Canterbury DHB

ANNUAL PLAN 2016/17

Incorporating the Statement of Intent 2016-2020
& Statement of Service Expectations 2016/2017

Statement of Responsibility

The Canterbury District Health Board (DHB) is one of 20 DHBs, established under the New Zealand Public Health and Disability Act in 2011. Each DHB is categorised as a Crown Agent under the Crown Entities Act, and is accountable to the Minister of Health for the funding and provision of public health and disability services for their resident population.

This Annual Plan has been prepared to meet the requirements of the New Zealand Public Health and Disability Act, Crown Entities Act, and Public Finance Act and the expectations of the Minister of Health.

The Plan sets out our goals and objectives and describes what we intend to achieve, in terms of improving the health of our population and ensuring the sustainability of the Canterbury health system. The Plan also contains service and financial forecast information for the current year and three subsequent out-years: 2016/17, 2017/18, 2018/19, 2019/20.

Sections of this Annual Plan are extracted to form the Statement of Intent which is presented to Parliament. The Statement of Intent is used at the end of the year to compare our planned and actual performance, and audited results are presented in our Annual Report.

The Canterbury DHB also has a Māori Health Action Plan and a Public Health Action Plan, both of which are companion documents to the Annual Plan. These Plans set out further actions and activity to improve our population's health and reduce inequalities in health status and outcomes. Both documents are available on our website: www.cdhb.health.nz.

The Minister of Health has been very clear in setting his annual expectations for 2016/17. DHBs must focus on service integration, cross government collaboration and the delivery of national expectations.

The Canterbury DHB has made a strong commitment to whole of system planning and service delivery. Clinically-led local and regional alliances have been established as vehicles for implementing system change and improving health outcomes. This includes the large-scale Canterbury Clinical Network (CCN) District Alliance, the Realign Christchurch Campus Clinical Alliance and the South Island Regional Alliance.

In line with this approach and commitment, the actions outlined in this Annual Plan present a picture of the collaborative activity that will be delivered by the Canterbury DHB and its Alliance partners.[1]

In signing this Annual Plan, we are satisfied that it fairly represents our joint intentions and commitments. Together, we will continue to strive to improve the health and wellbeing of our community, and deliver against the expectations of Government.

Sir Mark Solomon
ACTING CHAIR | CANTERBURY DHB

Barry Bragg
CHAIR QUALITY FINANCE AUDIT & RISK COMMITEE| CANTERBURY DHB

Sir John Hansen
CHAIR | CANTERBURY CLINICAL NETWORK

Honourable Jonathan Coleman
MINISTER OF HEALTH

Honourable Stephen Joyce
MINISTER OF FINANCE

March 2017

[1]*The CCN Work Plan and the South Island Regional Health Services Plan for 2016/2017 can be found on the Canterbury Clinical Network and South Island Alliance websites: www.ccnweb.org.nz and www.sialliance.health.nz.*

Office of Hon Dr Jonathan Coleman

Minister of Health
Minister for Sport and Recreation
Member of Parliament for Northcote

19 APR 2017

Sir Mark Solomon
Acting Chairperson
Canterbury District Health Board
PO Box 1600
Christchurch 8140

ta.marksolomon@gmail.com

Dear Sir Mark

Canterbury District Health Board 2016/17 Annual Plan

This letter is to advise you that together with the Minister of Finance, I have approved and signed Canterbury District Health Board's (DHB's) 2016/17 Annual Plan for one year only with the expected result of $38.5 million deficit. Note that this approval does not include approval of the out years forecast results.

I wish to emphasise how important Annual Plans are to ensure appropriate accountability arrangements are in place. I appreciate the significant work that is involved in preparing your Annual Plan and thank you for your effort.

The Government is committed to improving the health of New Zealanders and continues to make significant investments in health services, including for electives initiatives. In Budget 2016 Vote Health received an additional $2.2 billion over four years, demonstrating the Government's on-going commitment to protecting and growing our public health services.

As you are aware, the refresh of the New Zealand Health Strategy is now complete and the Strategy provides DHBs and the wider sector with a clear strategic direction for delivery of health services to New Zealanders. I note that you have committed to the Health Strategy and its themes in your 2016/17 Annual Plan and I look forward to seeing your progress throughout the year.

Living Within our Means

DHBs are required to budget and operate within allocated funding and to identify specific actions to improve year-on-year financial performance to live within their means. This includes seeking efficiency gains and improvements in purchasing, productivity and quality aspects of DHBs' operation and service delivery. Additionally, improvements through national, regional and sub-regional initiatives must continue to be a key focus for all DHBs.

Over the coming years there are financial challenges for your Board from projected deficits. The PricewaterhouseCoopers (PwC) stage two financial review completed in 2016 provides you with recommendations to address those challenges that includes tighter financial management of key operating costs, a review of the future facilities building plan, and

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reducing the depreciation rate. It also recommended that alternative financing options, such as leasing rather than owning some facilities, are explored.

I encourage your Board to consider the recommendations as part of efficiencies to reduce the projected deficits in the coming years. This is in line with Government's expectation that savings are found and will require a close look at your DHB's operational and capital expenditure. Note that savings should be found through prudent financial management as opposed to reductions in frontline health services.

For 2016/17, I expect that you will have contingencies in place, should you need them, to ensure that you achieve your planned net result, and that out years are informed by the PwC review. Refer to the correspondence to the Chair of Canterbury DHB dated 22 December 2016 for Ministers' expectations.

National Health Targets

Your Annual Plan includes positive actions that will support health target performance for your population. However, as you know, I am concerned about the pace of improvement in relation to the *faster cancer treatment* health target and remind you that this needs to be a particular focus of your service delivery, as does the *improved access to elective surgery* health target given the additional investment made in this area.

As you are aware, the *raising healthy kids* health target was launched at the beginning of July 2016 and will see 95 percent of obese children identified in the B4 School Check programme offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions by December 2017. I am pleased to note that your Annual Plan shows a clear plan for achievement of the target and I look forward to hearing of the progress made in your district.

System Integration including Shifting Services

As you are aware, DHBs are expected to continue focussing on integrated healthcare and to shift services closer to home in 2016/17, in line with one of the core Health Strategy themes of providing services and care closer to home. The ability of DHBs to shift services is varied based on local need, context and scalability and can range from co-locating outpatient clinics in the community, through to redesign of services.

I understand that Canterbury DHB has committed to implement a new after-hours model for Selwyn, a community rehabilitation enablement and support team in Kaikoura, and an enhanced primary care capitation funding model to support integrated family health centre development. If these activities trigger the service change protocols you will need to follow the normal service change process.

Cross-government Initiatives and Collaboration

Delivery of Better Public Services continues to be a key focus for the Government. Of the ten whole-of-government key result areas, the health service is leading the following areas:

- increased infant immunisation
- reduced incidence of rheumatic fever
- reduced assaults on children.

In addition to these areas, the health service has a significant role in supporting and contributing to other cross-agency work that will have significant impacts on health outcomes, such as Reducing Unintended Teenage Pregnancy (as a sub-focus of the Better

Public Service Result One), Whānau Ora, the Children's Action Plan, Healthy Families New Zealand and Youth Mental Health.

I note that you have included a clear focus and appropriate actions to demonstrate that you are working as one team to deliver on these priorities within your 2016/17 Annual Plan.

Annual Plan Approval

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

I would like to thank you and your staff for your valuable contribution and continued commitment to delivering quality health care to your population, and wish you every success with the implementation of your 2016/17 Annual Plan. I look forward to seeing your achievements, in particular in relation to IT programmes, mental health and the New Zealand Health Strategy.

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

Yours sincerely

Hon Dr Jonathan Coleman
Minister of Health

cc Mr David Meates
Chief Executive
Canterbury District Health Board
PO Box 1600
Christchurch 8140

david.meates@cdhb.govt.nz

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Part I

Overview

Foreword from the Chair and Chief Executive

Turning our challenges into strengths

Over the past several years we have talked about the challenges we face. We are proud to be part of a health system that can say, despite the unrelenting pressures, and unprecedented challenges the Canterbury Health System has continued to radically change the way in which health services are provided.

We've continued to innovate and respond to the changing needs of our community. We've reduced the need for multiple visits, increased access to care and cut back the time people waste waiting for treatment. Year on year, we're investing our time and resources to make a difference.

What we have achieved hasn't been easy and we're not discounting the challenges we face. This is about recognising that people from all over our health system are stepping up to the daily challenges and putting patients first – determined not to do the easy thing, but the right thing. Everyone who works in our health system has a lot to be proud of and their combined efforts and commitment has meant that health services in Canterbury have not missed a beat.

Empowering people to stay well

More than 34,000 children received childhood vaccinations in the past year and 96% of all children in Canterbury were fully immunised by eight months. We achieved the national immunisation target in every quarter of the year. As well as being above the national average we have also achieved the target for Māori, with 95% of Māori tamariki being fully immunised by eight months of age.

More than 54,000 smokers in Canterbury received brief advice to quit last year and in the final quarter of the year, we delivered brief advice to 98% of all hospitalised smokers. This is a significant achievement and smoking prevalence in Canterbury has dropped from 18.3% in 2006 to 15% in 2014.

Supporting people earlier and closer to home

In 2015/16, the rate of hospital admissions in Canterbury considered 'avoidable through early intervention and treatment' was 2,637 per 100,000 people, 30% below the national rate of 3,717. Our Acute Demand Management Service plays a major role in easing the pressure on our hospitals, and over 33,000 referrals were made for community-based acute care in the last year. This approach has been critical in balancing our constrained capacity.

Mental health is one of our key themes and despite the phenomenal increase in demand for mental health services we are performing above national targets.

On average more than 40 children and 530 adults start care or make contact with mental health services every month. However latest national results show that over the past year 90% of adult referrals have been seen within 21 days and almost 98% within 56 days.

This achievement reflects the hard work that's going into improving our models of care and the increased collaboration across community services. In the past year, more than 600 young people and 5,500 adults accessed brief intervention counselling and support through their general practice.

Our mental health service also now works alongside teachers and school communities to better equip and enable the support of children and families who are struggling with their mental health and wellbeing. We are currently working with 109 schools throughout Canterbury.

Adding value under pressure

Despite the ongoing repairs across our hospital sites and our constrained theatre capacity, we delivered 21,039 elective (planned) surgical discharges for Canterbury residents in the past year. That's 565 more than the national health target and 3.4% higher than the previous year.

Changes to staffing models, lean elective pathways and innovative electronic booking systems have enabled Canterbury to increase elective service provision by 54% over the past seven years. A remarkable outcome in our challenging environment.

A further 15,500 people received acute (emergency) surgery in our hospitals. That's more than 36,500 people who have had operations in the past twelve months. More than 129,000 patients attended a first specialist assessment. We are now just 1% off national waiting time targets with 99% of people waiting no more than 4 months for their assessment or surgery.

The predicted post-earthquakes pressures has seen over 94,000 attendances at our emergency departments in the past year – a 13% increase since the earthquakes. However, our ED team has continued to meet the waiting time health target, with their determination ensuring more than 95% of patients are admitted, discharged or transferred within six hours.

In addition there were 107,000 people seen through the acute GP after hour services which has been an integral part of how the Canterbury Health System has continued to balance the increased demand.

Working as one team - our successful partnerships

Meeting the changing health needs of our population is complex. While our Annual Plan and Statement of Intent are an integral part of describing what we are wanting to achieve over the next few years, it is important to note that it is a reflection of a much larger programme of work.

A significant portion of this work is driven through the Canterbury Clinical Network, where the DHB works alongside eleven partner organisations to redesign and transform the way we deliver health services. We would like to acknowledge the commitment and support of our alliance partners in bringing to life a health system that our community can be proud of.

We would also like to acknowledge the ongoing commitment from our workforce. So many people who work for us have risen to the challenge, stepping up to make things better and to meet the changing needs of our community. People are working under incredible circumstances, in tiring and draining environments, but still put their patient's needs before their own. We are in awe of their dedication.

In 2015/16 the Canterbury health system won the Prime Minister's Award for Public Sector Excellence in recognition of the outstanding collaboration occurring across our health system and the considerable results being achieved for the people of Canterbury.

If we are going to continue to make a difference, we will need to work more closely across our health and social services networks to respond to the needs of our population. Continued investment in integration is a key part of our direction and is reflected in our Annual Plan for 2016/17.

Delivering services and living within our means

A review of the Canterbury DHB's financials was undertaken by Pricewaterhouse Coopers (PWC) on behalf of Ministers.

The subsequent PWC report stated that there is no evidence to suggest that Canterbury is incurring excessive, unnecessary or unmanaged expenditure. Further, it recognised that historically the DHB has had an operating surplus of approximately $50 million per annum – before capital-driven costs are taken into account. In fact the report notes that Canterbury does as well or better than other similar sized DHBs.

The PWC report recognised that Canterbury remains a high-performing health system continuing to attract significant interest internationally, and is rated highly by a number of independent external experts. The report acknowledged the DHB's achievements in managing demand-driven expenditure and absorbing national price increases that exceed funding increases. The report also commends Canterbury's integration strategy where building community capability and capacity to reduce demand on more expensive hospital and aged residential care has paid dividends.

Subsequent analyses have confirmed that Canterbury has the lowest cost growth amongst similar sized DHBs. The Health Round Table (an international bench-marking agency) has Canterbury hospitals as the most efficient over-all, compared with similar hospitals in both New Zealand and Australia. An ongoing challenge will be balancing the impact of the earthquakes on the health and wellbeing of our community and having the fourth fastest growing population of any DHB.

Maintaining our performance – 2016/17

It is clear that the future will continue to be challenging. We are in the midst of rebuilding our facilities, capacity is stretched to the limit and demand for services continues to increase. At the same time we need to continue to innovate and to deliver on Government expectations.

Major decision are being made with regards to the future of almost every building we own. Already over 86% of the beds (and patients) in Christchurch Hospital have been moved at least once and there will be several more years of ongoing disruption as we make repairs.

Our people have been the key to our success. The drive and determination of our clinical and operational teams has kept our system moving forward in the aftermath of New Zealand's biggest natural disaster. However, after five years of earthquakes, relentless demand and infrastructure repairs, the pressures are taking their toll. Many people are tired and are finding it hard to keeping going.

Recent staff surveys involving over 4,000 respondents indicate that while people want to be here, many felt exhausted. More than third of our workforce feel their disrupted working environment and increased workloads are having a negative impact on their wellbeing.

In response we are focused on supporting the wellbeing of everyone who work for the Canterbury health system. We need to keep people engaged and motivated to ensure not only the continued delivery of current services, but the future sustainability of our health system. Over the coming year we will continue to invest in supporting our people and confirming their role in our vision.

Canterbury is home to 543,820 people who deserve the best care we can collectively provide. With the support of our partners and our people, the Canterbury Health System is determined that it will continue to meet the health needs of its community and continue the journey towards a fully integrated health and social system.

Sir Mark Solomon
ACTING CHAIR

David Meates
CHIEF EXECUTIVE

March 2017

Introducing the Canterbury DHB

1.1 Who are we

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

Canterbury has the second largest population of all twenty DHBs. We are responsible for a population of 543,820 people, 11.5% of the New Zealand population.

We own and operate six major facilities: Christchurch, Christchurch Women's, Hillmorton, Burwood, Princess Margaret and Ashburton Hospitals, and almost 30 smaller rural hospitals and community bases.

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

In 2014/15: 117,832 inpatients were discharged from our hospitals, we preformed 20,353 elective surgeries and delivered 5,895 babies. There were: 91,253 presentations in our Emergency Departments, 183,286 consultations with community based specialist mental health services and 649,182 specialist outpatient appointments.

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

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

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

Inclusion of the Chatham Islands

Since June 2015, Canterbury has also been responsible for the Chatham Islands population. The islands are Located 840km east of Christchurch with a population of 600 people.

1.2 What do we do

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

In 2016/17 we will receive approximately $1.654 billion in revenue to meet the needs of our population, which includes $1.303 billion (10.85%) of the population based funding provided to DHBs by the Ministry of Health.

In accordance with legislation we use that funding to:

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

Purchase the health services provided to our population, and through our collaborative partnerships with other service providers, ensure these services are responsive, coordinated and effective.

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

Promote and protect our population's health and wellbeing through investment in health promotion and education and delivery of evidence-based public health initiatives. This includes a major focus on community recovery strategies following the Canterbury earthquakes.

1.3 Our operating structure

Our Board is responsible to the Minister of Health for the overall performance of the DHB. As an owner of Crown assets, the DHB is also accountable to the Government for the financial and operational management of those assets.

The Board delivers against this responsibility by setting strategic direction and policy that is consistent with Government objectives, meets the needs of our population and ensures sustainable service provision.

Five advisory committees assist the Board to meet its responsibilities. These committees comprise of a mix of Board members and community representatives. As part of Canterbury's commitment to shared decision-making, service providers and clinical leaders also regularly present and provide advice to the Board.

Operational management has been delegated to the Chief Executive. The Chief Executive is supported by an Executive Management Team who provide clinical, strategic, financial, and cultural input into decision-making and have oversight of quality and safety.

Since 2010, Canterbury has provided executive and clinical services for the West Coast DHB. The two DHBs now share senior clinical and management expertise including a joint Chief Executive, Executive and Clinical Directors. We also have joint planning and funding, finance, public health, people and capability, information support and corporate services teams.

1.4 Our alliance partnerships

Health resources are increasingly limited. We have to be focused and smart to achieve and sustain improved outcomes for our population. There are many service providers, organisations and agencies who have a shared interest in improving the health of our population — it makes sense to work collectively.

Since 2009 Canterbury has had a clinically-led health Alliance in place. The Canterbury Clinical Network (CCN) is an alliance partnership of healthcare leaders, professionals and providers from all sectors of our health system including: the three primary health organisations, radiology, laboratory, pharmacy and home and community support providers, midwives, St John ambulance services and the DHB.

Through the Alliance, we work with our partner organisations to determine and design the most appropriate and effective service delivery models for our health system. The collective work programme of the Alliance is much wider than the activity reflected in this Annual Plan but activity across priority areas is strongly reflected throughout this document.

In 2015 we also established a clinical alliance on our Christchurch Hospital campus – the Realign Alliance. Realign is the name given to the way Christchurch campus leaders are working together to improve care. There are two service level alliances focused on adult acute care and surgical services, and four work groups: looking at emergency department interface, patient overflow, seven day working and theatre utilisation.

1.5 Our regional role

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

In 2014/15, over 7,000 people from other DHBs were discharged from Canterbury services and over 12,000 people had an outpatient appointment with a Canterbury specialist. This demand is growing steadily and in the five years to 2015, there was a 14% increase in inpatient admissions and a 35% increase in outpatient appointments.

The services we provide on a regional basis include: eating disorder services, brain injury rehabilitation, child and youth inpatient mental health services, neonatal services, diabetes and respiratory services, cardiothoracic, haematology, neurosurgery, plastics, gastroenterology and ophthalmology services.

Canterbury also provides some services on a national or semi-national basis including: laboratory, paediatric oncology, endocrinology, mental health forensic services and spinal services.

Canterbury has also been instrumental in developing and rolling out several major information solutions which are now being used regionally. These include: HealthPathways, the Electronic Request Management System and HealthOne, all of which are enabling faster, safer, and more informed treatment.

The Electronic Request Management System (ERMS), for example, was first launched in Canterbury in 2009. This system has streamlined referrals, improved consistency of practice and reduced patient waiting times. In March 2016 we reached a major milestone, with more than a million electronic ERMS referrals having been generated across the South Island.

1.6 Our accountability to the Minister

As a Crown entity and responsible for Crown assets, the DHB observes government legislation and policy as directed by the Minister of Health. This includes engaging with the Minister and seeking prior approval before making any significant service change, capital investment or disposing of Crown land.

The Canterbury DHB also strives to maintain open communication with the Ministry of Health, including regular financial and service performance reporting and a no surprises policy.

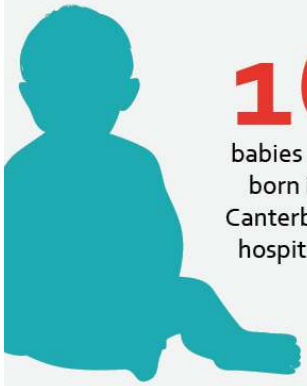
The DHB's reporting obligations include:

- Monthly financial reports.
- Monthly wait time and elective services compliance reporting.
- Quarterly service performance and health target performance reports.
- Quarterly quality and adverse events reporting.
- Quarterly updates on service delivery to plan.
- Bi-annual risk reports.
- Annual Quality Accounts.

The Crown Entities Act also requires DHBs to report annually to Parliament on their financial and service performance. We publish these audited accounts as our Annual Report which is available on the DHB's website www.cdhb.health.nz.

Refer to Appendix 10.5 for DHB's legislative objectives.

ON AN Average CANTERBURY DAY



16 babies are born in Canterbury hospitals

250

presentations to ED

502 consultations with our specialist mental health services

684 radiology tests are completed

16 children receive a Before School Check (B4SC)

323

people are discharged from hospital

56 people have elective surgery

1,753 outpatient appointments

5,069 people are supported in aged resident care

16 older people received a comprehensive clinical assessment—using InterRAI

17 8-month-olds are fully vaccinated

123 people receive advice to quit smoking

8 people are given a green prescription referral for increased physical activity

92 women have a cervical smear

166 children have a free dental check+

17 people receive brief intervention counselling in primary care*

66 people have a cardiovascular disease risk assessment

6,745 laboratory tests are completed

28 subsidised procedures delivered in general practice rather than in hospital.

+ represents the 2014 calendar year. All other figures are for the 2014/15 financial year and are based on the DHB's Annual Report.
** includes telephone consultations.*

Identifying Our Challenges

2.1 The Canterbury dilemma

There has been a real and significant increase in demand for health services across our system, and worrying signs in terms of the mental health and wellbeing of our population. Our health system is almost at full capacity and resources are stretched.

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

In Canterbury however, we are also contending with a number of unique pressures and challenges as a consequence of New Zealand's largest national disaster.

Five years on from the earthquakes, prolonged levels of stress, anxiety and poor living arrangements continue to exacerbate chronic illness and increase demand right across our health system.

Patterns following other international disasters show that psychosocial recovery after a major disaster can take upwards of a decade. While the long-term impacts are hard to pre-determine, health outcomes for children are particularly concerning.

