Māori	91%	92%	95%
		Pacific	96%	98%	
		Total	93%	94%	
Young people (Year 8) completing the HPV vaccination programme	A[21] ✧	Māori	31%	58%	75%
		Pacific	34%	59%	
		Total	37%	62%	
Older people (65+) receiving a free influenza ('flu') vaccination	A[22] ✧	Māori	40%	42%	75%
		Pacific	52%	52%	
		Total	62%	64%	

[17] The B4 School Check is the final core check, under the national Well Child/Tamariki Ora schedule, which children receive at age four. It is free and includes assessment of vision, hearing, oral health, height and weight, allowing concerns to be identified and addressed early. Obesity is particularly concerning in children as it is associated with a wide range of health conditions and increased risk of illness and can also affect a child's educational attainment and quality of life. A referral for children identified with weight concerns allows families to access support to maintain healthier lifestyles.

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

[19] From July 2021 the national expectation for Breast Screening was extended to include women 45 to 69 years. Reported baseline results have been updated from previous years. Results are no longer comparable with previously published results.

[20] Immunisation at eight months is a national performance measure and the subset, children 'reached', is defined as children fully immunised and those whose parents have been contacted and provided with advice - but may have chosen to decline immunisations or opt off the National Immunisation Register.

[21] The Human Papillomavirus (HPV) vaccination aims to protect young people from HPV infection and the risk of developing HPV-related cancers later in life. The programme consists of two vaccinations and is free to young people under 26 years of age. Baseline results refer to young girls only, the programme was widened in 2020/21. The 2018/19 HPV result is subject to data quality issues and we believe is under-reflecting performance.

[22] Almost one in four New Zealanders are infected with influenza each year. Influenza vaccinations can reduce the risk of flu-associated hospitalisation and have also been associated with reduced hospitalisations among people with diabetes and chronic lung disease. The vaccine is especially important for people at risk of serious complications, including people aged over 65 and people with long-term or chronic conditions.

Early detection and management services

WHY ARE THESE SERVICES SIGNIFICANT?

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

Early detection and management services are those that help to maintain, improve and enable people's good health and wellbeing. These services include detection of people at risk, identification of disease and the effective management and coordination of services for people with long-term conditions. These services are by nature more generalist and accessible from multiple providers at a number of different locations. Providers include general practice, allied health, personal and mental health service providers and pharmacy, radiology and laboratory service providers.

Our vision of an integrated system presents a unique opportunity. By promoting regular engagement with local primary and community services, we can better support people to maintain good health, identify issues earlier and intervene in less invasive and more cost-effective ways. Our integrated approach is particularly effective where people have multiple conditions requiring ongoing intervention or support and helps to improve their quality of life by reducing complications, acute illness and unnecessary hospital admissions.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Oral Health Services					
These services support lifelong health and wellbeing. High levels of enrolment and timely access to treatment are indicative of an accessible and efficient service.	Note	Target Group	2018/19 Results	2019/20 Results	2021/22 Target
Children (0-4) enrolled in DHB-funded oral health services	A[23]✧	Māori	84%	82%	95%
		Pacific	85%	88%	
		Total	83%	86%	
Children (0-12) enrolled in DHB-funded oral health services receiving their oral health exam according to planned recall	T✧	Māori	89%	87%	90%
		Pacific	85%	75%	
		Total	88%	87%	
Adolescents (13-17) accessing DHB-funded oral health services	A[24]✧	Total	66%	62%	85%

General practice Services					
These services support people to maintain their health and wellbeing. High levels of engagement with general practice are indicative of an accessible, responsive service.	Note	Target Group	2018/19 Results	2019/20 Results	2021/22 Target
Newborns enrolled with a PHO by three months of age	A	Māori	82%	80%	85%
		Pacific	86%	93%	
		Total	95%	93%	
Proportion of the total Canterbury population enrolled with a Primary Health Organisation (PHO)	A	Māori	85%	84%	95%
		Pacific	108%	98%	
		Total	93%	95%	
Youth (0-19) accessing brief intervention counselling in primary care	A[25]Δ	Total	552	435	>400
Adults (20+) accessing brief intervention counselling in primary care	AΔ	Total	6,353	6,187	>5,500
Number of skin lesions (including cancer) removed in primary care	AΔ	Total	2,404	2,322	>2,000
Number of integrated HealthPathways in place across the health system	Q[26]	Total	699	685	>600

[23] Oral health is an integral component of lifelong health and wellbeing. Early and regular contact with oral health services helps to set lifelong patterns and reduce risk factors such as poor diet, which have lasting benefits in terms of improved nutrition and healthier body weights.

[24] Adolescent oral health data is provided by the Ministry of Health. No data is available for Māori or Pacific utilisation.

[25] The Brief Intervention Counselling service supports people with mild to moderate mental health concerns, including depression and anxiety. The service includes the provision of free counselling sessions (or extended consultations) and includes face-2-face and phone consultations. The expansion of specifically targeted service options for young people, including the CYMHS and YAMAHA networks, are expected to result in fewer referrals to this service for this age cohort.

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

Long-Term Condition Services					
These services are targeted at people with high health needs with the aim of supporting people to better manage and control their conditions.	Note	Target Group	2018/19 Results	2019/20 Results	2021/22 Target
Number of spirometry tests provided in the community rather than in hospital	A[27Δ]	Total	2,426	2,128	>2,000
People receiving subsidised diabetes self-management support when starting insulin	A[Δ]	Total	379	320	>300
Population identified with diabetes having an HbA1c test in the last year	A[28Δ]	Māori	89%	87%	>90%
		Pacific	88%	85%	
		Total	90%	88%	
Population with diabetes having an HbA1c test and acceptable glycaemic control	Q[Δ]	Māori	63%	61%	>60%
		Pacific	58%	56%	
		Total	72%	71%	

Pharmacy and Referred Services					
These are services which a health professional uses to help diagnose or monitor a health condition. While largely demand driven, timely access to services enables improved clinical decision-making and reduces unnecessary delays in treatment.	Note	Target Group	2018/19 Results	2019/20 Results	2021/22 Target
Number of laboratory tests completed for the Canterbury population	A[Δ]	Total	2.9m	2.8m	E<2.8m
Number of subsidised pharmaceutical items dispensed in the community	A[Δ]	Total	7.0m	7.6m	E<10m
People on multiple medications receiving medication management support	A[29Δ]	Total	1,434	896	>1,200
Number of community-referred radiology tests completed	A[Δ]	Total	55,038	51,614	E>55,000
People receiving their urgent diagnostic colonoscopy within two weeks	T[30]	Total	77%	80%	90%
People receiving their MRI scans within six weeks	T	Total	47%	76%	90%
People receiving their CT scans within six weeks	T	Total	65%	93%	95%

[27] Spirometry is a tool for measuring and assessing lung function for a range of respiratory conditions. Providing this service in the community means people do not need to wait for a hospital appointment and conditions can be identified and treated earlier.

