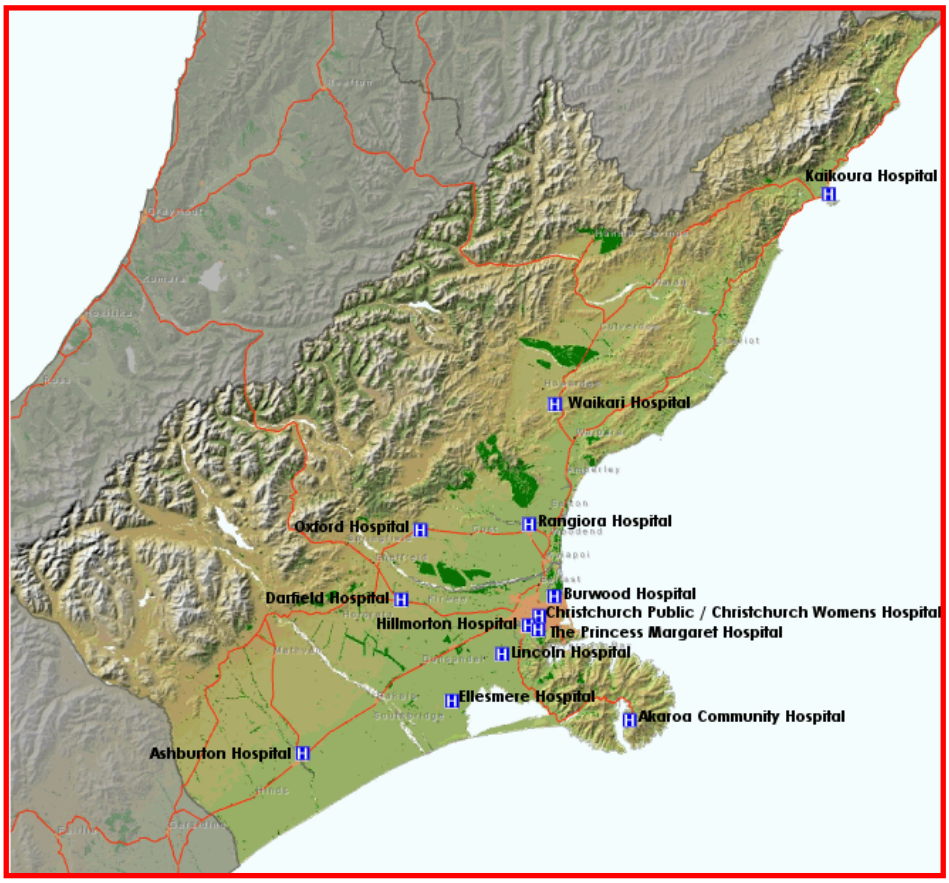

Statement of Intent 2008/2011

Canterbury District Health Board

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

STATEMENT OF INTENT
1 July 2008 – 30 June 2011

Produced in 2008 by the
Canterbury DHB
PO Box 1600, Christchurch
www.cdhb.govt.nz

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OUR VISION AND VALUES

The Canterbury District Health Board (DHB) is the second largest of the twenty-one DHBs in New Zealand by population and the largest by geographical area. The DHB's district covers Kekerengu in the North, Rangitata in the South and Arthur's Pass in the West and comprises the six Territorial Local Authorities of Kaikoura, Hurunui, Waimakariri, Christchurch City, Selwyn and Ashburton.

As a DHB we are responsible for working with our community to decide which health services are needed and how to best use our limited funding to improve the health and well-being of our population. Funded by Government we must note Government policies when making these decisions, particularly the New Zealand Health Strategy 2000, New Zealand Disability Strategy 2001 and the New Zealand Māori Health Strategy, *Te Korowai Oranga,* 2002.

In summary the Canterbury DHB:

- **Plans** in consultation with stakeholders and our community, the strategic direction for health and disability services in the Canterbury district;
- **Funds** health and disability services provided in Canterbury through more than 800 service contracts with health and disability service providers;
- **Provides** hospital and specialist services encompassing women's and children's services, medical and surgical services, mental health, older person's health, rural health services, laboratory and hospital support services and rehabilitation services; and
- **Promotes** community health and well-being through health promotion, health education and population health programmes.

We are also the largest employer in the South Island with over 8,000 staff. Working closely with tertiary education providers and clinical training agencies we aim to build the capability of our health workforce, provide leadership and career development and ensure a good and safe working environment.

OUR VISION TĀ MĀTOU MATAKITE	**OUR VALUES** Ā MĀTOU UARA	**OUR WAY OF WORKING** KĀ HUARI MAHI
To promote, enhance and facilitate the health and well-being of the people of Canterbury. Ki te whakapakari, whakamaanawa me te whakahaere i te hauora mo te orakapai o kā tākata o te rohe o Waitaha.	Care and respect for others. Manaaki me te kotua i etahi atu. Integrity in all we do. Hapai i a mātou mahi katoa i ruka i te pono. Responsibility for outcomes. Kaiwhakarite i kā hua.	Be people and community focused. Arotahi atu ki kā tākata meka. Demonstrate innovation. Whakaatu whakaaro hihiko. Engage with stakeholders. Tu atu ki ka uru.

CORE DIRECTIONS	HEALTH GAIN PRIORITIES	DISEASE PRIORITIES
Improve the Health and Wellbeing of our Community	Child and Youth Health	Cancer
Find Better Ways of Working	Older People's Health	Cardiovascular Disease
Work Together	Māori Health	Diabetes
Develop our Healthcare Workforce	Primary Health	Respiratory Disease
Be a Leader in Health	Disease Prevention/ Management	

EXECUTIVE SUMMARY

In 2004, while developing our long-term vision for our District Strategic Plan 2005-2010, the Canterbury DHB selected five Core Directions, five Health Gain Priorities and four Disease Priorities around which to concentrate efforts to improve health outcomes. These strategic priorities were selected through a health needs assessment and public consultation process and are coupled with national expectations to set our objectives and goals and to plan our actions and activity each year.

This Statement of Intent sets out our objectives and strategies for the next three years against the DHB's strategic priorities, and against national expectations. It also provides an overview of the services we deliver and the performance targets we have set ourselves for the period ahead. Our vision is to promote, enhance and facilitate the health and well being of the people of Canterbury and we will do this by working to meet our service and financial performance targets.

To achieve these commitments we must accelerate change in the way we work and focus on the continued development of patient centred models of care and the redesign of patient pathways to better manage acute demand and the burden of long-term (chronic) conditions. We must also look to improve organisational fitness and focus on quality and patient safety to meet our responsibility to our community. This change will require the DHB, other DHBs in the southern region, the Ministry of Health (Ministry), Primary Health Organisations, local health and disability providers, community and primary organisations and other Government agencies to work together to maintain and improve the health and independence of the people we serve.

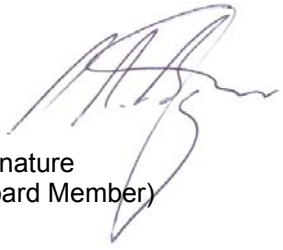
The DHB is committed to delivering effective quality services while maintaining a breakeven financial position. In past years we have successfully managed within our budget. A key factor of this success has been efficiency gains made across the organisation and 'one-off' funding from land sales. However in light of increasing demand, an ageing population and financial pressure resulting from wage settlements, consumable costs and inflation the reality is that we must accelerate change in order to maintain sustainable financial results.

We are looking at all aspects of our business to determine how we can be more cost effective while continuing to achieve our focus and priorities. Trade-offs and prioritisation will be increasingly required to ensure our commitments are realised. Our way forward includes a range of efficiency and effectiveness initiatives, regional and national initiatives, service reconfiguration and outcome focused investment. We will be focusing on the development of joint pathways between primary and secondary care to improve the patient journey and reduce duplications and delays across the whole of the health sector.

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

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

Signature
(Board Member)



Signature
(Board Member)

TABLE OF CONTENTS

1. INTRODUCTION

1.1 About the Statement of Intent

The Canterbury DHB is one of 21 DHBs established on 1 January 2001, under section 19 of the New Zealand Health and Disability Act 2000. All DHBs are categorised as Crown Agents under section 7 of the Crown Entities Act 2004 which states that the Board of a DHB must ensure that the DHB acts in a manner consistent with its objectives, functions, and current Statement of Intent.

This Statement of Intent is for the three-year period 2008/09 to 2010/2011 and has been prepared to meet the requirements of both the New Zealand Health and Disability Act 2000 (section 42 and section 39(8)) and the Crown Entities Act 2004 (section 139(1)).

The Statement of Intent describes to Parliament and to the communities of the Canterbury district what the Canterbury DHB intends to achieve over the coming three years in terms of reducing inequalities and improving the health and well being of our community. The document incorporates activities under the three roles or 'output classes' of the DHB; our Governance role, Funder role and Provider role.

Performance measures and targets are included to describe what we are trying to achieve in terms of improved outcomes for our population against our strategic priorities and in the context of the Government's strategic and service priorities for the public health and disability sector.

The Statement of Intent is aligned to, and consistent with, Government strategies and accountability documents including:

- New Zealand Public Health and Disability Act 2000;
- Crown Entities Act 2004;
- Public Finance Act 1989 (and subsequent amendment acts);
- DHB Crown Funding Agreement;[1]
- The New Zealand Health Strategy;
- The New Zealand Disability Strategy;
- The Māori Health Strategy, *He Korowai Oranga*;
- The Mental Health Strategy, *Te Tahuhu*;
- The Health of Older People Strategy;
- The Primary Care Strategy; and
- The Pacific Health and Disability Action Plan.

The Statement of Intent includes:

- **Section 4** – A outline of the DHB's strategic priorities from a national and local level, signalling where the DHB is looking to make improvements in the health and well-being of our population;
- **Section 5** - A statement of forecasted service performance that the DHB will seek to achieve, during 2008/09 and in the two subsequent years, with non-financial performance measures and targets against the DHB's strategic priorities and output classes; and
- **Section 6** - A financial forecast for 2008/09 and for the two subsequent financial years, 2009/10 and 2010/2011.

At the end of the 2008/09 year, auditors working on behalf of the Office of the Auditor-General compare the performance planned in the Statement of Intent with the actual performance delivered, described in the DHB's Annual Report.

[1] *The Crown Funding Agreement is the agreement between the Crown and the DHB, where the Crown provides funding to the DHB in return for the provision of, or for arranging the provision of, specified health and disability services.*

1.3 Reporting to the Minister of Health

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

- Indicators of DHB Performance outlined in our District Annual Plan and reported quarterly as part of Crown Funding Agreement reporting;
- Requirements under service contracts held with the Ministry and reported in accordance with those service contracts;
- Information requirements contained in the Operational Policy Framework reported quarterly;[2]
- Hospital Benchmarking Information reported quarterly;
- Performance against national Health Targets reported quarterly; and
- Financial reporting to the Ministry's Funding and Performance Directorate, on a monthly basis.

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

A number of initiatives may warrant formal consultation with the Ministry, such as reconfiguration of services. The DHB will identify any consultation needs in each instance and meet our obligations in this regard (including consulting with the Minister of Health). The New Zealand Public Health and Disability Act specifies consultation in relation to the development of, and changes to, the District Strategic Plan, changes to the District Annual Plan and the disposal of land.

1.2 Improving Māori Health and Reducing Inequalities

In accordance with the Government's health strategies and policies, in particular section 4 of the New Zealand Public Health and Disability Act, *Treaty of Waitangi*, the Canterbury DHB is committed to reducing health inequalities and improving health outcomes for Māori.

We are committed to enabling greater Māori participation at all levels of the health and disability sector and have identified a number of ways in which to support Māori to contribute to decision-making and to participate in the delivery of health and disability services in Canterbury.

- We meet with Ngai Tahu as Manawhenua of the district, through Manawhenua ki Waitaha, a representative group which comprises the seven Ngai Tahu Runanga. In the past year a Memorandum of Understanding has been signed with Manawhenua ki Waitaha formalising the relationship between our Boards at a governance level.
- We also meet with Te Runanga o Nga Maata Waka representatives and engage in both formal and informal interactions with many Māori providers, agencies and community organisations. The DHB will endeavour over the coming three years to established formal relationship agreements with Taura Here community groups.[3]
- The Canterbury DHB has an Executive Director of Māori and Pacific Health, reporting directly to the Chief Executive. We also have a Te Kahui Taumata group of senior Māori staff to provide Māori specific advice and a Kaumatua who actively participates in the Te Kahui Taumata group.
- The DHB has also established a Māori Health Team (based in Christchurch Hospital), working in key services to achieve better health outcomes for Māori and a better experience in mainstream services, particularly services that require cultural protocols (including: Paediatrics, Oncology, the Emergency Department and the Mortuary).

[2] *The Operational Policy Framework refers to a set of documents which outline the operational level accountabilities that all DHBs must comply with. These are given effect through the Crown Funding Agreement between the Ministry and the DHB.*

[3] *Taura Here refers to all other collective pan-tribal Māori groups.*

2. OUR ENVIRONMENT

This section provides background on the environment in which we operate. It outlines our population profile, identifies specific health issues for the Canterbury district and describes how our operating environment influences the choices the DHB will make.

In September 2004 the DHB completed its second comprehensive Health Needs Assessment bringing together information describing the Canterbury population and the health status of Canterbury residents. We plan to undertake a review and update of our Health Needs Assessment in 2008/09.

The material presented in the following two sections is drawn from our 2004 Health Needs Assessment and the most recent 2006 Census completed by Statistics New Zealand (NZ).

2.1 Our Population

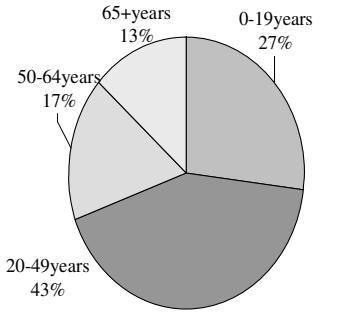
Canterbury's usual resident population, at the 2006 Census, was 466,416 with Statistics NZ predicting that this would rise to 529,150 by 2016. The latest 2006 figures show Māori make up 7.2% of the Canterbury population, Asian people 6.1% and Pacific people 2.2%. Ngai Tahu was the largest identified iwi in Canterbury, followed by Nga Puhi and Ngati Porou. The main Pacific ethnic groups are Samoan, Tongan, Cook Island Māori and Niuean.

Our 2004 Health Needs Assessment reported that just over a quarter (27%), of the Canterbury population lives outside the urban Christchurch boundary. There are differing degrees of rurality but approximately 7,000 people (1.5% of our population) live in remote areas and have to drive for more than an hour for primary health care services. Most people identifying as Māori, Asian or Pacific live in Christchurch City.

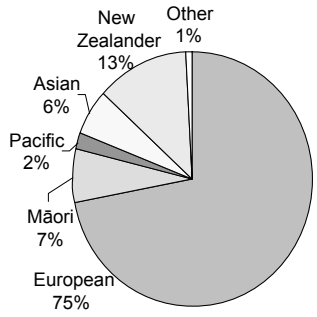
2006 figures show around 14% of the population is aged between 15 and 24 years. This is similar to the national figure. As with the national population, an increasing percentage of our child and youth populations are Māori, Asian and Pacific. These ethnic groups have younger populations in general and latest figures show that while 34% of the total Canterbury population is under 25 years old - approximately 55% of the Māori population is aged under 25 and around 60% of the Pacific population in Canterbury is under 30 years of age. There are proportionately almost twice as many Pacific children as non-Pacific children under the age of 10 in the Canterbury district.

Poorer health status is linked with high degrees of deprivation and the 2006 Census showed Canterbury had around 100,000 people living in NZ Deprivation Deciles 8, 9 and 10 (the highest levels of deprivation). Specific local figures from the 2004 Health Needs Assessment reported that the percentage of Māori and Pacific people living in these areas was higher with 43% of Pacific and 30% of Māori in deciles 8, 9 and 10 compared to 17% of Asians and 15% of Europeans. Eighteen percent of Canterbury's under 15 age group were living in deciles 8, 9 or 10. With a significant proportion of our child and youth populations living in these higher decile areas the DHB has identified child and youth health as the first of our five strategic priorities.

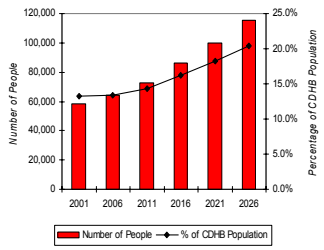
CANTERBURY DHB
POPULATION AGE



CANTERBURY DHB
POPULATION ETHNICITY



CANTERBURY DHB
OVER 65 PREDICTIONS



The 2006 Census shows 13% of the total Canterbury population is aged over 65. This is a slightly higher proportion of elderly relative to the New Zealand population, with latest national figures showing 12% of the country's population aged over 65. Two of Canterbury's rural areas, Kaikoura and Ashburton, continue to have even higher percentages of the population aged over 65 (15% and 16% respectively).

While there are fewer older Māori and Pacific people in New Zealand, with the lower life expectancy due in part to higher morbidity rates through diabetes and cardiovascular disease, the percentage aged over 65 will rise - with the number of Māori over 65 expected to increase from 1.3% in 2001 to 3% by 2021.

Addressing the health needs of Canterbury's ageing population is one of the DHB's key challenges over the coming years and is the second of our five strategic priorities.

2.2 Our Health Profile

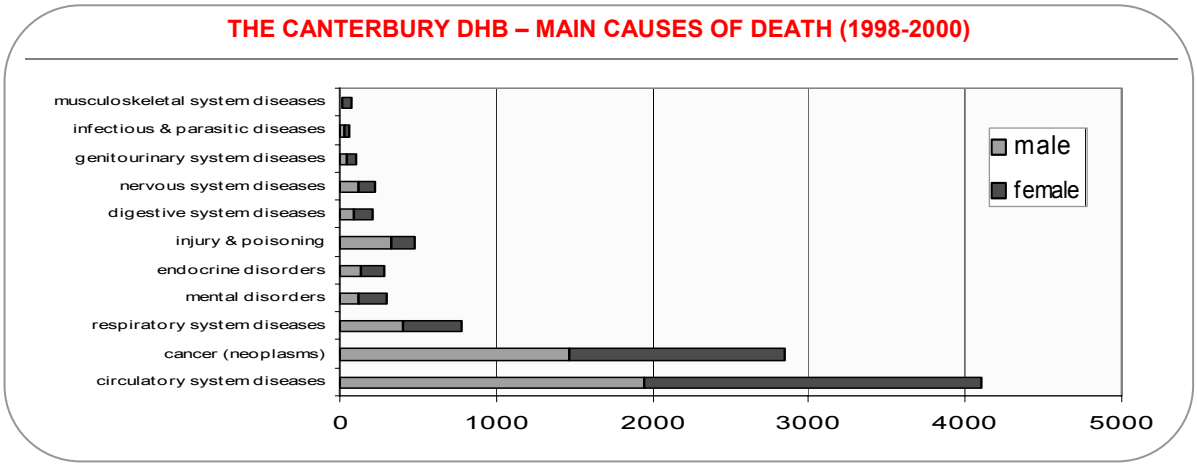
In order to address the health needs of our community it is important for us to understand the health status of our population and the conditions and illnesses, which are prevalent in the Canterbury district. This understanding has assisted us in selecting our long-term strategic priorities.

The health status of residents in most areas in Canterbury is the same as, or better than, the national health status. Canterbury also has the highest life expectancy at birth of all the countries DHB districts (77.8 years).

The main causes of death in Canterbury are diseases of the circulatory system (ischaemic heart disease, stroke, heart attack), cancers and respiratory diseases.

Diabetic complications (such as heart disease, blindness and kidney failure) are also major contributors to the burden of disability experienced by people from middle age, particularly Māori and Pacific people, who are proportionately at higher risk of diabetes and its associated complications.

The prevalence of these diseases is reflected in the choice of Cancer, Diabetes, Cardiovascular Disease and Respiratory Disease as our four identified disease priorities for the next five-ten years.



A number of conditions which result in death or disability (including diabetes) are attributable to similar risk factors: smoking tobacco, not being physically active, eating foods that are not healthy, drinking too much alcohol or using recreational drugs. The 2002/03 NZ Health Survey reveals that most New Zealanders believe they have very good health. However, more than half of all adults are overweight, half do not get thirty minutes of exercise a day, and 20% of people aged over 45 have been diagnosed with cardiovascular disease.[4]

[4] *The NZ Health Survey can be found on the Ministry website, www.moh.govt.nz.*

Tobacco smoking is a major risk factor and preventable cause of death. Canterbury's average smoking rates (23%) are lower than that of NZ as a whole, where the average rate is 25% for most age groups. However, nearly 9,000 people over the age of 35 are admitted to hospital in Canterbury every year with smoking related illnesses, costing the district's hospitals around $23 million annually.

Disease prevention and the management of long-term (chronic) conditions is one of our five strategic priorities with emphasis on healthy eating, active living, smoking cessation, intersectoral collaboration and the development of integrated continuums of care. The DHB has also developed a framework for the management of long-term conditions, which we will continue to develop and implement in the coming three years.

Timely and consistent primary health care can help prevent disease development, complications and hospitalisations. Ambulatory sensitive admissions to hospital are those which result from diseases and conditions which are sensitive to interventions delivered through primary care. It is considered that a good percentage of these admissions are avoidable.

In Canterbury, socio-economically deprived people are hospitalised with potentially preventable conditions at almost twice the rate of those less-deprived. Canterbury's hospitalisation rates for childhood asthma are high, as are the notified rates of pertussis (whooping cough). Māori and Pacific children (an increasing percentage of our younger population) also have high rates of hospitalisation for vaccine-preventable diseases, and higher rates of tooth decay and glue ear.

Primary health is also one of our five strategic priorities and, working alongside PHOs, the Canterbury DHB intends to focus on earlier intervention, improving equity of access to health services, the prevention and management of long-term conditions and addressing acute demand.

Suicide rates in Canterbury are no higher than the national average but continue to be of concern, especially for males. Although not a priority area, we will continue to implement national and local solutions for improved mental health services and equity of access for consumers.

Māori and Pacific Profile

Māori are twice as likely to develop diabetes,and on average develop diabetes nine years earlier than their counterparts of other ethnicities. Māori children also have high hospital discharge rates for asthma, particularly in Canterbury where rates for children under five are higher than the national average.

Pacific people are more likely than other ethnicities to be admitted to hospital for diseases of the skin and conditions related to pregnancy. The high rate of tobacco smoking amongst Pacific youth aged 15-24 is a particular concern and is much higher than the average rate in Canterbury.

Improving the health of Māori and Pacific populations is critical in Canterbury, as throughout NZ, given that on average these ethnic groups have the poorest health status. Nationally and regionally a range of health strategies acknowledge the importance of improving Māori and Pacific health outcomes in order to reduce and eventually eliminate health inequalities that negatively affect these groups. To add local focus we have included Māori health amongst our five strategic priorities.