Damage to our infrastructure was extensive, and repair strategies are not simple. Invasive repairs are having to be carried out by relocating and shifting patients and services as we go. This not only disrupts the continuity of care, but complicates our operating environment and adds additional cost to service delivery. Theatre and bed capacity is reduced and we are hiring theatres and outsourcing some surgeries to ensure we can meet demand and delivery expectations.

We also face the challenge of making the best use of $384m of combined insurance proceeds and internally funded capital ($320m and $64m), to manage $518m of earthquake damage. The shortfall means our recovery programme requires ruthless prioritisation. At the same time we are responsible for ensuring the continued safety of staff and patients.

Major decisions are being made with regards to the future use of almost every building. Already over 86% of the beds (and patients) in Christchurch Hospital have been moved at least once to allow for repairs, reinstatement and re-strengthening.

The financial impacts of the earthquake are significant, including not only the treatment costs related to increasing demand but also the less obvious costs of inter-hospital transfers, service outsourcing, temporary accommodation and alternative parking solutions and unplanned capital and depreciation charges related to infrastructure repairs.

The operational costs of the earthquake to date, have been externally evaluated at well over $100 million.

Our situation is further exacerbated by the unanticipated interplay between fluctuating population projections and the national population based funding formula. The formula was never designed to deal with the dynamic population shifts and demand changes we are experiencing.

Population estimates do not fully account for the incoming rebuild population. Statistics New Zealand figures show 6,921 people coming into the city (net international migration) in the year to January 2016. In the year prior to earthquake it was 2,081. Changes to visa regulations have meant most of these people are now eligible for government-provided healthcare.

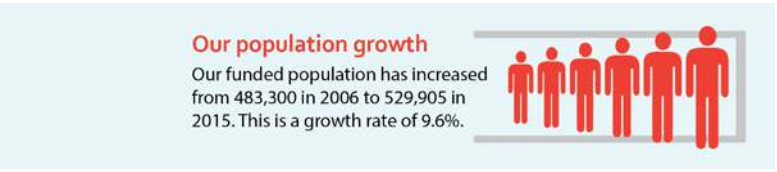
Calculations of deprivation levels, based on where people live, are also questionable in an environment of rapid and forced migration. On paper, deprivation levels in Canterbury have improved dramatically in the past five years but the true level of need across our displaced population is much harder to establish.

We are also acutely aware that our journey towards recovery has been uneven. The significant achievement in some areas is diminished by what is seen as a lack of progress in others. Our workforce is weary and staff commitment is being tested.

We need to take time to focus on the wellbeing and resilience of our staff and the people working across our health system - recognising the extraordinary achievements they have made, and supporting them to look after themselves and their families.

To ensure the long-term sustainability of our health system, we must consider the unique and emerging needs of our population, and use all the data and information at our fingertips to better understand and respond to the constraints of our environment.

2.2 Population profile

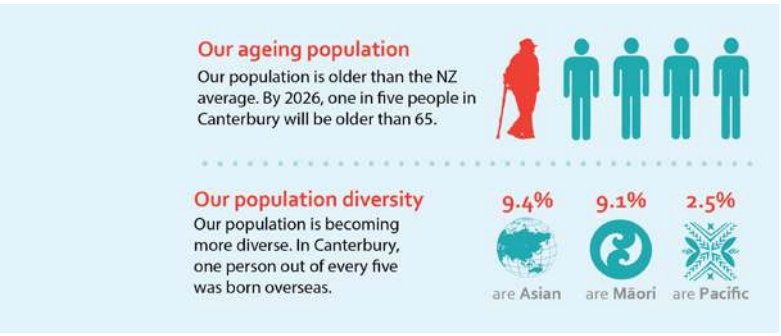


Canterbury is the second largest DHB in New Zealand and in 2016/17 will be home to 543,820 people. Despite a short dip in our population after the earthquakes, 2013 census results show our population has returned to pre-quake levels and continues to grow.

There has been a steady increase in the average age of our population - one of the biggest ongoing challenges for our health system. Canterbury has the largest total population aged over 65 in the country and the fifth fastest rate of population growth in this age group.

Many conditions become more common with age, including heart disease, cancer, stroke and dementia. While more people living longer is a successful outcome, as we age we develop more complicated health needs meaning we are more likely to need specialist services. The increasing average age of our population, will put significant pressure on our workforce and infrastructure.

Latest population predictions show 15.8% of our population are aged over 65 – a total of 85,810 people.



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

Our Asian population is proportionately our fastest growing population group. By 2026 11.7% of our population will be Asian. We need to carefully consider the unique health needs of this large population group, including the growing number of refugee and migrant families coming into Canterbury.

Our Māori population is also growing steadily. We have the second fastest growing Māori population in the country and the sixth largest. There are currently 49,680 Māori in Canterbury and by 2026 they will represent 10.4% of our population. Our Māori population is considerably younger compared to the total population and a third are under 15 years of age.

Since June 2015 the Canterbury DHB has also been responsible for the health and wellbeing of the Chatham Islands population. In 2016/17 the Chatham's is home to 600 people – 58% of them are Māori.

2.3 Health profile

Canterbury's population continues to have a higher life expectancy compared to the New Zealand average. However, in line with international patterns, the prevalence of long-term conditions such as heart disease, cancer, respiratory disease and depression continues to increase.

The leading causes of death, and illness in Canterbury are largely preventable including: cardiovascular diseases, cancer and respiratory disease. Diabetes is the ninth highest cause of death, but an underlying factor for cardiovascular disease and contributes significantly to avoidable hospital admissions.

A reduction in known risk factors, such as tobacco smoking, hazardous drinking, poor diet and lack of physical activity, could dramatically reduce the impact of these diseases and prevent hospital admissions or even premature death.

All four major risk factors also have strong socio-economic gradients, contributing greatly to health inequalities between population groups.

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

- Our obesity rates are slightly lower than national rates but almost a third (27.7%) of our adult population are classified as obese.
- 15% of our total population are current smokers compared to the national average of 18%, but smoking rates amongst our Māori and Pacific populations are significantly higher.
- 10% of our population are likely to drink in a hazardous manner. This is lower than the national average (15%), but still amounts to one in every 10 adults in Canterbury.

The NZ Health Survey also reported that 20.7% of our population have been diagnosed with a common mental illness (such as depression or anxiety disorders) compared to just 17% of the population nationally.

While new research indicates some sections of our population are coping better with the psychological impact of the earthquakes, there has been a marked increase in demand for mental health support.

This is a focus area for our health system in light of the increased demand following the earthquakes, and international disaster research suggests that we can expect to see continue mental health service demand for upwards of a decade. The long-term health impacts for children are particularly worrying.

Mental health and behavioural disorders are currently the sixth most common cause of death in Canterbury.

2.4 Operating environment

Meeting the health needs of a large population is a complex business. Canterbury also has a distinct set of organisational and operational challenges as a result of our unique post-disaster environment, and our status as a large tertiary (specialist) hospital.

DEMAND PRESSURES

Prolonged levels of stress, anxiety and poor living arrangements continue to exacerbate chronic illness and negatively impact on the health and wellbeing of our population. Increased demand is evident right across our health system but particularly across mental health, child and youth and emergency services.

Over the last three years (to December 2015) there has been a 77% increase in rural presentations to specialist mental health services and a 60% increase in presentations to child and youth community services.

International research and post-disaster experience would indicate that this is not surprising, and we can expect these patterns to continue for several years.

There also continues to be uncertainty about the influx of people into Christchurch. Statistics projections do not appear to fully account for the rebuild population, however spikes in demand from this population are being felt across our system.

Between 2011/12 and 2014/15 the census population aged 25-29 increased by 10% but emergency department presentations for this age group increased by 38%. Over the same period there has been a 370% increase in the number of people from overseas presenting in our emergency departments.

We have implemented a number of strategies to reduce the impact of an unenrolled and undercounted population on our system – but it remains an issue.

FACILITIES PRESSURE

The Government's continued commitment to the redevelopment of Burwood and the Acute Services and Outpatient Buildings on the Christchurch Hospital site remains critical to our health system's recovery.

But the redevelopments are only part of the picture. With more than $518m worth of damage to over 200 buildings and 14,000 rooms, the DHB is also engaged in an intensive remediation and repair programme.

Major decisions are being made with regards to the future use of almost every building across all of our sites. There will be several years of ongoing disruption as we shift and relocate services to make repairs. Already over 86% of the beds (and patients) in Christchurch Hospital have been moved at least once.

While this work is underway capacity is substantially reduced. Our staff continue to work out of converted offices, temporary buildings and portacoms and we are having to increase inter-hospital transfers and contract private capacity, while we manage repairs and wait for the new facilities to be completed. Carefully considered and aligned thinking is needed to ensure the safety of our staff and patients while we maintain service continuity.

The increased service costs of this dependency is not sustainable longer-term and any delays or deviations to the repair or redevelopment plans place additional pressure on our staff and our operating budgets.

FISCAL PRESSURES

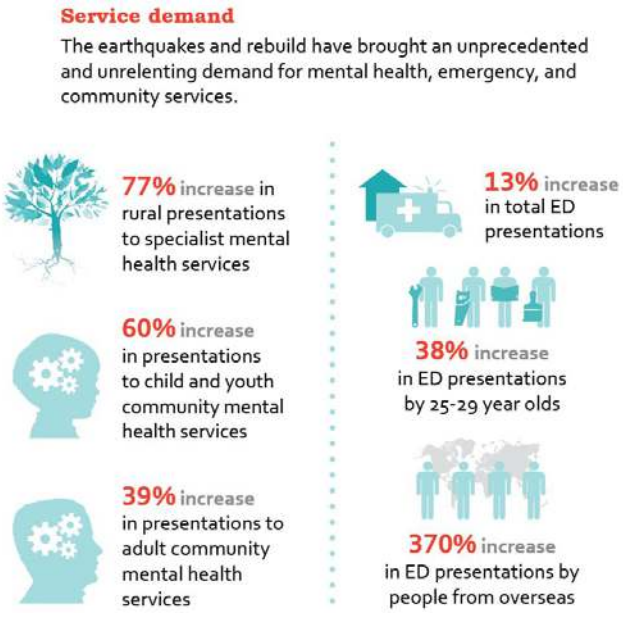
Numerous factors contribute to the fiscal pressures on DHBs including: increasing demand for services, rising treatment and infrastructure costs and wage and salary increases. Our ability to contain cost growth within affordable levels is made more difficult by increasing public expectations, the costs of new technology and demand for seven-day-a-week service.

For Canterbury there are a number of additional pressures. While the total overall cost of the earthquake repairs remains an unknown factor, it is apparent that a considerable amount of the work will not be covered by our insurance proceeds.

There are significant operational cost increases as a result of the earthquake including: the costs of responding to post-earthquake demand, outsourcing costs related to lost capacity, and unplanned capital and depreciation charges.

The DHB is also experiencing an unexpected drop in revenue related to fluctuating population projections and the inability of deprivation measures to take account of forced migration. Population growth is significantly outstripping funding growth and we are left with less funding to respond to emerging need.

If we are to ensure the long-term sustainability of the Canterbury health system, solutions need to be found for meeting the additional, unexpected and ongoing costs associated with the earthquakes.



2.5 Critical success factors

The following are areas where the greatest gains can be made in terms of improving both health and system outcomes. They also represent factors critical to our success, where failure would threaten the achievement of the strategic objectives outlined in this plan and the future viability of our health system.

DOING THE RIGHT THINGS

Supporting people to stay well: If service demand patterns continue to grow unchecked, we will not have the resources to meet future need. Improving the general health and wellbeing of our population, and the management of people's long-term conditions, is the only way to get ahead of the demand curve. While these gains may be slow they are the foundation from which we will build a more effective and sustainable health system.

Prioritising resources for greater impact: Because our resources are increasingly limited, we need to prioritise our investment and focus our efforts where they will have the biggest impact. It is critical that we continue to target and support our most vulnerable population groups. We also need to evaluate our performance and use data and evidence to ensure the initiatives we have in place are making a real difference in the health of our population.

DOING THINGS RIGHT

Improving patient flow: Long waits and long hospitals stays are linked to negative outcomes for patients, and indicate less efficient and effective use of our system's resource. By improving the flow of patients through our system we can facilitate earlier diagnosis, provide faster access to treatment, and reduce lengths of stay. Health outcomes will be better and public confidence and trust in the health system will grow.

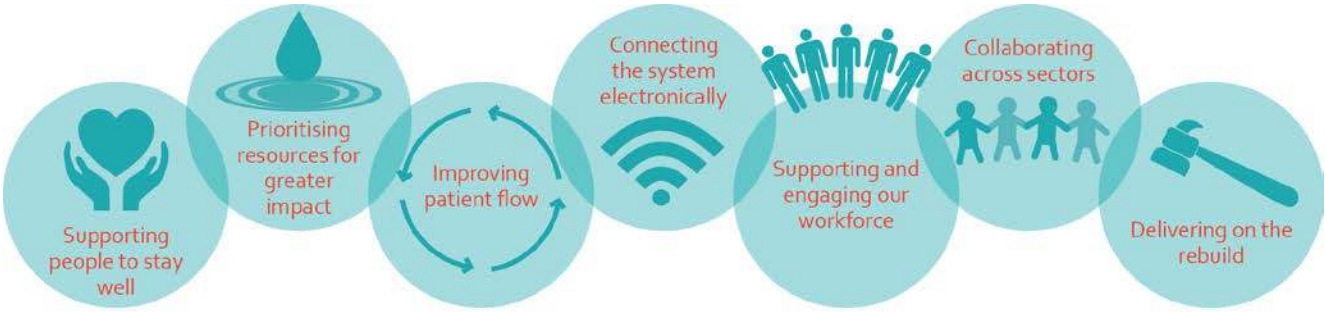
Connecting the system electronically: Unreliable paper-based information systems and poorly performing information technology platforms lead to inefficient service delivery, waste clinical and patient time and reduce the continuity and safety of care. It is critical that we improve access to information that supports clinical decision-making and reduce waste and rework across our system. By providing the right care the first time, not only will we avoid unnecessary expenditure but people's experience and outcomes will be improved.

Supporting and engaging our workforce: Recent staff surveys indicate that while people want to be here, many are exhausted. More than 30% feel their disrupted working environments and increased workloads are having a negative impact on their wellbeing. Without a motivated and engaged workforce we cannot achieve genuine and lasting transformation. It is critical that we support the wellbeing of our staff, keep them empowered and informed and ensure that our health system is one people want to be part of.

RESPONDING TO THE EARTHQUAKE IMPACTS

Collaborating across sectors: If we are to ensure the sustainability of our health system, solutions need to be found for meeting the increased demand from our more vulnerable population groups. We already have in place a strong clinically-led health system alliance. But many of the determinants of good health and wellbeing sit outside the direct control of the health system. It is critical that we implement wider cross-sectorial strategies, and build on our collaborative partnerships with other government agencies, to support the recovery of our shared population.

Delivering on the rebuild: Canterbury is in the midst of the largest and most complex building project in history of New Zealand's health service. Any delays to the timeframes set for delivery of the new Burwood and Christchurch Hospital facilities will create additional financial and operational pressures. Careful consideration must also be given to choices made during the rebuild that will have future operational impacts for the DHB. The safety of our staff and patients depends on the whole of the repair and redevelopment programme being delivered in line with agreed timeframes and budgets



Part II

Long-term Outlook

Setting Our Strategic Direction

3.1 Strategic context

New Zealand's health system is generally performing well against international benchmarks. However an ageing population and the growing prevalence of long-term conditions is increasing demand for health services. At the same time financial and workforce constraints limit our capacity.

Alongside these health sector challenges, there is growing acknowledgement of the social determinants of health and the role good health plays in social outcomes. Health outcomes for our communities are interlinked with issues of education, employment, housing and justice, and we are increasingly being asked to take a broader view of wellbeing.

These pressures mean health services cannot continue to be provided in the same way. While hospitals will continue as settings for highly specialised care, we need to move away from traditional hospital-based or hospital-centred models.

There are clear opportunities that are supporting the transformation of our health system including shifts towards earlier intervention and investment in home and community based care, new technology and more connected information systems.

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

3.2 National direction

Acknowledging these challenges and opportunities, the long term vision for New Zealand's health service is articulated through the New Zealand Health Strategy. The recently refreshed Strategy intends to support all New Zealanders to 'live well, stay well, get well' and sets out five themes to give focus for change:

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

In supporting people closer to home, DHBs are expected to commit to government priorities and provide 'better, sooner, more convenient health services', and 'better public services'.[3]

DHBs are also guided by a range of population or condition specific strategies, including: the He Korowai Oranga (Māori Health Strategy), 'Ala Mo'ui (Pathways to Pacific Health and Wellbeing), Health of Older People Strategy, Primary Care Health Strategy, Mental Health and Addiction Service Development Plan (Rising to the Challenge), Cancer Strategy and Diabetes Strategy.

Alongside these longer-term directions, the Minister of Health's letter of expectations signals annual priorities for the health sector.

In 2016/17 the focus is on:

- Implementing the NZ Health Strategy: DHBs need to be focused on the critical areas to drive the changes identified in the Strategy
- Living within our means: DHBs must continue to consider where efficiency gains can be made and look to improvements through national, regional and sub-regional initiatives
- Working across government: Supporting vulnerable families and improving outcomes for children and young people is a priority, as part of health's contribution to Better Public Services
- Delivering national health targets: while health target performance has improved, this needs to remain a focus for DHBs, particularly the Faster Cancer Treatment target
- Tackling obesity: DHBs are expected to deliver on the new health target to address childhood obesity and show leadership in working to reduce the incidence of obesity
- Shifting and integrating services: DHBs need to continue to work with primary care to move services closer to home and achieve better co-ordinated health and social services
- Improving health information systems: DHBs need to complete current national and regional IT investments and support the co-design process of the Health IT Programme 2015-2020.

The Canterbury DHB is committed to the delivery of health sector goals and making progress against national targets. Activity prioritised in the coming year is highlighted in Part III of this Plan.

Our key deliverables have also been mapped onto the New Zealand Health Strategy Roadmap to highlight the alignment between the local and national direction. Refer to the Appendix 10.6, 10.7 and 10.8 for the Letter of Expectations, Canterbury's commitment against the national Health Targets and our key deliverables against the NZ Health Strategy.

[3] *Refer to the Ministry of Health's website for a copy of the refreshed New Zealand Health Strategy www.moh.health.nz.*

3.3 Regional commitment

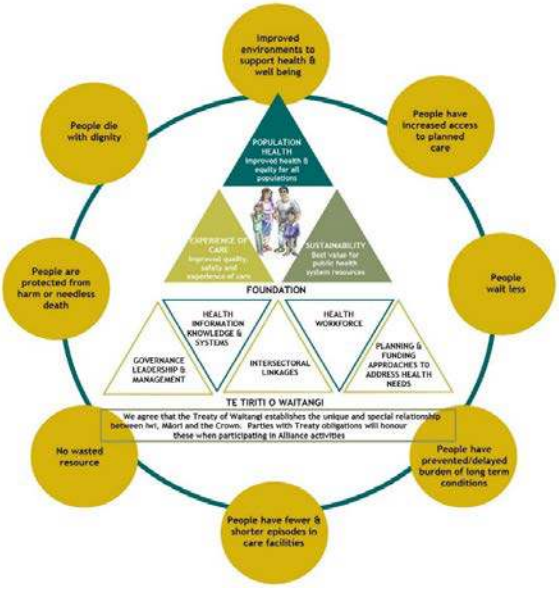
In delivering its commitment to better public services, and better, sooner, more convenient health services the Government has clear expectations of increased regional collaboration between DHBs.

The Nelson Marlborough, Canterbury, West Coast, South Canterbury and Southern DHBs form the South Island Alliance - together providing services for over one million people, or 24% of the NZ population.

While each DHB is individually responsible for the provision of services to its own population, we recognise that working regionally enables us to better address our shared challenges.

The South Island Alliance is jointly funded by the six South Island DHBs to help improve the system within which health services are delivered and the alignment across the South Island.

Now entering its sixth year, the Alliance has proven itself as a successful model, bringing clinicians, managers, service providers, and consumers together to work towards the shared regional vision of *best for people, best for system.*



The Alliance outcomes framework defines what success looks like for South Island health services, and outcomes measures will be implemented this year to track if we are heading in the right direction.

The South Island Regional Health Services Plan outlines the agreed regional activity for the next three years across seven priority service areas: cancer, child health, health of older people, mental health and addictions, information services, support services, and quality and safety.

In addition, regional workstreams will focus on: cardiac services, elective surgery, palliative care, public health, stroke, major trauma and hepatitis C pathways. Workforce planning, through the Regional Workforce Development Hub and regional asset planning, contribute to improved delivery in all service areas.

The Canterbury DHB is involved in the regional service level alliances and workstreams and takes the lead in nine priority areas. The DHB's commitment in terms of the regional direction is outlined in Part III of this Plan.[4]

3.4 The Canterbury vision

The focus on a whole of system approach and an integrated, connected system is not new in Canterbury.

In 2007, health professionals, providers, consumers and key stakeholders came together to rethink the future of our health system. The challenges we faced were well understood. We knew if we didn't actively transform the way we delivered health services we would need to fund 2,000 more aged residential care beds, find 20% more general practitioners and double the size of Christchurch Hospital by 2020.

We needed to do things differently and rethink our relationships with each other and with the people we cared for – and we did. Together we developed a vision for the future that has delivered a fundamental reorientation of the Canterbury health system.

Our vision is an integrated Canterbury health system. A system that keeps people healthy and well in their own homes, by ensuring the right care and support is provided at the right time, in the right place, by the right person.

In committing to this direction we recognised it was not just about our hospitals, but everyone working together to do the right thing for both the patient and the system. People's needs were often met in hospital settings when they would be happier, and better managed, in the community or in their own homes.

Since establishing our vision, health professionals and service providers from across Canterbury have worked tirelessly to redesign the way we deliver health services. Together we are connecting our health system, moving services closer to home and reducing the time people waste waiting.

The health and system outcomes we are seeing as a result of this commitment have been striking.

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

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

Our Canterbury Clinical Network (CCN) Alliance, with its eleven health provider partners, embodies our commitment to a whole of system approach. It is through our Alliance that we have been driving much of the system transformation happening across primary and community services.