[28] Diabetes is a leading long-term condition and contributor to many other conditions. An annual HbA1c test (of blood glucose levels) is a means of assessing the management of people's condition. A level of less than 64mmol/mol reflects an acceptable blood glucose level.

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

[30] By improving clinical decision-making, timely access to diagnostics enables earlier and more appropriate intervention and treatment. This contributes to improved quality of care and health outcomes and, by reducing long waits for diagnosis or treatment, improves people's confidence in the health system. A colonoscopy is a test that looks at the inner lining of a person's large intestine (rectum and colon). The radiology measures are national performance indicators and refer to non-urgent scans.

Intensive assessment and treatment services

WHY ARE THESE SERVICES SIGNIFICANT?

Intensive assessment and treatment services are those more complex services provided by health professionals and specialists working closely together to respond to the needs of people with more severe, complex or life-threatening health conditions. They are usually (but not always) provided in hospital settings, which enables the co-location of specialist expertise and equipment. Some services are delivered in response to acute events, others are planned and access is determined by clinical referral and triage, treatment thresholds and national service coverage agreements.

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

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

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Quality and Patient Safety					
These are national quality and patient safety markers and high compliance levels indicate robust quality processes and strong clinical engagement.	Note	Target Group	2018/19 Results	2019/20 Results	2021/22 Target
Staff compliant with good hand hygiene practice	Q[31◇]	Total	82%	82%	80%
Inpatients (aged 75+) receiving a falls risk assessment	Q◇	Total	98%	92%	90%
Response rate to the national inpatient patient experience survey	P[32]	Total	24%	19%	>30%
Proportion of patients who felt 'hospital staff included their family/whānau or someone close to them in discussions about their care'	P	Total	50%	65%	>65%

Specialist Mental Health and Alcohol and Other Drug (AOD) Services					
These are services for those most severely affected by mental illness and/or addictions who require specialist intervention and treatment. Reducing waiting times, while meeting demand for services, is indicative of a responsive and efficient service.	Note	Target Group	2018/19 Results	2019/20 Results	2021/22 Target
Proportion of the population (aged 0-19) accessing specialist mental health services	A[33Δ]	Māori	5.6%	6.1%	>3.1%
		Pacific	2.4%	2.3%	
		Total	3.7%	4.1%	
Proportion of the population (aged 20-64) accessing specialist mental health services	A[Δ]	Māori	9.8%	10.6%	>3.1%
		Pacific	4.6%	4.8%	
		Total	3.9%	4.0%	
People referred for non-urgent mental health and AOD services seen within 3 weeks	T	Total	70%	67%	80%
People referred for non-urgent mental health and AOD services seen within 8 weeks	T	Total	88%	83%	95%

[31] The quality markers are national DHB performance measures set to drive improvement in key areas. High compliance indicates robust quality processes and strong clinical engagement. In line with national reporting results refer to the final quarter of each year (April-June). Further detail and quarterly results for the full year can be found on the Health Quality and Safety Commission website www.hqsc.govt.nz.

[32] There is growing evidence that patient experience is a good indicator of the quality of health services and stronger patient partnerships and family-centred care have been linked to better health outcomes. The national DHB inpatient experience survey covers four patient experience domains: communication, partnership, co-ordination and physical and emotional needs.

[33] There is a national expectation that around 3% of the population will need access to specialist level mental health services during their lifetime. Data is sourced from the national PRIMHD dataset and results are three months in arrears.

Maternity Services					
While largely demand driven, service utilisation is monitored to ensure services are accessible and responsive to need.	Note	Target Group	2018/19 Results	2019/20 Results	2021/22 Target
Number of maternity deliveries in Canterbury DHB facilities	A	Total	6,044	5,943	E.6,000
Women registered with a Lead Maternity Carer by 12 weeks of pregnancy	A[34]◇ †	Māori	66%	n.a	80%
		Pacific	58%	n.a	
		Total	79%	n.a	
Proportion of maternity deliveries made in primary birthing units	Q[35]	Total	16%	16%	>13%

Acute and Urgent Services					
Acute services are delivered in response to accidents or illnesses that have an abrupt onset or progression. Early intervention can reduce the impact of the event and shorter waiting times are indicative of a responsive system.	Note	Target Group	2018/19 Results	2019/20 Results	2021/22 Target
Number of acute demand packages of care provided in the community	A[36]Δ	Total	35,393	35,547	>30,000
Number of presentations at Canterbury Emergency Departments (ED)	A	Total	101,130	104,907	E.110k
People admitted, discharged or transferred from Canterbury EDs within 6 hours of presentation	T	Māori	92%	92%	95%
		Pacific	94%	92%	
		Total	90%	91%	
Proportion of the population presenting to ED (per 1,000 people)	Q	Total	178	181	E.<190
Patients referred with a high suspicion of cancer, receiving their first treatment within 62 days of referral	T	Total	94%	96%	90%

Elective and Arranged Services					
Elective and arranged services are provided for people who do not need immediate hospital treatment. Reducing waiting times, while meeting demand for services, is indicative of a responsive and efficient service.	Note	Target Group	2018/19 Results	2019/20 Results	2021/22 Target
Number of First Specialist Assessments provided	A	Total	66,982	55,218	E.60,000
Proportion of patients waiting longer than four months for their first specialist assessment	T◇	Total	69%	71%	100%
Proportion of First Specialist Assessments that were non-contact (virtual)	Q[37]	Total	15%	13%	>15%
Number of planned care intervention delivered	A[38]	Total	new	31,013	31,695
Proportion of patients given a commitment to treat but not treated within four months	T◇	Total	55%	73%	100%
Proportion of people receiving their surgery on the day of admission	P	Total	87%	85%	>85%
Number of outpatient consultations provided	A	Total	653,717	630,837	E.650k
Outpatient appointments where the patient was booked but did not attend their appointment	Q[39]	Māori	9%	7%	<5%
		Pacific	12%	10%	
		Total	5%	4%	

[34] Early registration with a Lead Maternity Carer (LMC) is encouraged to promote the good health and wellbeing of the mother and the developing baby. Data is sourced from the national Maternity Clinical Indicators report. Results for 2019 are yet to be released.