2.3 Our Operating Environment

Demand Challenges

There is an increasing demand for health services in Canterbury. The ageing and growing population and the increasing burden of long-term conditions are amongst the factors which contribute to this rising demand.

Between 2001 and 2006 the population of the Canterbury region grew by 9.5% and the number of people over the age of 65 increased by 10.8% and those over 85 by 20.8%. With utilisation of health services tending to increase with age, Canterbury's growing older population will result in increased demand for health and disability services in the coming years.

In 2006/07 there were approximately 65,900 inpatient and day case medical and surgical discharges from DHB hospitals. This represents an increase of 14% over the last five years. While some of this growth is explained by increases in the population, demand from other DHBs in the Southern Region for the provision of hospital and specialist level services has also contributed to this increase.

The number of discharges for acute services has increased by 16% over the last five years representing a significantly faster growth than the population. This increase in demand for acute services is also reflected in the increasing attendances at the Christchurch Hospital Emergency Department. In 2001/02 there were approximately 64,100 attendances and in 2006/07 approximately 71,900 - a 12% increase.

Funding Challenges

The DHB is committed to planning and funding health services that best meet the needs of our population and to achieving our strategic objectives and health targets as set-out in this document. However we have to achieve this within a capped budget and a breakeven financial position. Demand pressures, cost pressures and the cost of new technologies make this a significant challenge.

Recent health sector wage settlements have been well above the rate of funding and in the past few years an unprecedented level of investment had been made in staff wages; partly to cope with service pressures and partly to recognise anomalies around international wage rates. This trend of high wage increases will need to be contained in the future as the roll-on effect will otherwise be a reduction in patient services in order to fund higher wage bills.

During the next few years we will face this significant financial pressure resulting from wage settlements, inflationary pressures, increased demand and increased costs in terms of technology and consumables. The DHB's funding strategy must therefore balance the use of additional demographic funding to meet these financial pressures against the need to further invest in services that support improved health outcomes for our population.

We will seek to change the way that we fund services to ensure funding arrangements are supportive of service change, rather than working against the efforts of frontline staff. We will also seek to move funding streams to support a smooth patient journey between primary and secondary care and will develop and support patient pathways in key priority areas including joint primary/secondary respiratory and diabetes pathways.

Our funding strategy over the next three years will establish funding approaches that:

- Improve our ability to achieve change within secondary care and across the primary/secondary continuum;
- Focus hospital and specialist services on the delivery of key activities and outcomes rather than focusing on counting outputs at a detailed level;
- Provide an increased focus on quality, efficiency, effectiveness and value for money;
- Initiate and support service development in priority areas and ensure services located in hospital settings complement community based services; and
- Improve our understanding and tracking of funding commitments and the potential impact of service development on forecasted requirements.

THE CANTERBURY DHB - 'ON AN AVERAGE DAY'

$3 million is spent	261 people are admitted to a public hospital	198 people are seen in the Emergency Department	17 babies are born	46 people are admitted for elective surgery
$340,000 is spent on pharmaceuticals	25 admissions were potentially preventable	3286 people are seen in general practice	1.0 have a low birth weight	90% are satisfied with their care

3. THE NATURE AND SCOPE OF OUR ACTIVITY

The Canterbury DHB has an established governance and organisational structure to enable us to carry out our responsibilities to our community effectively and efficiently. The activities of the DHB fall into one of the three roles or output classes of the organisation:

Governance
The Board of the DHB has all the powers necessary for the governance of the organisation and is responsible to the Minister of Health for managing the organisational health of the DHB. Refer below to section 3.1.

Funder (Planning and Funding)
The Planning and Funding role of the DHB covers our responsibility for determining the health and disability service needs of the Canterbury district and for contracting and funding the provision of those services - section 3.2.

Provider (Hospital and Specialist Services)
The Provider role of the DHB covers our responsibility for the delivery or provision of hospital and specialist services to the Canterbury district and people of the wider southern region - section 3.3.

3.1 Governance – Managing the Organistional Health of the DHB

The governance structure for DHBs is set out in the New Zealand Health and Disability Act. The Board consists of eleven members who have overall responsibility for the operation of the DHB. Seven members are elected as part of the three-yearly local body election process (held in October 2007) and four are appointed by the Minister of Health.

There are a number of sub committees to the Board, comprised of a mix of both Board members and community representatives. Three are Statutory Committees, required under the New Zealand Public Health and Disability Act 2000:

- **The Hospital Advisory Committee** - monitors the financial and operational performance of the hospitals the DHB owns, as well as assessing strategic issues relating to the provision of hospital and specialist services;

- **The Community and Public Health Advisory Committee and the Disability Support Advisory Committee** – provide the Board with advice on the health and disability needs of the resident population and how the services funded or provided by the DHB, along with the policies it adopts, will impact on that population and promote the inclusion and participation of people with disabilities to maximise their independence. These two Committees comprise the same body of membership.

The public are welcome to observe the meetings of the Board and its three Statutory Committees. The meetings are usually held monthly and details of the meetings (such as agendas, minutes, membership and terms of reference) are available on our website www.cdhb.govt.nz. Where appropriate, certain discussions may be held without public presence and this is allowed for under the New Zealand Public Health and Disability Act.

The Canterbury DHB has also established a *Finance, Audit and Risk Committee (FARC),* to enhance the Board's governance function by providing advice on the financial operation of the DHB and the *Remunerations and Appointments Committee*, established to deal with the employment of the Chief Executive and other industrial and employment matters. As non-statutory committees these committees operate in a slightly different manner to the Statutory Committee's of the Board and their meetings are not open to the public.

3.1.1 Leadership and Shared Decision Making

While the responsibility for DHB performance rests with the Board, it has a delegation policy, assigning operational and management matters to the Chief Executive. Our Board and Chief

Executive ensure that their strategic and operational decisions are fully informed through appropriate involvement and support at all levels of the decision making process.

Shared decision making is a key focus for the Canterbury DHB. A number of advisory committees and councils have been established over the past three years to assist the Board and Chief Executive to make informed decisions and to ensure we meet the expectations of our community and stakeholders in terms of patient safety, quality service provision, capability, capacity and value for money.

- **Manawhenua Ki Waitaha** – A Memorandum of Understanding has recently been signed between the Board and Manawhenua Ki Waitaha being our first formal step to enabling the participation of Māori in DHB decision making and in the planning and delivery of health and disability services. The Memorandum of Understanding commits the DHB to regular meetings with, and reporting to, Manawhenua Ki Waitaha as a pathway to shared decision making.[5]

- **Clinical Board** - The Clinical Board is a multi-disciplinary DHB-wide clinical forum that provides oversight of the DHB's clinical activity and advice to the Chief Executive. The Clinical Board is charged with having a proactive role in setting clinical policy and standards and encouraging best practice and innovation. The Board will also support the DHB's vision and values and will provide a leadership role for the organisation.

- **Quality and Patient Safety Council** - The Quality and Patient Safety Council provides governance for the DHB with respect to quality and patient safety and provides advice to the Chief Executive on these issues. The Council promotes the sharing of information, establishment of best practice and facilitation of continuous improvement, looking to offer support and guidance to positively influence quality care. The Council also sponsors both the DHB's Quality Strategic Plan and the DHB's Quality and Innovation Awards and has developed key policies, which promote quality and patient safety.

- **Consumer Council: Health Services Planning** - In 2007 as part of our focus on long-term health services planning, the DHB established a Consumer Council to provide input into decision making as part of the Health Services Planning Programme. The Consumer Council will give focus to a true partnership model that will provide a strong and viable voice for the community and consumers in health service planning and service delivery.

Executive support is provided to the Chief Executive by the Executive Management Team which includes General Managers of Planning and Funding, Community and Public Health and Corporate Services divisions along with an Executive Director of Māori and Pacific Health, an Executive Director of Nursing and a Chief Medical Officer who provide clinical and cultural leadership and oversight of patient safety and quality (Appendix 2 provides an Organisational Chart of the Canterbury DHB).

3.1.2 Quality and Safety

The Canterbury DHB has a strong commitment to the provision of high quality health care services and strives to ensure provision of an integrated service that strongly encourages evidence based clinical care and is responsive to consumer needs.

Through the DHB's Quality and Patient Safety Council we have established a Quality Strategic Plan to promote quality and patient safety throughout Canterbury's health sector. We have developed the Quality and Innovation Awards to recognise and publically acknowledge excellent quality, innovation and improvement initiatives generated by our staff and staff of community-based services. We have also recently established the position of Medical Director of Patient Safety; this new role will work alongside quality leaders and DHB staff seeking to eliminate the harm that can occur to patients in hospital settings and to promote the DHB's focus on quality and patient safety.

The DHB's key quality framework document is our Quality Strategic Plan (2007-2010) that promotes leadership as the underlying driver of quality improvement and quality improvement as a continuum.[6] Developed within the context of the national document *Improving Quality: A Systems Approach for the*

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

[6] *The Quality Strategic Plan is available on www.cdhb.govt.nz.*

NZ Health and Disability Sector; our Quality Strategic Plan presents five key goal areas: community participation/involvement, initiating organisational change and development, clinical risk management, instituting mechanisms for effective reporting and accountability and knowledge management for clinical services and quality.

A number of excellent quality-based achievements have already been made and the DHB will continue to work on establishing pathways to support innovation and quality improvement:

- The development and promotion of key quality and patient safety policies including the Culture of Patient Safety policy, No Blame Incident/Accident Reporting policy and Open Disclosure policy;
- Linking an intranet tool to the Quality Strategic Plan enabling interactive capture of comments, ideas and initiatives and encouraging a 'live' document with true meaning for front-line staff;
- Enhancement of the DHB's Quality and Innovation Awards Programme - to date 86 projects have been entered into the programme, many of which have gone on to achieve national success; and
- Development of a functional requirements document and tender process for a new Incident/Event Management Software System. This System will assist us to address the ongoing identification and mitigation of serious clinical risk to the quality and delivery of health and disability services. It will also assist and support the national approach to the consistent management of healthcare incidents and inform the development of preventive strategies and the redesign of patient care processes to eliminate repeated harm.

3.1.3 Building Capability

Capability is defined as "what an organisation needs in terms of access to leadership, people, culture, relationships, processes and technology, physical assets and structures to efficiently deliver the outputs required to achieve its goals".[7]

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

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

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

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

Improving the patient journey and supporting patient pathways between primary and secondary services have a key role to play in the reduction of acute demand and in managing the burden of long-term conditions (particularly the disproportionate burden which falls on Māori and Pacific people, older people and those lower income groups). Longer-term planning for health services across all sectors is also critical in terms of future sustainability and in enabling the Canterbury DHB to ensure that the right services are provided at the right time, in the right place, and by the right provider.

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

The DHB's Health Services Planning Programme is nearing completion and this planning will present a framework to support a Facilities/Site Master Plan and Strategic Workforce Plan. These Plans will enable us to undertake any major facility re/development in an informed manner, to better prioritise capital expenditure and funding applications, and to reconfigure service delivery models to match the best location for the delivery of patient centred services.

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

3.1.4 Information Systems and Services

Information Services support the Canterbury DHB in the delivery of effective health services, through the provision of quality information systems and services. This involves working on national, regional and local projects that improve our capability to provide effective, quality services.

DHBs have adopted a collective approach to implementing the Government's Health Information Strategy (HIS-NZ). Regional workshops have determined a collective view of the strategic importance of Action Zones within the Strategy and have provided initial input into prioritisation.

Alongside our commitment to the implementation of HIS-NZ the Canterbury DHB has also established a local Information Services Strategic Plan (ISSP).[8] In the coming year we plan to continue the implementation of our ISSP the direction of which re-enforces the objectives outlined in national strategies and involves working closely with stakeholders to implement solutions that satisfy clinical and business requirements. The key challenges over the coming year include:

- Replacement of the HOMER Patient Management System **-** The HOMER system which is used in our acute hospital settings is approaching 'end of life'. We are beginning a programme to prepare a replacement of this software which will meet the clinical requirements for long-term sustainability. The replacement will be progressively phased in over the next few years;
- Development of a Clinical Information System **-** A single integrated patient management system is a key area for the DHB with the immediate focus being a Clinical Information System (CIS) Portal to enable clinical staff to access various patient information systems through a single access point. This system will avoid duplication and wastage and enhance efficient and effective practice;
- Integration of the Health Practitioners Index (HPI) – Integration of our local index will allow us to link to the national HPI numbers once they are assigned, and will again enhance effective and efficient practice and increase the quality of national collections. Considerable effort will be required to integrate this into DHB systems and national reporting; and
- Support of the national Health Information Strategy (HIS-NZ) - We will also be demonstrating our commitment to HIS-NZ through continued implementation of the Action Zones within the Strategy.

3.1.5 Workforce Development

Workforce development and strong organisational health is central to the DHB's ability to provide effective quality services and meet the challenges of improving our community's health. The Canterbury DHB aims to make Canterbury a preferred district for health workers by supporting flexibility and innovation, providing leadership and skill development opportunities and by being a 'good' employer. We will also encourage our workforce to lead by example in terms of healthier lifestyles and practices.

Four key challenges have been identified to ensure sustained organisational health:

- Encourage a flexible approach to meet the changing needs of our community;
- Develop a workforce providing the 'right skills' for the best health outcome to ensure long-term capability and capacity for service provision;

[8] *The Canterbury DHB's ISSP is available on www.cdhb.govt.nz*

- Ensure Canterbury's health sector is a good place to work; and
- Create a safe health-promoting environment to support and retain staff.

The DHB seeks to provide a workplace that supports the retention of staff and will continue to identify areas of improvement and to ensure a rewarding and positive environment. The DHB is committed to developing a workplace profile and understanding the needs and expectations of its workforce. We are also committed to being a 'good employer' in terms of leadership opportunities, a positive culture for the organisation, engagement with staff, harassment and bullying prevention and the provision of a safe and healthy environment.

Workforce development activities over the next three years will include a number of key approaches to building and maintaining capability and capacity. We will:

- Undertake practical steps within our control or influence to maximise our future workforce;
- Participate at a national and regional levels in collaborative activity on workforce issues, including remuneration setting;
- Understand/target workforce support towards promoting employee engagement in the workplace;
- Establish a recruitment strategy specific to addressing current and future workforce needs; and
- Adopt a behavioural change model to affect safety behaviour and practice in the workplace in an effort to further influence employee incident levels.

3.1.6 Productivity and Value for Money

The Canterbury DHB's current funding is considered to be insufficient to meet projected wage and inflationary pressures and the increasing costs of demand driven services. Productivity and efficiency gains will continue to be key in ensuring financial breakeven, and a significant focus of our funding approach will be centred on the need to ensure that the investments made are returning value for money that operations are effective and efficient. With current financial and demand pressures the DHB also needs to be able to reprioritise established structures to allow for up-front investment in areas which will return long-term gains in terms of improved health outcomes for our population.

We are committed to ensuring that the services funded are evidence based and giving priority to interventions that provide the most benefit relative to the resources used. We will continue to focus on the reduction of inequalities in health status and support the development of new services in areas where funding will influence positive changes in the health status of our population. Shared decision making and the advice of the DHB's advisory councils will help us to achieve this commitment as will the DHB's prioritisation principles.[9]

A variety of productivity measures and benchmarking processes are used to assess and promote service quality and efficiency and these will continue to be developed and applied. These measures include caseload and consultation evaluations, consumer satisfaction, complaints and timeliness. The DHB monitors overall productivity through resource utilisation and the value of the services provided compared to the costs of providing those services.

We will continue to take an ongoing approach to reviewing our infrastructure costs and, where appropriate, initiatives will be implemented to manage and/or reduce these costs. Effectiveness, productivity and quality initiatives such as the Improving the Patient Journey Programme, improvements in bed management systems and elective services management have enabled a reduction in over-crowding and wait-times despite an overall growth in demand and we will continue to seek similar improvement in quality and effectiveness.

In the coming years the preferences for sources of savings to enable breakeven and to provide funds for reinvestment will include:

- Efficiency gains (delivering the same service in more efficient ways);
- Service re-configuration (the same outcome by delivery of services in different ways); and
- Service reductions through reduced access or full cessation in low priority areas.

[9] *The DHB's Prioritisation Principles are: Effectiveness, Cost, Equity, Māori Health and Acceptability.*

Clinical input will be key to ensuring quality, patient safety, effectiveness and best practice approaches are considered and factored in the decision making process, alongside productivity, efficiency and value for money. Service reductions will only take place with the approval of our Board and (as appropriate) following consultation with our community and/or the Minister of Health.

3.1.7 Intersectoral Collaboration and Consultation

While we have established our strategic objectives and priorities we realise that our vision will not be achieved through our actions alone. It is imperative, particularly in the current funding environment, that we look to establish partnerships with other agencies and organisations, providers, DHBs consumers and our community. The DHB will aim to share resources, combine effort, provide consistency and work to influence the social detriments of health that are external to the health system in order to achieve the best health outcomes for our population.

We will collaborate with the Territorial Local Authorities and the Regional Council on shared goals for improving intersectoral activity and delivering quality health outcomes for the Canterbury population. This work will be informed by the councils' Long Term Council Community Plans, the Greater Christchurch Urban Development Strategy, shared health needs assessment and our health service planning programme and strategic planning. We will also work alongside Territorial Local Authorities to encourage consideration of environmental design as a health determinant and recognition of the importance of urban design in promoting good health.

We will work with community agencies and organisations on a shared approach to the health of our community and will continue to support intersectoral initiatives such as Healthy Christchurch which recognises that all sectors and groups have a role to play in creating a healthy city, whether their specific focus is recreation, employment, youth, transport or any other aspect of city life.[10]

We have also signalled our increased focus on shared decision making and will maintain our commitment to a participation model. We are committed to Māori participation at a governance level and will work to implement the Memorandum of Understanding signed with Manawhenua Ki Waitaha. The DHB will also maintain our commitment to the Quality and Patient Safety Council and the Clinical Board and we look forward to increased participation from these multidisciplinary advisory groups in setting the direction for the DHB and in helping to achieve improved health outcomes.

Our commitment to patient centred models of care, the management of acute demand and implementation of a framework for managing long-term conditions requires active collaboration and partnership with primary and community health care providers. The DHB will be seeking to enhance these partnerships to progress key priorities and to improve patient pathways and continuums of care.

Regional collaboration will also enable us to improve continuums of care and work towards mutual goals and we will be looking to share innovation and to learn from other DHBs. We are committed to regional planning in terms of national programmes such as implementing the Cancer Control Strategy and will look to share resources and goals and to make the best use of limited funding.

At a national level we will work with education and justice sectors to improve outcomes for the Canterbury population through health, nutrition, physical activity and mental health initiatives; crossing the sectors in an effort to meet shared goals. The Canterbury DHB is committed to a number of national programmes in the coming year which will improve the health of our community including B4 Schools Checks and Newborn Hearing Screening and we will work closely with the Ministry to implement these programmes.

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[10] *This group began as an initiative sponsored by the DHB, the CCC, Te Runanga O Ngai Tahu, He Oranga Pounamu, Pegasus Health, the Christchurch School of Medicine and the Ministry and now involves over 200 organisations who have signed the 'Healthy Christchurch Charter'. Information on Healthy Christchurch can be found at www.healthy.christchurch.org.nz*

3.1.8 Associate and Subsidiary Companies

The Canterbury DHB is a joint shareholder in the South Island Shared Services Agency Limited (SISSAL), which is wholly owned by the six South Island DHBs: Nelson Marlborough, West Coast, Southland, Otago, South Canterbury and the Canterbury DHB. SISSAL provides a consultancy service to the DHBs and works in partnership with them on health planning and funding issues providing services such as: contract and provider management, audit and analysis, strategy and service development and project management. SISSAL is funded by the DHBs to provide these services with an annual budget of around $2.8m and produces its own Statement of Intent.

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

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

  Funding of Brackenridge comes from two sources; a contract directly with the Ministry and contracts with Child, Youth and Family Services. Future direction for Brackenridge includes consideration of growth in community settings and a commitment to the NZ Disability Strategy and the 2003 National Health Committee report, '*To have an Ordinary Life*'.

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

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

3.2 Planning and Funding Health and Disability Services

The Canterbury DHB and the Board are responsible for planning and funding the public health and disability services provided in the Canterbury district in accordance with national health and disability strategies, national policy and the needs of the people in our district.

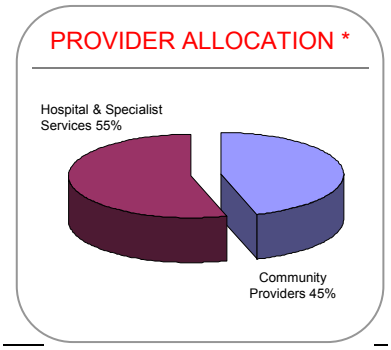
In its Planning and Funding role the DHB (through its Planning and Funding division) coordinates processes like a regular Health Needs Assessment that identifies the need for health and disability services in our district and public consultation that ensures that our community is involved in the planning that we do. The Planning and Funding division is responsible for developing services to cover identified gaps in service delivery and making sure that any advice provided to our Board is aligned with national strategies and Government policy. This division also coordinates the involvement/input of other divisions, department and stakeholders in the writing of planning documents, including this Statement of Intent, the DHB's Annual Plan and the District Strategic Plan.

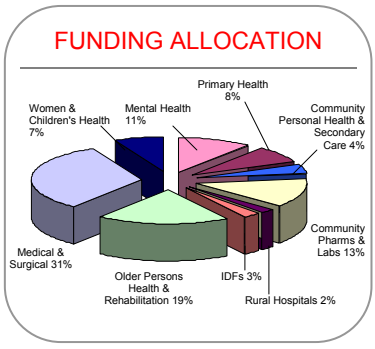
In funding health and disability services, we strive to maintain and improve the health status of the people of our district - within the funding allocated. The Canterbury DHB receives funding from the Government for most personal health, mental health, Māori health and health of older peoples' services in line with a national Service Coverage Schedule and the Crown Funding Agreement.[11]

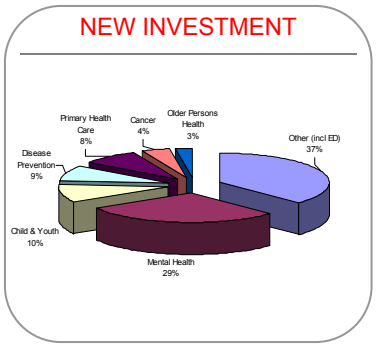
Using the funding available from Government, the DHB enters into co-operative agreements or arrangements with other people/organisations (including our own hospital and specialist services) to assist us in meeting our objectives, improving health or disability outcomes for our population or enhancing efficiencies in the health sector. The DHB may also negotiate and enter into service agreements in terms of Section 25 of the New Zealand Public Health and Disability Act for another person or organisation to provide services on our behalf.