Across our hospitals we are also empowering people to improve pathways and processes and harnessing innovation to deliver better outcomes for our patients.

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

Sharing of data and evidence has been a key enabler of change and access to real-time information is helping us to improve the quality and safety of the care we provide – and saving patient's time.

The importance of clinical leadership in the success of our vision is also an element that cannot be overstated. It is with a foundation of strong clinical leadership that we have been able to drive much of the transformation we have achieved across our health system.

When the earthquakes struck we were extremely fortunate to have such a strong collective vision and effective system-wide partnerships. These partnerships and clinical alliances kept our health system together through one of the worst natural disasters in our country's history.

Five years on from the earthquakes, demand patterns are changing. In line with other international recovery profiles, the post-disaster impacts on the health and well-being of our population are being acutely felt.

The DHB is in the unenviable position of having to meet increasing service demand with fewer hospital beds, a shortage of theatres, and the ongoing disruption of major repairs - while at the same time maintaining a safe environment for staff and patients

We are also experiencing significant earthquake-related financial challenges related to dynamic population and deprivation shifts, escalating earthquake repair costs and, with capacity tightly restricted, increased outsourcing costs.

Despite our new and unprecedented challenges, our Board remains committed to our vision and strategic direction. We are determine to continue the successful transformation of our health system.

We remain focused on the delivery of three clear strategic objectives:

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

In considering our challenges and the factors critical to our success, our areas of focus for the coming year will include establishing closer cross-sectorial partnerships and prioritising collective resources for greater impact.

A redesign of our home and community, primary and community mental health, rural health and provider-arm service models are planned for the coming year – as we look to improve the coordination and flow of patients across our system and reduce inequalities of access and outcome.

We will also continue to focus on improving our organisational health and capability and rebuilding our infrastructure. Both significant undertakings and crucial for the future sustainability of our system.

Our prioritised activity and key deliverables for the coming year are outlined further in Part III this Plan.

Managing Our Business

We are required to deliver on a broad mandate to a diverse range of stakeholders. The values of our organisation, the manner in which we interact with others, and the investment choices we make are key factors in our success.

This section highlights our organisational strengths and the way in which we will manage our business to support our transformation and deliver on the collective goals of our health system.

4.1 A patient-centred culture

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

Over the last eight years we have invested in leadership and engagement programmes that encourage people to ask 'What is best for the patient?' and empower them to redesign the way we deliver services to improve the effectiveness of our system.

In 2015 Canterbury won the prestigious Institute of Public Administration Award 'Improving Performance through Leadership' for its innovative staff leadership programmes: 'Xcelr8', 'Particip8' and 'Collabor8'. These programmes promote lean thinking approaches to service and system redesign and support the development of a culture that focuses on the patient. All three programmes are open to anyone in the Canterbury health system, not just DHB employees.

We further engage and empower our workforce to focus on the patient through our annual Quality Improvement and Innovation Awards. These awards recognise excellence in quality improvement in our hospitals and across the wider Canterbury system.

4.2 Effective leadership

We are fortunate to have Board members who contribute a wide range of expertise to their role. Their governance capability is supported by a mix of experts, professionals and consumers on the Board's advisory committees, and clinical and cultural leads attend committee meetings to provide advice and input.

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

Our Board and Chief Executive further ensure their strategic and operational decisions are fully informed at all levels of the decision-making process, including the following governance and advisory mechanisms:

CLINICAL LEADERSHIP

Clinical leadership is intrinsic to our success and we engage health professionals from across Canterbury in service redesign and the development of new models and integrated patient pathways to improve the quality and effectiveness of our services.

The DHB has a Clinical Board that advises the Chief Executive on clinical issues and takes an active role in setting clinical standards and encouraging best practice and innovation. Members support and influence the DHB's vision and play an important role in raising the standard of patient care.

Clinical input into decision-making is embedded in the DHB's shared clinical and management model in place across all service divisions. Clinical leadership is also established across all of our alliance workstreams.

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

CONSUMER PARTICIPATION

The DHB also has a 16-member Consumer Council to formally embrace the inclusion of those who use health services in their design and development. As an advisory group to the Chief Executive, the Consumer Council supports a partnership model that ensures a strong and viable voice for consumers in health service planning and service redesign.

There are also a number of consumer and community reference or advisory groups in place right across the Canterbury health system. Consumer representatives sit on almost all of the Alliance workstreams where their advice and input assists in the development of new models of care and service improvements.

MĀORI PARTNERSHIPS

Through our partnership and formal Memorandum of Understanding with Manawhenua Ki Waitaha (representing the seven Ngāi Tahu Rūnanga), the DHB actively engages Māori in the planning and design of health services and the development of strategies to improve Māori health outcomes.

The DHB works closely with Te Kāhui o Papaki Ka Tai, the primary care Māori reference group, whose members are focused on harnessing collective activity to improve outcomes. Canterbury also has a Māori and Pacific Provider Leadership Forum to improve the planning and delivery of services and provide advice and insight to support improved decision-making.

The DHB's Executive Director of Māori and Pacific Health provides further cultural leadership and input into decision-making at the executive level.

4.3 Successful partnerships

Our vision is wider than just the DHB. Working collaboratively has enabled us to respond to the changing needs of our population (particularly in response to the earthquakes) and is a critical factor in achieving the objectives set out in this plan.

THE CANTERBURY CLINICAL NETWORK

In 2009 we established the Canterbury Clinical Network (CNN) District Alliance. The CCN is the broadest health alliance in New Zealand with eleven partner organisations including the DHB, Canterbury's three Primary Health Organisations, pharmacy, laboratory, radiology, ambulance, midwifery and home-based community service providers. We share a joint vision for our health system and come together to improve the delivery of health care and realise opportunities to transform and integrate our system.[5]

The overarching purpose of the CCN is to provide people with quality care, closer to their own homes, in a way that allows them to play an active role in managing their health. This includes supporting the establishment of Integrated Family Health Services, the development of integrated patient pathways and the strengthening of clinical leadership as a fundamental driver of improved patient care.

Central to our alliancing approach are a number of highly functional, clinically-led workstreams and service level alliances that identify and recommend new service delivery approaches and improvements. The alliance workstreams also support the delivery of national expectations including achievement of the national health targets. The CCN Work Programme for 2016/17 is reflected throughout this Plan.

OUR TRANSALPINE PARTNERSHIP

The Canterbury and West Coast DHBs now share senior clinical and management expertise as well as joint corporate services teams. Formalising our collaboration with shared services, joint positions and transalpine pathways has allowed us to actively plan the assistance and services we provide to the West Coast and to build the most appropriate workforce and infrastructure in both locations.

With an initial priority of connecting up the two systems more than 1,700 telemedicine consultations have taken place between Canterbury and the Coast since 2010 - providing access to specialist advice while saving families the inconvenience of travelling long distances for treatment.

The West Coast has also gone 'live' with Health Connect South, bridging the two DHBs with a single, shared clinical record and enabling a much closer clinical partnership. This software enables clinical records to be read by clinicians involved in the delivery of a patient's care regardless of whether that care occurs on the West Coast or in Canterbury – improving clinical decision making and reducing treatment delays.

Actions to further develop our transalpine partnership in the coming year are reflected through this Plan, as is our work plan with our wider regional DHB partners.

CROSS-SECTORAL COLLABORATION

The Canterbury DHB also works in partnership with organisations from other sectors - recognising the role we all play in shaping the health of our population, whether our focus is health, education, employment, housing, justice, or enhancing environments.

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

The Urban Development Strategy Implementation Committee was established in 2007. The DHB is a member and provides ongoing oversight of the Urban Development Strategy alongside the Christchurch, Waimakariri and Selwyn Councils, Ngai Tahu, Environment Canterbury and the NZ Transport Agency. The DHB is providing staff resourcing to strengthen collaborative approaches and support Health in All Policies as a tool for policy development.

Healthy Christchurch is a DHB-led, cross-sectoral partnership based on the World Health Organisation Healthy Cities model. There are currently over 200 Healthy Christchurch Charter signatories, ranging from government agencies and business networks to voluntary sector groups and residents' associations.

The All Right? social marketing campaign is a partnership between the DHB and the Mental Health Foundation. The campaign works to support and improve people's mental health and wellbeing as our community recovers after the earthquakes. The campaign has been well received and is informed by international evidence and local research.

We have inherited the lead for the delivery of the psycho-social recovery strategy from the Canterbury Earthquake Recovery Authority (CERA) and will continue to work collaboratively with government and non-government agencies to promote and support the mental health and wellbeing of our community.

We will also continue our commitment to the development of the Canterbury Children's Team and work with the Ministries of Social Development and Education on a number of social sector investment models to improve long-term outcomes for the most vulnerable children and their families.

[5] Refer to www.ccc.health.nz for an overview of the CCN and to Appendix 10.9 for a summary of the strategic focus for 2016/17.

NATIONAL COLLABORATION

At a national level, we work with the Ministries of Education, Social Development, Police and Justice to improve outcomes for our population and achieve shared goals. We are committed to implementing better public health services programmes including the rollout of the Prime Minister's Youth Mental Health Project and Vulnerable Children's Legislation.

Canterbury DHB is working nationally alongside other DHBs, the Ministry of Health, Accident Compensation Corporation (ACC) and St John Ambulance on a joint Spinal Cord Impairment initiative. This is a major initiative seeking to make improvements across the patient continuum for those with spinal cord injuries.

Canterbury will also continue to actively participate in the delivery of national programmes led by the: National Health IT Board, Health Quality and Safety Commission, Health Workforce NZ, Health Promotion Agency, PHARMAC and NZ Health Partnership Ltd.

4.4 Subsidiary companies

The Canterbury DHB has two operational subsidiaries. Both are wholly owned subsidiaries with their own Board of Directors (appointed by the DHB) and report to the DHB, as their shareholder, on a regular basis.

Canterbury Linen Services Limited: Incorporated as a company in 1993 the company provides laundry services to DHB hospitals and external commercial clients. The Canterbury DHB owns all shares, as well as the land and buildings for which the company pays a rental. Plant and equipment, motor vehicles and the rental linen pool are the major fixed assets of the company. The key output for 2015/16 was the processing (collection, laundering and delivery) of 4.8 million kilos or 13.6 million items of laundry.

Brackenridge Estate Limited: Incorporated in 1998 Brackenridge provides residential care, respite services and day programmes for people with intellectual disability and high dependency needs. Land and residential houses both on site and in the community are the major fixed assets of the company – a third of the clients live on the Estate. The primary source of funding is service contracts with the Ministry of Health and 176 clients were supported last year. The DHB currently owns all shares, however Brackenridge is considering transitioning to non-DHB ownership.

Alongside these two subsidiary companies:

The South Island Shared Services Agency Limited: Established in 2000, this is a shelf company owned by the South Island DHBs. Following a move to an alliance model in 2011, staff are now employed by Canterbury DHB and operate as the South Island Alliance Programme Office. With an annual budget of just over $6.2m, the Alliance is jointly funded by the South Island DHBs to provide services such as audit, regional service development and project management. Canterbury's contribution for 2016/17 is $2 million.

The New Zealand Health Innovation Hub: A joint partnership between Canterbury, Counties Manukau, Waitemata and Auckland DHBs, the Hub works to engage with clinicians and industry to develop, validate and commercialise health technologies and improvement initiatives that will deliver health and economic benefits to the system. Structured as a limited partnership, the four foundation DHBs each have a 25% shareholding. Further detail can be found at www.innovation.health.nz.

4.5 Commitment to quality

Our commitment to patient-centred care and zero harm is supported by two of our system's greatest strengths - our clinical leadership and our support for continuous quality improvement.

The DHB's approach to improving systems is through rapid cycle learning and improvement science. The DHB is utilising the NZ Performance Excellence in Healthcare Framework to guide the organisation's continuous improvement efforts.

Working with the South Island Quality and Safety Alliance we are implementing quality improvements through a community of practice. This is supporting the South Island DHBs to meet their commitments to the Health Quality and Safety Commission (HQSC) programmes and to build on improvements.

The national HQSC Quality and Safety markers will continue to be part of the set of measures used by our governance groups to monitor the effectiveness of our improvement activity. Performance against the markers is reported regularly to the DHB's Clinical Board and Quality, Finance, Audit & Risk Committee. Performance against the markers is also reported annually in the DHB's Quality Accounts.

In the coming year, in line with the national HQSC direction, our Clinical Board will champion quality and safety projects focused in the following areas:

Improving the patient experience: By working alongside consumers we gain insight from their experience. In collaboration with our Consumer Council, we are facilitating focus groups and gathering patient stories. We survey patients fortnightly using national survey methods and plan to further increase participation rates this year. This information is reported at department level and used in quality improvement activities.

Preventing healthcare-associated infections: Hospital admissions expose patients to potential harm through healthcare-associated infection. Canterbury has been an early adopter of an infection prevention and control platform used for surveillance and management. We are committed to minimising risk in three specific areas: Hand Hygiene; Line-Associated Bacteraemia and Surgical Site Infections. We are also working closely with the HQSC and Auckland DHB to support the national Surgical Site Infection Surveillance Programme.

Preventing harm from falls: Reducing the harm from falls is a key component of our strategies for improving the health of older people and reducing acute demand. In our hospital settings, we pay close attention to falls prevention and to the specific falls risk for each patient in our care. We have standardised falls alert visual cues in place and Safe Mobility Plans for each patient for use by clinical teams and family members. An electronic nursing patient observation system is now being introduced to record falls risk and make data visible in real time to assist with improving adherence to protocol and prevention activity.

Medication safety: The use of medications always carries the risk of a side effect or adverse outcome. Canterbury is participating in the national medicine reconciliation, e-medicines management and opioid campaign initiatives being driven through the HQSC. We also maintain an Adverse Drug Event Trigger Tool programme that provides valuable information about the severity and type of medication events occurring.

Surgical safety: We are committed to focusing on brief and debrief as part of the surgical procedure in our operating theatres to promote better communication and teamwork.

Early warnings: As part of our efforts to detect the deteriorating patient we will complete the roll-out of the electronic patient-vital-sign early-warning system. Together with improvements in communicating patient care goals, this system will support timely clinical decision-making and improve patient outcomes across our hospital services.

Quality Accounts: The DHB publishes annual quality accounts at the end of each year, outlining performance against national quality markers and key areas of innovation and improvement. The DHB's Quality Accounts can be found on our website.

4.6 Investment in people

The delivery of our vision relies heavily on having the right people, with the right skills, in the right place. We also need those people to be aligned with a common purpose, and to integrate systems and processes to support them and make the most of their talents.

WELLBEING, RESILIENCE AND SAFETY

Following the earthquakes, workforce wellbeing and resilience has emerged alongside leadership capability as one of the biggest challenges for our health system.

Results from our staff wellbeing and engagement surveys demonstrate positive levels of engagement with the organisations goals. But they also show that the post-earthquake stress increasingly evident across our community, is also affecting our workforce.

The 2014 Survey highlighted that over a third of respondents had a WHO-5 Wellbeing Index score of less than 13, indicative of poor emotional wellbeing and an indicator of potential mental health risk. These staff have a reduced capacity to cope with stressors and an elevated degree of psychological burden.

Acknowledging the links to engagement, productivity and the quality of patient care, a significant long-term commitment is being made to supporting our staff.

Changes to the Health and Safety in Employment Act also came into effect in April 2016, materially extending organisational accountability and liability in relation to workplace safety.

We have responded to these challenges by creating a Wellbeing, Health and Safety Team. They will focus on the development and implementation of a Wellbeing Strategy to support our staff and health and safety policy, strategy and resources to support the business.

It is intended that through these changes we will better support existing wellbeing initiatives within a broader longer-term Wellbeing Strategy for the organisation. We also aim to provide clarity in relation to responsibility for strategic and operational wellbeing, and health and safety.

At a broader level the DHB is committed to being a good employer, and is aware of legal and ethical obligations in this regard. We continue to promote equity, fairness and a safe and healthy workplace, underpinned by a clear set of organisational values, including a code of conduct and a commitment to continuous quality improvement and patient safety.

The DHB has reviewed its Child Protection Policy against changes to Vulnerable Children's Legislation and will implement appropriate safety checking requirements in line with the Legislation.

Our Workforce

The average age of our workforce is 46 years old, and our oldest workforce group is Support Services with an average age of 52

9,594 people are employed by the Canterbury District Health Board

We are the largest single employer in the south island

48% of our staff work part-time

101 different ethnic groups across our workforce

9.4% turnover rate compared to 9.5% nationally

3.1% sick leave rate compared to 3.8% nationally

81% of our workforce is female

47% of our workforce are nurses

2014 Staff & Family Wellbeing Survey

30% of surveyed staff identified poor working conditions such as noise and overcrowding as a key stress affecting them in their job

20% identified disrupted work environments as a negative impact on their wellbeing

60% of managers reported feeling somewhat or extremely burdened by the responsibility to lead

We are supportive of national engagement process through the Health Sector Relationship Agreement and the National Bipartate Action Group and meet regularly with unions to discuss issues of mutual interest. Active participation in the national Employment Relations Strategy Group also helps to establish parameters to ensure bargaining will deliver on both sector and organisational expectations.

LEADERSHIP CAPABILITY

Our leadership capability has already supported some stunning successes in patient care and integration that are drawing attention from around the world. Continued development of our staff and their leadership capability is a key strategy for enabling the continued transformation of our health system.

We have a strong core development training calendar and invest in a number of innovative development programmes that support leadership development. These award winning programmes can be accessed by health professionals across Canterbury including:

- 2020 leaders: A peer support leadership model.
- Xcelr8: A programme that enhances the ability of established leaders to pick up the pace of change, excel in leadership and management, and to do more with what we already have.
- Particip8: A programme that empowers emerging leaders and innovators to influence others, and work together to make an effective difference.
- Collabora8: A programme that introduces frontline staff to Lean Thinking.

We have stepped up our participation in the Health Workforce NZ sponsored South Island Workforce Development Hub to support critical role identification and expand workforce capability through sharing of training resources right across the health sector.

We will continue to incorporate E-Learning into our developmental approach including HealthLearn, a standardised online learning platform that can be customised to the different needs of our workforce.

EXPANDING OUR WORKFORCE CAPACITY

We continue to strengthened our interactive and targeted recruitment strategies, including branding, profiling and Facebook to keep people connected. We also identify available talent through national and regional initiatives, links with the education sector, and support for internships and increased clinical placements in our hospitals.

Canterbury nursing leaders work closely with the Ara Institute and the University of Canterbury to ensure that the undergraduate nursing programmes aligns to the future workforce need. We continue to offer clinical placement for students undertaking Bachelors of Nursing and Diploma of Enrolled Nursing.

We seek to increase the number of Māori in our health workforce by taking the South Island lead for Kia Ora Hauora, a national initiative aimed at increasing the number of Māori working in health fields.

We also supporting the development of our rural clinical workforce both in Canterbury and on the West Coast, with recent investment in Rural Learning Centres in Ashburton and Greymouth. The aim is to encourage people to work in rural locations by reducing isolation factors through peer support and mentoring.

4.7 Investment in innovation

Alongside the investment in leadership development, Canterbury also has a supportive health innovation environment, being one of the four founding DHBs of the national Health Innovation Hub and business unit Via Innovations. We are also a member of the Canterbury Development Corporation's Canterbury Regional Innovation System.

Through these innovation networks, clinicians are able to access innovation support and expertise in commercialisation. For the DHB, this active research and innovation environment helps to ensure new research is translated and adopted into practice as quickly as possible. This helps to keep us at the forefront of best practice, harnessing innovations that improve service delivery and patient outcomes.

A significant body of clinical research is also conducted within the Canterbury DHB, with over 400 current projects on our Research Register. Research is supported by the Research Office (jointly funded by the University of Otago and the DHB) which provides advice and guidance to anyone involved in health research within these organisations.

4.8 Information solutions

Connecting our health system is central to our vision. Improved access to patient information at the point of care enables more effective clinical decision-making, improves standards of care and reduces the time people spend waiting for treatment.

Canterbury was instrumental in developing and rolling out several of the information solutions which are now being used regionally. These include: HealthPathways, HealthOne and ERMS which have streamlined the way we make requests and send referrals.

We have also invested in the development of 'live data' systems where real time information on the day to day operations within our hospital is enabling responsive decision making and planning – reducing overflow, bed shortages and the need to cancel elective surgery.

Information management is a national priority, and DHBs are expected to implement the national Health Information Technology Plan. The South Island DHBs have collectively determined strategic actions to deliver on the national Plan and Canterbury has committed to this approach.

We will continue to work closely with clinicians and our partner South Island DHBs to ensure that the right information is available in the right place, at the right time. In the coming year Canterbury will lead the implementation of two more locally developed health solutions across the South Island and will replace our legacy patient administration systems with one new system (PICS) in line with the rest of the region.

Further detail on the regional information strategy can be found in the South Island Regional Health Services Plan. Refer to Appendix 10.10 for a map of major information solutions and the links between them.

Investment for 2016-2019 includes:

The South Island PICS: PICS will replace individual patient administration systems with one single system and will further integrate the South Island. Canterbury and the West Coast will upgrade their old systems and implement the new PICS in 2016/17. Implementation at Burwood is already underway.

HealthOne: A secure information system HealthOne enables the sharing of core health information (allergies, test results, medications etc.) between all the health professionals involved in a person's care, no matter where they are based. We are leading the rollout of HealthOne with Canterbury, West Coast and South Canterbury now live and Nelson Marlborough and Southern scheduled for 2016/17.

Health Connect South (HCS): HCS is a clinical workstation and data repository (portal) that brings a patient's clinical information into one view, supporting clinical decision-making at the point of care. Canterbury is leading the roll-out and HCS is in place across Canterbury, West Coast and South Canterbury DHBs. This will be extended in 2016/17 to include Nelson Marlborough and Southern DHBs establishing a single clinical record across the South Island.

eMedications: This is a foundation system with three main components and is being rolled out regionally, promoting patient safety by improving medication management. In 2014/15 Canterbury implemented ePA (prescribing and administration) in our mental health services with other sites to follow in 2015/16. We will also implement eMedications reconciliation in the coming year.