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

[36] Acute demand packages of care are provided through Canterbury's community-based Acute Demand Management Service with the aim of supporting people in their own homes or in the community rather than having people presenting to ED or hospital for treatment.

[37] This measure has been updated to include both non-contact (virtual) assessments, where the assessment is provided without the patient needing to be present, and telehealth assessment where a patient has their appointment but 'virtually' via phone call or using telehealth technology to reduce the need for travel. Additional detail is able to be captured regarding patient contacts following the shift to a new patient management system in 2018/19. Prior year's results have been updated to reflect a consistent approach to this measure.

[38] The new planned care intervention measure reflects a change in national expectation, recognising the delivery of elective surgery but also minor procedures and non-surgical interventions that contribute to people's health and wellbeing, including those delivered in community settings. Canterbury's planned care interventions target is made up of three components: elective surgical discharges, Minor Procedures and Non-Surgical Interventions.

[39] When appointments are missed, it can negatively affect people's recovery and long-term outcomes and it is a costly waste of resources for the DHB.

Rehabilitation and support services

WHY ARE THESE SERVICES SIGNIFICANT?

Rehabilitation and support services are those that provide people with the support they need to continue to live safely and independently in their own homes, or regain functional ability, after a health-related event. Services are mostly provided to older people, or people with mental health or complex personal health conditions, following a clinical assessment of the person's needs.

These services are considered to provide people with a much higher quality of life as a result of being able to stay active and positively connected to their communities. Even when returning to full health is not possible, access to responsive support services enables people to maximise their independence. In preventing acute illness, crisis or deterioration of function, these services have a major impact on the sustainability of our health system, by reducing acute service demand and the need for more complex interventions or residential care. These services also support patient flow by enabling people to go home from hospital earlier.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Assessment, Treatment and Rehabilitation (AT&R) Services					
These services restore or maximise people's health or functional ability following a health-related event such as a fall, heart attack or stroke. Service utilisation is monitored to ensure people are being appropriately supported after an event.	Note	Target Group	2018/19 Results	2019/20 Results	2021/22 Target
People accessing community-based pulmonary rehabilitation courses	A[40]	Total	275	227	>250
People (65+) accessing the community-based falls prevention service	A[41]	Total	2,127	1,852	>1,500
People supported by community rehabilitation and support services	A[42Δ]	Total	1,933	1,686	>1,600
Proportion of inpatients referred to an organised stroke service after an acute event	Q	Total	84%	86%	80%
Proportion of AT&R inpatients discharged to their own home rather than into Aged Residential Care (ARC)	Q[43]	Total	88%	84%	>80%

Home-Based and Community Support Services					
These are services designed to support people to maintain functional independence. Clinical assessment ensures access to services is appropriate and equitable.	Note	Target Group	2018/19 Results	2019/20 Results	2020/21 Target
People supported by district nursing services	A[Δ]	Total	8,820	8,568	E. >7,000
People supported by long-term home-based support services	A[Δ]	Total	8,466	7,870	E. >8,000
Proportion of the population (65+) supported by long-term, home-based support services	A[Δ]	Total	9.4%	8.0%	E. 10%
People supported by long-term home and community support services who have had a clinical assessment of need using the InterRAI tool	Q[44Δ]	Total	91%	91%	95%
People supported by hospice or home-based palliative services	A[Δ]	Total	3,716	3,509	E. 3,700
Number of Advance Care Plans registered to support end of life care	A	Total	781	782	>700

[40] Respiratory and lung diseases are major contributors to avoidable hospital admissions in Canterbury, particularly over winter. Pulmonary rehabilitation programmes are designed to help patients with Chronic Obstructive Pulmonary Disease (obstructive lung disease) to manage their symptoms and better manage their condition.

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

[42] The Community Rehabilitation Enablement and Support Team (CREST) provides a range of short-term home-based rehabilitation services to facilitate early discharge from hospital or avoid admission entirely through proactive referral. The measure is the number of people having received unique packages of care.

[43] While living in Aged Residential Care (ARC) is appropriate for a small proportion of our population, for most people remaining safe and well in their own homes provides a higher quality of life. A discharge home reflects the effectiveness of services in terms of assisting that person to regain their functional independence.

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

Respite and Day Support Services					
These services provide people with a break from a routine or regimented programme, so that crisis can be averted, or a specific health need can be addressed. Largely demand driven, service utilisation is monitored to ensure services are accessible.	Note	Target Group	2018/19 Results	2019/20 Results	2021/22 Target
People supported by community-based mental health crisis respite services	A$^{\Delta}$	Total	1,052	754	E.1,000
Occupancy rate of mental health crisis respite beds	A[45]$^{\Delta}$	Total	88%	74%	85%
Older people supported by day care services	A$^{\Delta}$	Total	578	297	E.550
Older people accessing aged care respite services	A[46]$^{\Delta}$	Total	1,101	1,192	E.1,000
Older people supported by aged care respite services, being discharged to their own home	Q[47]$^{\Delta}$	Total	89%	88%	>80%

Aged Residential Care Services					
The DHB subsidises ARC for people who meet the national thresholds for care. While our ageing population will increase demand, slower demand growth for lower-level care is indicative of more people being supported in their own homes for longer.	Note	Target Group	2018/19 Results	2019/20 Results	2021/22 Target
Proportion of the population (75+) accessing rest home level ARC services	A[48]$^{\Delta}$	Total	4.3%	4.0%	E.<4.5%
Proportion of the population (75+) accessing hospital-level ARC services	A$^{\Delta}$	Total	6.1%	6.0%	E.6.0%
Proportion of the population (75+) accessing dementia ARC services	A$^{\Delta}$	Total	2.6%	2.5%	E. 2.5%
Proportion of the population (75+) accessing psychogeriatric ARC services	A$^{\Delta}$	Total	0.8%	0.7%	E. <1%
People entering ARC having had a clinical assessment using InterRAI	Q[49]$^{\Delta}$	Total	84%	87%	95%

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

[46] Aligns with the Canterbury model of care to keep people in their homes longer.

[47] Respite services aim to support people for short durations, to regain function or to give carers a break. The proportion of people being discharged home (rather than staying on in ARC) reflects the effectiveness of services in terms of assisting people to maintain or regain their functional independence.

[48] The Canterbury region has higher ARC rates than national levels and by providing more services that help older people maintain functional independence for longer, people can remain in their own homes reducing the demand for rest-home-level care. Access rates for more complex care such as dementia and psychogeriatric care are less amenable and more attributable to the aging of our population. Measures refer to people accessing DHB funded ARC services and exclude people choosing to enter ARC privately or people living independently in retirement villages.