Along with planning and undertaking service contracting for services, as the Funder, the DHB is also responsible for monitoring and evaluating service delivery, including audits, for primary care services, mental health services, support services for people with aged related disabilities (including residential services), Māori and Pacific health services and hospital and specialist services. In essence the Planning and Funding responsibilities of the DHB's include:

- Determining the health and disability status and needs of the Canterbury population;
- Planning, prioritising and implementing national and local health and disability strategies to support strategic priorities, achieve national expectations and meet the needs of our population;
- Involving stakeholders and the community through consultation, participation and partnerships;
- Undertaking service contracting and review of service delivery models and pathways to improve access to services, reduce duplication and provide best use of resources;
- Reviewing provider contracts to achieve the best outcomes for the funding invested including monitoring, auditing and evaluating service delivery, effectiveness and value for money; and
- Ongoing contribution to provider service development and facilities and workforce planning to promote sustainability in terms of service delivery in Canterbury.







[11] *Funding for public health services and for disability support services for people under 65 years of age is not provided through the DHB, but directly from the Ministry to the organisations that provide those services.*

** Note that these funding graphs do not include the recent additional electives funding announced in May 2007.*

3.1 Providing Health and Disability Services

3.3.1 Primary Care Services

A robust primary health care system is central to improving New Zealanders' health overall, and to reducing health inequalities between different groups. New Zealand is experiencing a growing prevalence of long-term conditions such as diabetes and cardiovascular disease, and some groups of New Zealanders suffer from these conditions more than others including Māori and Pacific people, older people and those on lower incomes. Long-term conditions require an increased focus across the primary/secondary interface to ensure that they are recognised early and managed effectively.

The three key goals from the national Primary Care Strategy are:

- **Transparent National Priorities -** DHBs, PHOs and the Ministry focused on national health priorities and working collaboratively to improve sector performance;
- **Collective Stewardship and Governance -** Communities and PHOs engaged to identify population needs and target responses consistent with national priorities; and
- **Enhanced Delivery -** A continuum of accessible services focused on reducing the incidence and impact of long-term conditions.

There are five PHOs in the Canterbury district with over 95% of our population enrolled. Canterbury's PHOs work in a collaborative model with each PHO taking a 'lead' role in the implementation of different projects and initiatives. This provides our population with collaborative primary care services that a more competitive service model might not. We meet regularly with the five PHOs to jointly address key issues and plan future initiatives and general practice representatives sit on a number of the DHB's advisory councils and committees to ensure appropriate input into local health strategies.

CANTERBURY PHOS

Canterbury Community PHO
Rural Canterbury PHO
Hurunui Kaikoura PHO
Partnership Health PHO
Christchurch PHO

We value our relationship with Canterbury's PHOs and work closely on areas such as acute demand management, after hours care, the management of long-term conditions, and health promotion and population health initiatives which will improve long-term health outcomes for our population and help to reduce unnecessary or avoidable hospital admissions.

In the past year we have achieved a number of key successes in partnership with PHOs:

- Implementation of a variety of new primary care services, with a focus on support services for enrolled populations including primary mental health services and child health liaison workers;
- Implementation of subsidy funding rollouts reducing costs for 25-44 year-olds to attend general practice in Canterbury. The rollout also reduced pharmacy prescriptions for this age group; and
- Introduction of a variety of community-based acute demand services with a focus on providing services in the community to prevent unnecessary hospital admissions including acute community nursing, acute observation and equipment initiatives.

Our key priorities for the next three years are:

- Supporting the collaboration and partnership between primary and secondary services through ongoing integration projects and the development of joint primary/secondary pathways in key priority areas;
- Supporting PHO and general practice representation on secondary care and DHB steering groups and working parties to provide an improved understanding of roles and to capture opportunities to improve the patient journey and build patient centred models of care;
- Improving data sharing systems between primary and secondary services to improve service delivery and reduce wastage and duplication; and
- Improving collaboration on future planning and shared goal setting to better meet national expectations and achieve national Health Targets.

3.3.3 Hospital and Specialist Services

The DHB's role as Provider covers the provision of hospital and specialist services to the population of Canterbury and includes a wide range of inpatient, outpatient and community-based services. These services are provided by our six Hospital and Specialist Service divisions (refer to Appendix 3 for an overview of the services provided by each service division).

CANTERBURY DHB
HSS SERVICE DIVISIONS

- Medical and Surgical Services
- Mental Health Services
- Rural Health Services
- Women's and Children's Services
- Older Person's Health and Rehabilitation Services
- Hospital Support and Laboratory Services

The Canterbury DHB owns 14 hospitals in the Canterbury district, which are managed by our Hospital and Specialist Services division and while the majority of services are provided from these hospitals, some specialist services are delivered from community bases or through out-reach clinics. A significant proportion of our specialist mental health services are provided in community settings.

In its Provider role the DHB faces significant challenges in terms of service delivery including: increasing demand and complexity of conditions, rising costs of technology and treatment, high expectations of service delivery, legislation compliance costs, increasing labour costs and pressures of industrial action. We have a range of strategies to cope with current and future challenges but these challenges are real and immediate.

While increasing demand and available funding heavily influence service delivery the DHB strives to ensure that the services we provide to our population are of high quality, are timely and are sustainable. A significant challenge includes managing variation in the patient journey which has a particular impact on quality and time both for the patient and for staff.

The Improving the Patient Journey Programme has been a significant improvement programme for us over the last four years. The core focus has been on improving the flow of patients through the hospital setting by removing delays and wastes to patient and staff time.

The key priorities for our Hospital and Specialist Services over the next 12-24 months are focused on:

- Implementation of the DHB's Improving the Patient Journey Programme and Lean Thinking philosophies and a continued focus on best practice approaches to the delivery of services to reduce delays in patients care, improve health outcomes and maintain high levels of patient satisfaction;
- Implementation of local and national strategies, programmes and policy to improve capability and capacity and provide improved health outcomes;
- Delivery of contracted volumes and compliance with national electives service patient flow indicators to ensure our population receives equitable access to hospital and specialist services;
- Continued review of service delivery models and pathways to improve quality and access, reduce duplication, ensure best use of resources, increase the range of treatment options;
- Continued review of consumables usage and supply chain processes particularly inventory and purchasing and of the introduction of any new treatment regimes and costs of new technology;
- Continued review and evaluation of employee cost control processes, nursing workforce costs, treatment-related costs and review of leave management and roster activity; and
- Continued implementation of operational efficiency initiatives including improving financial rigour and organisational fitness through appropriate training, lean thinking and business planning.

Because of the size of the Canterbury DHB we provide an extensive range of hospital and specialist services, some of which are also provided to people from outside the Canterbury district; coming from DHBs where these specialist services are not available. Those DHBs are responsible for meeting the costs of the services provided to their population; referred to as 'inter-district' services or Inter-District Flows (IDFs). These IDFs are closely monitored to ensure that our ability to provide for our own population is not affected by demand from other districts.

Our Hospital and Specialist Services division makes an annual services contract with our Planning and Funding division and as part of this contract the Hospital and Specialist Services agree to provide certain 'outputs' or volumes. For 2008/09 these are summarised in the following table:

HOSPITAL AND SPECIALIST SERVICES - KEY CONTRACTED SERVICE OUTPUTS [12]

Contracted Output or Service	Measure/Unit	Volumes		Variance
		2007/08 Planned	2008/09 Planned	
Medical In-patient	Case weights [13]	33,878	33,899	0.1%
Surgical In-patient	Case weights	37,357	39,161	4.8%
Medical Out-patient	Attendances/Procedures	164,436	173,902	5.8%
Surgical Out-patient	Attendances/Procedures	130,498	125,919	-3.5%
Mental Health	Full Time Equivalent	334.9	345.4	3.1%
Mental Health	Bed days [14]	87,308	79,278	-9.2%
Emergency Department	Attendances (non-admitted)	-	45,409	-
Maternity	Deliveries	5,550	5,774	4.0%
Disability Support Services	Bed days	68,811	68,475	-0.5%

3.3.3 Elective Services (i.e. booked surgery)

There are two types of hospital admissions: acute (or emergency) services for patients who are very ill and require immediate treatment and elective services (or booked surgery) for patients who have conditions that do not require immediate hospital treatment. Acute demand has grown faster than growth in our population and these acute presentations put at risk our ability to deliver the desired level of elective services to our population (through staffing and resources shortages).

However, the Canterbury DHB is committed to meeting the Government's expectations around elective services and to providing our population with the same level of services as the population of other DHBs, particularly in the three key policy areas of:

- **Patient Flow Management -** The DHB has made a commitment to achieve and maintain compliance with all national Elective Services Patient Flow Indicators (ESPIs);
- **Level of Service -** We will ensure that our Hospital and Specialist Services provide the volume of services (operations) that they are contracted to provide. We are committed to delivering on our elective services commitments and will review the key operations we perform to ensure that we are delivering the right level of service for the people in our district.
- **Order of Service -** We are committed to ensuring that patients are assessed and prioritised for surgery on a consistent basis, and that they receive surgery according to the priority given.

In the past year the DHB has achieved ESPI compliance at a DHB level for a twelve month period and secured additional electives funding for the majority of elective services. We have also approved an Elective Services Sustainable Compliance Plan and Accountability Framework to refocus the DHB on the principles of clarity, timeliness and fairness.

A number of key achievements have improved the delivery of elective services including:

- Appointment of GP Liaison roles to enhance referral gateway management across more services;

[12] *This table does not include volumes associated with planned volumes under the elective, orthopaedic or cataract initiatives.*

[13] *Case weights are a relative measure of the cost of a procedure.*

[14] *Bed days describe how many hospital beds are occupied by patients and for how long.*

- A renewed focus on improving prioritisation practice commencing with the hip and knee physiotherapy screening process; and
- Improved patient flow and productivity through a number of nurse and Allied Health led initiatives.

The DHB will continue to focus on similar initiatives to improve electives service delivery and meet Government expectations and our immediate focus is on:

- Ensuring delivery of agreed increased elective volumes;
- Using acceptable prioritisation processes to determine need and ability to benefit;
- Streamlining patient flow and increasing capacity while maintaining ESPI compliance; and
- Supporting joint initiatives with primary care to improve patient flow and measure unmet need.

3.3.4 Mental Health Services

The Canterbury DHB provides mental health and addiction services on the basis of the national Mental Health Strategy, *Te Tahuhu – Improving Mental Health.* Te Tahuha builds on current mental health strategies, draws together Government interest in mental health and addiction and sets out expected outcomes. Specifically, Te Tahuhu broadens the Government's interest in mental health from people who are severely affected by mental illness, to include all New Zealanders, while continuing to place emphasis on ensuring that people with the highest need can access specialist services.

The Strategy sets out ten leading challenges or action priorities which we are endeavouring to achieve to improve mental health and addiction outcomes. Our commitment to meeting the challenges has led to the development of a local Strategic Framework that aligns the ten Te Tahuhu challenges with the strategic objectives of Canterbury DHB and with our local Mental Health and Addictions Plan (2004).

TE TAHUHU
10 LEADING CHALLENGES

Promotion & Prevention
Building Mental Health Services
Responsiveness
Workforce & Culture for Recovery
Māori Mental Health
Primary Health Care
Addiction
Funding Mechanisms for Recovery
Transparency & Trust
Working Together

Our Framework emphasises a 'System of Care' model based on advancing recovery for people with serious mental illness. This marks a shift away from secondary and specialist services towards a community-based system of care with increased collaboration between providers, service users and their families/whanau.

Simplifying access pathways to services, and enabling the provision of flexible service options while working within the nationwide service framework is a challenge. The majority of additional mental health funding we have recently received has been invested in the community/primary sector and has expanded the range of community-based services available to our population. The additional funding has provided a platform from which the sector can address issues such as how to improve access and ensure services are responsive to the needs of consumers.

Over the past year we have implemented a number of initiatives and projects which will continue to assist us in improving access and responsiveness and building community and primary capability:

- Development of Mental Health Database which includes collection and analysis of detailed service activity data by unique individual and by service area. This information has lead to quite dramatic changes in service behaviour and will greatly enhance planning decisions;
- Continuation of ACCESS Canterbury, a planning and leadership forum focussed on primary mental health and the development of GP Liaison Workers to support people severely affected by mental illness in the primary care sector;
- Participation in the Effective Interventions Watch House Pilot a programme designed to improve identification of serious mental health and alcohol and drug conditions in the police cells;
- Implementation of a joint initiative between the Canterbury DHB and Te Puni Kokiri to support Māori Mental Health Providers with organisational development;
- Participation in the completion of the Regional Forensic Plan to guide service development and future investment in forensic services and build capability across the sector; and

- Implementation of a Single Point of Entry for Adult and Child and Youth Services and increased consult liaison services for primary and community providers (supporting assessment and treatment for clients who do not require case management by specialist mental health services).

Blueprint Funding

The proportion of funding that DHB's receive for mental health services is tagged or 'ringfenced' specifically for those services and is referred to as 'Blueprint' funding. Blueprint funding is allocated to ensure the provision of targeted services to those considered most in need and we will receive an additional $2.8M (of ringfenced mental health funding) in 2008/09. This additional Blueprint funding will be focused on:

- Increasing investment in child and youth services;
- Increasing investment in community and primary care services;
- Supporting and developing Peer Support Services;
- Progressing the cultural responsiveness of mainstream services and the development of the Kaupapa Māori Mental Health Sector; and
- Supporting increased flexibility and innovation in service delivery.

We are committed to supporting flexible mental health support options particularly around youth and Māori mental health services and will continue to examine the current range and mix of mental health services to better understand effectiveness, efficiency and how responsive services are to the needs of service users and their families. As part of our commitment to improving services and meeting the needs of service users the DHB will aim to provide 'crisis' or relapse prevention plans for all of our long-term clients to help reduce readmissions to secondary and specialist services.

3.3.5 Older People's Health Services

The Canterbury DHB is progressively implementing the national Health of Older People Strategy which all DHBs are required to implement before 2010 to better meet the needs of older people now and in the future.

The health of older people is a particular focus for us and our local aged care strategy, *Healthy Ageing, Integrated Support* sets out how we will develop more integrated health and disability services that are responsive to older people's varied and changing needs. Over the past year, through the implementation of our local Strategy we have:

- Developed the Specialist Community Model of Caring and Rehabilitating the Elderly (CARE) and rolled out the International Resident Assessment Instrument (InterRAI), a comprehensive geriatric assessment tool;
- Worked with community pharmacies to roll out the Medicines Use Review Service, targeting patients with long-term conditions, those on multiple medications and those with multiple prescribers to assist people to better manage their medications; and
- Worked with PHOs to increase the enrolment of patients in the CarePlus programme, aimed at better supporting people with two or more long-term conditions - 40% of CarePlus enrolees are over the age of 65 years. We also supported PHOs to work towards a target of 75% of their enrolled populations (over 65) receiving the flu vaccine. Both of these programmes with assist in avoiding unnecessary hospital admissions for older people.

Our ongoing priorities are the continued implementation of both our local Strategy and the national Health of Older People Strategy. We will focus on enhancing community-based services that enable older people to remain safely in their own homes and will:

- Continue to strengthen the primary/secondary interface and ensure people receive appropriate and effective care and service to allow them to remain in their own homes and to avoid unnecessary hospital admissions;
- Continue to develop the InterRAI assessment tool to provide consistency in the assessment process, evidence based evaluation and improving care planning in residential care settings;
- Implement the recommendations of the Acute Demand and After Hours scoping paper to improve services for people in an acute state, living in aged residential care facilities;

- Support quality improvement in home based support services, looking to learn from initiatives in place at other DHBs; and
- Continue to focus on health promotion for older people including: minimising the impact of serious harm from falls, supporting community-based rehabilitation services, supporting flu prevention and medicines management and improving the effectiveness of psychiatric services for the elderly.

3.3.7 Disability Services

The services provided for people with disabilities are designed around the NZ Disability Strategy. The vision is to have a fully inclusive community, where people with disabilities can live in a society that highly values them and continually enhances their full participation.

The implementation of this vision for disability services is enabled locally through our Disability Strategy Action Plan which sets out objectives and priorities for implementing the national Strategy at a local level. In the past year we have worked to implement the principles of the Strategy including:

- The development of the Orthopaedic pathway for patients requiring hip or knee joint replacement;
- The completion of Phase 2 of the Burwood re-development programme using the DHB's Accessibility Plan, giving us the opportunity to upgrade service delivery to better meet the needs of people with disabilities;
- Completion of the design for a model of care for the Brain Injury Service; and
- Commencement of a significant strategic planning process for the Spinal continuum of care.

In developing our Disability Action Plan, we recognised that we cannot address every barrier over night but can take a step by step approach to practical and attitudinal changes that will benefit everyone. We see the NZ Disability Strategy as a 'whole of Government strategy' of which we form only a part and during the coming three years we will continue to work to achieve our objectives in the areas we are able to influence, including:

- Development of patient centred models of care that meet the needs of individual patients including a model of care for Brain Injury Services and for the spinal continuum; and
- Promotion of accessibility in the development of new facilities and services.

3.3.8 Māori Health Services

The national Māori Health Action Plan, *Whakatataka*, sets out to achieve change by directing activity at improving Māori health rather than concentrating on ad-hoc programmes and initiatives. The Action Plan seeks to build on the strengths within whanau and Māori communities and contains four pathways for action.

WHAKATĀTAKA

PATHWAYS FOR ACTION

Te Ara Tuatahi
Developing whānau, hapū, iwi and Māori communities

Te Ara Tuarua
Increasing participation throughout the health and disability sector

Te Ara Tuatoru
Creating effective health and disability services

Te Ara Tuawhā
Working across sectors

Four additional priority areas have also been identified nationally:

- Building quality data and monitoring Māori health;
- Developing whanau ora based models;
- Increasing Māori participation at all levels of the health and disability sector (particularly governance and workforce development); and
- Improving access to primary health care.

These pathways and priorities are integral to ongoing work within the Canterbury DHB.

Our local Māori Health Plan, *Whakamahere Hauora Māori ki Waitaha,* was signed-off by the Board in early 2008. The Plan recognises the DHB's Treaty of Waitangi obligations within the framework of the NZ Public Health and Disability Act and is consistent with the national Māori Health Strategy and Action Plan. A number of achievements have been made in implementing these priorities including:

- An Ethnicity Data Collection Project has been introduced to support the DHB to build quality data and monitor Māori health gains. The Project focuses on updating codes for all patients coded as

Not Stated or Other and raising the awareness of the importance of accurate ethnicity code collection. Over 2,000 patients previously coded Not Stated/Other have had their codes updated;

- Collaboration has been successful around strategies that promote whanau ora particularly around improved healthy nutrition and increased physical activity for Māori through community-based projects including: Kaikoura's Positive Vibration (focusing on overweight children) and the Hundie Club (focusing on overweight/obese adults);
- A formal Memorandum of Understanding has been signed with Manawhenua Ki Waitaha to establish a clear relationship between the two Boards and to improve Māori participation in the planning and development of health and disability services;
- Support has been provided for improving Māori provider capability through the Māori Provider Development Scheme. Ten contracted Māori providers have been being funded through the scheme in 2007/08 with quality improvement a priority for successful funding; and
- Three of the five PHOs in Canterbury have approved Māori Health Plans in place to improve the uptake of services by Māori. The remaining two PHOs have draft Plans which are expected to be approved in the coming year.

Our key areas of focus relate to continued implementation of our Māori Health Plan in alignment with national goals and priorities including:

- Ensuring Māori participation in the development of health and disability services by further developing governance level relationship mechanisms and expanding our Board's understanding how Māori views and values can impact on the governance role;
- Improving utilisation of health and disability services by Māori by supporting PHOs to develop and implement Māori Health Plans for their enrolled populations and establishing a Māori Health Directorate to focus specifically on Māori health issues and the reduction of inequalities in health status; and
- Supporting Māori participation in the health workforce by establishing a specialist recruitment service in Canterbury, allocating scholarships for study in health and developing a better understanding of our current Māori workforce capacity.

3.3.9 Pacific Health Services

The national Pacific Health and Disability Action Plan 2002 sets out the strategic direction and actions for improving health outcomes for Pacific people and reducing inequalities. The Plan is aimed at health and disability organisations and Pacific communities and aims to promote affordable, effective and responsive health and disability services for all New Zealanders.

The Canterbury DHB has a local Pacific Health and Disability Action Plan, which is aligned with the national Plan. Our specific focus includes:

- Supporting Pacific peoples' participation in health service development and seeking input into planning processes;
- Supporting the capacity and capability of pacific providers through the implementation of the Pacific Health Workforce Plan (assisting to develop a competent and qualified Pacific health and disability workforce) and ongoing facilitation of the (Ministry's) Pacific Provider Development Fund; and
- Working (through our Ethnicity Data Collection Project) to ensure robust data is collected on Pacific needs and health outcomes enabling improved planning and specific service development in areas of indentified need and inequality.

PACIFIC HEALTH AND DISABILITY ACTION PLAN

PRIORITY AREAS

Pacific child and youth health

Promoting pacific healthy lifestyles and well-being

Pacific primary health care and preventive services

Pacific provider development and workforce development

Promote participation of disabled pacific peoples

Pacific health and disability information and research

4. OUTCOMES AND OBJECTIVES

This section outlines what the Canterbury DHB hopes to achieve over the next three years. The outcomes and objectives listed are based on Government policy and describe how we will contribute to the Government's policy directions for the whole of New Zealand.

Our local direction was established through a health needs assessment and public prioritisation process that took place in developing our District Strategic Plan in 2005/06. This local direction influences the areas where we will place priority, but is still in alignment with national expectations.

Details on the specific actions and activity we will undertake to implement policy and progress outcomes and objectives both nationally and locally are provided in our District Annual Plan for the 2008/09 year.

4.1 National Objectives for DHBS

The national objectives to which the Canterbury DHB will contribute are set out in the NZ Public Health and Disability Act 2000:

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

4.2 National Priorities for 2008/09 (Government Policy)

The Minister of Health's annual 'Letter of Expectations' is sent to all DHBs, identifying the Minister's specific expectations and priorities for the coming year. These expectations, in additional to national health and disability strategies, and our own strategic priorities, enable us to plan and prioritise activity.

A set of national Health Targets have also been identified in order to focus DHB efforts and make more rapid progress on key national priorities. These Health Targets have been included in our selected set of performance measures and have been clearly identified in our District Annual Plan for 2008/09. The Health Target are set out in the following table, and are aligned in this document either to our local strategic and disease priorities or to a more specific expectations of one of the DHB's three output classes.