The National Patient Flow Project: This Project will create a new national view of wait times, health events and outcomes across the patient journey through secondary and tertiary care. Canterbury has implemented Phase I and will complete Phase II and begin Phase III in 2016/17.

The National Maternity Clinical Information System: The NMCIS will link relevant information collected about a woman and her baby from pregnancy until baby is 4-6 weeks old. Relevant health care providers: midwives, GPs, hospital specialists and nurses can work better together to support mother and baby. The DHB will implement the NMCIS in the second half of this year.

The Self-Care Patient Portal: The Portal enables patients to be involved and engaged in their care and is an essential part of the national vision. Canterbury has completed a pilot implementation of the Portal. During 2015/16 we worked with the three Canterbury PHOs to develop patient engagement platforms and a formal procurement process has been commenced.

4.9 Investment in facilities

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

The $696 million redevelopment on the Burwood and Christchurch Hospital sites is the largest health-related building project in New Zealand's history. It will allow us to regain part of the capacity lost after the earthquakes and will support the implementation of improved models of care. It will also allow us to make efficiency savings by co-locating and consolidating services.

However, it is important to note that it will not resolve all of our facilities issues. The Burwood Hospital redevelopment will be completed in 2016 but the Acute Service Building and the Outpatients Building on the Christchurch Hospital campus are not scheduled for completion until late 2018.

Buildings on all sites also suffered extensive damage in the earthquakes. Almost all of our 200 buildings need repairs, some have had to be closed and demolished, and many of our staff are still working in inadequate and temporary locations. The DHB has a long ten year earthquake repair programme to work through.

In the meantime, we have to meet increasing service demand and maintain a safe environment for staff and patients - with fewer hospital beds, a shortage of theatres and the ongoing disruption of major repairs.

Close alignment and timing of the redevelopment and repair programmes is essential to support safe delivery of care and to avoid costly and wasteful investment.

Operational oversight and decisions on operational costs for the redevelopment and several critical infrastructure projects including the energy centre, hospital carpark and tunnel and outpatients building have been transitioned to the Ministry of Health.

The DHB is working with the Ministry and the Government appointed Hospital Redevelopment Partnership Group, to try and ensure programmes are aligned, delays are minimised and rebuild decisions do not have negative long-term operation impacts.

Anticipated activity for 2016-2019 includes:

Rangiora: The Rangiora Community Hub is replacing the old hospital facility. The first phase is complete with maternity services and inpatient beds now operating from the Hub. Phase II includes the relocation of the temporary Outpatients Building from

Christchurch Hospital and timings are dependent on the construction of the new Outpatients Building.

Akaroa: The Board has approved in principle the development of an IFHC on the Akaroa Hospital site. The DHB is working with the community to develop an appropriate facility for the area.

Burwood Health Campus: The redevelopment of the Burwood campus is nearing the end and is scheduled for completion in 2016. The redeveloped facility will provide: 230 inpatient beds, an extended radiology department and an outpatient department able to manage 80,000 visits a year.

The Acute Services Building: Construction of the new Acute Services Building on the Christchurch Hospital campus is scheduled for completion in 2018. The new building is expected to provide: additional operating theatres and beds, purpose-designed spaces for children, an expanded intensive care unit, state-of-the-art radiology and emergency departments and a rooftop helipad.

Christchurch Hospital Outpatient's Building: Project oversight for the Outpatients Building sits with the Ministry of Health. Design has commenced, with site activity planned for late 2016. The building is scheduled for completion in 2018.

Christchurch Hospital Energy Centre, Carpark and Tunnel: Like the Burwood and Christchurch Hospital redevelopments, operational oversight and decisions on operation costs for these critical projects has been transitioned to the Ministry of Health. Construction is expected during the period covered by this Plan.

The Christchurch Health Precinct: This is a major anchor project under the Christchurch City rebuild and teaching and research facilities are being considered across this space. The DHB is working in a partnership with Otakaro Limited, the Universities of Canterbury and Otago and the Ara Institute of Canterbury.

Canterbury's Rural Hospitals: The DHB is also carefully considering the role of all of its rural hospitals. With a focus on the provision of modern services to our rural populations, it is unlikely that all of our rural hospitals will continue to operate in their current form.

4.10 Asset planning

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

The DHB has an Asset Management Plan that helps inform the capital requirements of the DHB in the short to medium term. This Plan outlines our current asset base, the condition of those assets and any planned refurbishments, upgrades or replacements.

Our Asset Management Plan was updated in 2009 prior to the Canterbury earthquakes. Since then, our capital intentions have been updated annually to reflect known changes in asset states and intentions in line with our earthquake programme of works and the Burwood and Christchurch Hospital redevelopments.

The DHB also is in the process of developing a more extensive ten-year Long-term Investment Plan. This Plan will encompass planned asset repairs, refurbishments and upgrades as well as the impact changing patterns of demand and new models of care will have on our future asset requirements.

Our ambition is to develop the Canterbury DHB as a high reliability organisation that successfully delivers against its strategic goals by making considered and fully informed investment and operational decisions.

In developing our business case for the redevelopment of the Burwood and Christchurch Hospital sites, we captured what we believe are the key elements of a high reliability organisation in an integrated benefits realisation model.

This model recognises the return on investment in terms of system and service performance outcomes and identifies a set of key performance indicators:

- Increased diagnostic access
- Increased intervention rates
- Increased surgical discharges
- Decreased acute medical discharges
- Decreased wait times
- Decreased adverse events
- Decreased aged residential care rates
- Improved financial position.

As part of the development of our Long-term Plan, we will seek to improve our investment thinking and further develop and monitor performance metrics to ensure that we are investing wisely.

Our major capital intentions for the next several years are signalled in section 8.5. Our current and future capital intentions are also signed to the South Island Alliance to help inform regional capital planning.

Refer to Appendix 10.11 for a snapshot of our current asset performance metrics. These are being reviewed as part of our long-term planning.

4.11 Service reconfiguration

The Service Coverage Schedule between the Ministry and the DHB is the translation of government policy into the required minimum level and standard of service to be made available to the public.

In our current circumstances, there are risks to service coverage related to revenue and capacity constraints, infrastructure damage, rebuild delays and disruptions and unpredictable service demand patterns.

However, despite our challenging environment the Canterbury DHB is committed to continuing to manage and resolve any service coverage issues and at this stage we are not seeking any formal exemptions to the Service Coverage Schedule for 2016/17.

We will continue to identify service coverage through the monitoring of performance indicators, risk reporting, formal audits and complaint mechanism and ongoing review of patient pathways.

SERVICE REDESIGN AND RECONFIGURATION

We anticipate new models of care and service delivery will continue to be developed as we respond to the emerging needs of vulnerable population groups as we move into the fifth year following the earthquakes.

In line with our shared decision-making principles, we look to our clinically-led alliance workstreams and leadership groups for advice on the development of new service models. We also endeavour to keep a steady stream of information flowing across the system with regards to the transformation of services.

We recognise our obligations under the national operational policy framework to notify the Minister of Health with respect to any significant service change and will continue to do so.

At times, we may wish to enter into cooperative or service agreements and arrangements to assist in meeting our objectives and delivering against our goals as outlined in this Annual Plan. In doing so (in accordance with Section 24(1) and Section 25 of the NZPHD Act 2000), we will ensure that any arrangements or service agreements do not jeopardise our ability to deliver the services required under our statutory obligations in respect of our accountability and funding agreements with the Crown.

ANTICIPATED SERVICE CHANGE FOR 2016-2017 INCLUDES:

DESCRIPTION OF CHANGE		AREA IMPACTED
Internal service reconfiguration	Temporary service shifts and ward relocations to support the repair of buildings and infrastructure and permanent relocations following the completion of the Burwood and Christchurch campus redevelopment and the decanting of the Princess Margaret Hospital site.	Burwood, Christchurch, Princess Margaret and Hillmorton Hospital services
Internal service redesign	Internal service redesign to improve capacity, safety and outcomes including the redesign of patient pathways and the improved coordination between services driven under the Realign Alliance. Incudes service change in line with the following major programmes: Elective Services Redesign (100 Days Project), the Frail Older Person's Pathway, Enhanced Recovery After Surgery (ERAS), Faster Cancer Treatment and Theatre Utilisation.	Medical & Surgical services Oncology services ED service interface Child & Youth mental health services
System-wide service redesign	Service redesign to support service integration or the development of new models of care to sustainably meet service demand or improve individual and population health outcomes. This includes key projects under the CCN Alliance and cross sector projects in collaboration with other government agencies.	Primary & community NGO mental health services Home & community services Rural health services
Change to service delivery model, provider or location	Changes to services in response to prioritising resources onto areas of more immediate or greater need, or in order to achieve greater gain in terms of health or system outcomes. This includes aligning practice or intervention rates with national service specification or accepted practice in other DHBs in order to reduce treatment or operation costs.	Respiratory services Hepatitis C services Elective and acute services Children's services Pharmacy services Obesity related services Smoking cessation services
Externally driven service change	Regionally driven service redesign or reconfiguration to support equity of access, sustainability of vulnerable services and regional consistency in line with the South Island Health Services Plan. This also includes change or redesign of services in response to national policy or legislation, updates to national service specifications or a refocus of national funding.	

Monitoring Our Performance

HOW WE KNOW IF WE'RE MAKING A DIFFERENCE

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

DHBs have a number of different roles and associated responsibilities. In our governance role we are striving to improve health outcomes for our population, as a funder we are concerned with the performance of the whole of the health system and as a provider we are concerned with the quality and effectiveness of the services we deliver.

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

In developing our vision for the Canterbury health system, we established three high-level strategic objectives or goals. Alongside these strategic goals we identified six associated outcome indicators.

These are a mix of population health indicators that are important to our stakeholders and together provide an insight into how well our health system is performing. Being longer-term indicators and the aim is for a measurable improvement over time, rather than achievement of a fixed target.

Working with the rest of the South Island DHBs, we have also collectively identified a core set of contributory or impact measures. Because change in this space will be evident over a shorter period of time, these indicators have been selected as our headline or main measures of performance.

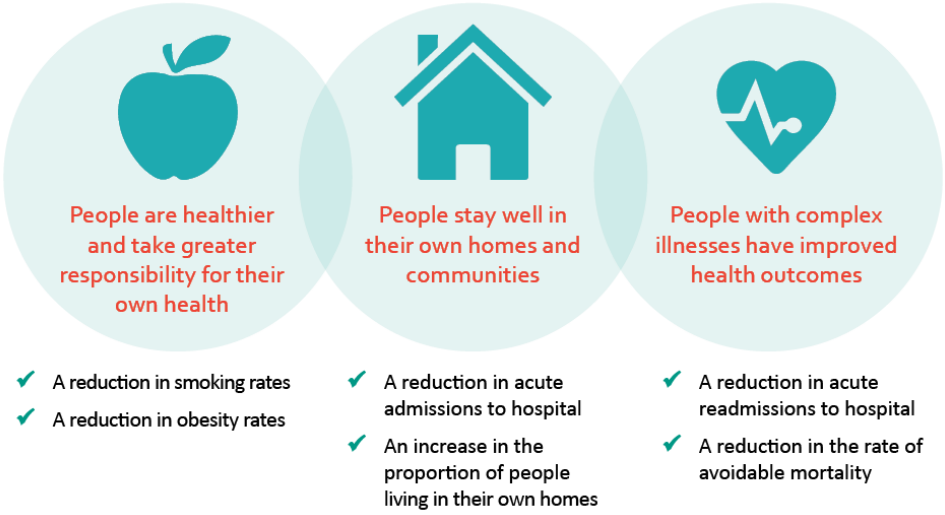
We have set local standards against these contributory measures in order to evaluate our performance annually. Performance expectations reflect the strategic objectives of our health system: increasing the effectiveness of prevention programmes; reducing acute or avoidable demand for hospital services; and maintaining or increasing service access while reducing waiting times and delays in treatment.

As part of our obligations under legislation DHBs must also work towards achieving equity. To promote this goal, the targets set against each of the performance indicators are the same across all population groups.

All of the indicators are monitored alongside our forecast of service performance, and reported in our Annual Report at the end of the year.

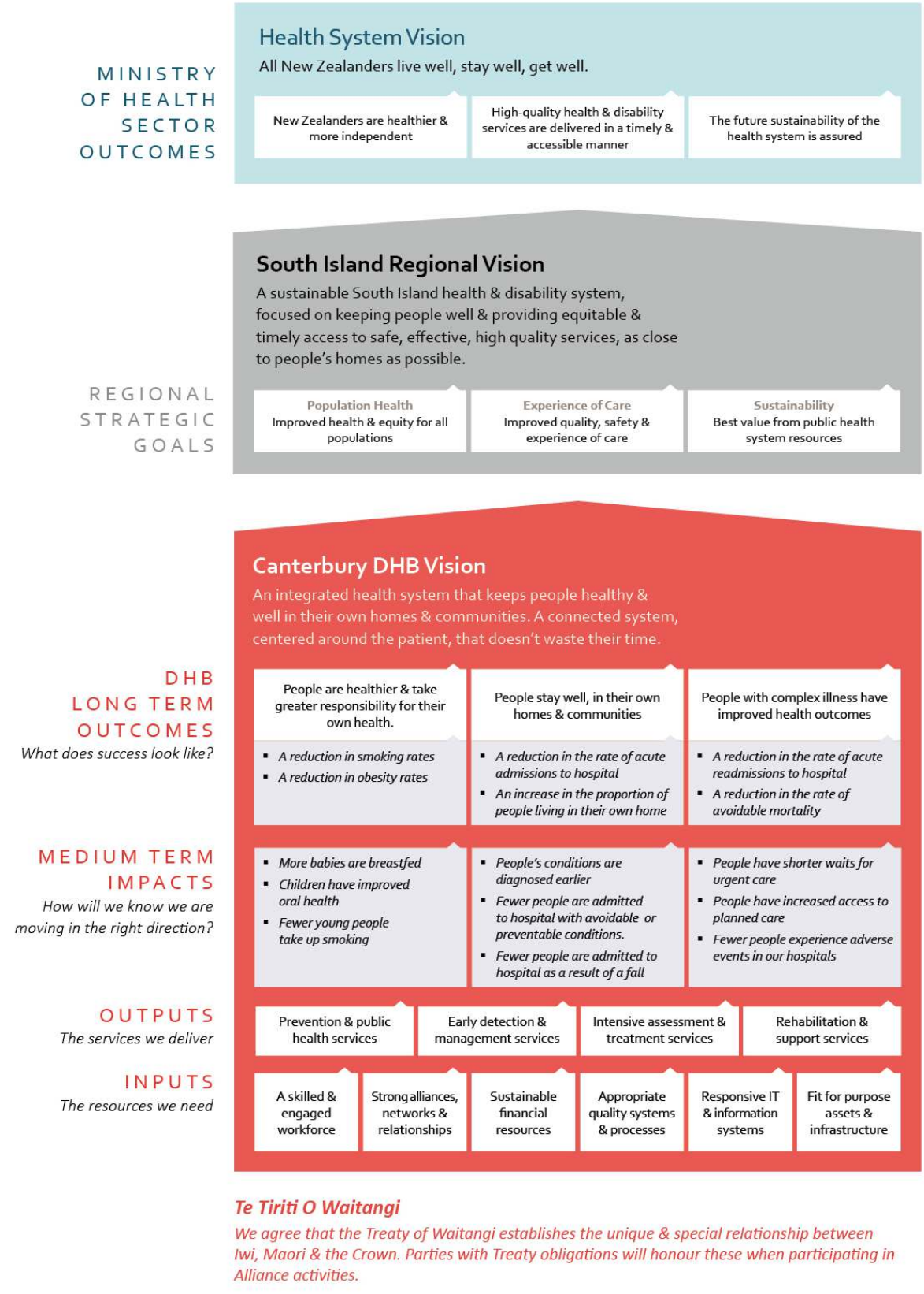
The desired outcomes and objectives are also captured in the Canterbury DHB's Outcomes Framework which defines what success looks like from a wider health system perspective. This Framework is shared with our Alliance as a means of evaluating the success of our collective initiatives and programmes. [6]

The intervention logic diagram on the following page demonstrates the anticipated value chain. It illustrates how the services the Canterbury DHB funds and provides will impact on the health of our population contribute to the goals of the South Island region and deliver on the expectations of Government.



[6] *Refer to Appendix 12 for the DHB's Outcome Framework.*

Overarching Intervention Logic



Te Tiriti O Waitangi

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

Strategic Objectives

5.1 People are healthier and take greater responsibility for their own health

WHY IS THIS A PRIORITY?

New Zealand is experiencing a growing prevalence of long-term conditions such as respiratory and cardiovascular disease, diabetes, cancer and depression. These conditions are major drivers of poor health and premature mortality (death) and account for significant pressure on health services. The likelihood of developing long-term conditions increases with age and as our population ages the demand for health services will continue to grow. These conditions are also more prevalent amongst Māori and Pacific Island populations and are closely associated with significant disparities in health outcomes across population groups. The World Health Organisation (WHO) estimates more than 70% of all health funding is spent on managing long-term conditions.

Tobacco smoking, inactivity and poor nutrition are major risk factors for a number of the most prevalent long-term conditions. These are avoidable risk factors and can be reduced through supportive environments and improved awareness and personal responsibility for health and wellbeing. Supporting people to make healthier choices will improve the quality of life and health status of our population and reduce avoidable demand and pressure on our health system.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

LONG-TERM OUTCOME INDICATORS

A REDUCTION IN SMOKING RATES

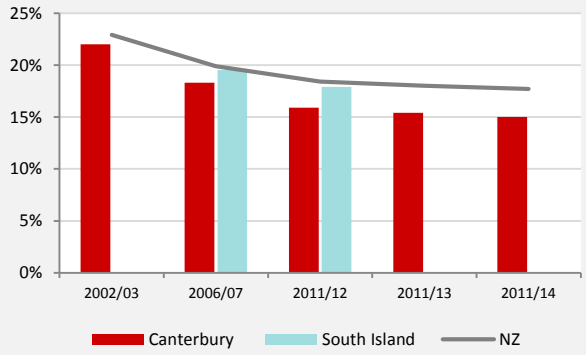
Tobacco smoking kills an estimated 5,000 people in NZ every year and is a major risk factor for six of the eight leading causes of death worldwide. Smoking is also a major contributor to preventable illness and long-term conditions, such as heart and respiratory disease and cancer.

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

Supporting people to say 'no' to smoking is our foremost opportunity not only to improve overall health outcomes but also to reduce inequalities in the health of our population.

Data source: National NZ Health Survey [7]

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



A REDUCTION IN OBESITY RATES

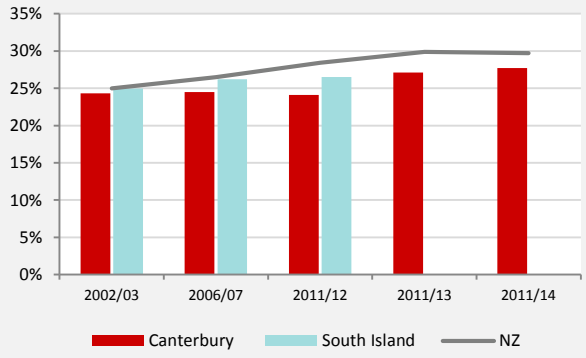
There has been a steady rise in obesity rates in New Zealand. The most recent NZ Health Survey found that 30% of adults and 10% of children are obese.

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

Supporting our population to achieve healthier body weights is fundamental to improving people's health and wellbeing and to preventing and managing long-term conditions and disability at all ages.

Data source: National NZ Health Survey [8]

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



[7] *The NZ Health Survey is completed nationally by the Ministry of Health and since 2011 results have been combined year-on-year (hence the different time periods presented). Results are unavailable by ethnicity. The 2013 Census results for smoking (while not directly comparable) demonstrate that Māori smoking rates are improving but are still high compared to the rest of the population: 30.7% of Canterbury Māori (15+) identified as regular smokers down from 40.2% in 2006 but higher than the total population at 14.5%.*

[8] *The NZ Health Survey defines 'Obese' as having a Body Mass Index (BMI) of >30 or >32 for Māori and Pacific people.*

MORE BABIES ARE BREASTFED

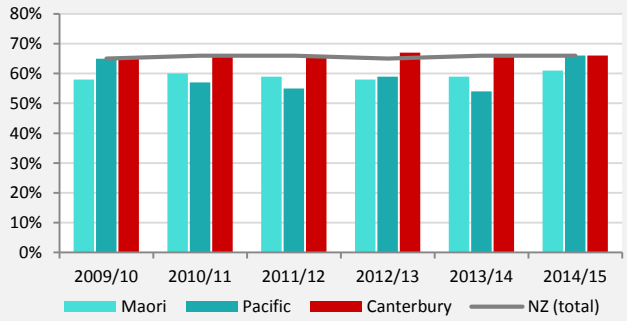
Breastfeeding helps lay the foundations for a healthy life, contributing positively to infant health and wellbeing and potentially reducing the likelihood of obesity later in life.

Breastfeeding also contributes to the wider wellbeing of mothers and bonding between mother and baby.

Appropriate access to support services and a change in both social and environmental factors influence breastfeeding behaviour and support healthier lifestyle choices. An increase in breastfeeding rates can therefore be seen as a proxy indictor of the impact of our health promotion and engagement activities.

Data source: Plunket [9]

Measure: % of babies exclusively or fully breastfed at six weeks	Base	Target			
	14/15	16/17	17/18	18/19	19/20
	66%	75%	>75%	>75%	>75%



CHILDREN HAVE IMPROVED ORAL HEALTH

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

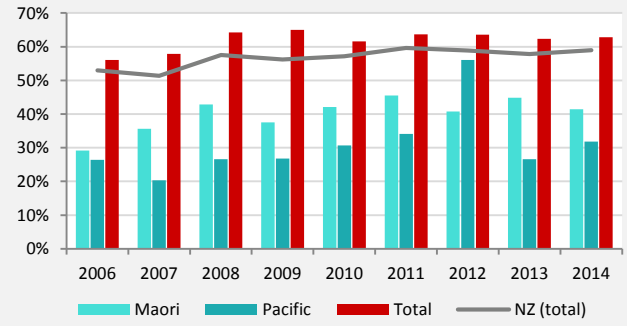
Good oral health not only reduces unnecessary hospital admission, but also signals a reduction in risk factors, such as poor diet, which have lasting benefits in terms of improved nutrition and health outcomes.