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

Appendix 5 Statement of Financial Expectations

Canterbury's financial outlook

Like the rest of the health sector, we are experiencing growing demand pressures as our population ages and increasing fiscal pressures as treatment, infrastructure and wage costs raise. We also face several unique challenges related to rapid population growth, our role as a tertiary provider and facilities constraints which add to our operating challenges.

Increasing demand costs: Significant population growth and the ageing of our population and major events over the last decade have contributed to increasing demand and treatment related costs, particularly those associated with acute service demand and mental health services. Predicted population growth indicates that even further capacity will be needed to meet system needs.

Interest, depreciation and capital charges: Interest, depreciation and capital charges are driven off upward movements in asset valuations and earthquake repair work which have contributed to significant asset revaluations over the last decade. As anticipated when the business case was approved, the recently commissioned Waipapa facility will add further depreciation and capital charge expense to the DHB. While we will receive capital charge relief for Waipapa, under the new capital charge regulations, the relief is lower than the capital charge expense as the relief formula is adjusted for the deficit incurred by the DHB.

Multi Employment Collective Agreement (MECA) settlement costs: While we received partial funding to offset some of the cost in past years, settled MECAs have significantly exceeded the affordability parameters of the DHB. The flow on impact of these settlements, along with the substantial claims of unsettled expired MECAs and expectations of staff on Individual Employment Agreements over the coming year, will put immense pressure on our financial sustainability. This pressure will also flow onto external providers who will look to the DHB for additional funding to manage their increased costs.

Holidays Act compliance: While we have made a provision for costs associated with compliance with the Holidays Act, this has been based on sampling. The actual liability will not be finalised until after a detailed remediation project has been completed. Ongoing costs associated with this project will impact on employee costs and cashflow to settle the historic amounts will require additional Crown funding.

COVID-19: The cost of resourcing the Managed Isolation & Quarantine Facilities (MIQF), providing testing, immunisations and other COIVD-19 related services are assumed to be fully funded. However, there are a range of unfunded resultant costs associated with the COVID-19 response and recovery that continue to impact negatively on the DHB finances, for example, disruption to supply chain has significantly increased the cost of clinical supplies.

Forecast financial results

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

Canterbury DHB will receive approximately $2.232 billion of total revenue from all sources to meet the needs of our population in 2021/22, including COVID-19 MIQF and testing related services. The DHB is forecasting a deficit of $149 million for 2021/22, including net COVID-19 and Holidays Act related revenue and costs of $16 million.

OUT-YEARS' SCENARIO

Our fiscal pressures are compounded by significant capital-related charges associated with the repair of damaged buildings, and the building of new ones. Interest, depreciation and capital charges contribute to our total deficit in the outyears of this Plan.

The combined annual interest, depreciation and capital charge (after net capital charge funding adjustments) will increase from $123 million in 2020/21 to approximately $125 million in 2021/22.

The remainder of the deficit is related to operating costs, and the Board and management team have made a strong commitment to identify efficiencies to reduce this operating deficit. We continue to work collaboratively with the Ministry of Health to establish a sustainable financial track for out years, leading to a projected break-even financial result in 2024/25.

Bridging the gap

We have a significant financial deficit. If we are to be sustainable into the future, we must rethink how we will meet our population's needs within a more moderate growth platform.

In the past ten years, our ability to absorb revenue and cost impacts have largely been delivered by slowing our rate of growth in acute demand, reducing our dependence on aged residential care and integrating information and service delivery models between primary, community and hospital settings.

However, future predicted population growth, recent growth in acute demand and additional cost pressures mean we need to further challenge the way health services are delivered and configured. We also need to identify further efficiencies and quality improvements

to ensure we deliver a sustainable model of health care into the future.

In returning to a financially sustainable operating result, a comprehensive program of work and initiatives is being rolled out deliberately focused on making the most effective and efficient use of the resources we have available. This will include modernising service delivery models, optimising the revenue streams, capturing the lessons learnt and successes from across our health system and prioritising resources into services providing the greatest return on investment.

Following the commissioning of Waipapa, we have repatriated outplaced services and will continue to actively work on repatriating clinically appropriate out-sourced services back into our facilities over time. This work will also include a purposeful and deliberate approach to clinical services and production planning, with a forward focus on meeting the growing demand for health services. This will be a sizable piece of work and will support improved use of our system resources and significantly reduce our operating expenditure.

The migration to Waipapa will also allow us to introduce our resource optimisation programme, making efficiency savings by co-locating and consolidating services, integrating rosters and supporting more integrated service models pre and post admission to support patient flow.

A strong focus on leave care, absenteeism and the management of sick and annual leave will also contribute to reducing our organisational liabilities without impacting on the quality of service delivery.

Savings identified for the coming year and two out-years have been highlighted in the Delivering Against National Priorities and Targets section of this Plan. Service changes proposed for the coming year are outlined in the Service Configuration section.

The Board and Executive Management Team are committed to reducing the DHB's financial deficit and ensuring sustainable future for our health system. Equity of access and quality of services will remain a key focus and the DHB will continue to work with our people, providers and communities as we move forward in our journey.

Major assumptions

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

- The DHB will retain early payment arrangements.
- Operating deficits will be fully funded, as equity.
- Capital charge for out-years is based on the current rate of 5%. Any rate change in the future is assumed to be financially neutral.
- Capital charge associated with pre-approved and future-approved Crown equity for capital projects is funded, per existing capital charge regulations.
- Capital charge associated with historic and future earthquake settlement proceeds redrawn as equity will continue to be payable to the Crown.
- Any future targeted funding to meet additional mental health service provision will be sustainable over the longer-term.
- Costs of compliance with any new national expectations will be cost neutral or fully funded, as will any legislative changes, sector reorganisation or service devolvement.
- $94 million (being the forecast undrawn portion of CDHB's $290 million earthquake settlement proceeds transferred to the Crown, as at June 2021), will be available to fund the earthquake repair and reinstatement programme as required.