Health Targets - Ministry Expectation (long-term)		Alignment
Improving immunisation coverage	Progress towards 95% of two year olds fully immunised.	Child and Youth Health pg 33
Improving oral health	Progress towards 85% adolescent oral health utilisation.	
Improving elective services	▪ Each DHB will maintain compliance in all Elective Services Patient Flow Indicators (ESPIs). ▪ Each DHB will set an agreed increase in the number of elective service discharges, and provide the amount of service agreed.	Provider Hospital and Specialist Services pg 49
Reducing cancer waiting times	All patients in category A, B and C will wait less than six weeks between first specialist assessment and the start of radiation oncology treatment (excluding category D).[15]	Cancer pg 43
Reducing ambulatory sensitive (avoidable) hospitalisations	There will be a decline in admissions to hospital that are avoidable or preventable by primary health care for those aged 0-4 years, 45-64 years and 0-74 years across all population groups.	Child and Youth Health pg 33 Primary Care pg 39
Improving diabetes services and cardiovascular disease (CVD)	▪ There will be an increase in the percentage of people in all population groups, estimated to have diabetes, accessing free annual checks. ▪ There will be an increase in the percentage of people in all population groups, on the diabetes register, who have good diabetes management. ▪ There will be an increase in the percentage of people in all population groups who have their CVD risk assessed.	Diabetes pg 46 CVD pg 45
Improving mental health services	At least 90% of long-term mental health clients will have up to date relapse prevention plans.	Provider Hospital and Specialist Services pg 49
Improve nutrition Increase activity reduce obesity[16]	DHB activity will support sector-wide health targets to increase: ▪ the proportion of infants exclusively and fully breastfed (74% at six weeks, 57% at three months, 27% at six months); and ▪ the proportion of adults (15+) consuming at least three servings of vegetables/two servings of fruit per day (70% vegetables, 62% fruit).	Disease Prevention and Management pg 41
Reduce the harm caused by tobacco	DHB activity will support sector-wide national health targets to: ▪ Increase the proportion of 'never smokers' among Year 10 students by at least 3 percent (absolute increase) over 2007/08 (baseline 57.9%) with an increase for both Māori and Pacific Year 10 'never smokers' that is greater than that for European; and ▪ Reduce the prevalence of exposure of non-smokers to Second Hand Smoke (SHS) inside the home to less than 5% with a reduction in the prevalence of exposure of non-smokers to SHS inside the home for Māori and Pacific that is greater than that for European.	

[15] *The wait time is defined as the time between the specialist decision to commence radiotherapy and the start of treatment. The measure reflects patient categorised into categorises A, B and C. Category D patients have planned treatment (either as part of a trial or because of given protocols) and therefore may have to wait to start treatment and are not included in targets.*

[16] *The nutrition, activity and obesity targets and the tobacco targets are national targets which the Ministry and all DHBs are jointly contributing towards. The DHB will contribute to achieving these targets on a local level, by implementing its HEHA Ministry Approved Plan and its Tobacco Control Plan.*

4.3 Canterbury's Strategic Priorities

In alignment with national priorities and expectations the Canterbury DHB will continue to deliver the best results possible in all areas of service delivery and to meet our responsibilities in each of our three roles (output classes).

However, in determining our long-term direction and goals we identified five strategic health gain priorities and four disease priorities which represent the areas where we believe there is the biggest potential for improving the health of our population. It is in these areas that we will focus our efforts in the coming years.

We also identified a set of core directions or 'tools' by which we will improve our function and performance. These core directions will provide us with the foundations needed to make improvements in the delivery of ongoing services, meet national expectations, implement change in priority areas and manage the organisational health and capability of the DHB.

Evolving from activity around our core direction a number of key areas of focus, or programmes of activity, have been developed for the DHB. These do not replace our strategic priorities but are key to achieving change in service delivery and to improving health outcomes for our community. These are areas where the DHB will place investment in terms of resource and funding over the next few years:

- Improving Organisational Fitness;
- Supporting Patient Centred Models of Care;
- Managing Acute Demand;
- Managing Long-Term Conditions; and
- Achieving National Health Targets.

The Canterbury DHB's approach in all areas will be consistent: ensuring effective resource utilisation to improve access to services, implementing a best practice approach service delivery to promote quality and patient safety and supporting the development of primary/secondary pathways to provide an integrated continuum of care. We will also focus on sharing the responsibility for health outcomes and sharing population and patient focused information to better inform decision making and to address inequalities in health status and health outcomes.

CANTERBURY DHB
HEALTH GAIN PRIORITIES

Child and Youth Health
Older People's Health
Māori Health
Primary Health
Disease Prevention and Management

CANTERBURY DHB
DISEASE PRIORITIES

Cancer
Cardiovascular Disease
Diabetes
Respiratory Disease

CANTERBURY DHB
CORE DIRECTIONS

Improve the Health and Wellbeing of the Community
Find Better Ways of Working
Work Together
Develop our Healthcare Workforce
Be a Leader in Health

Outcome measures by which we will evaluate and assess our performance against our local strategic priorities and against national expectations are outlined in the following section.

5. FORECAST SERVICE PERFORMANCE - MEASURES

One of the functions of this Statement of Intent, and in particular this section, the Forecast of Service Performance is to show how the DHB will evaluate and assess what we do in 2008/09 using performance measures and targets against desired outcomes and objectives.[17] These measures and targets will be subject to an annual review by auditors appointed by the Office of the Auditor General.

The performance measures we have chosen to include are not a comprehensive list and do not cover all of the activity of the DHB - but reflect a picture of activity against the strategic priorities identified in our District Strategic Plan. They also present a picture of activity against national expectations of the DHB's three roles or output classes: Governance, Funder and Provider and present a picture of activity against national priorities through the use of the national Health Targets in our set of performance measures.

For our Governance and Provider roles we have presented a focused set of performance objectives and measures to demonstrate how the DHB will meet legislative responsibilities and national expectations. In terms of our Funder role we have presented a set of objectives and performance measures against our five strategic and four disease priorities to demonstrate our performance in terms of funding and facilitating the improved health and well-being of our community.

The targets we have set against our performance measures are based on the assumption that, notwithstanding funding and financial pressures, we will be able to maintain current levels of service provision. With limited funding available, the scope for service expansion is limited and therefore our performance targets tend to reflect the objective of maintaining current performance levels against increasing population growth. The targets also reflect our commitment to reducing inequalities between population groups.

Where possible, we have included past performance (baseline data) and national averages to give context in terms of what we are trying to achieve and to better evaluate our performance. The DHB is undertaking an evolving process in collaboration with our Quality and Patient Safety Council to developing longer-term impact assessment measures against our strategic and disease priorities and where these have been agreed they have also been included to develop the picture of performance.

Also included are a key set of planned 'outputs' for the coming year that will contribute to achieving the outcomes and objectives desired by the DHB. Again this does not reflect all of the outputs of the DHB but those which contribute to the picture of achievement. More specific detail concerning the outputs of the DHB can be found in our District Annual Plan 2008/09.

Alongside the outputs for our strategic and disease priorities we have indicated which output class of the DHB is primarily responsible for the delivery of those outputs. While we have more direct control of the outputs where we are the Provider of the service, in those areas where we are the Funder (and therefore contract with external providers to deliver the service) our control is limited to influencing change through contracting, support and encouragement, partnership or leadership. Those outputs where the DHB is Funder present more of a risk for us in terms of reliance on a third party to deliver the outputs needed to achieve our desired outcomes or objectives.

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

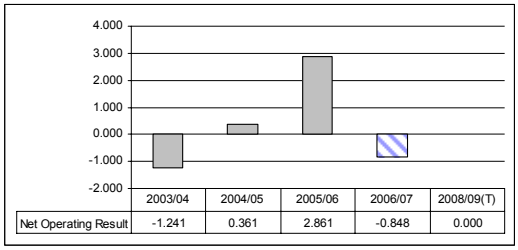
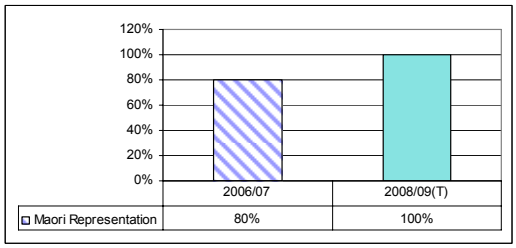
[17] *As stated in the Crown Entities Act (s142).*

Managing Organisational Health – Governance of the DHB

Long Term Objective: *Improve the DHB's capability and capacity to meet the needs of our population and deliver against national expectations and national objectives by providing effective leadership and governance to the DHB.*

The DHB is effectively and efficiently governed by its Board

The DHB is responsible for identifying needs, allocating funding and providing services to meet the needs and improve the health outcomes of the Canterbury population. The performance of these responsibilities must be guided, overseen and monitored by an effective governance Board.

Medium Outcome Measures	2006/07	2008/09	09/10	10/11	
Maintain sustainability. Achieve and maintain a financial breakeven position.	$0.848	$0	$0	$0	
Maintain quality of leadership. Achieve and maintain ongoing Board and Committee training sessions (governance and organisational).	4	>4	>4	>4	
Maintain Partnerships with local iwi and Māori groups. Achieve and maintain Māori representation on the Board and Statutory Advisory Committees.	80%	100%	100%	100%	

Key Outputs	2008/09
Monitor organisational performance against strategic and annual plans and operational results through review of monthly and quarterly reports to the Board.	Quarterly performance reviews monitored.
Deliver accountability documents to the Ministry and Parliament within required timeframes and in accordance with legislative guidelines.	District Annual Plan and Statement of Intent meet annual requirements.
Maintain public participation and community involvement by advertising all Board and Statutory Committee meetings and providing for public attendance.	100% of meetings advertised.
Undertake Treaty of Waitangi training to expand the understanding of how Maori views and values impact on the Boards governance role.	Training provided.
Maintain the Board's relationship agreement with Manawhenua Ki Waitaha.	Terms of reference for Māori engagement with the Board are produced.

Child and Youth Health

Long Term Objective: Improve health outcomes for our younger populations, particularly for those with high needs or those living in environmentally disadvantaged situations and demonstrate the establishment of good foundations for well being healthy behavioural patterns and improved access to health and disability services to avoid hospital admission.

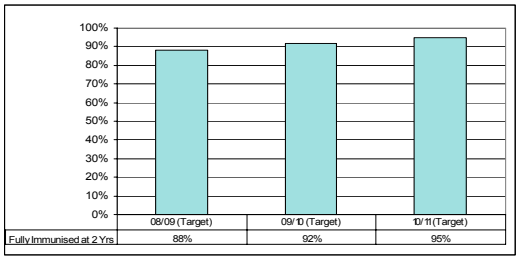
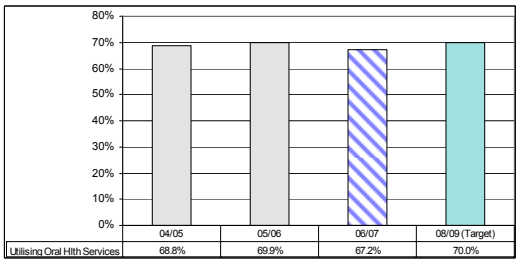
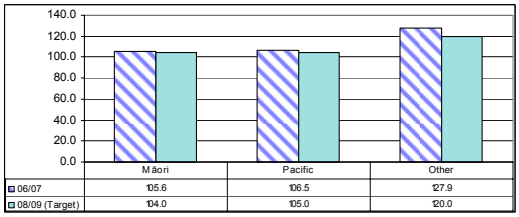
Build healthy foundations for our child and youth populations to ensure long-term well being.

Higher rates of ambulatory sensitive (avoidable or unnecessary) hospital admissions can indicate poor access to effective primary and social services. Canterbury's avoidable hospital admission rates are higher than the national average for the 0-4 year old age group. A reduction in these rates will indicate improvements in health and will also provide the potential to free up health resources allowing them to be directed to other priority areas. The DHB will work in partnership with primary and community sector to reduce unnecessary admissions and build solid foundations for life-long good health by funding and facilitating the provision of high quality preventative care and early intervention – particularly:

Breastfeeding which contributes positively to infant health and influences the likelihood the obesity later in life;

Immunisation which is one of the most cost-effective and successful preventative health interventions known and is an important component in keeping both children and adults free from preventative disease, particularly Māori and Pacific children who have higher rates of vaccine-preventable diseases; and

Regular dental care which also has life-long benefits for improved health. While water fluoridation can significant reduce tooth decay across all population groups - less than 5% of children in Canterbury have access to fluoridated water and many adolescents, especially high risk groups, do not seek oral health care beyond year 8, despite this being a free service. Māori children are three times more likely to have decayed, missing or filled teeth.

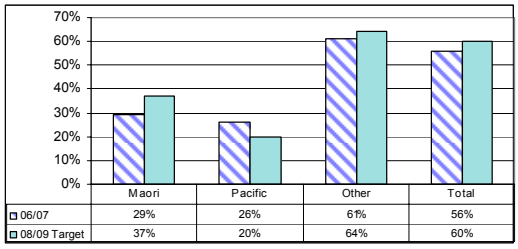
Medium Outcome Measures		**2006/07**	**2008/09**	**09/10**	**10/11**	
Improve utilisation of services. An increase in the percentage of children fully immunised at age two.[18]	Māori	na	88%	92%	95%	
	Pacific	na	88%	92%	95%	
	Other	na	88%	92%	95%	
	Total	na	88%	92%	95%	
An increase in the percentage of adolescents (13-17 years) utilising oral health services.[19]		67.2%	70%	>70%	>70%	
Improve the quality of treatment. A decrease in Ambulatory Sensitive Hospital Admissions for those aged 0-4 years (ISR).[20]	Māori	105.6	≤104	<102	<100	
	Pacific	106.5	≤105	<102	<100	
	Other	127.9	≤120	<112	<100	

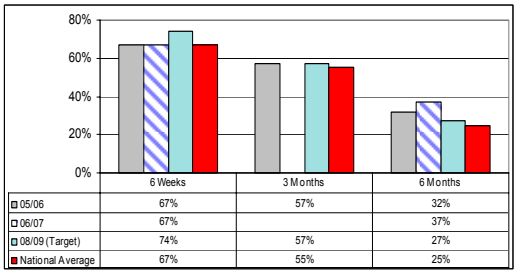
[18] *These figures are taken from the eligible population on the National Immunisation Register (NIR). At year-end 2006/07 none of the children on Canterbury NIR had yet reached age two.*

[19] *Oral health results are provided by HealthPac on a calendar year. The access rates for 2007 have not yet been provided and the DHB is therefore unable to set long-term targets without a more recent or full data set.*

[20] *The Admission rate is based on admissions for 37 conditions including: Asthma, Dehydration, Diabetes, Ruptured Appendix, Vaccine Preventable Diseases, Dental Conditions, Gastroenteritis and Failure to Thrive (poor nutrition). The targets reflect our intention to move towards the national average with a focus on where performance is poor in comparison to other DHB regions.*

Medium Outcome Measures		2006/07	2008/09	09/10	10/11
An increase in the percentage of children who have no holes or fillings (caries free) at age 5. [21]	Māori	29%	27-47%	27-47	27-47
	Pacific	26%	10-30%	10-30	10-30
	Other	61%	64%	>64%	>64%
	Total	56%	60%	>60%	>60%
Improve the pathways between services. Maintain high percentages of children exclusively/fully breast fed.[22]	6 wks	67%	>74%	>74%	>74%
	3 mths	n/a	>57%	>57%	>57%
	6 mths	37%	>27%	>27%	>27%





The focus in the coming year will be building the foundations for a healthy life by encouraging breastfeeding, promoting healthy nutrition and physical exercise in schools and early childhood centres, working with out-reach immunisation coordinators and PHOs to improve immunisation rates and with PHOs, private dentists and dental therapists to improve enrolment in oral health services.

The DHB will be implementing the national Oral Health Reform in the coming year, improving the oral health service provided to our district and building our oral health workforce to ensure sustainable services. The DHB will also implement a number of nationally funded screening programmes to improve early intervention including Newborn Hearing Testing, B4 School Checks and the national Violence Intervention Guidelines.

Key Outputs for 2008/09 (from the District Annual Plan)	Delivery Date 08/09	Output Class
Establish a Breastfeeding Advocacy Service to support Baby Friendly Communities.	Q1	Funder
Fund additional peer support programmes and community-based initiatives to support increased breast-feeding rates.	Q1-Q2	Funder
Complete a DHB Immunisation Direction Paper - reviewing current strategies to improve childhood immunisation rates and identify opportunities to extend these.	Q1	Funder
Investigate alternative pathways in order to reach children in priority groups and promote completion of scheduled immunisations.	Q2-Q4	Funder
Provide Newborn Hearing Screenings to allow for early intervention.	Q1-Q2	Funder
Provide B4 Schools Screening to identify physical and psychosocial issues that can be addressed before children starts school.	Q1-Q2	Funder
Support joint initiatives with dentists to improve oral health utilisation rates.	Q2-Q4	Funder
Finalise a detailed plan for the implementation of the Ministry's Oral Health Reform to upgrade and realign school and community oral health services.[23]	Q1-Q2	Provider

[21] *Small population numbers for these age groups make it difficult to set targets for Maori and Pacific and therefore confidence intervals have been built into the targets.*

[22] *No 3mth figure was provided by Plunket for this year.*

[23] *The DHB's ability to deliver this action is dependant on timely Ministry sign-off for the DHB's Oral Health Business Case to allow for scheduled implementation. Any delay in the implementation of the Oral Health Reform will also affect the DHB's ability to improve child and youth oral health rates and the utilisation of oral health services by adolescents.*

Older Person's Health

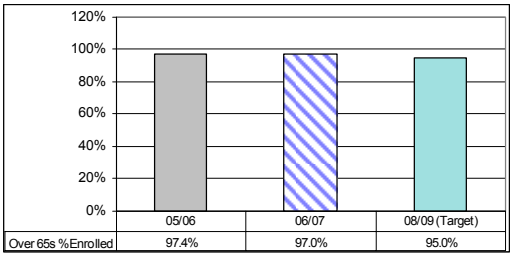
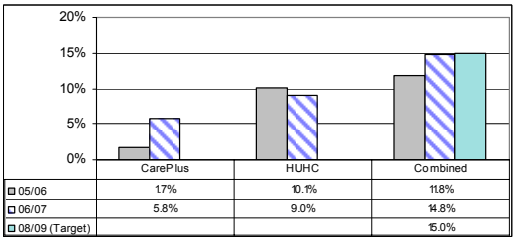
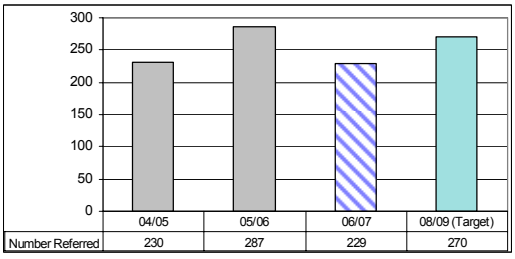
Long Term Objective: Improve health outcomes for older Canterbury residents, deliver positive outcomes, and meet increasing demand, within available resources. Demonstrate an emphasis on flexible, holistic, high quality, needs-based care provided in the community to assist older people to stay well and to age in place (in their own homes).

Ensure our older population remain healthier and are appropriately supported in the community.

Between 5-6% of Canterbury's population aged over 65 live in residential care with the remainder living at home. Many older people prefer to age in their own homes and this 'ageing in place' philosophy requires people to be safe in their homes and to maintain good health for longer. Around 1,000 older people are hospitalised annually in Canterbury as a result of injury due to accidental falls for example, and the impacts can include: death, prolonged hospital stay, loss of confidence, restriction on social activities, loss of independence and increased risk of institutional care.

The Canterbury DHB currently spends more on residential care services than other DHBs and long-term these levels of expenditure are not sustainable. The DHB will need to concentrate on innovative and cost-effective initiatives to support the increased demand of its ageing population and the growing cost of residential services. [24]

Effective primary and disability support services are important in keeping people well and avoiding hospital and residential care admissions, including effective screening and medication management. We will work in partnership with the community and primary sector to facilitate the provision of preventative care and early intervention and support.

Medium Outcome Measures	2006/07	2008/09	09/10	10/11	
Improve access to treatment. Maintain the percentage of the Canterbury population over 65 enrolled with PHOs.	97%	>95%	>95%	>95%	
Maintain high percentages of people over 65 enrolled with a PHO, who are accessing Care+ or High User Health Card services. [25]	14.8%	>15%	>15%	>15%	
Improve the quality of treatment. Maintain high percentages of people over 65 receiving influenza vaccinations.	74%	>75%	>75%	>75%	
Improve the pathways between primary and secondary services. Increase the number of people referred to Stay on Your Feet fall prevention programmes.	229	>270	>290	>300	

[24] *The Canterbury DHB's funding share received for the over 65 age group is approximately 12% of the national total, while our proportion of the total funding spent on Aged Residential Care is closer to 16%. This differential would indicate that the proportion of people over 65 living in resident care in Canterbury is higher than the national average.*

[25] *The goal of Care+ is to develop individualised primary care programmes for people with two or more long-term (chronic) conditions - specific goals are set for each person and monitored on a quarterly basis – people over 65 tend to have more complicated conditions.*

To successfully enable good health, prevent unnecessary hospital and residential care admissions and promote the ageing in place philosophy, the DHB will focus on effective health promotion campaigns covering physical activity, nutrition, disease prevention, oral health, elder abuse and falls prevention. Falls prevention is a key focus to improve the quality of life for older people, keep them safe in their own homes and avoid unnecessary hospital admissions The DHB will also support effective primary and disability support services and will aim to make the best use of specialist services with a strong community base and coordinated assessment. Improving the pathways between services will be a key focus for the coming year as will utilisation of effective and targeted primary care services and a focus on improved medicines management.		
Key Outputs for 2008/09 (from the District Annual Plan)	**Delivery Date 08/09**	**Output Class**
Implement a medicines management pilot for PHO enrolled patients on 14 or more medications to support improved medications management.	Q3-Q4	Funder
Integrate falls minimisation/prevention strategies into care planning in HSS Older Person's Health Services.	Q3	Provider
Deliver more supportive discharge for patients through a redesign of services.	Q1	Funder
Deliver simplified referral pathways and assessment processes to improve coordination between community support services.	Q4	Funder
Support a pilot of the InterRAI Assessment Tool by residential providers.	Q1	Funder
Implement quality improvement programmes in home-based support and residential care services.	Q3-Q4	Funder
Deliver specifically designed or redesigned services to meet the specific needs of older clients with psychiatric conditions and enhance Memory Assessment Services.	Q3-Q4	Provider

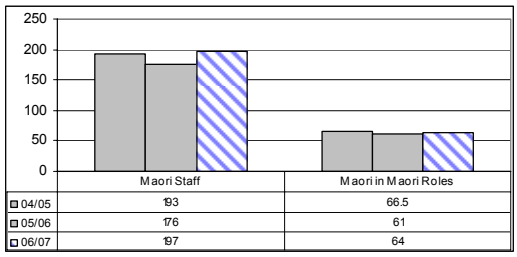
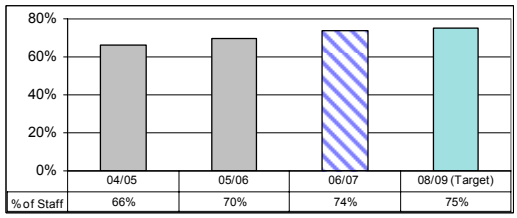
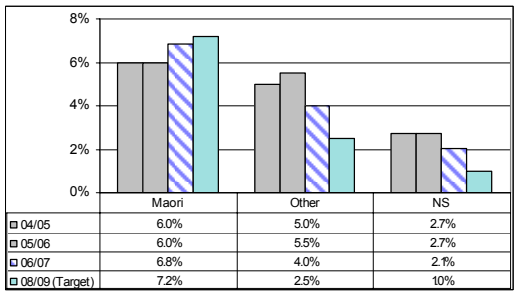
Māori Health

Long Term Objective: Improve health outcomes for Māori in Canterbury, reduce inequalities in access to services and demonstrate that Māori and their whānau are supported to achieve their maximum health and wellbeing - Whānau Ora.