Māori and Pacific children are more likely to have decayed, missing or filled teeth. As such, improved oral health is seen as a proxy indicator of the effectiveness of services in targeting and reaching those most at risk.

The target for this measure has been set to maintain total population rates while placing particular emphasis on improving the oral health of Māori and Pacific children.

Data Source: School and Community Oral Health Services [10]

Measure: % of five-year-olds caries free (no holes or fillings)	Base	Target			
	2014	2016	2017	2018	2019
	63%	66%	66%	>66%	>66%



FEWER YOUNG PEOPLE TAKE UP SMOKING

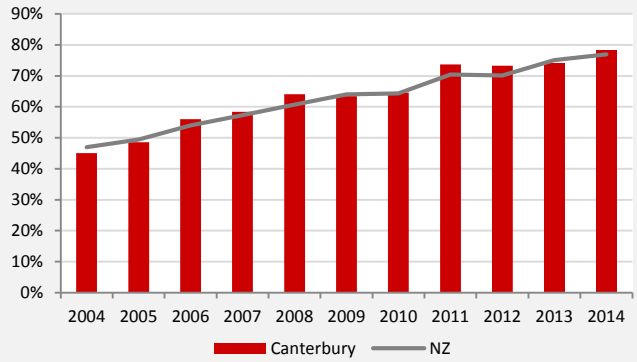
The highest prevalence of smoking is amongst younger people and preventing young people from taking up smoking is a key contributor to reducing smoking rates across the total population.

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

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

Data Source: National Year 10 ASH Snapshot Survey [11]

MEASURE: % of never smokers amongst Year 10 students	Base	Target			
	2014	2016	2017	2018	2019
	78%	>75%	>75%	>75%	>75%



[9] *Well-Child/Tamariki Ora (WCTO) breastfeeding data is currently not able to be combined so performance data from the largest provider (Plunket) is presented. While this covers the majority of mothers, because the smaller providers primarily target Māori and Pacific mothers - results for these ethnicities are likely to be under-stated. The standard is based on national WCTO standards for breastfeeding at 6 weeks.*

[10] *This measure is a national DHB performance indicator (PP11) and is reported annually for the school year.*

[11] *The ASH Survey is a national survey used to monitor student smoking since 1999. Run by Action on Smoking & Health it provides an annual point preference snapshot of students aged 14 or 15 years at the time of the survey – see www.ash.org.nz.*

5.2 People stay well in their own homes and communities

WHY IS THIS A PRIORITY?

When people are supported to stay well and can access the care they need closer to home and in the community, they are less likely to need hospital-level or long-stay interventions. This is not only a better health outcome, but it reduces the pressure on our hospitals and frees up health resources. Studies show countries with strong primary and community care systems have lower rates of death from heart disease, cancer and stroke, and achieve better health outcomes at a lower cost, than countries with systems that focus more heavily on a specialist or hospital level response.

Our investment in general practice and community-based allied health services is enabling the DHB to deliver services closer to home, with improved access leading to early detection, diagnosis and treatment. The general practice team also is a vital point of ongoing continuity, particularly in terms of improving care for people with long-term conditions and supporting people to stay well.

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

HOW WILL WE DEMONSTRATE OUR SUCCESS?

LONG-TERM OUTCOME INDICATORS

A REDUCTION IN ACUTE HOSPITAL ADMISSIONS

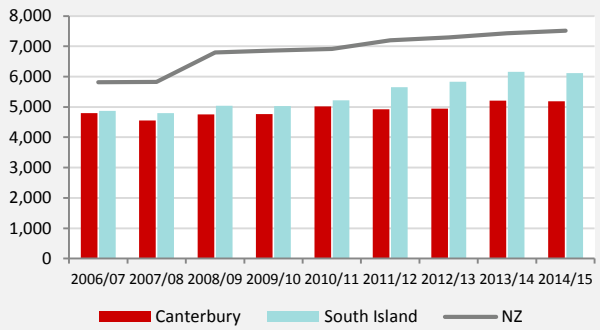
Long-term conditions have a significant impact on the quality of a person's life. However, with the right approach, people can live healthier lives and avoid the deterioration of their condition that leads to acute illness, hospital admission, complications and even premature death.

Reducing acute admissions also has a positive effect on the health system, enabling more efficient use of specialist resources that would otherwise be captured responding to demands for urgent care.

Lower acute admission rates are used as a proxy indicator of improved long-term conditions management and access to timely and appropriate treatment in the community.

Data Source: National Minimum Data Set

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



MORE PEOPLE LIVING IN THEIR OWN HOME

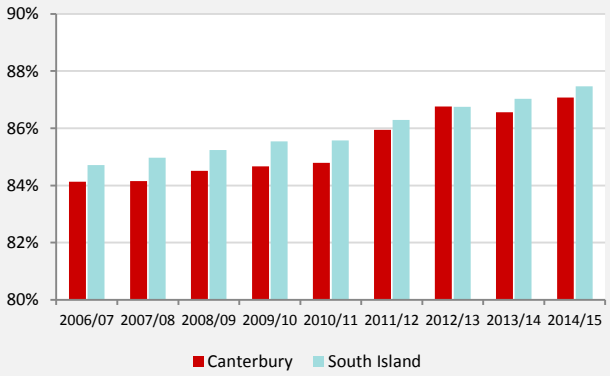
While living in residential care is appropriate for a small proportion of our population, studies have shown a higher level of satisfaction and better long-term outcomes, when people remain in their own homes and positively connected to their local communities.

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

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

Data Source: SIAPO Client Claims Payment System

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



CONDITIONS ARE DIAGNOSED EARLIER

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

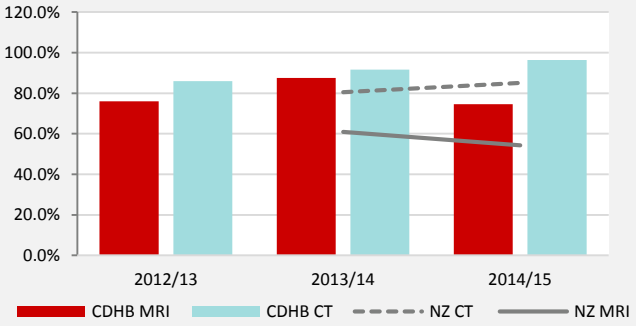
People also want certainty regarding access to health services when they need it, without long waits for diagnosis or treatment.

Wait times for diagnostics therefore can be seen as a proxy indicator of the effectiveness of our health system, particularly when we are seeking to minimise wait times while meeting increasing demand.

Data Source: DHB Patient Management System

Measure: % of people waiting less than 6 weeks for MRI/CT scans

	Base	Target			
	14/15	16/17	17/18	18/19	19/20
MRI	74%	85%	85%	85%	85%
CT	96%	95%	95%	95%	95%



FEWER AVOIDABLE HOSPITALISATIONS

A number of admissions to hospital are for conditions which are seen as preventable through lifestyle change, early intervention and the effective management of long-term conditions - including improved coordination of care across primary and secondary services.

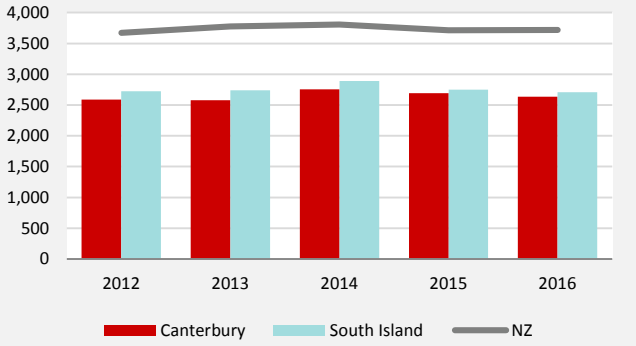
Not only will a reduction in avoidable admissions contribute to improved health outcomes, but it will also reduce unnecessary pressure on our hospital services.

This indicator is seen as a proxy measure of the accessibility and quality of primary care services and a marker of a more integrated and connected health system.

Data Source: Ministry of Health Performance Reporting [12]

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

Base	Target			
14/15	16/17	17/18	18/19	19/20
2,637	<2,637	<2,637	<2,637	<2,637



FEWER FALLS-RELATED HOSPITALISATIONS

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

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

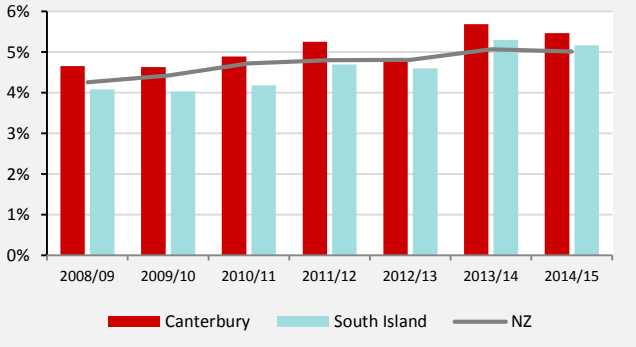
Solutions to preventing falls include: appropriate medications use, improved physical activity and nutrition, restorative support and a reduction in personal and environmental hazards.

Lower fall rates are used as a proxy indicator of the responsiveness of our system to the needs of our older population, as well as a measure of the quality of the individual services being provided.

Data Source: National Minimum Data Set [13]

Measure: % of the population (75+) admitted to hospital as a result of a fall

Base	Target			
14/15	16/17	17/18	18/19	19/20
5.5%	<5.5%	<5.5%	<5.5%	<5.5%



[12] *This measure is a national DHB performance indicator (SI1) and covers hospitalisations for conditions considered preventable including: asthma, diabetes, angina, vaccine-preventable diseases, dental conditions and gastroenteritis. The measure is defined as a rate per 100,000 people and the target is set to reduce equity between population groups. Results differ to those previously published, following a reset of the definition by the Ministry of Health in 2016. Performance data was provided nationally to all DHBs and the baselines are to March.*

[13] *This measure has been reset to reflect updated national ICD code definitions, so results differ to those previously published. From 2013/14 results also reflect the updated 75+ population in line with the 2013 Census. The target has been set to reduce current rates.*

5.3 People with complex illness have improved health outcomes

WHY IS THIS A PRIORITY?

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

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

HOW WILL WE DEMONSTRATE OUR SUCCESS?

LONG-TERM OUTCOME INDICATORS

A REDUCTION IN ACUTE READMISSIONS

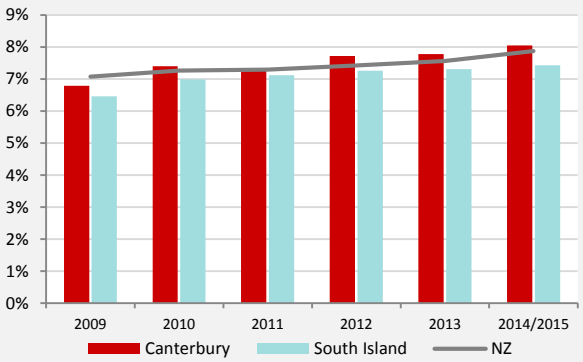
As well as reducing public confidence and driving unnecessary costs - patients who are readmitted to hospital are more likely to experience negative longer-term outcomes and a loss of confidence in the system.

The key factors in reducing acute readmissions include improved patient safety and quality processes, and improved patient flow and service integration. Ensuring people receive effective (and safe) treatment in our hospitals, as well as appropriate support and care on discharge.

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

Data Source: Ministry of Health Performance Reporting [14]

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



A REDUCTION IN AVOIDABLE MORTALITY RATES

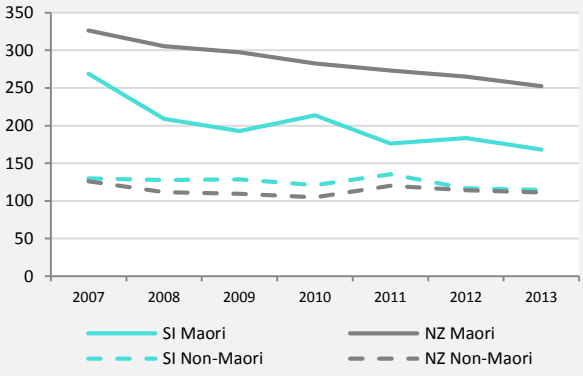
There are many upstream determinants of health, such economic, social and environmental factors that have an influence on people's life expectancy. However premature mortality (death before are 65) is still partly preventable through lifestyle change, earlier intervention and the effective management of long-term conditions.

Timely diagnosis and access to safe and effective treatment are crucial factors in improving survival rates for complex illnesses such as health disease and cancer.

A reduction in avoidable mortality rates can therefore be used as a proxy indicator of the responsiveness of the health system to the needs of people with complex illness, and a measure of access to timely and effective care and treatment.

Data Source: National Mortality Collection [15]

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



[14] *This measure is a national DHB performance indicator (OS8). The results differ to those previously published following a reset of the definition by the Ministry of Health in 2016. Because the definition is still undergoing review the DHB has elected to present the 'raw' or unstandardised rate as this is easier to replicate and match against local admissions and therefore enables closer analysis of performance.*

[15] *The performance data presented sourced from the national mortality collection which is three years in arrears, 2013 results are provisional.*

SHORTER WAITS FOR URGENT CARE

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

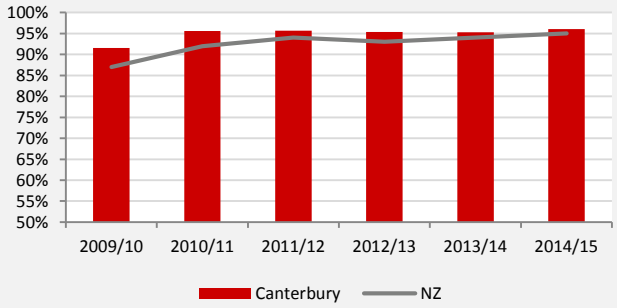
Long waits in ED are linked to overcrowding, poor patient experience, longer hospital stays and negative outcomes for patients. Enhanced performance will not only contribute to improve patient outcomes by enabling early intervention and treatment, but will improve public confidence and trust in our health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

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

Data Source: DHB Patient Management System [16]

Measure: % of people admitted, discharged or transferred from ED within 6 hours

Base	Target			
14/15	16/17	17/18	18/19	19/20
96%	95%	95%	95%	95%



SHORTER WAITS FOR PLANNED CARE

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

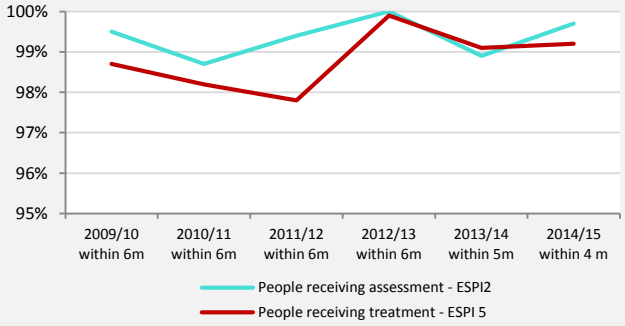
Improved performance against this measure requires us to make the most effective use of our resources to ensure wait times are minimised, while a year-on-year increase in volumes is delivered.

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

Data Source: Ministry of Health Elective Services Website [17]

Measure: % of people receiving assessment and treatment within 4 months

Base	Target			
14/15	16/17	17/18	18/19	19/20
ESPI2 99.7%	100%	100%	100%	100%
ESPI5 99.2%	100%	100%	100%	100%



FEWER ADVERSE EVENTS

Adverse events in hospital, as well as causing avoidable harm to patients, reduce public confidence and contributes unnecessary costs into the system.

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

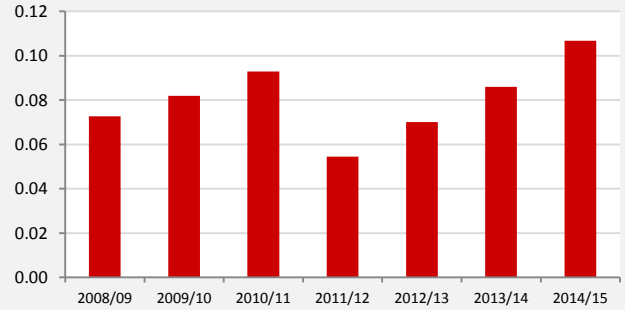
Improving patient safety and quality standards in our hospitals will greatly improve outcomes for our patients.

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

Data Source: DHB Incident Reporting System [18]

Measure: Rate of SAC level 1 & 2 falls

Base	Target			
14/15	16/17	17/18	18/19	19/20
0.11	0.06	0.06	0.06	0.06



[16] *This indicator is the national DHB 'Shorter Stays in ED' health target and results differ slightly from previous results to align with national reporting which presents the final quarter (Q4) as the year-end result. The previously published result (95%) was across the full year.*

[17] *The Elective Services Patient Flow Indicators (ESPIs) are nationally DHB performance measures. Monthly performance reports are provided by the Ministry of Health. In line with ESPIs target reporting the results presented are those from the final month of the year.*

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

Part III

Annual Operating Intentions

Delivering On Our Service Priorities

Investing in cross sector partnerships to deliver better public health services

Vulnerable families are a key government focus and social sector agencies are expected to work together to provide public health services that better meet the needs of priority populations. DHBs will have a particular focus in the coming year to support cross-agency and cross-sector work that delivers improved outcomes for children and young people.

The Earthquakes have had a considerable impact on Canterbury residents. Many people have shifted from their homes and become disconnected from their usual community and support networks. It is critical that we respond to the needs of our more vulnerable populations and keep them at the centre of everything we do.

6.1 Supporting vulnerable children

Maltreatment in childhood can have significant enduring effects on a child's development and their wellbeing in later life. Far too many children also suffer from assaults which can diminish their life chances and, in the worst cases, result in death. Working together with community and primary care partners and other government agencies through the Children's Action Team will create real opportunities for the DHB to make a difference in the lives of vulnerable children.

WHATS NEXT - OUR PERFORMANCE STORY FOR 2016/17		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCE OF SUCCESS
Continue to support the establishment of Canterbury's Children's Team.	▪ Continue to participate in the Local Governance and Children's Team Advisory Group to support implementation and delivery. ▪ Develop and implement referral pathways between children's services to support early response, assessment and treatment. ▪ Support health professionals to attend necessary training to participate in the Children's Team. ▪ Develop and implement outcome measures for children and families engaged with the Children's Team to evaluate the service response. ▪ Support the identification of wider options to ensure support for vulnerable children and their families who don't meet the entry criteria for the Children's Team.	✓ All staff working within or alongside Children's Teams are appropriately screened and trained. ✓ Referral pathways in place. ✓ Outcome metrics identified, monitored and evaluated Q2. ✓ The Children's Team develops to scale within agreed timeframes Q4.
Implement a collaborative and integrated response to better meet the needs of vulnerable and at risk children - to reduce neglect or assault.	▪ Develop guidelines for health professionals on responding to children and young people who disclose they have concerns about their parents/caregivers mental health status or addiction. ▪ Maintain delivery of Gateway Assessments for children referred by Child Youth & Family Service (CYFS) and monitor access and referral patterns to improve the service response. ▪ Explore mechanisms to enable screening and brief intervention for Alcohol Related Health Harm (ARHH) in emergency departments. ▪ Continue to invest in the DHB Violence Intervention Programme (VIP) and ensure high audit scores for each of the child and partner abuse components. ▪ Maintain the National Child Protection Alert System and continue to train staff in the identification of harm and neglect and the use of the Alert System in line with the DHB's Child Protection Policy.	✓ Guidelines developed. ✓ 100% of children referred by CYFS received Gateway assessments. ✓ Mechanism for collecting quantitative ARHH data established Q3. ✓ ARHH training for ED staff developed Q4. ✓ VIP audit scores of 80/100 maintained Q4.
Comply with statutory regulations in line with the Vulnerable Children's Act.	▪ Review the DHB's Child Protection Policy in line with requirements of the Vulnerable Children's Act. ▪ Review service contracts at renewal, to ensure external providers have a Child Protection Policy in place in line with the Act. ▪ Support the implementation of procedures and training of staff and line managers to ensure the safety vetting of core workers. ▪ Ensure no one convicted of the specified offences under the Act is employed, or remains employed, without a formal exemption.	✓ Child Protection Policy reviewed every 3 years. ✓ No person convicted of specified offences under the Act is employed by the DHB – without a formal exemption

6.2 Improving immunisation rates

Immunisation uses the body's natural immune response to protect people from harmful infections. Once immunised, the body responds on exposure which prevents the disease from developing. Improved immunisation coverage leads to reduced rates of vaccine preventable disease and better health and independence for our children.

Canterbury has a clinically-led, cross-sector Immunisation Service Level Alliance in place that provides collective oversight of service delivery and identifies opportunities to improve immunisation rates. This has been a very successful approach and the DHB has achieved consistently high childhood immunisation rates, including recently achieving the highest immunisation health target coverage rate in the country for Māori children.