  The balance of $94 million will be insufficient to address all the required EQ repairs, due to unplanned costs coming out of this settlement related to the redevelopment of the Waipapa Building and completion of the Boiler House and Energy Centre and is fully committed.
- As agreed with the Ministry, revenue and equity timing of the earthquake insurance draw-downs will be flexible and based on DHB requests, rather than necessarily matching the earthquake capital and operating repair spend for a particular year.
- Additional saving targets requiring service changes and/or Ministerial consent are approved in a timely manner.
- The redevelopment of Canterbury facilities is in accordance with the detailed business cases agreed with the Ministry and previous Cabinet. Associated capital expenditure and resulting depreciation and capital charge for formally agreed detailed business cases that will take place during the term of this Plan have been included, as appropriate.
- Revaluations of land and buildings will continue in line with NZ accounting standards. The DHB revalued its land and building assets as at 30 June 2021. The indicative impact, of net valuations, on depreciation and capital charge expenses and capital charge funding, is included in the Plan.
- Employee cost increases for expired wage agreements, including minimum wage flow-on impact if any, will be settled on fiscally sustainable terms, and within the DHB's nominal allowance, inclusive of step increases and the impact of accumulated leave revaluation. External provider increases will also be settled within available funding levels.
- Treatment-related and non-clinical supplies costs will increase in line with known inflation factors, insourcing electives that are currently out-

sourced and foreseen adjustments for the impact of service growth.

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

There are several significant risks impacting the CDHB financial plan, as follows:

- MECA increases greater than 1.5% and further industrial action.
- Cost associated with the Euthanasia bill (November 2021) and low and moderate family care support payments, if not fully funded.
- COVID-19 2020/21 non-presentation impact on 2021/22 (increased referrals and admissions to secondary care).
- COVID-19 non-direct supply chain impacts.
- Bowel screening impact of addition of 150 new colon cancer initial and follow-up surgeries not-funded under elective uplift.
- Air ambulance and electricity price uplift greater than assumed.
- CWD pricing national uplift less than projected cost.
- COVID-19 vaccination programme impact on ongoing 'business as usual' (BAU) services.
- Winter demand higher than projected.
- Care Capacity Demand Management (CCDM) costs exceeding assumption.
- Capitation – enrolled population growth continues to be greater than the funded Canterbury population growth.
- Other NGOs price uplift exceeding assumption.
- Pay equity calculations yet to be determined and may exceed top-slice additional funding.
- MOH approval delayed, or not being granted for any service changes related to savings initiatives.
- Transition to Health NZ.

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

Capital investment

NATIONAL BUSINESS CASES

The national business cases currently approved or the DHB is making plans for include:

- Relocation of mental health inpatient services from The Princess Margaret Hospital, approved December 2018.
- Christchurch Hospital Waipapa Tower 3 and Enabling works, approved November 2020.
- Christchurch Hospital Compliance Works project revised detailed business case, approved July 2021.
- Hillmorton Hospital campus facility master plan programme business case submitted to the Ministry of Health and Capital Investment Committee in November 2020, awaiting approval.
- Canterbury Health Laboratories and Cancer Centre facilities redevelopment were included in the wider Programme Business Case for the Christchurch Hospital campus submitted to Hospital Redevelopment Partnership Group and Ministry of Health for consideration in November 2019, awaiting approval.

CAPITAL EXPENDITURE

Canterbury's capital plan for 2021/22, excluding yet to be approved planned strategic investments, totals $122 million and is comprised, indicatively, of:

- $57 million progress payments for the approved detailed business case to relocate inpatient mental health services from The Princess Margaret Hospital.
- $2 million progress project payments for the approved relocation of Child and Family mental health outpatient services currently located on The Princess Margaret Hospital site.
- $16 million for the capital expenditure portion of the earthquake programme of works (includes ring-fenced Christchurch Hospital campus compliance works progress spend).
- $4 million progress payments for the approved Selwyn Health and Social Services Hub fit-out.
- $3 million for linear accelerator replacement funded by the Crown.
- $6 million for the Parkside (A&B) enhancement tranche 1, of which $5 million is Crown funded.
- $34 million for other baseline spend, primarily on replacement assets and systems which are past their economic useful life.

Anticipated investments for out-years, in addition to business cases submitted and under consideration by Crown officials, include but are not limited to:

- Strategic Information Technology developments towards a digital hospital including: Anaesthetic Electronic Record, e-orders (Labs), Payroll replacement system, Health One and ERMS.
- Clinical equipment aligning to strategic service delivery including additional linear accelerator (T5) and additional Cathlab.
- Repair and reinstatement of the Christchurch Hospital Energy Centre and Carpark.
- Continued repair and reinstatement of assets under the DHB's earthquake repair programme.
- Christchurch Hospital campus – remaining Parkside enhancement works, Tower 4, kitchen, fit-out of remaining T3 wards, workplaces etc.
- Compliance and remediation works at other CDHB hospital campuses e.g. passive fire and asbestos removal.
- Chatham Island masterplan and Ashburton hospital inpatient and infrastructure works.

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

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

Debt and equity

The Canterbury DHB repaid equity to the Crown of $180 million as part of our contribution towards the Burwood and Christchurch Hospital redevelopments.

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

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

The forecast amount drawn down as at 30 June 2021, is $196 million, with a balance of $94 million yet to be redrawn.

Considering projected equity movements, the Crown's equity in the DHB will rise from $1.12 billion as at June 2021 to $1.22 billion by June 2022, primarily driven by equity drawdowns for the Mental Health inpatient projects and earthquake capital works. The higher equity balance will result in an increase in the capital charge payable to the Crown.

Additional considerations

DISPOSAL OF LAND

Under the NZ Public Health and Disability Act 2000, no DHB may dispose of land without the prior written approval of the Minister of Health and the DHB must first have complied with its statutory clearance and public consultation obligations under the Act.

The DHB is yet to determine its future requirements for the former Christchurch Women's Hospital site in the central city and The Princess Margaret Hospital site in Cashmere. The former Christchurch Women's Hospital site is vacant bare land, the buildings having previously been demolished and removed. The remaining services at The Princess Margaret Hospital will be migrated to new Specialist Mental Health facilities being constructed at on the Hillmorton Hospital campus.

Over the next few years, Canterbury DHB will also consider its future service and facility requirements in some of its rural localities. Necessary approvals will be sought prior to disposal of any DHB land identified as surplus to requirements.

ACTIVITIES FOR WHICH COMPENSATION IS SOUGHT

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

ACQUISITION OF SHARES

Under the New Zealand Public Health and Disability Act 2000, no DHB may hold any shares or interests in an entity or in a partnership or joint venture, or settle or be appointed trustee of a trust, except with the consent of the Minister or as permitted by Regulations made under the Act:

The DHB is not intending to subscribe for shares in any bodies corporate or interests in associations in 2021/22.

ACCOUNTING POLICIES

The accounting policies adopted are consistent with those in the prior years. These are presented in the DHB's Statement of Intent and Annual Report, available on our website.