Improve the acceptability of health and disability services to increase Māori utilisation of services to support a reduction in inequalities in health status and improve health outcomes.

Although progress has been made, Māori, on average, have the poorest health status of any group in NZ and are less likely to access mainstream primary and secondary health and disability services. With an increasing Māori population in Canterbury Māori participation in service development needs to be fostered to improve the cultural responsiveness of mainstream services. This includes active participation at governance and advisory levels, a focus on Māori-led service provision and service development and increased participation in the health workforce.

The DHB recognises the disproportional representation of Māori in terms of chronic conditions particularly diabetes and respiratory disease and will target programmes in these areas of need. A clear understanding of gaps and inequalities needs to be maintained in order to effectively target service and improve access for those people most in need. This has been recognised in the DHB's Māori Health Plan where effective ethnicity data collection, health status monitoring and identification of areas of inequality are a focus.

Medium Outcome Measures	**2006/07**	**2008/09**	**09/10**	**10/11**	
Improve utilisation of services by improving responsiveness. Monitor the number of DHB (i) staff identifying as Māori (ii) Māori staff working in Māori specific roles.[26]	(i) 197 (ii) 64	- -			
Increase the number of staff with ethnicity disclosed.	74%	75%	>80%	>80%	
Improve the quality of service planning. Increase the percentage of inpatients classified by ethnicity group (reducing those recorded as Not Stated or Other).[27]	Māori Other Not Stated	6.8% 4% 2.1%	>7.2% <2.5% <1.0%	>7.2% <2.5% <1.0%	>7.2% <2.5% <1.0%	
Improve the pathways between primary and secondary services. Increase the percentage of PHOs with DHB approved Māori Health Plans.	60%	100%	100%	100%	

[26] *The DHBs focus is on monitoring these staffing levels and on increasing the number of staff with disclosed ethnicity to improve the robustness of this data over time – hence no targets have been set for increasing staffing levels from the current level as this is for information only.*

[27] *This target reflects the DHB's long-term goal to bring reporting into line with current Census figures.*

The DHB will focus on improving the participation of Māori in the development and provision of health and disability services and in the health sector workforce. This participation will enable the DHB to improve the acceptability of mainstream services for Māori and to increase utilisation of services.		
Key Outputs for 2008/09 (from the District Annual Plan)	**Delivery Date 08/09**	**Output Class**
Provide advice and input to PHO Māori Health Plans to ensure they meet the needs of their enrolled Māori populations.	Q2	Funder
Allocate Māori Provider Development Funding with quality improvement as a focus.	Q2-Q4	Funder
Deliver Māori-led smoking cessation programmes and increase the number of smokefree Marae to improve health status across a number of key priority areas.	Q1-Q4	Provider
Provide ethnicity breakdowns against Cancer (radiation oncology) treatment rates and oral health utilisation rates to identify and reduce inequalities in access.	Q4	Provider
Fund a Roadshow for Canterbury schools encouraging health as a career with supporting resource materials.	Q2-Q4	Funder
Fund scholarships for study in primary health for 10 students in the 2008/09 year.	Q1-Q4	Funder
Deliver an updated Health Needs Assessment for the Canterbury region.	Q2	Funder
Deliver one Health Inequalities Workshop each quarter to improve awareness and understanding of health inequalities and promote the use of the Health Equity Assessment Tool (HEAT).	Q1-Q4	Provider

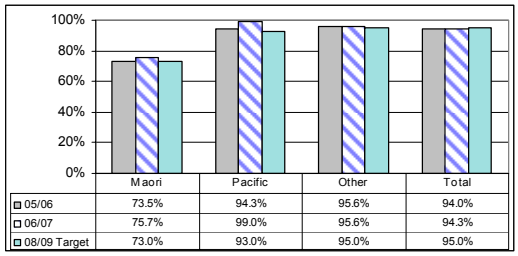
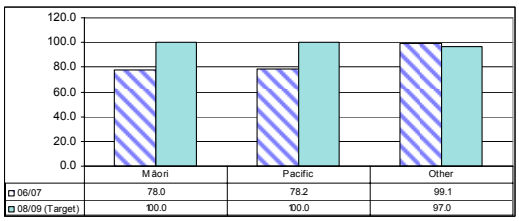
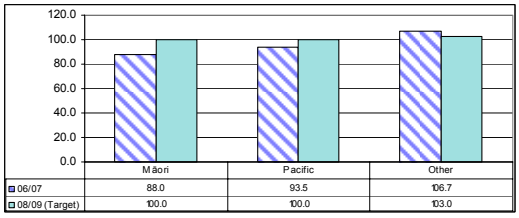
Primary Health

Long Term Objective: Increase the number of people accessing primary health services in Canterbury, particularly those people with high needs and those on lower incomes and demonstrate improvements in the range and effectiveness of services provided in primary care settings.

Reduce barriers to primary care to improve the health of our community and avoid unnecessary hospitalisations and build partnerships to improve the management of acute demand.

Primary care is often the first point of contact with health services and reducing barriers to access helps people stay well. Costs are a key barrier to access for some people and hospitalisation rates for people on lower incomes are higher than the Canterbury average. The DHB will need to work closely with PHOs to reduce access barriers to primary care and will work to support innovative models of care for high-need population groups including Māori, Pacific and those in lower socio-economic groups.

The DHB will also work closely with community and primary sectors to manage growing acute demand pressures. A reduction in the rates of unnecessary hospital admissions will provide the potential to free up health resources allowing them to be directed to other priority areas.

Medium Outcome Measures		**2006/07**	**2008/09**	**09/10**	**10/11**	
Improve access to services. Maintain high PHO enrolment levels with an increase in Māori enrolment as a high needs group.[28]	Māori	76%	>73%	>73%	>73%	
	Pacific	99%	>93%	>93%	>93%	
	Other	96%	>95%	>95%	>95%	
	Total	94%	>95%	>95%	>95%	
Maintain a high percentage of the total eligible enrolled PHO population, enrolled in Care+ services.		86%	>80%	>80%	>80%	
Improve the quality of treatment. A decrease in Ambulatory Sensitive Hospital Admissions for those aged 45-64 years (ISR).	Māori	78.0	< 100	< 100	< 100	
	Pacific	78.2	< 100	< 100	< 100	
	Other	99.1	≤ 97	≤ 97	≤ 97	
A decrease in Ambulatory Sensitive Hospital Admissions for those aged 0-74 years (ISR).	Māori	88.0	< 100	< 100	< 100	
	Pacific	93.5	< 100	< 100	< 100	
	Other	106.7	≤ 103	< 102	< 100	
Improve the pathways between primary and secondary services. An increased in the number of valid NHI recorded on prescriptions to enable better medications management.		92%	95%	95%	95%	

[28] *The targets set for 2008/09 take into account an increase in the percentage of the Canterbury population which distorts the percentage figures between 2006/07 and 2008/09.*

The DHB will work with PHOs to implement the Acute Demand Management Programme and the recommendations of the After Hours Direction Paper to ensure people receive the most appropriate level care in the most appropriate place. The DHB will also support PHOs to enhance services to manage long-term conditions and to develop integrated pathways of care in priorities areas including Māori Health, Diabetes and Respiratory Disease.

Collaborative strategies for optimising the effectiveness of community pharmaceutical and laboratory expenditure will also need to be developed to ensure long-term sustainability and to reduce wastage. There are currently more pharmacy prescriptions dispensed per person in Canterbury than the national average, for all age groups except those over 65. We are currently not meeting national quality targets in terms of the recording National Health Index (NHI) numbers on prescriptions and focus on this area will improve data analysis on prescribing patterns and health needs.

Key Outputs for 2008/09 (from the District Annual Plan)	**Delivery Date 08/09**	**Output Class**
Facilitate timely and accurate discharge summaries from secondary to primary care.	Q3-Q4	Funder
Implement the priorities of the Acute Demand Management Programme.	Q1-Q4	Funder
Implement the Framework for managing long-term conditions.	Q1-Q4	Funder
Establish joint primary/secondary pathways to improve the management of respiratory disease.	Q1-Q4	Funder
Establish joint primary/secondary pathways to improve the elective services referrals process.	Q1-Q4	Funder
Complete a Community Pharmacy Direction Paper, identifying strategies for sustainability.	Q3	Funder
Identify and facilitate opportunities to improve the sharing of laboratory data.	Q3-Q4	Funder
Deliver analysis to determine where and why valid NHIs are not being recorded and define actions to improve NHI recording.	Q1-Q2	Funder

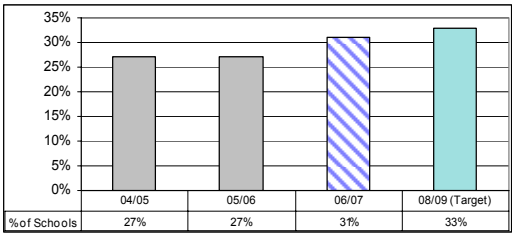
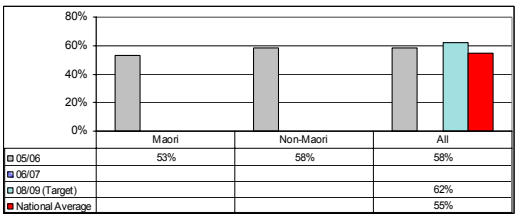
Disease Prevention and Management	
Long Term Objective: Reduce the risks associated with long-term (chronic) conditions and the impact of long-term illness and promote well-being by enabling our community to make healthy choices through supportive physical, social, economic and policy environments and a greater commitment to improved health and wellbeing.	
Long-Term Impact Measures	**2003/04**
A reduction in the proportion of the Canterbury population who are obese. [29]	21%
An increase in the percentage of the population who are regularly active. [30]	51%
A reduction in the tobacco smoking rates in Canterbury (Males 15+).	22.5%
A reduction in the tobacco smoking rates in Canterbury (Females 15+).	21.5%

Enable healthy choices to support people to improve their overall health and wellbeing.

Good nutrition, physical activity and maintaining a health body weight are fundamental to health and to the prevention of disease and disability at all ages. Vegetable and fruit consumption has been found to be protective against cardiovascular disease and some common cancers, and may contribute indirectly to maintaining a healthy body weight.

Smoking kills an estimated 5000 people in New Zealand every year, including deaths due to second-hand smoke exposure. Smoking also a major contributor to inequalities in health and is a major cause of lung cancer and chronic obstructive pulmonary disease, heart disease, strokes and a variety of other cancers. The highest prevalence of smoking is amongst our young people aged 15-29, with approximately one in every four teenagers 15-19 currently smoking.

The DHB aims to work collaboratively across community, primary and secondary sectors to reduce risk behaviour, raise awareness and support healthy choices. The following measures are an indication of the pathways between sectors, the consistency of messages and education. They also indicate access to services that promote change and good health and provide a measure of the quality of services and their effectiveness in promoting change and healthy behaviour.

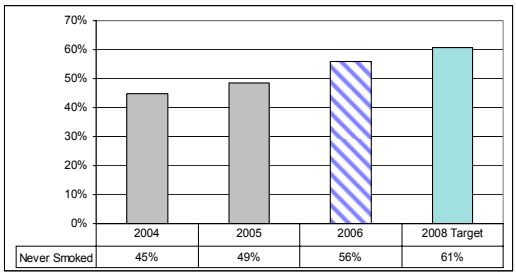
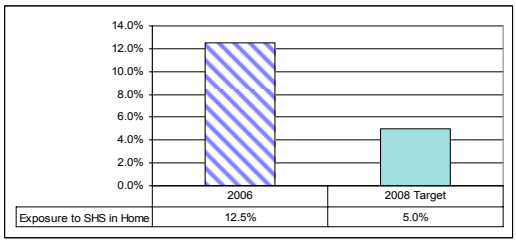
Medium Outcome Measures	2006/07	2008/09	09/10	10/11	
Improve access to services. An increase in the percentage of Canterbury schools working within the Health Promoting Schools Framework. [31]	31%	>33%	>35%	40%	
Improve the effectiveness of service provision and education. An increase in the percentage of the population (15+) having two or more servings of fruit a day. [32]	58%	62%	>62%	>62%	
An increase in the percentage of the population (15+) having three or more servings of vegetables a day.	66%	70%	>70%	>70%	

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

[30] *Regular Activity is defined as at least 30 minutes of moderate physical activity on five or more days of the week.*

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

[32] *Like the four long-term impact measures the results for these fruit and vegetable indicators comes from statistics from the NZ Health Survey collected nationally by the Ministry every three years – these are 2003/04 figures. This survey is currently being collected for the second time.*

Medium Outcome Measures	2006/07	2008/09	09/10	10/11	
Improve collaboration around healthy messages and practice. An increase in the proportion of 'never smokers' among Year 10 students by at least 3% with an increase for both Māori and Pacific that is greater than that for European.	56%	61%	>61%	>61%	
A reduction in the prevalence of exposure of non-smokers to Second Hand Smoke inside the home with a reduction for Māori and Pacific that is greater than that for European.	12.5%	>5%	>5%	>5%	

We will work collaboratively with early childhood centres, schools and community groups to promote healthy behaviour and promote good health behavioural habits amongst children and young people in Canterbury. This work will be driven through the DHB's Health Eating, healthy Activity (HEHA) Ministry Approved Plan. This work will also focus on providing access to education and nutritional advice and to physical activity programmes to support behavioural change.

The DHB will also aim to work collaboratively with community groups, Maori and Pacific communities and primary care to reduce the uptake of smoking – the average age of smoking initiation in adolescents is 14.6 years. Promoting clear and consistent messages across sectors is central to achieving a change in risk behaviours for our population.

Key Outputs for 2008/09 (from the District Annual Plan)	Delivery Date 08/09	Output Class
Fund additional schools and early childhood centres to support the implementation of national nutrition guidelines through implementation of the HEHA Nutrition Fund.	Q2-Q4	Funder
Fund community action projects to enable Māori/Pacific people to achieve HEHA goals.	Q2	Funder
Fund physical activity and nutrition professional development training to increase capability and capacity in the Māori and Pacific activity and nutrition workforce.	Q2-Q4	Funder
Increase the number of Appetite for Life (weight and nutrition) courses delivered in community and primary settings.	Q1-Q4	Funder
Implement the DHB's Tobacco Control Plan and deliver against the key actions in that plan to reduce the uptake in smoking and support increased quit attempts.	Q1-Q4	Provider
Engage primary and secondary clinical champions to support smokefree activity.	Q1	Provider
Deliver a collaborative Canterbury Regional Smoking Cessation Services Plan.	Q2	Provider
Deliver Auahi Kore initiatives and the Aukati Kai Paipa programme to promote smokefree lifestyles to the Māori community.	Q1-Q4	Provider
Present at Marae meetings on the impacts of smoking cessation across generations.	Q1-Q4	Provider
Increase the number of urban Marae with designated smoking areas or (ideally) smokefree.	Q4	Provider
Increase the number of Papatipu Rununga Marae who have designated smoking areas or are (ideally) smokefree.	Q4	Provider

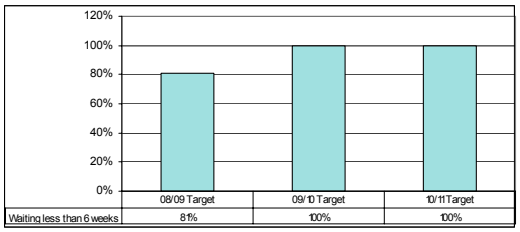
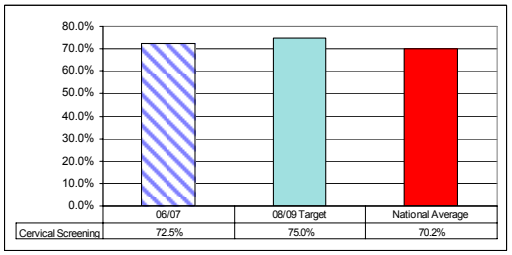
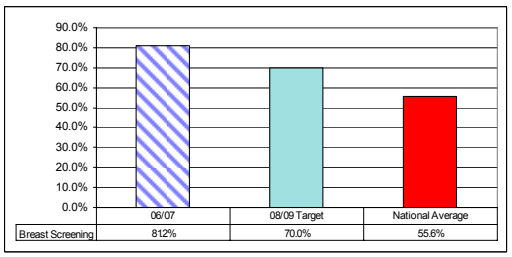
Cancer

Long Term Objective: Improve the health status of Canterbury residents at risk of developing cancer and demonstrate that those people who developed cancer are identified early through improved screening and diagnosis and are provided with appropriate and timely treatment to reduce the mortality rates from cancer.

Reduce the impact of cancer through the provision of timely and effective cancer treatment.

Cancer is a leading cause of death and a major cause of hospitalisation in New Zealand. One in three New Zealanders will have some experience of cancer, either personal or through a friend or relative. Māori are 18% more likely to be diagnosed with cancer than other population groups and while cancer survival rates are improving overall, Māori are nearly twice as likely as non-Māori to die from cancer.

Improved cancer screening and early cancer treatment along with coordinated and accessible palliative care services can greatly reduce the impact of cancer on patients and their families by improving outcomes and providing a better quality of life. However the increasing incidence of cancer is placing additional demand on the health sector and requires regional and local collaboration to build the capability and capacity required to provide early intervention and timely treatment.

Medium Outcome Measures		**2006/07**	**2008/09**	**09/10**	**10/11**	
Improve access and quality of treatment. An increase in the percentage of patients who wait less than six weeks between first specialist assessment and the start of radiation oncology treatment. [33]		na	81%	100%	100%	
Improve the pathways between primary and secondary services. An increase in the percentage of the eligible population screened under the national cervical screening programme.[34]	Māori Pacific Other Total	72%	>72%	>75%	>75%	
Maintain high percentages of the eligible population screened under the national BreastScreen Aotearoa programme.[35]	Māori Pacific Other Total	80%	>70%	>70%	>70%	

[33] *The DHB did not measure against the six week target in 2006/07 – results at six months 2007/08 demonstrate a performance of 81%. The DHB is committed to achieving the national Health Target of 100% of patients (excluding category D) waiting less than six weeks for radiation oncology treatment. However the DHB believes that during the 2008/09 year significant effort will be required to maintain our current performance. Our planned outputs for the 2008/09 year will explore the opportunities to utilise capacity available in other cancer centres and will use our best endeavours to make progress towards the 100% target.*

[34] *These results are provided through the National Cervical Screening Programme and relate to 36 months of coverage to June 2006. The national target is 75% and ethnicity breakdowns will be provided in outyears.*

[35] *These results are provided through the BreastScreen Aotearoa (BSA) Programme Report and relates to 24 month coverage to June 2006. The national target is 70% and ethnicity breakdowns will be provided in outyears.*

The DHB will focus on improving processes and the patient journey to reduce wait times and build capacity in terms of staffing levels and staffing flexibility. We will look to improve the pathway between DHBs in terms of sharing capacity and taking a regional approach to the provision of cancer services.

In the coming year the DHB will also work to address capacity issues in terms of equipment. We have three Linear Accelerators to provide radiation oncology treatment. Once of these machines (T3) has reached the end of its economic lifespan and in order to maintain current capacity levels this machine needs to be replaced. To increase future capacity we will also begin the process to install an additional fourth machine.

Key Outputs for 2008/09 (from the District Annual Plan)	**Delivery Date 08/09**	**Output Class**
Explore options for increasing current capacity by building workforce flexibility.	Q1-Q4	Provider
Support sustainability of the workforce by employing four new graduates under the Radiation Therapy New Graduate Programme.	Q1-Q4	Provider
Apply lean thinking processes to improve the quality of the patient journey and reduce wait-times for patients within current capacity in accordance with clinical guidelines.	Q1-Q4	Provider
Identify the treatment capacity of South Island DHBs and clarify population catchments, to ensure equity of access and reduction of wait times.	Q1-Q4	Provider
Produce a risk assessment and identify contingency options to manage capacity during down-time while the third Linear Accelerator (T3) is replaced.	Q1-Q2	Provider
Produce a Business Case for the replacement of T3 for Ministry approval.	Q1-Q2	Provider
Produce a Business Case for a fourth Linear Accelerator for Ministry approval.	Q1-Q3	Provider
Develop a local Cancer Action Plan to implement the national Cancer Control Strategy.	Q2	Funder
Provide input into the development of a Regional Cancer Plan to improve cancer service delivery and quality and to make best use of regional resources.	Q1-Q4	Funder

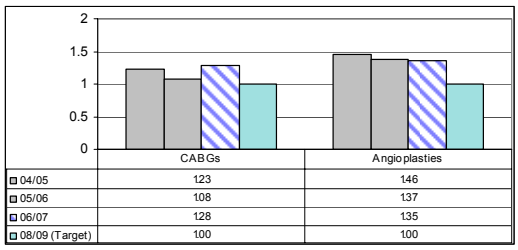
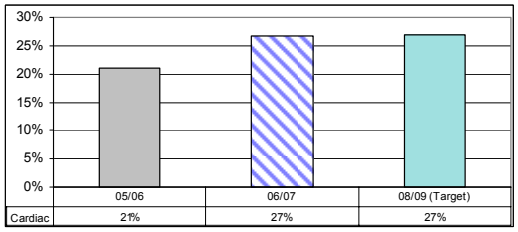
Cardiovascular Disease (CVD)

Long Term Objective: Improve the health status of Canterbury residents at risk of developing Cardiovascular Disease (CVD) and reduce mortality rates attributed to CVD, particularly for Māori and Pacific groups. Demonstrate that those people who are at risk are identified early and those who suffer an acute cardiovascular event have the skills to reduce the impact of that event on the quality of their life.