WHATS NEXT - OUR PERFORMANCE STORY FOR 2016/17		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCE OF SUCCESS
Engage the wider health and social service sector in promoting and encouraging immunisation.	▪ Maintain the Immunisation Service Level Alliance and providers group to provide oversight of immunisation service delivery and coverage and identify opportunities to increase rates. ▪ Invest in the DHB-wide promotion of Immunisation Week to raise awareness of the value of vaccinations. ▪ Maintain the 'Immunisation Toolkit' to support general practice teams to discuss and deliver immunisations. ▪ Continue to explore linkages with other social service agencies to raise awareness of the importance of vaccination.	✓ Canterbury DHB is represented at regional and national forums. ✓ Narrative report on interagency activities completed to promote Immunisation Week Q4.
Support the enrolment of new-borns on the National Immunisation Register (NIR).	▪ Continue to support lead maternity carers (LMCs) to promote and educate pregnant women on the value of immunisation. ▪ Maintain systems for multi-enrolment and seamless handover between maternity, general practice and Well Child services. ▪ Continue to support the NIR Team to deliver timely reporting in order to follow up children with no nominated provider.	✓ 95% of all new-born babies are enrolled on the NIR. ✓ 98% of new-borns are enrolled with general practice by three months of age.
Increase immunisation rates to reduce vaccine preventable diseases and improve health and wellbeing.	▪ Continue to monitor immunisation coverage at DHB, PHO and general practice level to identify service delivery gaps. ▪ Provide practice-level coverage reports to PHOs to identify unvaccinated children and engage with general practices with high declines to support improved service coverage. ▪ Continue to invest in the Missed Event and Outreach Service to locate and vaccinate missing children. ▪ Continue to support wards clerks to identify the immunisation status of children presenting in child health wards and refer them to Outreach Services if immunisations are not up to date.	✓ 85% of six week olds are fully vaccinated. ✓ 95% of eight month olds are fully vaccinated. ✓ 95% of two year olds are fully immunised. ✓ 95% of five year olds are fully vaccinated.
	▪ Continue to support the provision of HPV vaccinations to eligible young girls in general practice settings. ▪ Offer the HPV vaccination alongside the 11 year old event to increase uptake. ▪ Provide a Year 8 school-based HPV programme (alongside the general practice programme) to further support delivery of the HPV vaccination to eligible girls.[19] ▪ Use the Māori Kete and childhood immunisation programme learnings to increase HPV immunisation coverage for Māori girls. ▪ Monitor and report on HPV vaccination rates to encourage discussion and to identify opportunities to improve coverage.	✓ Quarterly reporting of HPV rates to the Immunisation SLA and the DHB Board. ✓ Inclusion of HPV rates on the quarterly Māori health dashboards reports Q1. ✓ 70% of eligible girls have received dose 3 of the HVP immunisation Q4.[20]
	▪ Promote the seasonal influenza vaccine, especially for people with chronic health conditions, aged 65+ and pregnant women.	✓ Seasonal flu plan in place Q2. ✓ 75% of people aged 65+ have a seasonal flu vaccination.

[19] *The DHB introduced a school-based programme, alongside its general practice programme, in February of 2016.*

[20] *Eligible girls for the 2016/17 year are those born in 2003 – with Dose 3 target delivery measured in June 2017.*

6.3 Reducing rheumatic fever rates

Rheumatic fever is a serious but preventable illness. While the symptoms may disappear on their own, the inflammation can cause rheumatic heart disease and can be life threatening. The South Island DHBs have adopted a regional approach to meeting the national expectation to reduce the incidence of rheumatic fever by two thirds. Canterbury will continue to support the Regional Prevention Plan and will align local activity with the agreed approach.

WHATS NEXT - OUR PERFORMANCE STORY FOR 2016/17		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCE OF SUCCESS
Reduce the incidence of rheumatic fever.	▪ Support national health promotion to highlight the risks of rheumatic fever and raise awareness of risk factors. ▪ Maintain the Tonsillitis and Sore Throat HealthPathway to ensure people's sore throats are appropriately managed. ▪ Undertake a root-cause analysis on any new rheumatic fever cases and report on lessons learnt and action taken.	✓ South Island rheumatic fever rates remain low (< 0.2 per 100,000 – 2 cases). ✓ Lessons learned reports shared with the Ministry of Health quarterly.
Maintain an integrated service response to coordinate the care of people identified with rheumatic fever.	▪ Provide notifiable disease forms electronically to ensure all cases of acute and recurrent acute rheumatic fever are appropriately notified to the Medical Officer of Health. ▪ Continue to fund care packages for patients with rheumatic fever including: free prophylactic benzathine penicillin injections, quarterly general practice visits and free dental care. ▪ Facilitate the effective follow-up of patients with rheumatic fever by providing management advice on HealthPathways. ▪ Provide advice to patients and parents to support adherence with regular penicillin injections to protect people from relapse. ▪ Undertake a six monthly audit of rheumatic fever secondary prophylaxis (antibiotic injection) coverage. ▪ Follow up on issues identified in the 2015/16 audit of recurrent hospitalisations for acute rheumatic fever and unexpected rheumatic heart disease. ▪ Support the South Island Public Health Workstream to review implementation of the Regional Rheumatic Fever Prevention Plan and align activity with any recommendations.	✓ Rheumatic fever cases are notified within seven days of hospital admission or diagnosis. ✓ Continued uptake of the rheumatic fever subsidy. ✓ Patient adherence with monthly antibiotic treatment within 5 days of due date. ✓ Annual antibiotic audit report provided to the Ministry of Health Q4. ✓ Annual review of regional Rheumatic Fever Plan.

6.4 Reducing unintended teenage pregnancy rates

Teen births have reduced in the last decade from 4,110 in 2004 to 2,984 in 2014, but New Zealand still has the second highest rate of teen pregnancies in the OECD. While it is important to note that not all teen parents have poor health and education outcomes, for many, starting child-rearing as a teenager entrenches the likelihood of low educational outcomes, long periods on a benefit, low earning power, poor mental health and life-long poverty.

The proportion of births to teenagers in Canterbury compared to New Zealand as a whole, but in line with national expectations we will seek to improve the consistency of information available on sexual health, and improve access to sexual health services and reliable forms of contraceptives, to improve outcomes for children and young people.

Young people under 22 can access free advice on sexual health and contraception from Family Planning Clinics in Christchurch, Rangiora and Ashburton. The Canterbury DHB also funds free sexual health consultations and low-cost contraception for young people (under 21) in general practice settings, including advice and emergency contraception prescriptions. These consultations can be accessed at any general practice, not just where the young person is enrolled.

Our Sexual Health Centre offers free sexual health care to young people under 24 including the diagnosis and management of sexually transmitted infections, referral to sexual abuse services and free access to the emergency contraceptive pill and other long-lasting, reversible contraception options.

Recently relocating from the hospital campus into a more youth-friendly community setting, the Sexual Health Centre also uses social media to engage with and support hard-to-reach and at-risk population groups. Sexual health and contraception information is also available on our HealthInfo website.

School-aged students in Canterbury are also able to access sexual health advice and support from public health nurses through our School Based Health Services.

Oversight of the deliverables in this new national priority area will be provided by the CCN Child and Youth Workstream, a clinically lead, multi-disciplinary, cross-sectoral leadership group.

WHATS NEXT - OUR PERFORMANCE STORY FOR 2016/17		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCE OF SUCCESS
Support the Better Public Health Service target of reducing unintended teenage pregnancy.	▪ Continue to fund free sexual health and contraceptive advice and provide low-cost access to emergency contraception for young people in primary care and community settings. ▪ Ensure consistent (and youth friendly) information on sexual health, reproduction and contraception options is available to young people online via HealthInfo. ▪ Work with the Public Health Nursing Service to ensure currency of training in approaching youth sexual health issues and the latest contraception options including Family Planning Training. ▪ Deliver a sexual health education session to ensure currency of training for general practitioners, practice nurses and allied health professionals in approaching youth sexual health issues and discussing the latest contraception options. ▪ Support Māori health providers to have access to professional training in youth friendly, culturally competent contraceptive choice discussions. ▪ Review the Youth Sexual Health HealthPathway material to ensure health professionals have access to current information. ▪ Review access to sexual health services and seek feedback from young people regarding barriers to practising safe sex and preventing an unintended teenage pregnancy. ▪ Work with Te Kāhui o Papaki Kā Tai (Māori and Pacific Health Primary Care Reference Group) to identify opportunities to engage with hard-to-reach and at-risk young people.	✓ Quarterly tracking of sexual health consultation volumes by age and ethnicity Q1. ✓ General practice education session delivered Q3. ✓ Youth Sexual Health HealthPathway reviewed Q4. ✓ Increased number of 'hits' on HealthInfo Youth Health pages -baseline 121. ✓ Increased number of sexual health consultations delivered in general practice - baseline 19,892. ✓ Narrative report on actions and service delivery Q4.

6.5 Delivering against the Prime Minister's Youth Mental Health Project

Increased anxiety and stress following the earthquakes is manifesting in increased child and youth presentations to mental health services across Canterbury. We are investing in youth friendly and responsive community-based mental health services to help support young people across our health system and reducing wait times for treatment to minimise the risk of long-term mental health and addiction problems.

In line with the expectations of DHBs under the Prime Minister's Youth Mental Health Project, we will prioritise children and young people with the highest need and focus on strengthening relationships across the sector and between agencies to make a positive impact on the mental health and wellbeing of young people. This work is overseen by the CCN Child and Youth Health and Mental Health alliance workstreams.

WHATS NEXT - OUR PERFORMANCE STORY FOR 2016/17		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCE OF SUCCESS
Continue to support the delivery of School Based Health Services (SBHS).	▪ Maintain delivery of SBHS in all decile one to three secondary schools, teen parent units and alternative education facilities. ▪ Continue to support SBHS providers to implement the Youth Health Care: Framework for continuous quality improvement. ▪ Design and develop a pastoral care model to support student wellbeing in alignment with the development of the expanded Haeata (Aranui) campus. ▪ Continue to support education/health sector forums to engage with the wider sector in supporting student wellbeing.	✓ Youth Health Care Framework in place in all SBHS schools. ✓ Model agreed for Haeata campus Q2. ✓ 2 Forums held Q4. ✓ 95% of Year 9 students receive a HEEADSSS assessment Q4.
Improve and strengthen the mental health service response for children and young people.	▪ Continue to invest in the School Based Mental Health Service (SBMHS) to support earlier intervention for young people. ▪ Build on the link between the Child Adolescent and Family Service and the SBMHS to improve the system response for young people with a higher level of need. ▪ Continue to support the BRAVE Programme for Youth and promote the use of SPARX for young people with depression. ▪ Continue to support the cross sector Youth Network 'YAMHA' to bridge the gap for young people no longer in school. [21] ▪ Maintain access to primary care based Brief Intervention Counselling (BIC) for youth 12-19 years. ▪ Continue to monitor activity and demand across the mental health system to highlight areas that need additional focus and support the redesign of mental health services to enable a sustainable response to psychosocial recovery demands.	✓ >90 schools engaged with SBMHS. ✓ >500 BIC sessions delivered for young people (12-19) in primary care settings. ✓ Access rates for mental health services for youth (0-19) are maintained >3.1%.
	▪ Continue to implement the Choice and Partnership Approach to reduce wait times for Child and Adolescent Mental Health Services (CAMHS) and Youth AOD specialist services. ▪ Monitor demand and wait time performance for CAMHS and Youth AOD to identify and address pinch points and capacity issues to ensure access and wait time targets can be met. ▪ Implement key service enhancements recommended by the mental health service redesign to address capacity, capability and sustainability issues and improve the integration of primary and community services.	✓ 80% of youth (0-19) referred for non-urgent mental health or addiction services are seen within 3 weeks and 95% within 8 weeks. ✓ 95% of CAMHS and Youth AOD clients have transition plans in place. ✓ 95% of all long-term clients (0-19) have current relapse prevention plans in place.
	▪ Implement the national Transition Guidelines and monitor delivery to ensure planning and follow-up for young people discharged from CAMHS and Youth AOD services.	

[21] *Yamaha is a Youth Services Network meeting regularly to streamline access, standardise referrals and up skill community services and agencies to better respond to the needs of young.*

Promoting good health and wellbeing

6.6 Disease prevention

Our health is heavily influenced by our environment which in its broadest sense includes built, natural, economic, social and cultural environments, which all influence a person's health and wellbeing. This way of thinking about health is highlighted in the updated New Zealand Health Strategy and is particularly relevant in Canterbury in terms of our earthquake recovery context and the impact this event has had on people's environments and their health.

The DHB's Community and Public Health Division leads the DHBs work in promoting health and wellbeing by working with partners from across both the health and social sectors to improve our environments and make the healthy choice the easy choice. Community and Public Health also takes the lead on behalf of the DHB working on the All Right? social marketing campaign in partnership with the Mental Health Foundation and has inherited the lead for the delivery of the psycho-social recovery strategy (from CERA) to support and improve people's mental health and wellbeing as our community recovers after the earthquakes.

Canterbury has a detailed 2016/17 Public Health Plan, which can be found at www.cdhb.health.nz.

WHATS NEXT - OUR PERFORMANCE STORY FOR 2016/17		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCE OF SUCCESS
Positively influence the determinants of health.	▪ Lead the inter-sectoral work of Healthy Christchurch. ▪ Maintain membership at a governance level of the Urban Development Strategy (UDS) Implementation Committee. ▪ Maintain membership of the UDS Partnership Group at senior management level. ▪ Promote the use of Health Impact Assessments and deliver health promotion through joint work plans with the Christchurch City Council and Environment Canterbury.	✓ Regular programme of Healthy Christchurch hui. ✓ 1-2 medium Health Impact Assessments completed. ✓ Evidence of Healthy Christchurch's role as a Healthy Communities partner under the UDS.
Promote the health and wellbeing of our population through specific settings and issues.	▪ Continue to work with the Mental Health Foundation to promote community mental wellbeing through the All Right? campaign. ▪ Continue to support the Ministry's Healthy Families Spreydon-Heathcote initiative.[22] ▪ Actively promote and engage in a prevention partnership with the Healthy Families Spreydon-Heathcote team and encourage engagement with the DHB's policy development work. ▪ Identify opportunities to engage the Healthy Families Spreydon-Heathcote team in health promotion activity including Health Promoting Schools (HPS) and Smokefree Aotearoa 2025. ▪ Raise awareness and identify opportunities for collaboration with the Healthy Families Spreydon-Heathcote initiative through established internal and external networks, i.e. Canterbury Clinical Network and Healthy Christchurch.	✓ 'All Right?' evaluation results available Q2. ✓ >70% of priority schools engaged in HPS Framework. ✓ Annual report on support and collaboration with Healthy Families Spreydon-Heathcote Q4.
Support the psychosocial recovery from the Canterbury earthquakes.	▪ Lead inter-sectoral collaborative activity around the psychosocial recovery via the Greater Christchurch Psychosocial Committee. ▪ Monitor and report on the Community in Mind Strategy. ▪ Work alongside partner organisations to review, conduct and report on the Canterbury Wellbeing Index, Community Wellbeing Survey and Youth Wellbeing Survey (last conducted in 2013).	✓ Wellbeing Index produced. ✓ Wellbeing Survey conducted and reported annually. ✓ Youth Survey conducted and reported by Q4.

[22] *Healthy Families Spreydon-Heathcote is national initiative contracted and managed by the Ministry of Health. The DHB has undertaken to work in collaboration on shared goals but is not the lead agency or contract holder for this initiative.*

WHATS NEXT - OUR PERFORMANCE STORY FOR 2016/17		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCE OF SUCCESS
Contribute to programmes and initiatives that improve housing quality.	▪ Work alongside Community Energy Action encouraging referral of vulnerable people to services to improve housing quality. ▪ Contribute to the Sustainable Homes Working Party to further enable sustainable home improvements — particularly promote and support the 'Build Back Smarter' initiative. ▪ Continue to contribute to cross-sector initiatives to resolve housing issues, particularly for unwell and at-risk families and support health organisations to identify issues and locate help.	✓ Timely and appropriate processing of referrals to community agencies able to impact on housing quality.
Enable prompt identification and analysis of emerging disease trends, clusters and outbreaks.	▪ Review, analyse and report on communicable diseases data, including via web applications and written reports. ▪ Produce disease-specific reports for communicable diseases of concern (i.e. Pertussis) and other diseases causing outbreaks. ▪ Review, analyse and report on other emerging disease data.	✓ 'Public Health Information Quarterly' distributed. ✓ Timely and effective identification of and response to outbreaks and elevated disease incidence.
Reduce the harm caused by alcohol, in line with the DHB Alcohol Position Statement.	▪ Develop an Alcohol Harm Reduction Strategy (AHRS), in partnership with the Christchurch City Council and Police. ▪ Develop and deliver training and new communication tools to engage and inform patients and professionals around alcohol misuse and improve the overall response of the health sector. ▪ Work with other agencies to deliver host responsibility training to improve the skills of Duty Managers in reducing alcohol harm. ▪ Assist Police with alcohol controlled purchase operations (CPOs) to reduce the supply of liquor to minors.	✓ Joint AHRS prepared Q1. ✓ 16 host training sessions delivered Q4. ✓ All license applications responded to within 15 working days. ✓ Minimum of 6 CPOs and 6 night-time visits delivered.

6.7 Reducing obesity rates

Low levels of physical activity and poor nutrition affect the life-long health of our population. Almost one third of adults in New Zealand are obese and over half are overweight. The rate of childhood obesity is also rising. A new health target will be implemented from 1 July 2016 with a focus on the prevention and management of obesity. The target signals the importance of effective management of obesity in children, as by intervening in the early stages we are more likely to ensure positive, sustained effects on health.

Canterbury will work through the CCN Child & Youth Workstream and South Island Child Health Service Level Alliance to adopt a consistent cross-sectorial approach to improving outcomes for overweight children. In recognising that the prevalence of overweight and obese people in our Māori and Pacific populations are two and three times that of our NZ European population, we will work with providers to ensure healthy weight programmes are responsive to the cultural needs of these high risk groups.

WHATS NEXT - OUR PERFORMANCE STORY FOR 2016/17		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCE OF SUCCESS
Maintain delivery against the B4SC targets to identify children in need of additional support.	▪ Monitor access and referral patterns for B4 School Checks (B4SC) to identify opportunities to improve delivery and coverage – and maintain high delivery rates for high needs children. ▪ Promote and educate parents on the value of B4 School Checks to encourage uptake. ▪ Work with public health nurses and ECE providers to identify and engage children who have not had a B4 School Check. ▪ Support the regional Well Child Tamariki Ora Quality Improvement Group to oversee and improve programme performance.	✓ Quarterly monitoring of B4SC rates. ✓ 90% of children receive a B4SC. ✓ 90% of Māori, Pacific children and children living in high deprivation areas receive a B4SC.
Develop and implement a 'whole of system' approach to the treatment of childhood obesity.	▪ Investigate options for the coordination of B4SC referrals alongside adult nutrition programmes – including Appetite for Life. ▪ Work with PHOs to develop a Motivational Conversations Programme to support health professionals to have difficult conversation with parents about health and nutrition. ▪ Develop and implement a referral pathway that provides a range of options to support overweight children and their families. ▪ Work with Sports Canterbury to identify options for expansion of the green prescription programme to encompass overweight children and their parents. ▪ Identify opportunities to achieve equitable uptake of referrals by Māori and Pacific children and children in high-deprivation areas.	✓ Motivational Conversations Programme in place Q2. ✓ Referral pathways for the treatment of childhood obesity agreed Q2. ✓ HealthPathways updated to reflect referral pathways Q3. ✓ 95% of obese children identified at their B4SC are referred to a health professional Q4.
Improve the quality and consistency of regional approach to childhood obesity.	▪ Participate in the South Island Child Health Service Level Alliance to support delivery against the regional Healthy Weight Programme. ▪ Support the development and dissemination of consistent regional protocols and intervention guidelines for managing child obesity, including the BeSmarter tool.[23] ▪ Support the roll-out the Group Lifestyle Triple P (Positive Parenting Programme) to the parents of overweight or obese children.	✓ Common regional protocols and guidelines agreed Q1. ✓ BeSmarter available Q1. ✓ Triple P training available regionally Q1. ✓ Quarterly updates on South Island activity.

[23] *BeSmarter is a healthy living tool that generates discussion using a visual guide that brings together elements of healthy eating and daily activity such as sleep, eating together and minimising takeaway food in a single colour handout that can be filled in with a family.*

6.8 Reducing smoking rates

Smoking is the largest single cause of preventable ill health and death. Smoking rates has declined sustainably in our adult population from 18.8% in 2006 to 14.5% in 2013, and we have one of the lowest smoking rates in the country. However, because of the size of our population, we have a large number of smokers. Significant ethnic disparities remain, 30.7% of Māori identified as regular smokers, and smoking in pregnancy rates have barely changed since 2008.

The national goal is to achieve a Smokefree Aotearoa by 2025 and we have worked with our primary care partners to update our Tobacco Control Plan to achieve this goal. Our plan highlights a need to focus on young Māori women who have much higher prevalence of smoking in pregnancy. It also supports greater integration and cross-sectorial collaboration to reduced smoking rates and an integrated approach to smoking cessation.

WHATS NEXT - OUR PERFORMANCE STORY FOR 2016/17		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCE OF SUCCESS
Support an integrated system-wide approach to achieving Smokefree Aotearoa 2025.	▪ Collaborate with Smokefree Canterbury and the CCN Population Health Workstream to update the DHB's Tobacco Control Plan. ▪ Continue to work with local councils to extend smokefree public spaces and further implement smokefree social housing. ▪ Continue to support social service organisations, schools and workplaces to establish smokefree policies and environments.	✓ Updated Tobacco Control Plan in place Q2. ✓ >75% of year 10 students have 'never smoked'. ✓ <5% of the population are current smokers, by 2025.
Support the provision of ABC advice and support to pregnant women who smoke. [24]	▪ Engage LMCs in delivering ABC and provide a feedback loop on performance against the national health targets to lift performance. ▪ Offer ABC and smoking cessation training to LMCs and provide Smokefree training to 3rd year midwives at the Ara Institute. ▪ Review the content of DHB funded parenting and pregnancy classes to ensure they include ABC and smoking cessation provision. ▪ Work with the regional Well Child Tamariki Ora Quality Improvement Workstream to identify opportunities to increase the proportion of Māori mothers smoke free at two weeks postnatal.	✓ Quarterly monitoring of health target results. ✓ Minimum of 8 training sessions offered to LMCs. ✓ 90% of pregnant smokers are offered advice and support to quit. ✓ 95% of mothers are smoke free two weeks post-natal.
Build on gains made in the delivery of the ABC programme across primary and secondary care, with a continued focus on achieving the national health targets.	▪ Support continued use of advanced IT tools in general practice that prompt and capture ABC activity. ▪ Track PHO and general practices health target results and follow-up with individual practices where performance is low. ▪ Maintain monthly feedback reports on performance by individual wards and promote the use of online performance dashboards. ▪ Undertake audit/analysis of care pathways where no intervention is recorded and follow up wards to improve performance and systems. ▪ Continue to identify ABC champions within general practice and across our hospital services to monitor and encourage performance. ▪ Supplement the support provided to practices by PHO liaison staff with specialist training from the ABC Smokefree team. ▪ Maintain a training calendar for Smokefree education and continue to support e-learning ABC modules for DHB staff.	✓ Quarterly monitoring of health target results. ✓ Minimum of 10 ABC training sessions delivered in primary care. ✓ >200 DHB staff receive ABC training. ✓ 90% of enrolled patients seen in general practice are provided with advice and help to quit. ✓ 95% of hospitalised smokers are provided with advice and support to quit.
Improve the quality, consistency and effectiveness of smoking cessation support.	▪ Integrate current disparate cessation services into a single Canterbury Stop Smoking Service. ▪ Adopt targeted responses for priority populations, to support increased quit attempts and reduce smoking rates. ▪ Update Smokefree Canterbury's website with any changes to cessation services, policy templates and toolkits.	✓ Increased number of people seeking cessation support. ✓ <5% of the population are current smokers, by 2025.