Group Statement of Financial Performance (Comprehensive Income)

	2019/20 Actual $'000	2020/21 Unaudited Actual $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000	2024/25 Plan $'000
REVENUE						
Ministry of Health revenue (Note 1)	1,872,987	2,000,593	2,091,407	2,171,185	2,273,401	2,380,568
Other government revenue	40,523	61,022	65,127	66,624	68,165	69,753
Earthquake repair revenue redrawn	6,846	364	800	300	-	-
Other revenue	59,149	65,133	75,073	77,480	79,745	81,769
Total Revenue	**1,979,505**	**2,127,112**	**2,232,407**	**2,315,589**	**2,421,311**	**2,532,090**
EXPENSE						
Personnel	978,834	995,203	1,029,965	1,058,221	1,091,874	1,126,674
Outsourced personnel & clinical serrvices	33,232	35,597	57,640	47,743	42,877	39,060
Clinical supplies	154,268	170,704	172,737	176,032	181,070	186,609
Earthquake building repair costs	6,846	364	800	300	-	-
Infrastructure & non clinical	118,440	125,513	119,319	120,430	123,119	125,165
External service providers	810,043	844,188	851,785	854,613	875,976	897,875
Total Expense Before Depreciation & Capital Charge	**2,101,663**	**2,171,569**	**2,232,246**	**2,257,339**	**2,314,916**	**2,375,383**
Surplus/(Deficit) Before Depreciation & Capital Charge	**(122,158)**	**(44,457)**	**161**	**58,250**	**106,395**	**156,707**
Depreciation and amortisation	79,773	89,676	92,104	91,741	85,993	85,491
Capital charge and interest expense	41,505	42,080	57,064	63,471	69,188	70,296
Total Depreciation, Capital Charge & Interest Expense	**121,278**	**131,756**	**149,168**	**155,212**	**155,181**	**155,787**
Surplus/(Deficit)	**(243,436)**	**(176,213)**	**(149,007)**	**(96,962)**	**(48,786)**	**920**
OTHER COMPREHENSIVE REVENUE & EXPENSE						
Revaluation of property, plant & equipment	(3,068)	95,482	-	-	-	-
Total Comprehensive Income/(Deficit)	**(246,504)**	**(80,731)**	**(149,007)**	**(96,962)**	**(48,786)**	**920**

Note 1: Includes capital charge relief funding for Waipapa and asset revaluation, where applicable.

Group Statement of Financial Position

	30/06/20 Actual $'000	30/06/21 Unaudited Actual $'000	30/06/22 Plan $'000	30/06/23 Plan $'000	30/06/24 Plan $'000	30/06/25 Plan $'000
CROWN EQUITY						
Contributed capital	410,658	1,126,421	1,374,917	1,584,801	1,663,940	1,848,210
Revaluation reserve	423,336	518,818	518,818	518,818	518,818	518,818
Accumulated surpluses	(343,264)	(519,477)	(668,484)	(765,446)	(814,232)	(813,312)
Total Equity	**490,730**	**1,125,762**	**1,225,251**	**1,338,173**	**1,368,526**	**1,553,716**
REPRESENTED BY:						
CURRENT ASSETS						
Cash & cash equivalents	4,056	50,775	120,487	210,945	289,792	373,107
Trade & other receivables	111,502	113,435	113,435	113,435	113,435	113,435
Inventories	14,549	13,811	13,811	13,811	13,811	13,811
Restricted assets	14,666	15,094	15,094	15,094	15,094	15,094
Assets held for sale	-	-	-	-	-	-
Investments	750	750	750	750	750	750
Total Current Assets	145,523	193,865	263,577	354,035	432,882	516,197
CURRENT LIABILITIES						
NZHPL sweep bank account	11,032	-	-	-	-	-
Trade & other payables	165,172	155,220	155,220	155,220	155,220	155,220
Employee benefits	343,643	381,696	381,696	381,696	381,696	381,696
Restricted funds	14,682	15,110	15,110	15,110	15,110	15,110
Borrowings & Finance Leases	205	1,682	1,682	1,682	1,682	1,682
Total Current Liabilities	534,734	553,708	553,708	553,708	553,708	553,708
Net Working Capital	(389,211)	(359,843)	(290,131)	(199,673)	(120,826)	(37,511)
NON CURRENT ASSETS						
Investments in Associates & HPL	-	4,253	4,253	4,253	4,253	4,253
Property, plant, & equipment	866,467	1,497,385	1,529,834	1,554,730	1,508,159	1,612,004
Intangible assets	46,314	40,537	37,865	35,433	33,510	31,540
Restricted assets	16	16	16	16	16	16
Total Non-Current Assets	912,797	1,542,191	1,571,968	1,594,432	1,545,938	1,647,813
NON CURRENT LIABILITIES						
Employee benefits	6,304	7,544	7,544	7,544	7,544	7,544
Borrowings and Finance Leases	26,552	49,042	49,042	49,042	49,042	49,042
Total Non-Current Liabilities	32,856	56,586	56,586	56,586	56,586	56,586
Net Assets	**490,730**	**1,125,762**	**1,225,251**	**1,338,173**	**1,368,526**	**1,553,716**

Note: Cash position assumes CDHB receives full equity deficit support indicative funding.

Group Statement of Movements in Equity

	2019/20 Actual $'000	2020/21 Unaudited Actual $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000	2024/25 Plan $'000
Total equity at beginning of the year	597,377	490,730	1,125,762	1,225,251	1,338,173	1,368,526
Total comprehensive revenue and expense for the year	(246,504)	(80,731)	(149,007)	(96,962)	(48,786)	920
OTHER MOVEMENTS						
EQUITY REPAYMENTS						
Assets disposal net proceeds remitted to Crown	-	-	-	-	-	-
Annual depreciation funding repayment	(1,861)	(1,861)	(1,861)	(1,861)	(1,861)	(1,861)
EQUITY INJECTIONS						
Earthquake repair capital redrawn	5,994	9,650	28,000	65,000	-	-
Equity support	130,000	180,000	153,000	139,000	81,000	32,000
Waipapa facility transferred from Crown	-	525,050	-	-	-	-
Mental Health Inpatients equity drawn	2,455	1,435	69,357	7,745	-	-
Chch Hospital Tower 3 facility transferred from Crown			-	-	-	154,131
Other movements	3,269	1,489	-	-	-	-
Total Equity at End of the Year	**490,730**	**1,125,762**	**1,225,251**	**1,338,173**	**1,368,526**	**1,553,716**

Note: Some equity injections are 'non-cash' transactions e.g. Waipapa, Tower 3, Tunnel and Energy Centre. The $9.650M of earthquake repair capital redrawn in 2020/21 relates to capital value of the tunnel asset transferred from the Crown. This amount plus the $525.050M equity for the Waipapa facility transferred from the Crown equates to the $534.700M total equity draw down as set out in the "Handover Agreement for the Christchurch Hospital Hagley and Related Project Works" document.