Reduce the impact of Cardiovascular Disease by supporting early risk identification and rehabilitation.

CVD includes coronary heart disease, other disease of the heart, circulation and stroke. It is a leading cause of death in Canterbury and the incidence of CVD is likely to increase as our population ages. CVD is usually linked with diabetes and is strongly influenced by lifestyle choice. As with other chronic conditions, healthy lifestyles lead to a decrease in risk factors and the DHB will promote physical activity, good nutrition, weight risk reduction and smoking cessation. Older people, Māori and Pacific people have higher rates of CVD.

With the DHB's ageing population and the number of Maori and Pacific people in Canterbury increasing, rising rates of CVD are likely to result in increased demand for specialist care. The DHB will have to work to ensure it has the capacity to provide people waiting for surgery for CVD with treatment within appropriate timeframes. The DHB will also need to ensure it provides quality care in terms of increasing access to rehabilitation programmes for people admitted for acute CDV events to reduce the impact of CVD on their future quality of life and reduce the risk of readmission.

Medium Outcome Measures		**2006/07**	**2008/09**	**09/10**	**10/11**	
Maintain access to services. Maintain standardised discharge rates for key procedures.[36]	CABGs	1.28	>1	>1	>1	
	ANGs	1.35	>1	>1	>1	
Improve the quality of services. An increase in the percentage of people attending a cardiac rehabilitation programme after admission for an acute cardiac event.[37]		27%	>27%	>27%	>27%	
An increase in the percentage of people admitted to an organised stroke service after admission for an acute event.		68%	>68%	>68%	>68%	

The focus over the coming year will be to build pathways between community, primary and secondary services. The DHB will seek to enhance secondary rehabilitation services by supporting complementary community-based services and will seek to support and encourage CVD risk assessment in primary care settings through PHOs.

Key Outputs for 2008/09 (from the District Annual Plan)	**Delivery Date 08/09**	**Output Class**
Support PHOs to develop CVD Readiness Plans and mechanisms for sharing data on CVD risk assessment screening with the DHB.	Q1-Q4	Funder
Establish a community stroke rehabilitation service to compliment existing services.	Q2-Q3	Funder

[36] *If all DHBs were providing services at the same level, the standardised discharge rate would be at 1. A rate higher than 1 indicates that the DHB is providing more than the average NZ rate and a rate lower than 1 indicates that the DHB is providing less than the average rate. Intervention analysis does not necessary indicate what the right rate might be, but compares individual DHBs with the national mean, taking DHB population demographics into account - CABGs Coronary Artery Bypass Grafts and ANGs Angioplasties.*

[37] *These figures include the Maori Cardiac Outreach Programme run at Rehua Marae, the Christchurch Hospital Cardiac Rehabilitation Programme run primarily in the Canterbury Horticultural Hall and the Heart Guide Aotearoa Programme. The DHB is still working on establishing a baseline for this and the stroke service indicator – hence the outyear targets.*

Diabetes

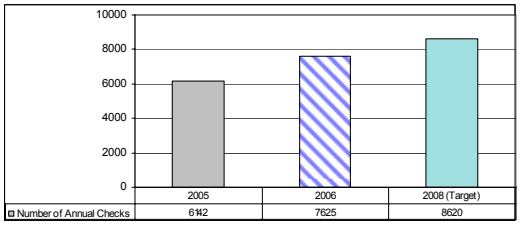
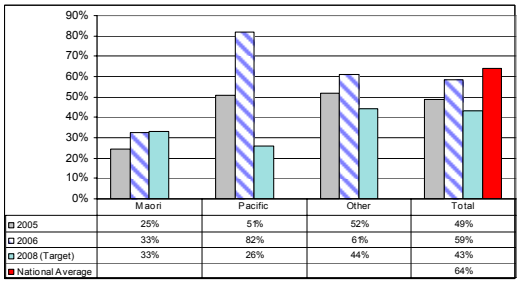
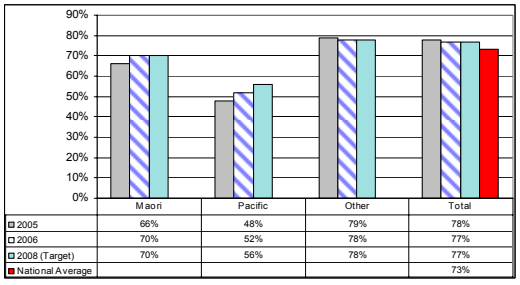
Long Term Objective: Improve the health status of Canterbury residents at risk of developing diabetes and demonstrate that those people who develop diabetes are identified and treated early and have the skills to enable good diabetes management in order to reduce the impact of their diabetes on their quality of life.

Long-Term Impact Measures	2005/06	2006/07
A reduction in the rate of admissions due to short-term diabetes complications.[38]	0.24	0.18
A reduction in the rate of lower extremity amputations due to diabetes complications.	0.23	0.25

Reduce the impact of diabetes by supporting diabetes management.

Diabetes is a significant cause of ill health and premature death in New Zealand. The prevalence of diagnosed diabetes across the population is currently estimated at around 4.6 percent. However diabetes rates for Māori and Pacific people are around three times higher than other New Zealanders.

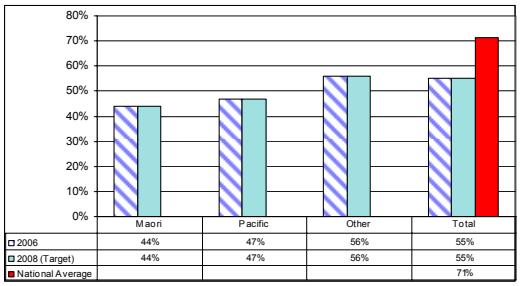
Reducing the incidence and impact of diabetes is a key focus in reducing inequalities in health status and outcomes. Enabling people with diabetes to manage their condition will reduce the long-term complications of diabetes which impact on the quality of life – such as blindness, amputation and renal failure.

Medium Outcome Measures		2006	2008/09	09/10	10/11	
Improve access to diabetes services. An increase in the number of annual diabetes checks delivered in Canterbury.		7,625	8,620	>8620	>8620	
Improve the quality of diabetes services. An increase in the percentage of people estimated to have diabetes, receiving free annual diabetes checks.[39]	Māori	33%	>33%	>33%	>33%	
	Pacific	82%	>26%	>26%	>26%	
	Other	61%	>44%	>44%	>44%	
	Total	59%	>43%	>43%	>43%	
An increase in the percentage of people on the diabetes register who received their annual check and had good diabetes management (HBA1c<8.0%).	Māori	70%	≥70%	≥70%	≥70%	
	Pacific	52%	≥56%	≥56%	≥56%	
	Other	78%	≥78%	≥78%	≥78%	
	Total	77%	≥77%	≥77%	≥77%	

[38] *Both of these measures are measured per 1,000 population (aged 19+).*

[39] *These targets are based on an increased 'expected number of diabetics' in the Canterbury population compared to the previous (2007) year, which has distorted the percentage figures. The DHB plans to deliver an additional 588 checks in 2008/09.*

Medium Outcome Measures		2006	2008/09	09/10	10/11
Improve the pathways between primary and secondary services. An increase in the percentage of people having diabetes checks also having an eye screen in the past two years.	Māori	44%	>44%	>44%	>44%
	Pacific	47%	>47%	>47%	>47%
	Other	56%	>56%	>56%	>56%
	Total	55%	>55%	>55%	>55%



In Canterbury we are currently below the national average in terms of the number of annual diabetes checks being undertaken and a clear focus is needed to understand the reason for this performance and to increase these rates. The DHB will also be focused on encouraging the uptake of free diabetes checks, increasing retinal screening rates and supporting community-based diabetes services and healthily lifestyle education to improve diabetes management.

Key Outputs for 2008/09 (from the District Annual Plan)	Delivery Date 08/09	Output Class
Facilitate quarterly PHO reporting of diabetes activity to provide an accurate picture of diabetes service delivery and outcomes in Canterbury.	Q2	Funder
Develop a collaborative Strategic Plan for Diabetes for the Canterbury region.	Q1-Q3	Funder
Undertake a consumer consultation/survey to identify issues and barriers to the uptake of free diabetes annual checks.	Q1	Funder
Identify opportunities to improve the uptake of annual checks by Māori and Pacific people as high needs groups.	Q2-Q4	Funder
Support diabetes workforce development for general practice teams to improve the quality of diabetes services and annual checks.	Q3-Q4	Funder
Implement a community-based retinal screening pilot.	Q3	Funder
Increase the number of people receiving access to community-based podiatry services.	Q2-Q4	Funder

Respiratory Disease

Long Term Objective: Improve the health status of Canterbury residents at risk of respiratory disease and demonstrate that those people who have developed chronic respiratory disease have access to timely treatment and services to enhance recovery and improve their quality of life.

Reduce the impact of respiratory disease by supporting respiratory disease management.

Respiratory disease is recognised as one of the developing chronic disease burdens associated with an ageing population. Up to 100,000 people may be affected by respiratory issues within the Canterbury population including Chronic Obstructive Pulmonary Disease (COPD), asthma and sleep disorders.

COPD has a substantial impact on the health and affects an estimated 15% of the adult population. Based on hospital admission data, the prevalence of Māori with COPD is more than twice that of non-Māori. In Canterbury it is estimated that between 5,000 and 20,000 people suffer from sleep-disordered breathing. Obstructive Sleep Apnoea (OSA) is the most common diagnosis and has been shown to increase long-term cardiovascular morbidity and mortality, and can lead to acute presentations, prolonged hospital admission and result in high short-term mortality.

Very closely linked to the prevalence of smoking, improvements in early diagnosis and the management of respiratory illness provide a major opportunity for the DHB to reduce inequalities and improve Māori health. However, rising levels of obesity and an ageing population are increasing the incidence of COPD and OSA and place increased demand pressure on specialist services in Canterbury. The DHB will focus on improving access to services and improving self management of risk behaviours and respiratory conditions and the development of pathways between primary and secondary services to achieve improved outcomes for the population.

Medium Outcome Measures	**2006/07**	**2008/09**	**09/10**	**10/11**	
Improve access to respiratory services. An increase in access to spirometry services.					These respiratory indicators are new performance measures for the Canterbury DHB. We will aim over the coming year to establish clear definitions for these indicators, to begin to collect this information and to establish baselines and targets for the chosen indicators for the 2009/10 year. We have included these as an indication of the intent of the DHB's investment in this area in the coming year.
An increase in access to sleep studies.					
Improve the quality of respiratory services. A reduction in readmissions for COPD.					
Improve the pathways between primary and secondary services. An increase in post acute admission follow-ups in primary care.					

A series of initiatives have been identified to improve and develop the respective roles of primary and secondary services to better support people with respiratory conditions, to improve the quality and effectiveness of services, make the best use of specialist respiratory and sleep expertise, and to build the capacity to cope with increasing demand.

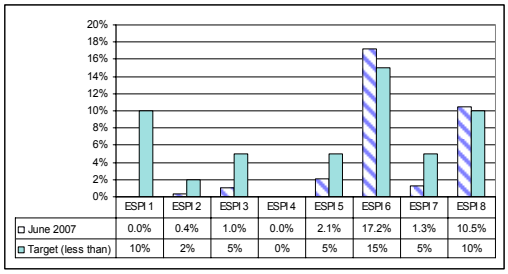
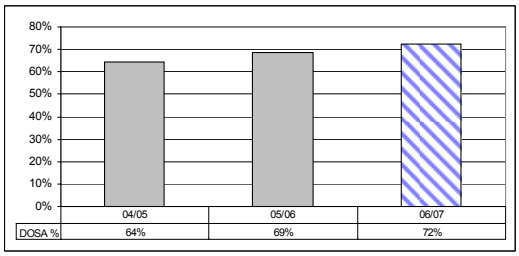
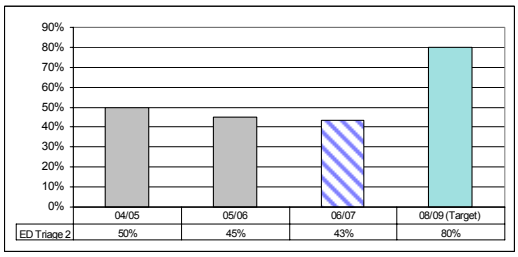
Key Outputs for 2008/09 (from the District Annual Plan)	**Delivery Date 08/09**	**Output Class**
Implement a jointly developed primary/secondary pathway for COPD.	Q4	Funder
Establish community clinics to improve access to pulmonary rehabilitation.	Q2-Q3	Funder
Improve access to community-delivered spirometry to improve diagnosis of COPD.	Q4	Funder
Implement a jointly developed primary/secondary pathway for sleep disorders.	Q4	Funder
Implement jointly developed primary/secondary pathways to improve the acute management of people with respiratory conditions.	Q1-Q4	Funder
Improve access to specialist advice without the requirement of an outpatient visit.	Q4	Funder
Establish advance acute management plans as part of the COPD pathway.	Q3	Funder

Providing Hospital and Specialist Services - Provider

Long Term Objective: Improved health status for Canterbury's residents through the provision of services in a timely manner, within available resources, for those with the greatest level of need.

Provide hospital and specialist services efficiently and effectively.

The DHB is the major provider of health services in Canterbury. To remain a clinically and financially sustainable provider we must ensure we provide quality services, retain an effective workforce, continue to improve operating efficiency and effectiveness, and meet all contract requirements within budget.

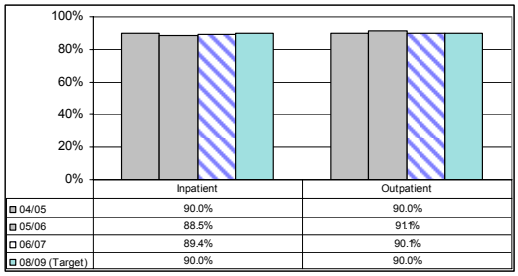
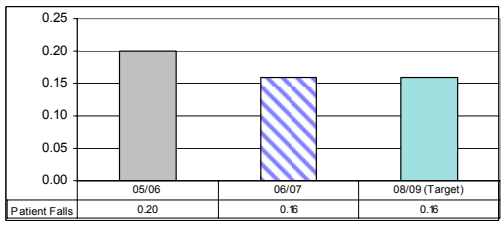
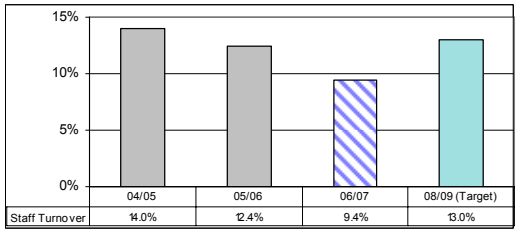
Medium Outcome Measures		**2006/07**	**2008/09**	**09/10**	**10/11**	
Improve access to services. Maintain compliance with all Elective Services Patient Flow Indicators (ESPIs). [40]	ESPI 1	100%	>90%	>90%	>90%	
	ESPI 2	0.4%	<2%	<2%	<2%	
	ESPI 3	1.0%	<5%	<5%	<5%	
	ESPI 4	Nil	Nil	Nil	Nil	
	ESPI 5	2.0%	<5%	<5%	<5%	
	ESPI 6	17.2%	<15%	<15%	<15%	
	ESPI 7	1.3%	<5%	<5%	<5%	
	ESPI 8	89.5%	>90%	>90%	>90%	
Improve the quality of services. An increase in the percentage of long-term mental health clients with up-to-date relapse (crisis) prevention plans.[41]		-	95%	>95%	>95%	
An increase in the percentage of Day of Surgery Admissions (DOSA) for elective surgery.[42]		72%	>72%	>72%	>72%	
An increase in the percentage of triage 2 patients seen in the Emergency Department (ED) within target times.[43]		43%	>80%	>80%	>80%	
An increase in the percentage of people presenting to ED being admitted, discharged or referred within 4hrs of arrival.		79.2%	90%	90%	90%	

[40] *Ministry expectations have set ESPIs compliance targets which all DHBs must achieve in order to receive additional electives funding – these are reflected here. The DHB has set internal 'buffers' seeking a higher level of achievement to drive continuous improvement and commitment to improved transparency and fairness – these are set out in our District Annual Plan.*

[41] *The DHB did not measure this indicator in previous years so there is therefore no baseline data for 2006/2007.*

[42] *This data covers Medical & Surgical, Women's & Children's, Rural and Burwood Hospital divisions and excludes day cases.*

[43] *This indicator reflects triage 2 patients who begin assessment and treatment by a health professional within Australasian College of Emergency Medicine time guidelines – which recommend triage 2 patients be seen within 10 minutes.*

Medium Outcome Measures		2006/07	2008/09	09/10	10/11	
Maintain a high percentage of patient overall satisfaction.	Inpatient	89%	>90%	>90%	>90%	
	Outpatient	90%	>90%	>90%	>90%	
Maintain a low rate of staphylococcus aureus bloodstream infections per 1000 inpatient bed days.[44]		-	<0.13	<0.13	<0.13	
Maintain a low rate of pressure ulcers per 1000 inpatient bed-days.[45]		0.18	<0.25	<0.25	<0.25	
Maintain a low rate of patient falls (causing moderate or serious injury) per 1000 inpatient day equivalents.[46] [47]		0.16	<0.16	<0.16	<0.16	
Be a Good Employer Maintain low staff turnover rates.		9.4%	<13%	<13%	<13%	
Maintain a low sick leave rate.		3.2%	<3.2%	<3.2%	<3.2%	
Reduce workplace injuries (per million hours).		7.6	<10	<9	<8	

Key Outputs	2008/09
Deliver the agreed increased number of elective services discharges.[48]	Base 12,891 Additional 1,289
Further develop the Electives Monitoring and Reporting Framework to achieve ESPIs compliance.	Patient flow efficiencies and capacity identified.
Implement 'Project RED' to equip the Christchurch Hospital Emergency Department for growing patient numbers and complexity over the next five years.	A decrease in the percentage of people spending more than fours hours in ED.
Implement the Releasing Time 2 Care Programme to improve the ward environment and remove waste, decrease variation and standardise processes.	Ward standardisation implemented DHB wide.
Contribute to the five national QIC Quality Improvement Programme projects to provide a focused and coordinated approach to quality improvement.	Local outputs completed based on the priorities set nationally.
Identify immediate and impending workforce shortages and discuss at local levels.	Locally applicable strategies are identified.
Develop strategies to affect safety behaviour and practice in the workplace in an effort to positively influence employee incident levels.	A behavioural change model is adopted.

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

[45] *Inpatient bed-days refers to the number of inpatient bed-days in the quarter calculated on the midnight census rate.*

[46] *Total falls includes only those falls associated with moderate or serious injury to provide a direct measure of injury caused.*

[47] *Inpatient Day Equivalents reflect the total inpatient days plus half the total day patient attendances.*

[48] *Delivery of these volumes is dependant on the DHB's ability to secure the capacity required to deliver increased volumes within available funding. These indicative volumes may be adjusted as the DHB refines its understanding of the unmet need in its community and the specialty level capacity available in both the public and private sectors.*

6. MANAGING OUR FINANCIAL RESOURCES

6.1 Financial Environment – Our Budget

The Canterbury DHB will receive a funding increase of approximately $60M for 2008/09. Costs are forecast to increase by $82M. This leaves a funding shortfall of $22M in 2008/09 together with the shortfall carried forward from 2007/08 of $13M, giving a total of $35M to be filled by efficiencies or revenue enhancements. The 2008/09 forecast is summarised as follows:

	$M (GST excl)
Net Increase in Funding/Revenue (include non-Base)	59.706
Less	
Increase in Expenditure (external and CDHB Provider service)	(78.206)
Incremental Interest, Depreciation and Capital Charge	(3.500)
Estimated 2008/09 Operating Shortfall	(22.000)
Shortfall carried forward from 2007/08	(13.000)
Gain on sale of surplus property	8.000
Required Annual Efficiencies/Revenue Enhancement	27.000
Budget Net Result After Efficiencies/Revenue Enhancement	0.000

Included in the forecast are the following key assumptions:

- Demographic and mental health blue print funding will be used to fund new services already committed. In the past, the DHB has increased the amount of services funded when we were not receiving demographic funding, using one-off funding. The balance of any demographic funding after funding committed services is used to replace one-off funding and new services have to be funded via reprioritisation of services;
- No additional costs will be incurred to deliver the objectives of the national QIC project;
- Cost to deliver additional elective surgery volumes will be within the funding received.
- The impact of new technologies will be funded from efficiencies;
- Employee cost increases will be at terms similar to the NZNO nurses MECA;
- External providers will receive funding increases similar to the base future funding track; and
- All other expense increases will be at base future funding track

The financial pressure on the DHB as a result of wage settlements exceeding the future funding track in 2007/08 and 2008/09 means that we will have to seek additional efficiencies/revenue of $35M to achieve the 2008/09 break-even result. Sale of surplus property will contribute $8M but this is 'one-off' funding which needs to be replaced by sustainable funding in future. The balance of $27M efficiencies/revenue will be achieved by a mixture of:

- Additional revenue from higher prices to match the impact of wage increases;
- Supply chain savings;
- Improving operational efficiencies and/or service reconfigurations; and
- Focusing on core activities/services.

6.1.1 Efficiencies and Service Reconfigurations

Included in the 2008/09 budgeted break-even results, are a number of efficiencies and/or service reconfigurations. Examples of the initiatives to be undertaken include:

- Continued implementation of the DHB's Improving the Patient Journey Programme, patient centred models of care, the framework for managing long-term conditions, the Acute Demand Management Programme, respiratory pathways and the Referrals Project;
- Continued review and evaluation of employee cost control processes, nursing workforce costs, treatment-related costs, the costs of new technology and review of leave management and roster activity;
- Achievement of procurement/usage savings on clinical and non-clinical consumables;
- Improve collaborative arrangements with other DHBs and external providers and ongoing review of provider contracts, both internal and external; and
- Continued work around streamlining the patient journey through single points of entry and review of service delivery models and pathways.

In addition, gain on sale from the disposal of surplus assets, as approved by the Minister of Health, are an integral part of the efficiency target.

Some of our planned initiatives are not just to generate savings but to ensure that we have sufficient staff/capacity to meet peak demands in the coming year, particularly with the increase leave entitlements recently awarded to staff. Some initiatives are longer term and are only expected to generate major savings in future years.

Initiatives will have input from clinicians, where appropriate, to ensure patient safety and related issues are adequately considered and factored in the decision making process.