[24] *The ABC Programme involves: Asking if a patient smokes, offering Brief Advice to quit and referring them to Cessation support.*

Connecting our system to support people to stay well

A fully integrated health system is one that provides a seamless flow of care rather than a series of isolated events. The answer to improving the health of our population and meeting the demands on our system is not more of the same services, but more of the right services delivered in the right place, at the right time, by the right person.

6.9 Continued service integration

Our approach to transforming our health system has been to bring together health professionals and service managers from all parts of the health sector, under the banner of the Canterbury Clinical Network (CCN) Alliance.[25]

By working alongside one another to design new models of care and patient pathways we have been able to streamline the interface between services and make better use of all the resource at our disposal. Clinically-designed referral and management pathways, direct access to diagnostics, subsidised GP procedures and alternative ambulance pathways all mean Canterbury patients spend less time waiting for treatment. By moving services closer to the patient and into the community we have improved the way our health system responds and greatly improved outcomes for our population.

Canterbury now has the 2nd lowest rate of acute medical admissions of any large DHB in the country. If we admitted patients to hospital at the national average over 18,000 more unwell people would have been admitted in the last year.

A key factor in the future sustainability of our health system is ensuring primary and community services have the capacity and capability to play their part in this integrated system. Core to this direction is continued investment in the development of the Integrated Family Health Service model (which is being described around the country as the Health Care Home), and progress on our Rural Sustainability Programme. Working alongside the three primary care organisations in Canterbury, the DHB will continue to support the reorganisation of general practice models, to ensure that general practice teams are ready to play their part in meeting our future challenges.

The new national Pharmacy Action Plan (under development) aims to enable pharmacy team to play a greater role in improving health outcomes. Canterbury is playing a lead role in the development of the national strategy and our CCN Pharmacy Services Level Alliance is well positioned to implement the new national plan in the coming year and expand on the role of pharmacy teams in supporting people to stay well.

WHATS NEXT - OUR PERFORMANCE STORY FOR 2016/17		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCE OF SUCCESS
Continue to support joint planning and clinical engagement in service improvement.	▪ Continue to support clinically-led and system-wide planning and service development through the CCN Alliance. ▪ Enhance alliance communication with a focus on profiling patient experience to celebrate collective success and engage wider social sector partners in alliance activity. ▪ Develop and agreed a shared Alliance 'Improvement Plan' outlining activity to achieve the new national System Level Measures.	✓ Endorsement of DHB Annual Plan by the Alliance Leadership Q1. ✓ Improvement Plan submitted to the Ministry October 2016.
Continue to align clinical information systems to enable improved patient care.	▪ Continue to invest in the HealthInfo site to provide people with the information they need to better manage their own health. ▪ Maintain HealthPathways to provide general practice with best practice advice to support the management of their patients. ▪ Continue to support the use of the Electronic Request Management System (ERMS) to streamline primary/secondary referrals. ▪ Continue to roll-out HealthOne to support improved clinical decision making by providing secure access to key health information. ▪ Continue to develop electronic standing orders to expedite care in primary care settings across Canterbury and the West Coast.	✓ >500 Community HealthPathways available.[26] ✓ 95% of general practices and pharmacies have HealthOne access. ✓ >80% of all GP referrals to CHCH Hospital are e-Referrals via ERMS. ✓ >20 Standing Orders available electronically.

[25] There are currently ten Alliance Partners – the three Canterbury PHOs, the Canterbury DHB, Access Home Health, Nurse Maude Association, Health Care of NZ Limited, Canterbury Community Pharmacy Group, Christchurch Radiology and St John Ambulance.

[26] The number of HealthPathways has plateaued as pathways are reviewed, consolidated and refined. The number refers to formal clinical pathways on the Canterbury Community HealthPathways site, and does not include resource pages or Hospital HealthPathways.

WHATS NEXT - OUR PERFORMANCE STORY FOR 2016/17		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCE OF SUCCESS
Support the continued transformation of general practice models as the point of continuity for patient care.	▪ Continue to invest in the development of Integrated Family Health Services (IFHS) through the CCN IFHS Project Team. ▪ Build on the initial successes of the IFHS programme to engage and support practices to implement the relevant standards of the Health Care Home programme. ▪ Align delivery of the Collaborative Care, Flexible Funding and IFHS programmes to support collaborative care principles as a key consideration in the development of IFHS models. ▪ Continue to invest in the supported primary care education programme to support the emergent integration models.	✓ Quarterly monitoring of IFHS outcomes metrics. ✓ 12% increase in the number of practices in the IFHS programme. ✓ Enhanced capitation proposal implemented. ✓ Rate of avoidable hospital admission for adults (45-64) – <2,637 per 100,000.
Maintain access to services that enable general practice to support people in the communities – without the need for a hospital appointment.	▪ Maintain direct GP access to diagnostics services including x-rays, ultrasounds, CT and MRI scans and spirometry tests to support earlier intervention and treatment. ▪ Continue to invest in subsidised procedures and provide specialist support to deliver services closer to home and improve access to treatment including: sleep assessments and skin lesion removal.[27] ▪ Continued to invest in the delivery of community-based acute demand services to better support people in the community rather than in our hospitals and reduce unnecessary presentations to ED.	✓ >30,000 community-referred radiology tests completed. ✓ >8,000 subsidised procedures delivered in primary care. ✓ >28,000 urgent care packages provided in the community.
	▪ Support the CCN Laboratory Service Level Alliance to implement and monitor delivery of the laboratory model to improve patient experience and support appropriate clinical intervention. ▪ Develop and implement a roadmap of actions to progress the staged delivery of e-ordering for lab tests and inter-lab ordering. ▪ Review the placement of laboratory collections centres to ensure optimum coverage for the region.	✓ Roadmap of actions in place Q1. ✓ E-ordering implementation plan agreed Q4. ✓ Collection centre resources optimised Q4.
Support the development of sustainable and tailored primary care solutions across rural Canterbury.	▪ Support the CCN Rural Health Workstream to develop, implement and monitor the delivery of sustainable health service models for rural communities, through the rural sustainability programme.[28] ▪ Establish and support local development groups to design and make recommendations on sustainable models of care. ▪ Engage and consult with rural communities and providers on the development of service and delivery models in their communities. ▪ Ensure that retention and recruitment initiatives are aligned to the models to promote a full staffing complement in rural areas. ▪ Promote increased use of video conferencing and telemedicine for education, peer support, clinical supervision and clinical sessions. ▪ Support the Rural Funding SLA to continue to review and refine the model for the distribution of rural subsidies across Canterbury. ▪ Formalise engagement with rural Māori and Pacifica communities in the development of local service models to ensure models are inclusive and support improved service uptake.	✓ Hurunui Development Group in place Q1. ✓ Oxford Community engagement Q2. ✓ Ashburton workforce strategy underway Q2 ✓ Scoping of sustainable Selwyn model Q3. ✓ First of the rural models recommended to ALT Q3. ✓ Rural Funding allocation model agreed and endorsed by the ALT Q3. ✓ Evidence of engagement with local Māori and Pacific groups.
	▪ Support the Ashburton Service Level Alliance to review, design and implement a sustainable after-hours model for Ashburton. ▪ Complete the implementation of the Kaikoura IFHS model and transition oversight to the local governance group. ▪ Continue consolidation of wrap-around services and discharge management for older people in Kaikoura.	✓ Ashburton after-hours model implemented Q1. ✓ Kaikoura IFHC governance agreed Q2. ✓ CREST8 available in Kaikoura Q3.

[27] *Current procedures include: skin lesion excisions, Mirena insertions, Pipelle biopsy, Sleep Assessments and Musculoskeletal injections.*

[28] *The rural communities of focus for 2016/17 are: Hurunui, Oxford, Selwyn, Rakaia, Methven, Rangiora, Ashburton, Akaroa and Kaikoura.*

WHATS NEXT - OUR PERFORMANCE STORY FOR 2016/17		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCE OF SUCCESS
Support the national transformation of pharmacy as a key part of the patient care team.	▪ Support the CCN Community Pharmacy Service Level Alliance to promote the role of the pharmacist in the multi-disciplinary team. ▪ Invest in the Medication Management Service (MMS) and Medication Therapy Assessments (MTA) to reduce the risk of harm from medications use. ▪ Offer training to pharmacists and technicians in counselling patients to effectively self-manage their medicines and improve their health literacy. ▪ Support the development of the national Pharmacy Action Plan particularly the principle of making better use of pharmacist's expertise in the safe and effective use of medicines. ▪ Support the development of a national framework for pharmacist services in the community (ongoing) and implement the services outlined in the framework to meet the needs of our population. ▪ Participate in the national process to plan the commissioning of pharmacist services in the community with the aim of cost-effectively matching modern supply to community need. ▪ Support the development and implementation of a sustainable solution to the pharmaceutical margin and other supply chain issues.	✓ >2,000 people referred to MMS and MTA. ✓ Increased number of patients receive LTCM services from their pharmacy Q4. ✓ Training delivered to pharmacists to support patients to better manage their medications Q4. ✓ Narrative report on progress with development and implementation of the national Pharmacy Action Plan.

6.10 Improving the management of long-term conditions

Long-term conditions (including Respiratory Disease, Diabetes and Cardiovascular Disease) are amongst the leading causes of death and avoidable hospital admissions. The World Health Organisation estimates over 70% of health funding is currently spent on the management of long-term conditions and with an ageing population this will increase.

Our approach to reducing this burden is to work right across our health system to support systematic care at every point of the health continuum and to align service models and funding to facilitate earlier intervention and treatment.

This work is driven by clinically led service groups who review patient pathways and identify opportunities to improve patient care. The clinically-led Integrated Respiratory Service was one of the first focus areas where we came together to redesign patient pathways and improve outcomes for people with respiratory disease. This collaborative approach has enabled earlier diagnosis and treatment, with services previously only available with a hospital appointment now being delivered in the community. The development of alternative ambulance pathways for people with Chronic Obstructive Pulmonary Disease (COPD), a major cause of preventable hospital admission, has been a major shift. Over 30% of COPD patients calling an ambulance in winter are now being safely treated in the community rather than in our hospitals.

This 'whole of system' approach links individual disease management programmes with the strong networks in place across PHOs and with public health and nutrition teams, non-government agencies and community organisations, including Sports Canterbury, Smokefree Canterbury, to support our population to make healthier choices.

In the coming year we will progress implementation of our Collaborative Care Programme, to improve the identification of people at-risk, support proactive self-management and enhance integrated care planning. The Programme is clinically led and supported by dedicated clinical liaisons and care coordinators who facilitate the development of shared care plans (with the patient) and support their ongoing disease management. The Programme also facilitates the sharing of care plans across all the clinical teams involved with the patient and will tie into the development of patient portals.

WHATS NEXT - OUR PERFORMANCE STORY FOR 2016/17		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCE OF SUCCESS
Improve access to best practice information and diagnostic tools to support intervention earlier in the continuum of care.	▪ Maintain HealthPathways to provide general practice with best practice advice, to support the management of their patients. ▪ Continue to encourage general practices to use advanced IT tools to identify patients at risk, prompt action and capture activity. ▪ Maintain direct GP access to diagnostics including spirometry and sleep assessments to support appropriate referral and treatment.	✓ >500 Community HealthPathways in place across the system. ✓ 100% of practices have advanced IT tools in place. ✓ >1,000 people referred to community-based spirometry testing.
Improve the coordination of care and support for patients identified with long term and complex health conditions.	▪ Encourage and support improved collaborative care for patients with complex and long-term conditions and promote shared care planning tools – with a particular focus on priority population groups. ▪ Continue to support training in the use of Personalised Care Plans for complex patients via the shared care electronic platform. ▪ Continue to promote the use of Acute Care Plans to support frequently admitted patients and those at risk of hospital admission. ▪ Align funding models to better enable the coordination and care of patients with complex and long-term health and social needs. ▪ Align delivery of the Collaborative Care, Flexible Funding and IFHS programmes to support collaborative care principles as a key consideration in the development of IFHS models.	✓ Quarterly monitoring of outcomes metrics. ✓ Maintain 6% uptake of collaborative care plans. ✓ Bi monthly Model of Collaborative Care Advancement meetings. ✓ Enhanced capitation implemented Q2. ✓ Rate of acute medical admission maintained at <5,500 per 100,000.
Support patients to take a more active role in the management of their own health and wellbeing.	▪ Support the development of patient portals to enable patients to access their records and take a more active role in the management of their own health and wellbeing. ▪ Continue to invest in programmes that promote a reduction in risk factors to support people at risk of developing long-term conditions. ▪ Encourage increased referrals to programmes that improve the management of complex conditions and reduce the risk of escalation. ▪ Promote the success of rehabilitation programmes to referrers and patients to increase referral and participation rates.	✓ Quarterly progress in implementing patient portals. ✓ >3,000 people access Green prescriptions for additional physical activity support. ✓ >200 people access pulmonary rehabilitation.

6.11 Diabetes

Diabetes is the largest and fastest growing health issue in New Zealand and along with heart disease is responsible for more deaths each year than smoking. While there is no cure for diabetes, for many people it can be prevented by following a healthy lifestyle, and through active management we can support those diagnosed with diabetes to live well and have active and healthy lives. Canterbury's Integrated Diabetes Development Group takes a multi-disciplinary approach to supporting patients across both primary and secondary care. A notable achievement for the service has been the introduction of community-based retinal screening, with this service expanding to Ashburton in early 2016.

WHATS NEXT - OUR PERFORMANCE STORY FOR 2016/17		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCE OF SUCCESS
Improve the identification and management of people with (and at risk of) diabetes.	▪ Continue to work with general practice to identify, code and manage their enrolled population with diabetes (and at risk of diabetes). ▪ Provide analysis of population and service utilisation data to support identification of pre-diabetes, high risk and high needs patients. ▪ Support the Integrated Diabetes Service Development Group to monitor progress against key service indicators and population outcomes to support continuous quality improvement.	✓ Six monthly circulation of diabetes data reports. ✓ >500 people referred to Green prescriptions for additional physical activity support. ✓ 90% of the population coded with diabetes have had an HbA1c test in the last year. ✓ An increased proportion diabetics have acceptable glycaemic control (HbA1c <64, <80 <100 mmol/mol).
	▪ Encourage increased referral of people at risk of Type 2 diabetes to programmes that reduce risk factors and improve wellbeing. ▪ Continue to support general practice to deliver appropriate levels of care and support to patients identified with diabetes – in line with clinical guidelines and minimum standards under the Diabetes Care Improvement Package (DCIP).	
Increase access to services that support people with diabetes to stay well, and reduce the risk of complications.	▪ Maintain the diabetes clinical pathways including referral and prescribing protocols to support best practice. ▪ Continue to invest in community-based education programmes to support people newly diagnosed with diabetes and provide tools for improving people's self-management of their diabetes. ▪ Maintain access to retinal screening and podiatry services for people with diabetes to reduce the risk of complications. ▪ Continue to invest in and develop services for young people with Type 1 diabetes and review the transition between youth and adult services for gaps and opportunities. ▪ Monitor wait times to specialist support for people with Type 1 or complex Type 2 diabetes to support earlier intervention.	✓ >800 people access diabetes education programmes. ✓ Increased number of people accessing retinal screening – base 6,795. ✓ Increased number of people referred to podiatry – base 1,348. ✓ No patients wait more than 4 months for a diabetes FSA.
Improve the quality and consistency of diabetes services.	▪ Continue to support clinical education of health practitioners to improve the care of people with diabetes. ▪ Continue to work closely with Diabetes Consumer Group to identify opportunities for improvement in service delivery. ▪ Continue to support quality improvement through monitoring of performance against national guidelines and standards. ▪ Review provision of diabetes services against the new national Living Well with Diabetes Plan to identify opportunities for improvement.	✓ Annual review and audit of podiatry programme. ✓ Ongoing review of delivery against the 20 Quality Standards. ✓ Review of programme against national plan Q2.
	▪ Monitor coding, service utilisation and HbA1c results for Māori and Pacific as high risk groups, and share monitoring reports to encourage improved targeting and engagement with services. ▪ Collaborate with Māori and Pacific health providers to develop additional strategies to identify and engage Māori with diabetes.	✓ Activity and outcomes reported by ethnicity Q1. ✓ Increase in number of Māori and Pacific people accessing diabetes services in line with expected prevalence.

6.12 Cardiovascular Disease

Cardiovascular disease affects a growing number of New Zealanders each year and includes coronary heart disease, stroke and other diseases of the heart and circulatory system. It is a leading cause of death and hospitalisation and long-term affects people's quality of life and life expectancy. Systematic identification and management of those at risk improves the long-term outcomes for people with cardiovascular disease. The proactive approach of increasing the number of Cardiovascular Disease Risk Assessments (CVDRAs) delivered in primary care has been a national target for the last few years and the DHB will continue to work with our primary care partners to support the identification and monitoring of cardiovascular risk becoming embedded in general practice across the Canterbury Health System.

WHATS NEXT - OUR PERFORMANCE STORY FOR 2016/17		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCE OF SUCCESS
Improve the identification of people at risk of CVD or in need of additional support.	▪ Continue to encourage general practices to use advanced IT tools to identify patients at risk, prompt action and capture activity. ▪ Monitor CVDRA delivery and provide practices with information on their CVDRA results, benchmarked against other practices and prioritised by high needs, to support identification of people at risk. ▪ Provide general practice with updates on enrolled patients discharged from hospital with a clinical cardiovascular risk of > 20% to allow for appropriate clinical follow-up with patients.	✓ 100% of practices have advanced IT tools in place. ✓ Quarterly reporting on progress against targets.
Support the use of effective strategies to improve good heart health including the continued delivery of Cardiovascular Disease Risk Assessments (CVDRAs) and structured CVD management discussions. [29]	▪ Continue to support individual general practices to implement their plans that include actions to engage eligible patients in a CVDRA. ▪ Continue to support PHO practice liaison teams to assist general practice with the recall and engagement of patients for CVDRA. ▪ Monitor performance of general practice and follow-up with practices where CVDRA performance is low. ▪ Encourage general practice to engage in the delivery of additional activities including: nurse led or low cost CVDRA consultations or CVDRA clinics in alternative locations to reach people at risk. ▪ Continue to support identification of CVD champions within general practice to support good heart health practice. ▪ Continue to support clinical governance groups to provide advice and guidance on the delivery of structured discussions on CVD risk and mitigations strategies with patients. ▪ Implement the Motivational Conversations Programme to support general practice staff in encouraging patient adherence to health advice, including the adoption of positive lifestyle behaviours.	✓ Monthly reporting to General Practice on their CVDRA performance. ✓ Motivational Conversations training in place Q3. ✓ 90% of the eligible population have had a CVDRA within the last 5 years. ✓ >14,000 structured CVD discussions delivered Q4.
Achieve a particular focus on delivery of services and a reduction in disparities for high needs populations.	▪ Collaborate with Māori and Pacific health providers to develop additional strategies to increase delivery of CVDRAs to Māori. ▪ Support practices to develop and implement practice-level Māori Health Plans that include strategies to engage Māori in CVDRAs. ▪ Monitor the delivery of CVDRA to Māori men (35-44) as a high risk group and share monitoring reports to encourage improved uptake. ▪ Encourage general practice to include the assessment and management of cardiovascular risk for their high needs population as part of their quality improvement standards.	✓ CVDRA activity reported by ethnicity Q1. ✓ Quarterly monitoring of PHO performance by ethnicity Q2. ✓ New targeted strategies for Māori identified Q2. ✓ Quarterly increase in CVDRA rates for Māori men (35-44) – baseline 62%. [30]

[29] *The actions in this section are in line with those agreed between the PHOs, DHB and Ministry of Health including use of Budget 2013 funding to support delivery of the More Health & Diabetes Checks.*

[30] *Baseline is from Q1 2015/16 year as data was not available for this age band prior to this date.*

6.13 Improving the management of acute demand

Continued growth in acute (urgent or unplanned) hospital admissions is one of the most significant challenges for DHBs to manage and acute demand places intense pressure on our constrained hospital resources. Canterbury's whole-of-system approach has engaged clinicians, health professionals and managers from across the system in providing their collective wisdom to develop strategies to reduce the pressures of acute demand, through the CCN Urgent Care SLA.

Our Acute Demand Management Service (ADMS) ensures an appropriate mix of urgent care services are available in the community so that only those people who need hospital services need to present at our hospitals. Our CCN partners and our Emergency Department team (working with their colleagues across the hospital) are making the best use of all the resources we have available to ensure people get the care they need quickly, and in the most appropriate place.

In the past year, over 30,000 episodes of care were managed in the community through ADMS and 95% of the 94,000 people who presented in our Emergency Department were seen within six hours. Canterbury now has one of the lowest rate of acute medical admissions of the larger DHBs in the country. If we admitted patients to hospital at the national average over 18,000 more acutely unwell people would have been admitted in the last year alone.