Group Statement of Cash Flow

	2019/20 Actual $'000	2020/21 Unaudited Actual $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000	2024/25 Plan $'000
CASH FLOW FROM OPERATING ACTIVITIES						
Cash provided from:						
Receipts from Ministry of Health	1,859,630	2,011,643	2,091,407	2,171,185	2,273,401	2,380,568
Earthquake repair revenue redrawn	6,846	364	800	300	-	-
Other receipts	106,156	120,142	139,500	143,204	146,840	150,372
Interest received	695	1,075	700	900	1,070	1,150
	1,973,327	2,133,224	2,232,407	2,315,589	2,421,311	2,532,090
Cash applied to:						
Payments to employees	880,391	955,910	1,029,965	1,058,221	1,091,874	1,126,674
Payments to suppliers	1,113,569	1,166,049	1,202,281	1,199,118	1,223,042	1,248,709
Capital charge and interest paid	28,979	54,605	57,064	63,471	69,188	70,296
GST - net	(1,219)	(370)	-	-	-	-
	2,021,720	2,176,194	2,289,310	2,320,810	2,384,104	2,445,679
Net Cash Flow from Operating Activities	**(48,393)**	**(42,970)**	**(56,903)**	**(5,221)**	**37,207**	**86,411**
CASH FLOW FROM INVESTING ACTIVITIES						
Cash provided from:						
Sale of property, plant, & equipment	17	2,736	-	-	-	-
Receipt from investments and restricted assets	-	-	-	-	-	-
	17	2,736	-	-	-	-
Cash applied to:						
Purchase of investments & restricted assets	225	1,036	-	-	-	-
Purchase of property, plant, & equipment	63,577	80,553	121,881	69,295	37,499	33,235
	63,802	81,589	121,881	69,295	37,499	33,235
Net Cash Flow from Investing Activities	**(63,785)**	**(78,853)**	**(121,881)**	**(69,295)**	**(37,499)**	**(33,235)**
CASH FLOW FROM FINANCING ACTIVITIES						
Cash provided from:						
Equity Injections						
Earthquake repair capital redrawn (Note 2)	5,994	-	28,000	20,090	-	-
Mental Health Inpatients equity drawn	2,455	1,435	69,357	7,745	-	-
Operating deficit equity support (Note 3)	130,000	180,000	153,000	139,000	81,000	32,000
	138,449	181,435	250,357	166,835	81,000	32,000
Cash applied to:						
Capital repayments	1,661	1,861	1,861	1,861	1,861	1,861
	1,661	1,861	1,861	1,861	1,861	1,861
Net Cash Flow from Financing Activities	**136,788**	**179,574**	**248,496**	**164,974**	**79,139**	**30,139**
NET CASHFLOW						
Net increase/(decrease) in cash and cash equivalents	24,610	57,751	69,712	90,458	78,847	83,315
Cash and cash equivalents at beginning of year	(31,586)	(6,976)	50,775	120,487	210,945	289,792
Cash and cash equivalents at end of year	**(6,976)**	**50,775**	**120,487**	**210,945**	**289,792**	**373,107**
REPRESENTED BY:						
Cash & cash equivalents	4,056	50,775	120,487	210,945	289,792	373,107
NZHPL sweep bank account	(11,032)	-	-	-	-	-
CASH & CASH EQUIVALENTS AT END OF YEAR	**(6,976)**	**50,775**	**120,487**	**210,945**	**289,792**	**373,107**

Note 2: Excludes Earthquake repair capital redrawn that are 'non-cash' transactions (e.g. Tunnel & Energy Centre).
Note 3: Assumes CDHB receives full equity deficit support.

Summary of revenue and expenses by arm

	2019/20 Actual $'000	2020/21 Unaudited Actual $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000	2024/25 Plan $'000
Funding Arm						
REVENUE						
Ministry of Health revenue	1,798,466	1,920,799	2,014,856	2,091,466	2,190,378	2,294,100
Other government revenue	2,792	2,274	2,301	2,174	2,197	2,222
Other revenue	412	936	8,105	7,664	7,884	8,112
Total Revenue	**1,801,670**	**1,924,009**	**2,025,262**	**2,101,304**	**2,200,459**	**2,304,434**
EXPENSE						
Personal Health	1,371,158	1,455,360	1,536,563	1,574,954	1,640,235	1,707,029
Mental Health	174,249	185,770	194,542	199,821	206,837	214,106
Disability Support	310,712	313,041	345,262	354,212	364,056	374,186
Public Health	23,260	21,783	18,541	4,191	4,298	4,407
Maori Health	2,579	2,431	3,403	3,489	3,577	3,667
Total Expense Before Depreciation & Capital Charge	**1,881,958**	**1,978,385**	**2,098,311**	**2,136,667**	**2,219,003**	**2,303,395**
Surplus/(Deficit) Before Depreciation & Capital Charge	**(80,288)**	**(54,376)**	**(73,049)**	**(35,363)**	**(18,544)**	**1,039**
Depreciation and amortisation	-	-	-	-	-	-
Capital charge and interest expense	-	-	-	-	-	-
Total Depreciation, Capital Charge & Interest Expense	**-**	**-**	**-**	**-**	**-**	**-**
Surplus/(Deficit)	**(80,288)**	**(54,376)**	**(73,049)**	**(35,363)**	**(18,544)**	**1,039**
Other comprehensive revenue and expense	-	-	-	-	-	-
Total Comprehensive Income/(Deficit)	**(80,288)**	**(54,376)**	**(73,049)**	**(35,363)**	**(18,544)**	**1,039**
Governance & Funder Admin						
REVENUE						
Ministry of Health revenue	5,465	5,897	6,997	5,335	5,213	5,170
Other government revenue	-	-	-	-	-	-
Other revenue	26	8	-	-	-	-
Total Revenue	**5,491**	**5,905**	**6,997**	**5,335**	**5,213**	**5,170**
EXPENSE						
Personnel	10,595	9,694	11,085	11,140	11,196	11,266
Outsourced personnel & clinical serrvices	2,281	2,955	3,815	2,978	2,915	2,894
Clinical supplies	52	95	42	43	44	45
Earthquake building repair costs	-	-	-	-	-	-
Infrastructure & non clinical	(7,603)	(7,631)	(8,341)	(9,222)	(9,338)	(9,431)
External service providers	-	-	-	-	-	-
Total Expense Before Depreciation & Capital Charge	**5,325**	**5,113**	**6,601**	**4,939**	**4,817**	**4,774**
Surplus/(Deficit) Before Depreciation & Capital Charge	**166**	**792**	**396**	**396**	**396**	**396**
Depreciation and amortisation	395	551	396	396	396	396
Capital charge and interest expense	-	-	-	-	-	-
Total Depreciation, Capital Charge & Interest Expense	**395**	**551**	**396**	**396**	**396**	**396**
Surplus/(Deficit)	**(229)**	**241**	**-**	**-**	**-**	**-**
Other comprehensive revenue and expense	-	-	-	-	-	-
Total Comprehensive Income/(Deficit)	**(229)**	**241**	**-**	**-**	**-**	**-**