6.1.2 Outyears Scenario

The DHB expects funding increases for out-years to be 4.3% for 2009/10 and 4.2% for 20010/11. The DHB has also assumed that we will contain total expenditure increases to below that rate to compensate for the 2007/08 and 2008/09 years where expenditure increases exceeded the funding received. All assumptions carry risks, especially the assumptions for future wage increases. Some employment agreement already in place allow for wage increases inclusive of step progression, to be above the projected funding increase. Therefore, for the assumption to be valid, we have to ensure that some employment agreements will settle in the future at below the projected funding increase.

Should we be unable to constrain cost increases to the funding increase, savings will be required to fund the increase expenditure. We may need to re-configure services and change how services are delivered to yield efficiencies. Ultimately, the DHB may need to reduce services in order to operate within the funding received. The Health Services Planning Programme, currently underway, is expected to be completed by the end of 2008 with a view to completing a Facilities Master Plan. This project will also greatly assist the DHB to better understand where, what and how many services need to be provided in the future - thus providing the information needed to assist us to operate within available funding while providing maximum health care to the population of Canterbury.

6.1.3 Key Assumptions and Risks

The key assumptions to achieve the breakeven budget for 2008/09, 2009/10 and 2010/11 include the following:

- Our short and mid-term direction and environment will remain similar and current Government health and funding policies will remain static. The sector will use health prioritisation tools to determine investment in new services.
- Baseline and outyears' funding will increase as per Ministry funding advice.
- Any future changes to the Population Based Funding Formula will not impact adversely on future funding levels and demographic funding will be received in future years.
- The growth in demand for services can be managed via initiatives and other increases in demand or new services can be met through reducing delivery in other service areas.[49]
- Net IDF revenue can be fully realised. IDF volumes remain stable and do not decline significantly except for services where it is more appropriate for those volumes to be performed by another

[49] *Any reduction in service areas will be carried out in accordance with the Operational Policy Framework.*

DHB. The price for some inter-district services will be negotiated upwards to incorporate the impact of higher wage settlements, in consultation with the Ministry.

- No industrial action will occur. In the event that any industrial action takes place, force majeure applies to health targets, ESPI and contracts with the Crown.
- Inflation pressures and tight fiscal outlook will require competing demands to be managed within the allocated funding and focus on achieving productivity improvements/savings.
- No revaluation of land and buildings will be required in 2007/08. No revaluation of land and buildings will be undertaken in 2008/09.[50]
- Contracts with suppliers and NGO providers will be settled below net FFT on average.[51]
- The introduction of new drugs or technology will be funded by efficiencies within the service.
- The average increase in non-employee related expenditure can be kept below net FFT.
- The rate for capital charge will remain at 8%.
- Interest rates and exchange rates will remain within Treasury forecasts.
- Early payment status is retained and any change in this status will change all other assumptions.
- The financial impact associated with any new Government or Ministry legislative, regulatory or compliance policy/initiative will be fully offset by increased funding.
- Any financial impact associated with changes to Disability Support Services boundaries between age related and non-age related services and any further contracts or services devolved by the Ministry will be cost neutral to the DHB.
- Collective employment agreements will be settled below or at terms similar to the NZNO MECA and step progression costs are assumed to be similar to historical levels.
- Efficiencies will be generated under the agreed Partnership programmes and tripartite agreements.
- Sick leave will be managed at or below current levels.
- The DHB will be able to recruit the required staff numbers to meet service demands as a result of the increase leave entitlements or changes to service configuration will take place to align services with available clinical workforce.
- Any cost increases (beyond net FFT) resulting from changes to income and asset testing thresholds will be met by additional funding provided by the Ministry.
- Service innovation savings realised, efficiencies achieved and cost over-runs addressed internally. Where savings from efficiency gains or service re-configurations are not sufficient to achieve breakeven, acceptable service reductions can be identified and realised in a timely manner.
- Projected proceeds from approved sale of surplus assets are realised and received as planned.
- In the event of a Pandemic any increased or associated costs will be nationally funded.
- The DHB will be ESPI compliant and receives additional elective funding that will be funded at National prices that reflect the true cost of wage settlements in 2007/08 and 2008/09.
- The PHARMAC budget for community referred pharmaceuticals is as agreed by the DHB (on the basis of forecast actual expenditure plus baseline FFT) and any forecast savings on STATs dispensing and other initiatives are achieved and the budget transferred to PHARMAC for cancer drugs will be based on historical DHB funding.

The assumptions underlying the Statement of Intent can be found in the Canterbury DHB's District Annual Plan 2008/2009.

The over-riding risk to achieving the financial performance relates to the key assumptions above not holding true and the risks around wage increase expectations for the health sector, both internal staff and external providers, following the national employment collective settlements. Other risks include the inability to implement identified service reconfiguration and/or facility realignment or service

[50] *The DHB's last revaluation of land and buildings took place in June 2006.*

[51] *FFT is the annual percentage price increase to DHBs from the Ministry.*

reduction, according to planned timeframes and the inability to achieve efficiencies and address cost over-runs internally.

6.2 Asset Planning and Investment

6.2.1 Business Cases

The Canterbury DHB is planning to submit the following business cases:

- Replacement of the T3 Linear Accelerator and installation of a fourth Linear Accelerator;
- Replacement of outdated Rostering System;
- Replacement/installation of the DHB's Patient Information System; and
- Replacement of Boilers in Christchurch Hospital.

The installation of the fourth Linear Accelerator is to enable the DHB to meet the radiotherapy waiting times target. In addition, as part of the Ministry's national Oral Health Strategy (Reform), the DHB had submitting a business case in 2007/08 to improve oral health services in Canterbury for children and adolescents. As these business cases have not been approved, their financial impact has not been included in our forecast.

6.2.2 Capital Expenditure

Assuming the DHB achieves break-even the estimated capital expenditure budget for 2008/09 is $30M and will be primarily for normal asset replacement and priority new equipment. Detailed requirements, in terms of compliance with recent Building Act changes are yet to be finalised by Territorial Local Authorities and these may require some buildings to be rebuilt.[52]

As referred to previously, a Health Services Planning Programme is in progress. This project will guide the development of our Facilities Master Plan. The DHB is forecasting that the building replacement as part of that legislative compliance will take place after 2010/11. Several projects will require internal resourcing and prioritisation as well as regional and national prioritisation. Funding for these significant projects will be discussed with the Ministry when the full implications of legislative requirements are known.

6.3 Debt and Equity

The DHB's estimated total term debt is expected to be $88M as at June 2009. It is assumed that the available cashflow from depreciation funding will be applied to fund capital expenditure, thus deferring the need to increase loans until the major property rebuilding projects in out-years.

The current approved credit facility available through the Crown Health Financing Agency is approximately $130M. In addition, working capital of approximately $50M is financed from a private bank (Westpac).

While the DHB does not have any banking covenants required of our loans the forecast key financial ratios for the DHB would be as follows:

Required	Forecast Ratio
Interest Cover Ratio:	Approx 9 times
Debt/Debt plus Equity Ratio:	Approx 25.7%
Shareholder Funds/Tangible Assets	Approx 46.6%

The DHB is not repaying equity and is instead retaining and investing the funds to meet future building replacement as indicated in Section 6.2.2.

[52] *The timeframes for meeting the new Building Act requirements are yet to be determined by the Territorial Local Authorities. This is a national issue and not specific to the Canterbury DHB and, as such, is a significant issue for the Ministry.*

6.3.1 Disposal of Land

Disposal of significant surplus assets over the next three years includes the Canterbury DHB owned sites at Hanmer Springs and potentially the former Christchurch Women's Hospital site.

The Minister of Health has given approval for the sale of the Hanmer Springs site. The timing of the sale is subject to negotiations with the purchaser. Due process will be undertaken with regard to any sale of the site of the former Christchurch Women's Hospital site. The financial assumptions include the estimated proceeds from surplus asset sale/s expected.

The Canterbury DHB's policy is that it will not dispose of any estate or interest in any land without having first obtained the consent of the responsible Minister and completed required public consultation.

6.3.2 Activities for which Compensation is Sought

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

6.3.3 Acquisition of Shares

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

6.3.4 Accounting Policies

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

6.4 Forecast Financial Statements 2008/09-2010/11

6.4.1 Forecast Group Statement Of Financial Performance

	2006/07 Draft $'000	2007/08 Forecast $'000	2008/09 Forecast $'000	2009/10 Forecast $'000	2010/11 Forecast $'000
Operating Revenue					
MoH Revenue	1,050,404	1,113,190	1,168,742	1,218,998	1,270,196
Patient Related Revenue	33,458	35,144	38,303	39,950	41,628
Other Revenue	27,296	28,279	35,886	28,703	29,534
Total Operating Revenue	1,111,158	1,176,613	1,242,931	1,287,651	1,341,358
Operating Expenditure					
Employee Costs	439,146	466,721	504,946	524,137	548,909
Treatment Related Costs	105,727	106,563	102,002	106,389	110,857
External Providers & IDF	433,074	482,631	497,076	516,450	538,142
Non Treatment Related & Other Costs	60,269	61,655	64,363	66,131	68,908
Total Operating Expenditure	1,038,216	1,117,570	1,168,388	1,213,107	1,266,816
Result before Interest, Depn & Cap Chrge	72,942	59,043	74,543	74,543	74,543
Interest, Depreciation & Capital Charge					
Interest Expense	(5,069)	(5,632)	(5,632)	(5,632)	(5,632)
Depreciation	(47,228)	(44,714)	(47,214)	(47,214)	(47,214)
Capital Charge Expenditure	(22,894)	(21,697)	(21,697)	(21,697)	(21,697)
Total Interest, Depreciation & Capital Charge	(75,191)	(72,043)	(74,543)	(74,543)	(74,543)
Net Operating Results	**(2,249)**	**(13,000)**	**0**	**0**	**(0)**

6.4.2 Forecast Group Statement Of Financial Position

	30/06/07 Draft $'000	30/06/08 Forecast $'000	30/06/09 Forecast $'000	30/06/10 Forecast $'000	30/06/11 Forecast $'000
Public Equity					
Opening Equity	287,326	268,142	253,281	253,281	253,282
Transition to IFRS	(15,074)				
Equity Repayment	(1,861)	(1,861)			
Net Result for the period	(2,249)	(13,000)	0	0	(0)
Total Public Equity	**268,142**	**253,281**	**253,281**	**253,282**	**253,281**
Current Assets					
Cash & Bank (OD)	50,633	43,712	48,716	50,931	53,144
MoH Debtor	8,854	9,000	9,000	9,000	9,000
Other Debtors & Other Receivables	14,386	16,000	16,000	16,000	16,000
Prepayments	658	800	800	800	800
Stocks	8,175	8,000	8,000	8,000	8,000
Total Current Assets	82,706	77,512	82,516	84,731	86,944
Current Liabilities					
Creditors & Accruals	74,264	70,000	70,000	70,000	70,000
Capital charge payable	13,852	5,425	5,425	5,425	5,425
GST	5,450	5,800	5,800	5,800	5,800
Interest Accrual	563	600	600	600	600
Staff Entitlement	100,545	102,000	102,000	102,000	102,000
Total Current Liabilities	194,674	183,825	183,825	183,825	183,825
Working Capital	(111,968)	(106,313)	(101,309)	(99,094)	(96,881)
Investments	11,689	11,170	26,170	41,170	46,170
Restricted Assets - Trust Fund	10,931	10,931	10,931	10,931	10,931
Fixed Assets	464,397	444,400	424,396	407,182	399,968
Total Non Current Assets	487,017	466,501	461,497	459,283	457,069
Term Staff Entitlement	(8,326)	(8,326)	(8,326)	(8,326)	(8,326)
Trust Funds Liabilities	(10,931)	(10,931)	(10,931)	(10,931)	(10,931)
Term Loans	(87,650)	(87,650)	(87,650)	(87,650)	(87,650)
Total Non Current Liabilities	(106,907)	(106,907)	(106,907)	(106,907)	(106,907)
Net Assets	**268,142**	**253,281**	**253,281**	**253,282**	**253,281**

6.4.3 Forecast Group Statement of Movement in Equity

	30/06/07 Draft $'000	30/06/08 Forecast $'000	30/06/09 Forecast $'000	30/06/10 Forecast $'000	30/06/11 Forecast $'000
Public Equity					
Opening Equity	287,326	268,142	253,281	253,281	253,282
Add/(Less):					
Equity Injection / (Repayment)	(1,861)	(1,861)	-	-	-
Revaluation of Property					
Transition to IFRS	(15,074)				
Net Result for the period	(2,249)	(13,000)	0	0	(0)
Total Public Equity	**268,142**	**253,281**	**253,281**	**253,282**	**253,281**

6.4.4 Forecast Group Statement Of Cashflow

	2006/07 Draft $'000	2007/08 Forecast $'000	2008/09 Forecast $'000	2009/10 Forecast $'000	2010/11 Forecast $'000
Cashflows from Operating Activities					
Cash provided from:					
MOH Receipts	1,051,140	1,113,044	1,168,742	1,218,998	1,270,196
Other Receipts	49,893	53,299	57,679	60,143	62,652
	1,101,033	1,166,343	1,226,421	1,279,141	1,332,848
Cash applied to:					
Employee Costs	424,411	465,266	504,946	524,137	548,909
Supplies & Expenses	593,859	655,080	663,442	688,970	717,907
Capital Charge Payments	12,780	30,124	21,697	21,697	21,697
Finance Costs	4,883	5,595	5,632	5,632	5,632
Taxes Paid	728	(350)	-	-	-
	1,036,661	1,155,715	1,195,717	1,240,436	1,294,145
Net Cashflow from Operating Activities	**64,372**	**10,628**	**30,704**	**38,704**	**38,704**
Cashflows from Investing Activities					
Cash provided from:					
Sale of Assets	11,315	519	10,790	-	-
Interest Received	5,146	8,510	8,510	8,510	8,510
	16,461	9,029	19,300	8,510	8,510
Cash applied to:					
Advance to JV/Trust Investments	11,304	-	15,000	15,000	5,000
Purchase of Assets	38,873	24,717	30,000	30,000	40,000
	50,177	24,717	45,000	45,000	45,000
Net Cashflow from Investing Activities	**(33,716)**	**(15,688)**	**(25,700)**	**(36,490)**	**(36,490)**
Cashflows from Financing Activities					
Cash provide from:					
Equity Injection					
Loans Raised	9,000	-	-	-	-
	9,000	-	-	-	-
Cash applied to:					
Loan Repayment					
Equity Repayment re FRS-3	1,861	1,861	-	-	-
	1,861	1,861	-	-	-
Net Cashflow from Financing Activities	**7,139**	**(1,861)**	**-**	**-**	**-**
Overall Increase/(Decrease) in Cash Held	37,795	(6,921)	5,004	2,214	2,214
Add Opening Cash Balance	12,838	50,633	43,712	48,716	50,931
Closing Cash Balance	**50,633**	**43,712**	**48,716**	**50,931**	**53,144**

6.4.5 Summary of Revenue and Expenses by Output Class

Funding Arm

	2006/07 $'000	2007/08 $'000	2008/09 $'000	2009/10 $'000	2010/11 $'000
Revenue					
MoH revenue	1,008,495	1,070,848	1,125,958	1,174,373	1,223,698
Total Revenue	1,008,495	1,070,848	1,125,958	1,174,373	1,223,698
Expenditure					
Other - Personal Health	720,784	756,879	801,618	836,084	871,202
Other - Mental Health	109,158	116,804	122,869	128,153	133,535
Other - Disability Support	169,591	189,143	194,741	203,117	211,647
Other - Public Health	1,481	1,159	1,188	1,239	1,291
Other - Maori Health	1,081	1,358	1,392	1,452	1,513
Other - Governance & Admin	3,934	4,037	4,150	4,328	4,510
Total Expenditure	1,006,029	1,069,380	1,125,958	1,174,373	1,223,698
Net Surplus/(Deficit)	**2,466**	**1,468**	-	-	-

Governance & Funder Admin

	2006/07 $'000	2007/08 $'000	2008/09 $'000	2009/10 $'000	2010/11 $'000
Revenue					
MoH revenue	3,934	4,037	4,150	4,328	4,510
Total Revenue	3,934	4,037	4,150	4,328	4,510
Expenditure					
Personnel	2,642	2,781	2,859	2,982	3,107
Other	1,036	1,256	1,291	1,346	1,403
Total Expenditure	3,678	4,037	4,150	4,328	4,510
Net Surplus/(Deficit)	**256**	-	-	-	-

Provider Arm

	2006/07 $'000	2007/08 $'000	2008/09 $'000	2009/10 $'000	2010/11 $'000
Revenue					
MoH revenue	610,930	625,054	667,516	698,220	727,545
Patient Related Revenue	33,458	35,144	38,303	39,950	41,628
Other	27,296	28,279	35,886	28,703	29,534
Total Revenue	671,684	688,477	741,705	766,873	798,707
Expenditure					
Personnel	436,504	463,940	502,087	521,155	545,802
Depreciation	47,228	44,714	47,214	47,214	47,214
Interest & Capital charge	27,963	27,329	27,329	27,329	27,329
Other	164,960	166,962	165,075	171,175	178,362
Total Expenditure	676,655	702,945	741,705	766,873	798,707
Net Surplus/(Deficit)	**(4,971)**	**(14,468)**	-	-	-

In House Elimination

	2006/07 $'000	2007/08 $'000	2008/09 $'000	2009/10 $'000	2010/11 $'000
Revenue					
MoH revenue	(572,955)	(586,749)	(628,882)	(657,923)	(685,556)
Total Revenue	(572,955)	(586,749)	(628,882)	(657,923)	(685,556)
Expenditure					
Other	(572,955)	(586,749)	(628,882)	(657,923)	(685,556)
Total Expenditure	(572,955)	(586,749)	(628,882)	(657,923)	(685,556)
Net Surplus/(Deficit)	-	-	-	-	-

Consolidated

	2006/07 $'000	2007/08 $'000	2008/09 $'000	2009/10 $'000	2010/11 $'000
Revenue					
MoH revenue	1,050,404	1,113,190	1,168,742	1,218,998	1,270,197
Patient Related Revenue	33,458	35,144	38,303	39,950	41,628
Other	27,296	28,279	35,886	28,703	29,534
Total Revenue	1,111,158	1,176,613	1,242,931	1,287,651	1,341,359
Expenditure					
Personnel	439,146	466,721	504,946	524,137	548,909
Depreciation	47,228	44,714	47,214	47,214	47,214
Interest & Capital charge	27,963	27,329	27,329	27,329	27,329
Other	599,070	650,849	663,442	688,971	717,907
Total Expenditure	1,113,407	1,189,613	1,242,931	1,287,651	1,341,359
Net Surplus/(Deficit)	**(2,249)**	**(13,000)**	-	-	-

7 APPENDICES AND REFERENCES

- Appendix 1: Glossary of Terms.
- Appendix 2: Organisational Chart
- Appendix 3: Hospital and Specialist Services Overview
- Appendix 4: Statement of Accounting Policies.

References

All Canterbury DHB documents referenced in this Statement of Intent are available on the Canterbury DHB website, (www.cdhb.govt.nz) or in hard copy from the Planning and Funding division by telephoning (03) 364 4160.

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

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

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

Appendix 1.

GLOSSARY OF TERMS USED IN THIS DOCUMENT		
ACC	Accident Compensation Corporation	Crown Entity set up to provide comprehensive, 24hour, no-fault personal accident cover for all New Zealanders.
	Acute Care	The provision of appropriate, timely, acceptable and effective management of conditions with sudden onset and rapid progression that require attention.
ASH	Ambulatory Sensitive Hospital Admissions	Hospitalisation or death due to causes which could have been avoided by preventive or therapeutic programme
AT&R	Assessment Treatment and Rehabilitation	These are specialist health services for older people provided by teams of health professionals specially trained to treat illness, rehabilitate and maintain the older person's ability and mobility so that they can retain an independent lifestyle.
ALOS	Average Length of Stay	ALOS is the sum of bed days for patients discharged in the period (ie lengths of stay) divided by the number of discharges for the period.
	Blueprint Funding	Blueprint funding is allocated by Government to work to ensure the development of mental health services for the 3% of the total NZ population with moderate to severe mental illness. Service development is based on the service levels set out in the Mental Health Commission's Blueprint for Mental Health Services in New Zealand: How Things Need to Be (1998).
CAPEX	Capital Expenditure	Spending on land, buildings and larger items of equipment.
CARE	Care and Rehabilitation of the Elderly	The CARE Model was developed for the delivery of specialist community health services for older people and aims to strengthen the primary/secondary interface and ensure older people receive appropriate and effective care in a home-based or community setting.
COPD	Chronic Obstructive Pulmonary Disease	A progressive disease process that most commonly results from smoking. Chronic obstructive pulmonary disease is characterised by difficulty breathing, wheezing and a chronic cough.
	Crown Entities	A generic term for a diverse range of entities referred to in the Crown Entities Act 2004, namely: statutory entities, Crown entity companies, Crown entity subsidiaries, school boards of trustees, and tertiary education institutions. Crown entities are legally separate from the Crown and operate at arms length from the responsible or shareholding Minister(s); they are included in the annual financial statements of the Government.
CE Act	Crown Entities Act	The Act which governs Crown Entities set out in 2004.
CTA	Clinical Training Agency	The CTA provides funding for Post Entry Clinical Training programmes, are nationally recognised by the profession and/or health sector and meet a national health service skill requirement rather than a local employer need.
COSE	Co-ordinator of Services for the Elderly	An Elder Care Canterbury initiative, running in two areas of Christchurch since October 2000. Staff, working alongside GPs, are responsible for co-ordinating packages of care for older people in the community. The most important outcome of the COSE project has been the provision of an overall link between any hospital and any provider service and the GP in Christchurch.
CWD	Case Weighted Discharge	Relative measure of a patient's utilisation of resources
	Credentialling	A process used to assign specific clinical responsibilities to health professionals on the basis of their training, qualifications, experience and current practice, within an organisational context. Credentialling is part of a wider organisational quality and risk management system designed primarily to protect the patient.
CFA	Crown Funding Agreement	This is an agreement by the Crown to provide funding in return for the provision of, or arranging the provision of, specified services.
CVD	Cardiovascular Disease	Cardiovascular diseases are diseases affecting the heart and circulatory system. They include ischaemic heart disease, rheumatic heart disease, cerebrovascular disease and other forms of vascular and heart disease.
DOSA	Day of Surgery Admission	DOSA is a patient who is admitted on the same day on which they are scheduled to have their elective surgery. The admission can be as either a day case or an inpatient.
	Determinants of Health	The range of personal, social, economic and environmental factors that determine the health status of individuals or populations.
DSS	Disability Support Services	Services provided for people who have been identified as having a disability, which is likely to continue for a minimum of six months and results in a reduction of independent function to the extent that ongoing support is required.
DRG	Diagnostic Related Group	The grouping of patients in accordance with their diagnosis.

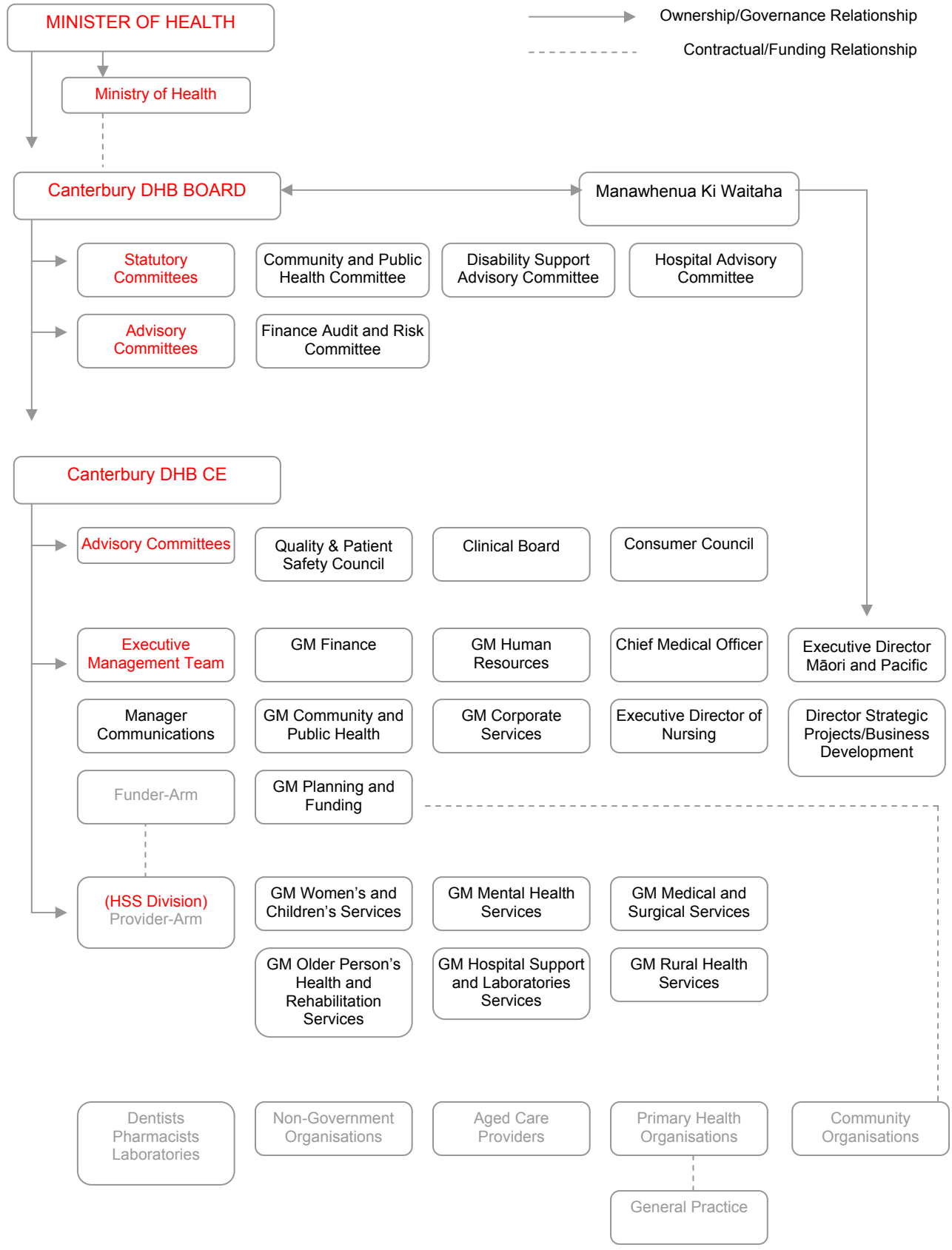
District Annual Plan	District Annual Plan	This document sets out what the DHB intends to do over the year to advance the outcomes set out in the District Strategic Plan, the funding proposed for these outputs, the expected performance of the DHB provider arm and the expected capital investment and financial and performance forecasts.
DHBNZ	District Health Board New Zealand	National representative body for all twenty-one DHBs.
DSP	District Strategic Plan	The DSP document identifies how the DHB will fulfil its objectives and functions over the next five to ten years by: identifying the significant internal and external issues that impact on the DHB and affect its ability to fulfil its mandate and purpose, acknowledging societal outcomes and identifying appropriate system outcomes as they relate to DHB population outcomes and outlining major planning and capability building
ESPIs	Elective Services Patient flow Indicators	The ESPIs have been developed by the Ministry to assess whether or not DHBs are on the right track with the Government policies on elective services.
EMT	Executive Management Team	Senior Management Team of the Canterbury DHB who report directly to the Chief Executive.
FSA	First Specialist Assessment	(Outpatients only) First time a patient is seen by a doctor for a consultation in that speciality for that reason, this does not include procedures, nurse appointments, diagnostic appointments or pre-admission visits.
	Follow-ups	Further assessments by hospital specialists.
FTE	Full Time Equivalent	An Employee who works an average minimum of 40 ordinary hours per week on an ongoing basis.
FFT	Future Funding Track	FFT is the annual percentage price increase to DHBs from the Ministry.
HbA1c	Haemoglobin A1c; also known as glycated haemoglobin.	The level of HbA1c reflects the average blood glucose level over the past 3 months.
HEAT	Heat Equity Assessment Tool	The HEAT Tool provides questions to assist people working in the health sector to consider how particular inequalities in health have come about, and where the effective intervention points are to tackle them.
HIS-NZ	Health Information Strategy– New Zealand	The Government's Health Information Strategy for all DHBs.
HNA	Health Needs Assessment	A process designed to establish the health requirements of a particular population
	Health Outcomes	A change in the health status of an individual, group or population which is attributable to a planned programme or series of programmes, regardless of whether such a programme was intended to change health status.
HealthPAC	Health Payments Agreements and Compliance	Formed from the merger of Health Benefits and the Shared Support Service Group within the Ministry. HealthPAC undertakes a number of activities based on a Service Level Agreement with the Ministry, and also provides information to several health agencies.
HPI	Health Practitioner Index	The HPI will be a comprehensive source of trusted information about health practitioners for the NZ health and disability sector. The HPI will uniquely identify health providers and organisations. This will allow health providers who manage health information electronically to do so with greater security. It will help our health sector to find better and more secure ways to access and transfer health-related information.
HPCA	Health Practitioners Competency Assurance	The purpose of the HPCA Act, which came into force on 18 September 2004, is to protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practice their professions.
HWAC	Health Workforce Advisory Committee	Committee who advises the Minister on how to ensure an adequate and responsive professional health workforce
HEAL	Healthy Eating Active Living 'Action Plan'	This Plan provides us with the platform to implement the national HEHA Strategy at a local level.
HEHA	Healthy Eating Healthy Action 'Strategy'	HEHA is the Ministry's strategic approach to improving nutrition, increasing physical activity and achieving healthy weight for all New Zealanders.
HSS	Hospital and Specialist Services	The Provider-arm of the Canterbury DHB.
ISSP	Information Services Strategic Plan	The Canterbury DHB's Plan for information services – in line with the national Health Information Strategy.
IDFs	Inter District Flows	An IDF is a service provided by a DHB to a patient whose 'place of residence' falls under the region of another DHB. Under PBF each DHB is funded on the basis of its resident population therefore the DHB providing the IDF will recover the costs of that IDF from the DHB who was funded for that patient.
InterRAI	International Resident Assessment Instrument	Comprehensive geriatric assessment tool.

KPP	Knowing the People Planning Project.	The Programme identifies those people with enduring mental illness and tracks their progress against ten elements of recovery from employment status through to use of hospital services.
LEAP	Late Effects Assessment Programme	LEAP is a clinic (and programme) for children and adolescents with cancer established to help monitor and support children and adolescents who have completed active cancer therapy.
LOS	Length of Stay	LOS is the time from admission to discharge, less any time spent on leave. It is normal to exclude boarder patients when calculating length of stay.
LTCCP	Long Term Council Community Plan	Plan that sets out the type of community the people of a region would like to live in, and the things they would like to see for their community. It shows how the Council (for that region) and other organisations will work to build that community.
MoU	Memorandum of Understanding	An agreement of cooperation between organisations defining the roles and responsibilities of each organisation in relation to the other or others with respects to an issue over which the organisations have concurrent jurisdiction.
MHINC	Mental Health Information National Collection	The national database of mental health information held by the NZ Health Information Service to support policy formation, monitoring and research.
MH-SMART	Mental Health Standard Measures of Assessment and Recovery	The aim of the MH-SMART initiative is to support recovery by promoting and facilitating the development of an outcomes-focused culture in the mental health sector. The principle means of achieving this will be by implementing a suite of standard tools to measure changes in the health status of mental health service users that is responsive to the needs of Maori and other cultures within a recovery framework.
	Morbidity	Illness, sickness.
	Mortality	Death.
NHI	National Health Index	The NHI number is a unique identifier that is assigned to every person who uses health and disability support services in NZ. A person's NHI number is stored on the NHI along with that person's demographic details. The NHI and associated NHI numbers are used to help with the planning, co-ordination and provision of health and disability support services across NZ.
NIR	National Immunisation Register	The NIR is a computerised information system that has been developed to hold immunisation details of NZ children and assist to improve immunisation rates.
NNPAC	National Non-admitted Patient Collection	Coding of outpatients – a pilot project under the national Health Information Strategy.
NASC	Needs Assessment & Service Co-ordination	NASC assists older people with long-term disabilities/ health problems (i.e. longer than 6 months) to remain living at home, safely and independently, for as long as possible. Needs Assessors complete an assessment of needs with the older person, and Service Coordinators use this assessment to develop care packages of support services to assist at home.
NZHIS	New Zealand Health Information Service	A group within the Ministry responsible for the collection and dissemination of health-related data. NZHIS has as its foundation the goal of making accurate information readily available and accessible in a timely manner throughout the health sector.
NGO	Non- Government Organisations	There are many ways of defining NGOs. In the context of the relationship between the Health and Disability NGOs and the Canterbury DHB, NGOs include independent community and iwi/Maori organisations operating on a not-for-profit basis, which bring a value to society that is distinct from both Government and the market. In reality this will mean that any profits are put back into the organisation, rather than distributed to shareholders.
OPF	Operational Performance Framework	The OPF is one of a set of documents known as the 'Policy Component of the DHB Planning Package' which sets out the accountabilities of DHBs. The OPF is endorsed by the Minister of Health and comprises the operational level accountabilities that all DHBs must comply with. These are given effect through the Crown Funding Agreements between the Minister and the DHB.
PMS	Patient Management System	PMS (secondary-care usage), or Practice Management System (primary-care usage). The system used to keep track of patients. In the case of secondary care the focus is usually on tracking the admissions, discharges or transfers of patients. In the case of primary care, the focus is on maintenance of the register.
PHARMAC	Pharmaceutical Management Agency	Agency which secures, for eligible people in need of pharmaceuticals, the best health outcomes that are reasonably achievable from pharmaceutical treatment and from within the amount of funding provided.
PBF	Population Based Funding	Involves using a formula to allocate each DHB a fair share of the available resources so that each Board has an equal opportunity to meet the health and disability needs of its population.

	Primary Care	Primary Care means essential health care based on practical, scientifically sound, culturally appropriate and socially acceptable methods. It is universally accessible to people in their communities, involves community participation, is integral to, and a central function of, the country's health system, and is the first level of contact with the health system.
PHO	Primary Health Organisation	A new development in service delivery PHOs encompass the range of primary care and practitioners and are funded by DHBs to provide of a set of essential primary health care services to those people who are enrolled in that PHO.
	Public Health	The science and art of preventing disease, prolonging life and promoting health and efficiency through organised community effort. A collective effort to identify and address the unacceptable realities that result in preventable and avoidable health outcomes, and it is the composite of efforts and activities that are carried out by people committed to these ends.
QIC	Quality Improvement Committee	The Quality Improvement Committee (formerly EpiQual) is a statutory committee established under the NZ Public Health and Disability Act 2000. It is appointed by, and accountable to, the Minister of Health. The Committee provides independent advice to the Minister on quality improvement in the health sector through monitoring of national quality initiatives and advises the Minister on how clinical outcomes may be improved through such initiatives.
Q1-Q4	Reporting Quarters	Q1 = 01 July to 31 30 September Q2 = 01 October to 31 December Q3 = 01 January to 31 March Q4 = 01 April to 30 June
	Secondary Care	Specialist care that is typically provided in a hospital setting
SISSAL	South Island Shared Services Agency Ltd	SISSAL provides a consultancy service to the South Island DHBs, and works in partnership with them on health planning and funding issues. SISSAL is funded by the DHBs on an annual budget basis to provide these services. The main services provided include contract and provider management, audit, strategy and service development, analysis, and project and change management.
Statement of Intent	Statement of Intent	The Statement of Intent covers three years and is the DHB's key accountability document to Parliament. It is a statutory obligation under the Public Finance Act. It has a high level focus similar to an executive summary, of the DHB's key financial and non-financial objectives and targets.
	STAT Dispensing	STAT Dispensing refers to all-at-once dispensing by pharmacies.
SDR	Standardised Discharge Ratio	The SDR measures the intervention rates for a selected group of procedures and compares them with the national average. If all DHBs were providing services at the same level, they would all be at 1. A SDR higher than 1 indicates that the board is providing more than the average rate in NZ, and a rate lower than 1 indicates that the board is providing less than the average rate in NZ. Intervention rate analysis does not necessarily indicate what the right rate might be, but compares individual boards with the national mean, taking board population demographics into account.
TLA	Territorial Local Authority	Local Council also known as: Regional Councils; District Councils; Territorial Local Authorities; Unitary Authorities; City Councils; Councils
	Tertiary Care	Very specialised care often only provided in a smaller number of locations
YTD	Year to Date	The 12 month period immediately prior to the date given.

Appendix 2.

ORGANISATIONAL CHART OF THE CANTERBURY DHB



Appendix 3.

HOSPITAL SUPPORT AND LABORATORY SERVICES

Covers support services such as: medical illustrations, specialist equipment maintenance, sterile supply, Meals on Wheels and hospital maintenance. It also covers the provision of diagnostic services through Canterbury Health Laboratories (CHL) for patients under the care of the Canterbury DHB and offers a testing service for GPs and private specialists. CHL is utilised by more than 20 public and private laboratories throughout NZ that refer samples for more specialised testing and is recognised as an international referral centre.

MEDICAL AND SURGICAL SERVICES

Covers medical services: cardiology/lipid disorders, endocrinology/diabetes, respiratory, rheumatology/immunology, infectious diseases, oncology, gastroenterology, clinical haematology, neurology, hyperbaric medicine and sexual health and surgical services: vascular, cardiothoracic, orthopaedics and neurosurgery, urology, plastic and cardiac surgeries and the services of the day surgery unit. Services also cover: emergency investigations, outpatients, anaesthesia, intensive care, radiology, nuclear medicine, clinical pharmacology, pharmacy, medical physics and allied health services. The Christchurch Hospital has a busy Emergency Department treating around 72,000 patients per annum.

MENTAL HEALTH SERVICES

Our Mental Health Service is one of the two largest providers in NZ covering: child and youth, adult specialty, community services and rehabilitation services, forensic (regional), acute psychiatric and alcohol and drug services, long-term care, assessment, treatment and rehabilitation and psychiatric services for adults with intellectual disabilities. A number of community based services and mobile teams also provide mental health services (including alcohol and drug services) throughout Canterbury. A number of services have regional beds as well as providing regional consultation liaison including Forensic, Eating Disorders, Alcohol and Drug and Child Adolescent and Family Services.

OLDER PERSON'S HEALTH AND REHABILITATION SERVICES

Covers assessment, treatment and rehabilitation services, psychiatric services for the elderly and psychiatric needs assessment, generic geriatric outpatients, specialist osteoporosis clinics, meals on wheels, community specialist services including InterRAI assessment, treatment and rehabilitation for over 65 year olds. Specialist under 65 year olds assessment and treatment services for disability funded clients. The Older Person's Health Service also operates geriatric and psychogeriatric day hospitals. Rehabilitation health services cover the spinal injuries unit, musculoskeletal services, brain injury rehabilitation services, pain management and orthopaedic rehabilitation. The Burwood Spinal Unit is one of only two such units in the country, treats 60% of NZ's spinal injury patients and is involved in leading international research to help patients rehabilitate and adjust.

RURAL HEALTH AND COMMUNITY SERVICES

Covers a wide range of services provided in rural areas generally based out of Ashburton Hospital but also covering services provided by the smaller rural hospitals. Services include: general medicine and surgery, palliative care, maternity services, assessment treatment and rehabilitation services for the elderly and long-term care for the elderly including specialised dementia care and diagnostic services. Also offered are rural community support services: day care services, district nursing, home support, meals on wheels and clinical nurse specialist services in many areas including respiratory, cardiac, diabetes, wound care, urology, continence and stoma therapy. The Rural Health Service also operates Tuarangi Home a facility providing hospital care for the elderly in Ashburton.

WOMEN AND CHILDREN'S HEALTH SERVICES

Covers acute and elective gynaecology services, primary, secondary and tertiary obstetric services, neonatal intensive care services, pregnancy terminations (at Lyndhurst Hospital) and primary maternity services through Lincoln Maternity, Rangiora Hospital and the Burwood Birthing Unit. This service also covers children's health: paediatric oncology, paediatric surgery, child protection services, cot death/paediatric disordered breathing, community paediatrics and paediatric therapy, public health nursing services and vision/hearing screening services. The Services' neonatal intensive care unit and staff are involved in world-leading research investigating improved care for pre-term babies.

STATEMENT OF ACCOUNTING POLICIES.

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

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

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

(iii) Assumptions
The main assumptions underlying the forecast are noted in Section 6 of the SOI.

New Zealand Equivalents to International Financial Reporting Standards (NZIFRS)
FRS-42 states that the (prospective) forecast statements for an upcoming financial year should be prepared using the same standards as the statements at the end of that financial year.

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

REPORTING ENTITY AND STATUTORY BASE

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

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

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

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

NATURE OF OPERATIONS

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

STATEMENT OF COMPLIANCE

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

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

SIGNIFICANT ACCOUNTING POLICIES

BASIS OF PREPARATION

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

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

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

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

Property, plant and equipment useful lives and residual value

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

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

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

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

Retirement and long service leave

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

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

Leases classification

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

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

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

Non-government grants

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

MEASUREMENT BASIS

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

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

SPECIFIC ACCOUNTING POLICIES

Subsidiaries

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

financial statements of subsidiaries are included in the consolidated financial statements from the date that control commences until the date that control ceases.

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

Basis for Consolidation

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

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

Associates

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

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

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

Transactions eliminated on consolidation

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

Foreign currency

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

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

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

Budget figures

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

Property, plant and equipment

Classes of property, plant and equipment

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

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

Owned assets

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

Land, buildings and building fitout are revalued to fair value as determined by an independent registered valuer, with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every five years.

Any increase in value of a class of land and buildings is recognised directly to equity unless it offsets a previous decrease in value recognised in the statement of financial performance. Any decreases in value relating to a class of land and buildings are debited directly to the revaluation reserve, to the extent that they reverse previous surpluses and are otherwise recognised as an expense in the statement of financial performance. Additions to land and buildings between valuations are recorded at cost.

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

Fixed Assets Vested from the Hospital and Health Service

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

Additions

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

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

Subsequent costs

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

Disposal of Property, Plant and Equipment

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

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

Donated Assets

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

Depreciation

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

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

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

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

Intangible assets

Software development and acquisition

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

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

Amortisation

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

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

Investments

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

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

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

Trade and other receivables

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

Inventories

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

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

Cash and cash equivalents

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

Impairment

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

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

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

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

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

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

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

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

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

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

Borrowings

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

Employee benefits

Defined contribution plans

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

Defined benefit plans

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

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

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

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

Annual leave, conference leave and medical education leave

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

Provisions

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

ACC Partnership Programme

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

The liability for the ACC Partnership Programme is measured using actuarial techniques at the present value of expected future payments to be made in respect of the employee injuries and claims up to the reporting date. Consideration is given to anticipated future wage and salary levels and experience of employee claims and injuries.

Expected future payments are discounted using market yields on government bonds at balance date with terms to maturity that match, as closely to possible, the estimated future cash outflows.

Trade and other payables

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

Derivative financial instruments

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

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

Income tax

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

Goods and services tax

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

Revenue

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

Revenue relating to service contracts

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

Services rendered

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

Interest income

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

Operating lease payments

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

Non-current assets held for sale

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

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

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

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

Borrowing costs

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

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

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

- NZ IAS 1 *Presentation of Financial Statements (revised 2007)* relaces NZ IAS 1 *Presentation of Financial Statements (issued 2004)* and is effective for reporting periods beginning on or after 1 January 2009. The revised standard requires information in financial statements to be aggregated on the basis of shared characteristics and introduces a statement of comprehensive income. The statement of comprehensive income will enable readers to analyse changes in equity resulting from non-owner changes separately from transactions with the Crown in its capacity as "owner". The revised standard gives Canterbury DHB the option of presenting items of income and expense and components of other comprehensive income either in a single statement of comprehensive income with subtotals, or in two separate statements (a separate income statement followed by a statement of comprehensive income). Canterbury DHB intends to adopt this standard for the year ending 30 June 2010, and is yet to decide whether it will prepare a single statement of comprehensive income or a separate income statement followed by a statement of comprehensive income.
- NZ IAS 23 *Borrowing Costs (revised 2007)* replaces NZ IAS 23 *Borrowing Costs (issued 2004)* and is effective for reporting periods commencing on or after 1 January 2009. The revised standard requires all borrowing costs to be capitalised if they are directly attributable to the acquisition, construction or production of a qualifying asset. Canterbury DHB intends to adopt this standard for the year ending 30 June 2010 and has not yet determined the potential impact of the new standard.
- NZ specific amendment to NZ IAS 2 *Inventories.* In November 2007 the New Zealand Accounting Standards Review Board approved an amendment to NZ IAS 2 *Inventories*, which requires public benefit entities to measure inventory held for distribution at cost, adjusted when applicable for any loss of service potential. Prior to the amendment, public benefit entities were required to measure inventories held for distribution at the lower of cost and current replacement cost. Application of the amendment is mandatory for reporting periods beginning on or after 1 January 2008. Canterbury DHB will adopt the amended standard for the year ending 30 June 2009 and expects the impact of adopting the new standard to be minimal.