Summary of revenue and expenses by arm (continued)

	2019/20 Actual $'000	2020/21 Unaudited Actual $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000	2024/25 Plan $'000
Provider Arm						
REVENUE						
Ministry of Health revenue	1,140,971	1,208,094	1,316,080	1,356,438	1,420,837	1,486,818
Other government revenue	37,731	58,748	62,826	64,450	65,968	67,531
Earthquake repair revenue redrawn	6,846	364	800	300	-	-
Other revenue	58,711	64,189	66,968	69,816	71,861	73,657
Total Revenue	**1,244,259**	**1,331,395**	**1,446,674**	**1,491,004**	**1,558,666**	**1,628,006**
EXPENSE						
Personnel	968,239	985,509	1,018,880	1,047,081	1,080,678	1,115,408
Outsourced personnel & clinical serrvices	30,951	32,642	53,825	44,765	39,962	36,166
Clinical supplies	154,216	170,609	172,695	175,989	181,026	186,564
Earthquake building repair costs	6,846	364	800	300	-	-
Infrastructure & non clinical	126,043	133,144	127,660	129,652	132,457	134,596
Total Expense Before Depreciation & Capital Charge	**1,286,295**	**1,322,268**	**1,373,860**	**1,397,787**	**1,434,123**	**1,472,734**
Surplus/(Deficit) Before Depreciation & Capital Charge	**(42,036)**	**9,127**	**72,814**	**93,217**	**124,543**	**155,272**
Depreciation and amortisation	79,378	89,125	91,708	91,345	85,597	85,095
Capital charge and interest expense	41,505	42,080	57,064	63,471	69,188	70,296
Total Depreciation, Capital Charge & Interest Expense	**120,883**	**131,205**	**148,772**	**154,816**	**154,785**	**155,391**
Surplus/(Deficit)	**(162,919)**	**(122,078)**	**(75,958)**	**(61,599)**	**(30,242)**	**(119)**
OTHER COMPREHENSIVE REVENUE & EXPENSE						
Revaluation of property, plant & equipment	(3,068)	95,482	-	-	-	-
Impairment of property, plant & equipment	-	-	-	-	-	-
Total Comprehensive Income/(Deficit)	**(165,987)**	**(26,596)**	**(75,958)**	**(61,599)**	**(30,242)**	**(119)**
In House Elimination						
REVENUE						
Ministry of Health revenue	(1,071,915)	(1,134,197)	(1,246,526)	(1,282,054)	(1,343,027)	(1,405,520)
Total Revenue	**(1,071,915)**	**(1,134,197)**	**(1,246,526)**	**(1,282,054)**	**(1,343,027)**	**(1,405,520)**
EXPENSE						
Payments to internal providers	(1,071,915)	(1,134,197)	(1,246,526)	(1,282,054)	(1,343,027)	(1,405,520)
Total Expense	**(1,071,915)**	**(1,134,197)**	**(1,246,526)**	**(1,282,054)**	**(1,343,027)**	**(1,405,520)**
Surplus/(Deficit)	-	-	-	-	-	-
Other comprehensive revenue and expense	-	-	-	-	-	-
Total Comprehensive Income/(Deficit)	-	-	-	-	-	-

Summary of revenue and expenses by arm (continued)

CONSOLIDATED	2019/20 Actual $'000	2020/21 Unaudited Actual $'000	2021/22 Plan $'000	2022/23 Plan $'000	2023/24 Plan $'000	2024/25 Plan $'000
REVENUE						
Ministry of Health revenue	1,872,987	2,000,593	2,091,407	2,171,185	2,273,401	2,380,568
Other government revenue	40,523	61,022	65,127	66,624	68,165	69,753
Earthquake repair revenue redrawn	6,846	364	800	300	-	-
Other revenue	59,149	65,133	75,073	77,480	79,745	81,769
Total Revenue	**1,979,505**	**2,127,112**	**2,232,407**	**2,315,589**	**2,421,311**	**2,532,090**
EXPENSE						
Personnel	978,834	995,203	1,029,965	1,058,221	1,091,874	1,126,674
Outsourced personnel & clinical serrvices	33,232	35,597	57,640	47,743	42,877	39,060
Clinical supplies	154,268	170,704	172,737	176,032	181,070	186,609
Earthquake building repair costs	6,846	364	800	300	-	-
Infrastructure & non clinical	118,440	125,513	119,319	120,430	123,119	125,165
External service providers	810,043	844,188	851,785	854,613	875,976	897,875
Total Expense Before Depreciation & Capital Charge	**2,101,663**	**2,171,569**	**2,232,246**	**2,257,339**	**2,314,916**	**2,375,383**
Surplus/(Deficit) Before Depreciation & Capital Charge	**(122,158)**	**(44,457)**	**161**	**58,250**	**106,395**	**156,707**
Depreciation and amortisation	79,773	89,676	92,104	91,741	85,993	85,491
Capital charge and interest expense	41,505	42,080	57,064	63,471	69,188	70,296
Total Depreciation, Capital Charge & Interest Expense	**121,278**	**131,756**	**149,168**	**155,212**	**155,181**	**155,787**
Surplus/(Deficit)	**(243,436)**	**(176,213)**	**(149,007)**	**(96,962)**	**(48,786)**	**920**
OTHER COMPREHENSIVE REVENUE & EXPENSE						
Revaluation of property, plant & equipment	(3,068)	95,482	-	-	-	-
Total Comprehensive Income/(Deficit)	**(246,504)**	**(80,731)**	**(149,007)**	**(96,962)**	**(48,786)**	**920**

Appendix 6 System Level Measures Improvement Plan

Available on the DHB's website www.cdhb.health.nz.

CANTERBURY DHB ANNUAL PLAN

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