WHATS NEXT - OUR PERFORMANCE STORY FOR 2016/17		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCE OF SUCCESS
Provide access to a mix of responsive community-based urgent care and acute demand services to reduce unnecessary hospital presentations.	▪ Continue to promote general practice as first point of contact 24/7 and maintain after-hours phone advice and triage services. ▪ Continue to support zero fees for children aged under 13 years. ▪ Maintain the HealthPathways to provide general practice with best practice advice, to support the management of their patients. ▪ Maintain direct GP access to diagnostics including urgent blood tests, X-Rays and ultrasounds to support appropriate referral and treatment. ▪ Continue to invest in the ADMS to appropriately manage urgent and acute episodes of care in the community rather than in hospital. ▪ Continue to invest in the COPD pathway, the heart failure initiative and alternative ambulance referral pathways to reduce avoidable presentations to hospital.	✓ 100% of children <13 have access to free GP visits afterhours. ✓ >400 patients utilise the COPD / Heart Failure ambulance pathways. ✓ >28,000 urgent care packages provided in the community. ✓ Rate of acute medical admission maintained at <5,500 per 100,000.
Improve the coordination and flow of patients to deliver shorter waits in our Emergency Departments.	▪ Continue to engage in the use of 'real time' data throughout acute services to support patient flow and demand planning including ED Dashboards to maintain visibility of key drivers and metrics. ▪ Continue to monitor mandatory and non-mandatory measures under the National Quality Framework (NQF) alongside the local ED metrics at monthly quality meetings to identify areas for improvement. ▪ Introduce reporting against ED wait times by ethnicity from July 2016. ▪ Continue to support the redirection policy and frequent attender programmes to ensure people are seen in the most appropriate place. ▪ Actively promote and evaluate the utilisation of the ED observation unit (short stay unit) as a mechanism to access appropriate referral pathways and avoid unnecessary prolonged hospital admission. ▪ Continue to promote and develop advanced nursing roles and senior medical staffing in ED. ▪ Engage through the Project Realign 'Acute Adult' Workstream to identify and implement targeted responses to improve the flow of patients to reduce wait times.	✓ On-screen-queues in use throughout ED. ✓ ED metrics monitored via operational dashboards. ✓ Real time data on admission and discharge rates available. ✓ Baseline performance for ED wait times by ethnicity established Q1. ✓ Appointment of 2 CNS Nurse Practitioner interns. ✓ Monthly review of NQF and ED metrics. ✓ 95% of ED people presenting at ED are admitted, discharged or transferred within 6 hours.
Support timely and appropriate discharge from our hospitals.	▪ Maintain ADMS and CREST services to support earlier discharge from hospital and to reduce the likelihood of readmission. ▪ Continue to implement the Frail Older Persons' Pathway and Enhanced Recovery After Surgery (ERAS) initiative to improve the coordination and flow of patients, reduce the length of stay in our hospitals and support people's rehabilitation.	✓ Reduction in the number of patients aged 75+ with LOS greater than 14 days – 2013 baseline 205.7. ✓ Acute inpatient average length of stay <2.35 days.

6.14 Mental health services

With the unique and ongoing stresses the earthquakes have placed on the Canterbury population, significant increases in demand are being experienced across our mental health services. Over the three years (to December 2015): there has been a 60% increase in child and youth presentations to community services and a 39% increase in adult presentations.

It is critical that our health system takes an integrated approach to meeting mental health service demand in Canterbury. We will invest in community-based options that will provide services closer to home and help to build much needed capacity across our system. This will be supported by expanded consult liaison across our hospital and specialist division, providing the benefit of specialist advice without the wait for a specialist appointment or the disruption of the primary/community care relationship. By also improving the integration between health and other social services we can provide a more responsive service addressing the broader needs of our community - housing, employment and physical health being an important part of the wider wellbeing picture for our population.

The increasing demand for mental health services is also placing strain on our workforce and we will look to support the wellbeing of those working in the health system in the coming year. Continued consideration will be given to the arrangements and connections between specialist, primary and community services, to ensure we are making the best use of all the resources available across our system as we respond to increasing demand.

Clear and consistent outcome and service goals are fundamental when we are seeking to establish whether we are making a difference - both at an individual level and at a wider system level. The DHB closely monitors service demand and utilisation and will work alongside the other South Island DHBs to adopt the national mental health outcome and commissioning framework as it is introduced.

This work is overseen by our clinically-led CCN Mental Health Workstream (which includes primary, secondary and community providers). We will also work with the Ministry of Health to ensure services are sustainable and our direction is aligned with the national Mental Health and Addiction Service Plan 'Rising to the Challenge'.

WHATS NEXT - OUR PERFORMANCE STORY FOR 2016/17		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCE OF SUCCESS
Use system metrics, planning expertise and international evidence to understand, and respond to evolving community need.	▪ Establish a whole of system monitoring framework that includes system-wide service demand, utilisation and outcomes metrics. ▪ Use system metrics to highlight areas that need additional focus and enable a sustainable response to psychosocial recovery demands. ▪ Use demand and wait time performance metrics to identify pinch points and risks affecting the ability of mental health system to respond to need and to reduce waiting times for treatment.	✓ Quarterly monitoring against system metrics. ✓ Access rates for mental health services for children (0-19) and adults (20-64) greater than 3.1%.
Strengthen the integration between primary and community services to support timely and appropriate access to services.	▪ Lead inter-sectoral collaborative activity around the psychosocial recovery via the Greater Christchurch Psychosocial Committee. ▪ Implement key service enhancements recommended by the mental health services redesign to address capacity, capability and sustainability issues. ▪ Implement key strategies and initiatives under the Prime Minister's Youth Mental Health Project to respond to the increased needs of our younger population groups (refer to section 6.5). ▪ Continue to support the provision of Brief Intervention Counselling (BIC) in primary care. ▪ Continue to support centralised DHB/NGO coordination and resource allocation processes to reduce duplication and wait times. ▪ Implement key strategies and initiatives to understand the key drivers behind community treatment orders (CTOs) and better support Māori clients through this process (refer to the Māori Health Plan).	✓ >90 schools are engaged with School Based Mental Health Services (SBMHS). ✓ >4,000 people access BIC in primary care. ✓ 80% of children and adults referred for non-urgent mental health services are seen within 3 weeks. ✓ 95% of children and adults referred for non-urgent mental health services are seen within 8 weeks. ✓ Quarterly monitoring of CTO rates by ethnicity.
Maintain a whole of system response to suicide prevention and postvention.	▪ Continue to support the Suicide Prevention Oversight Group to enable the implementation of evidence-based prevention strategies in alignment with the local and national strategies and emerging need. ▪ Continue to implement prevention screening tools and support training for staff to identify and support people at risk of suicide. ▪ Continue to provide cross-sector leadership in identifying high-risk situations or clusters and preparing evidence-based responses.	✓ Suicide Prevention and Postvention Plan in place. ✓ Cross sector meetings with, Education, MSD, Justice and Police. ✓ Youth screening tool on HealthPathways Q2.

WHATS NEXT - OUR PERFORMANCE STORY FOR 2016/17		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCE OF SUCCESS
Strengthen the interface between health and social services to improve the resilience and wellbeing of people with mental illness and alcohol and other drug issues.	▪ Work with the sector and the Werry Centre to implement the Supporting Parents Health Children Guidelines as they are released.	✓ Cross sector programmes developed.
	▪ Work with PHOs to proactively facilitate connections to primary care to engage unenrolled mental health clients with general practice. ▪ Adopt targeted responses aimed at improving the physical health and wellbeing of mental health clients. ▪ Develop and implement annual health status assessments for delivery by key workers in specialist and community-based mental health and alcohol and other drug (AOD) services. ▪ Develop and implement individually tailored smoking cessation plans for all specialist mental health service (SMHS) clients who indicate on initial screening that they smoke.	✓ 95% of clients engaged with MH and AOD services are enrolled with general practice. ✓ 50% of clients engaged with mental health and AOD services have annual health status assessment. ✓ 95% of SMHS smokers are provided with advice and support to quit.
	▪ Continue to support primary and community mental health services to increase capacity to deliver AOD Brief Intervention Counselling (BIC). ▪ Continue to work with Corrections and Courts to increase access to AOD assessment and treatment, including clinicians in Courts. ▪ Continue to provide 24/7 mental health nursing into the watch house. ▪ Continue to work closely with Police on the frequent callers program. ▪ Explore opportunities with MSD to increase support into employment for people engaged with mental health services.	✓ >300 people access alcohol BIC. ✓ Quarterly meetings between senior Police and SMHS staff. ✓ Police liaison role with SMHS maintained. ✓ Quarterly update on progress with developing cross sector initiatives.
Work within the Regional Mental Health Alliance to improve the quality and consistency of mental health services across the South Island.	▪ Embed the Hub and Spoke service delivery model for youth forensic services and adopt the agree pathway to increase capacity and responsiveness. ▪ Work with the regional team on the development of targeted responses aimed at improving the physical health and wellbeing of mental health clients in regional services. ▪ Collaborate regionally on seclusion and restraint processes with a specific focus on improving outcomes for Māori. ▪ Participate in the development of a regional model for AOD withdrawal management in line with the proposed legislative changes to compulsory treatment orders. ▪ Collaborate on the adoption of the national mental health outcome and commissioning framework as it is developed.	✓ Quarterly review of key metrics for adult and youth forensic service. ✓ Review rates for seclusion and compulsory treatment orders regionally Q2. ✓ AOD Withdrawal Management Plan agreed Q2.

6.15 Older people's health services

Canterbury's population is ageing, which reflects the health system's success in achieving longer life spans for our population. However, as we age we experience more illness and disability, and considerable health spending for an individual generally occurs in the last two years of life.

Under the leadership of the CCN Health of Older People's Workstream and Community Services Service Level Alliance we are supporting investment in a number of wrap-around strategies to better support older people to stay well and in their own homes and communities for longer. We are already seeing improved outcomes from these programmes with reduced acute hospital admissions for people aged over 65. We are also seeing an increase in the number of people aged over 75 supported in their own homes, and a drop in the number of older people living in aged residential care.

There is still scope for reducing demand and improving the quality of people's lives. We will continue to place emphasis on supported discharge and restorative care models as a means of improving health outcomes. Reducing social isolation will also be a focus, with earthquakes and forced migration having disrupted people's usual community support systems.

WHATS NEXT - OUR PERFORMANCE STORY FOR 2016/17		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCE OF SUCCESS
Support the timely and comprehensive assessment of people's needs to ensure the provision of appropriate care.	▪ Continue to promote the use of the InterRAI Geriatric Assessment tool across community, specialist and aged residential care (ARC) services. ▪ Monitor and report on the provision of InterRAI assessments and wait times for assessment – to identify opportunities for improvement. ▪ Work with ARC providers to support the provision of a subsequent InterRAI LTCF assessment ≤230 days of admission. ▪ Encourage the use of interRAI data in the development of care plans and report InterRAI metrics by ethnicity to identify any equity issues and support improved service planning. ▪ Support the regional OPH Workstream to track demand and service trends between DHBs and participate in regional teleconference to identify opportunities to improve assessment consistency.	✓ >95% of LT-HCSS clients have had an InterRAI and a care plan in place. ✓ >95% of people entering ARC have had an InterRAI assessment. ✓ Time taken from referral to assessment. ✓ Provision of LTCF assessments in ARC. ✓ Participation in quarterly regional teleconferences.
Support the delivery of an integrated and restorative model of care across home and community based support services.	▪ Continue to support Canterbury's HCSS providers to implement the in-between travel settlement outcomes and meet monthly to monitor and review service utilisation.	✓ In-Between Travel Settlement implemented. ✓ >1,500 people (65+) accessing CREST services.
	▪ Continue to invest in core community service programmes that have proved successful in supporting older people to stay well in their own homes – including CREST, Respite, and Day Services. ▪ Continue to implement the Enhanced Recovery After Surgery (ERAS) and Frail Older Person's Pathway initiatives to reduce the average length of stay (LOS) for older people and enhance recovery.	✓ Reduction in patients 75+ with LOS greater than 14 days – 2013 base 205.7. ✓ Acute medical admission rate for people 65 at or below national average.
	▪ Develop and implement a road map of actions to establish the new Home & Community Support Services (HCSS) model. ▪ Work with Canterbury's HCSS to fully integrate the district nursing case mix tool into the new service model. ▪ Continue the implementation of the Hub and Spoke service model, across OPH Community Services to support the provision of care closer to home, in partnership with primary care and social agencies	✓ Readmission rates for people 65 and 75+ at or below national average. ✓ ARC admission rates remain at or below current rates.
	▪ Use casemix to identify long-term HCSS clients at risk of social isolation and work with clients to develop goals to increase social connections. ▪ Promote social isolation issues to raise awareness of the issue.	✓ At risk client group identified Q1. ✓ Profile issue in community newsletter Q3.

WHATS NEXT - OUR PERFORMANCE STORY FOR 2016/17		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCE OF SUCCESS
Maintain the Cognitive Impairment Pathway (CIP) to improve assessment and support for people with dementia.	▪ Continue to explore service improvements and links to community support for people recently diagnosed with mild dementia. ▪ Continue to support and promote targeted training programmes for health professional in the context of dementia: including regional Walking in Another's Shoes and MoCA training.[31] ▪ Monitor pathway use, referrals and uptake of training to identify and address gaps and variation in service responsiveness. ▪ Review and update HealthPathways advice on managing the palliative care needs of someone with dementia. ▪ Support training for informal carers of people with dementia (and palliative care) in conjunction with Hospice NZ.[32]	✓ >1,000 CIP page views. ✓ >50 new referrals from GPs to Alzheimer's Canterbury. ✓ Link CIP and Dementia HealthPathways Q2. ✓ >50 people trained in WIAS training cycle. ✓ Post training survey indicates increased confidence in diagnosing mild dementia.
Maintain and enhance the integrated Falls and Fracture Liaison Service to reduce harm from falls.	▪ Continue to review and keep HealthPathways current to support general practice to identify and manage older people at risk of fragility fracture and falls. ▪ Complete the establishment of the Fracture Liaison Service including implementation of primary/secondary referral processes and data management to track referrals and monitor key outcome metrics. ▪ Establish systems to measure referrals from osteoporosis management into the community based falls programme. ▪ Expand the Falls Dashboard to include referral and outcome metrics that monitor performance of the falls and fracture liaison service and help to identify areas for improvement. ▪ Work with ACC, the Health Quality Safety Commission and the Ministry of Health to scope new initiatives that meet common goals.	✓ Quarterly narrative on falls and fracture liaison programme referrals. ✓ ACC representation on OPH Workstream Q1. ✓ >1,200 older people (65+) access the falls service. ✓ 10% decrease from forecast trend for people 75+ presenting to ED as a result of a fall Q4.[33]
Improve the quality and consistency of care across ARC services.	▪ Maintain key specialist roles to support the provision of specialist advice to primary care and ARC service providers. ▪ Work with the education and ARC sector to support and strength the Competency Assessment Programme for overseas trained nurses. ▪ Encourage Māori health teams to work with ARC providers to promote service responsiveness to Kaumatua upon entry to ARC. ▪ Monitor the implementation and uptake of Advance Directives, Personal Care Plans and E-medication systems across ARC.	✓ Number of Advanced Directives in place. ✓ Opportunities for improving responsiveness to Kaumatua identified.

[31] MoCA - Montreal Cognitive Assessment tool – this training is being driven regionally through the South Island Regional Alliance.

[32] Initiative yet to be confirmed – actions are a placeholder in anticipation.

[33] This measure relates to a decrease in the number of falls forecast using the baseline of July 2008 to December 2011.

6.16 Whānau ora services

We have made some positive gains for Māori in Canterbury, with substantial improvements in engagement levels in the childhood immunisation and B4 School Checks programmes and reductions in avoidable hospital admissions. With a collective approach from across the health system, we are determined to make further progress.

The DHB will work closely with Te Pūtahitanga (the South Island Whānau Ora Commissioning Agency), Pasifika Futures (the Pacific Whānau Ora Commissioning Agency) and the lead Whānau Ora agencies in Canterbury to support improved health outcomes for our Māori and Pacific communities. Because Whānau Ora is a key cross-government programme inter-agency relationships will also continue to be nurtured with Te Puni Kōkiri, the Ministry of Health and the Ministry of Social Development to ensure that Whānau Ora is high on everyone's agenda.

In the coming year the workstreams and service level alliances under the CCN Alliance will review how they can better target service delivery and improve engagement amongst high need and rural populations in order to improve equity of access and outcomes for all. There will be a particular focus on the five health Whānau Ora priorities identified by the national Whānau Ora Partnership Group: reducing smoking rates for pregnant women, reducing asthma admission rates for children, improving oral health outcomes for children, increasing the number of intervention referrals for children identified as obese and investigating mental health treatment order rates for adults.

The DHB has a Māori Health Action Plan (available on our website) which provides more detail on these areas of focus.

WHATS NEXT - OUR PERFORMANCE STORY FOR 2016/17		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCE OF SUCCESS
Strengthen the relationships with Te Pūtahitanga, Pasifika Futures and key Canterbury Māori and Pacific provider organisations to support improved outcomes for Māori and Pacific people in Canterbury.	▪ Maintain regular engagement with Te Pūtahitanga through South Island Māori GM network, Te Herenga Hauora. ▪ Engage with Pasifika Futures to identify opportunities to collaborate. ▪ Support the Healthy Families Spreydon-Heathcote initiative by participating in the initiative and aligning health promotion activity. ▪ Work with the local Māori and Pacific provider networks to better understand the desired outcomes for Whānau and align provider contracts and service specifications to achieve those outcomes. ▪ Promote the Māori Health Outcomes Dashboard to share and monitor performance against key metrics and better target collective effort.	✓ Regular engagement with Te Pūtahitanga. ✓ Regular engagement with Pasifika Futures. ✓ Quarterly reporting against Māori Health Outcomes Dashboard.
Support strategies and initiatives (outlined in our Māori Health Action Plan) to improve outcomes for Māori and Pacific people across Canterbury – in line with the national Whānau Ora priorities.	▪ Implement a single Canterbury Stop Smoking Service with targeted incentives to reduce smoking rates amongst pregnant Māori and Pacific women. ▪ Engage with Kimihia Parents College and Karanga Mai Parents College to establish a pathway to offer stop smoking support to teen parents. ▪ Work with ScreenSouth and the three Canterbury PHOs to identify general practices with high Māori enrolment, monitor screening coverage rates for wāhine and address gaps by contacting women. ▪ Work with PHOs to proactively facilitate connections to primary care to engage unenrolled children with frequent asthma admissions. ▪ Link the new-born hearing, WCTO and Community Oral Health Service referral process to improve enrolment rates with dental services. ▪ Promote 'lift-the-lip' training for B4 School Check providers to increase the number of children identified and referred to oral health services. ▪ Maintain high rates of B4 School Check delivery to Māori and Pacific children to identify issues early and support improve health outcomes. ▪ Develop and implement a referral pathway that provides a range of options to support overweight children and their families. ▪ Develop a process and pathway to enable direct referral from Māori and Pacific health providers to the Brief Intervention Service to support earlier engagement of Māori and Pacific people with services. ▪ Establish a process to ensure all Māori under Community Treatment Orders (CTOs) have involvement of a pukenga atawhai from specialist services or are engaged with a Māori mental health NGO provider.	✓ 95% of Māori women smokefree at two weeks postnatal. ✓ 80% of eligible Māori women aged 25-69 have had a cervical screen in the last three years. ✓ Reduction in the rate of avoidable hospital admission for Māori children (0-4) – baseline <4,946 per 100,000.[34] ✓ >65% of five-year-old Māori caries free (no holes or fillings). ✓ 95% of obese Māori children (identified at their B4SC) are referred to a health professional for assessment and nutrition, activity and lifestyle interventions. ✓ Rate of Māori CTOs relative to non-Māori.

[34] *Targets will be agreed and set in the System Level Improvement Plan due for submission to the Ministry in October 2016.*

Improving the coordination and flow of patients across our system

In line with our continuous improvement approach, we are constantly asking ourselves how we can change the way we work to make our systems and processes leaner, and even more patient-focused. Improving the coordination and flow of patients across our hospitals, and between departments, is essential to ensure we support people to stay safe, avoid harm in our hospitals and regain function after illness or an acute event.

Last year we identified five key themes for additional focus and results are already being demonstrated in terms of reduced waiting times, lengths of stay and readmissions. This year, under our Realign Alliance, we will continue to focus effort in these key areas. We will also focus on priority areas of collaboration with our DHB colleagues to improve patient flow across the South Island and between specialist level services across New Zealand.

6.17 Shorter waits for diagnostic services

Diagnostic services such as radiology tests are a key enabler of an integrated health system. Timely access to diagnostics and specialist advice can better inform a treatment plan, not only improving outcomes but minimising the harm and complications that can arise from a delay in intervention.

In the year ahead, our key focus is the establishment of an expanded radiology service at Burwood Hospital including the relocation of community radiology services currently located in Merivale. This expanded service will increase reporting capacity and assist in the management of radiology wait lists.

WHATS NEXT - OUR PERFORMANCE STORY FOR 2016/17		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCE OF SUCCESS
Improve the quality and consistency of diagnostic referrals.	▪ Maintain direct GP access to a full suite of diagnostics to reduce waiting time for diagnosis and treatment. ▪ Maintain HealthPathways alignment with the National Access Criteria for Community Referred Diagnostics to support appropriate referrals. ▪ Complete the implementation of InteleConnect software to enable full access to imaging and reports by referring clinicians.	✓ >500 Community HealthPathways in place across the system. ✓ InteleConnect software fully implemented Q3.
Improve the matching of capacity to demand across radiology services to facilitate timely and appropriate diagnosis and treatment.	▪ Implement resource planning (staff and equipment) strategies to enable the Radiology Service to meet ongoing demand while managing the transition to Burwood Hospital. ▪ Undertake service reviews where data analysis identifies service gaps, or when new national requirements are introduced to align capacity to demand, reduce waiting times and support decision making. ▪ Continue to implement demand management strategies and screen for inappropriate referral to reduce pressure on radiology services. ▪ Implement a secondary-care electronic ordering entry service (EOE) and develop a plan to implement EOE for community radiology. ▪ Update the Radiology Information System to link referrals to the National Patient Flow (NPF) Project following implementation of EOE. ▪ Support the South Island Information Services SLA to implement e-ordering for radiology tests across the other South Island DHBs.	✓ Expanded radiology service operational at Burwood Q1 ✓ Monthly reports on referrals circulated to clinical departments Q1. ✓ EOE implemented Q4. ✓ EOE referrals linked to the NPF Project Q4. ✓ 85% of people receive their MRI scan within six weeks of referral. ✓ 95% of people receive their CT scan within six weeks of referral.
Facilitate timely access to diagnostic services to minimise the impact of Cancer.	▪ Continue to implement actions identified through the national Endoscopy Quality Improvement (EQI) Programme to support improvements in colonoscopy services. ▪ Deliver additional colonoscopy volumes (using national colonoscopy initiative funding) to reduce colonoscopy waiting times. ▪ Undertake demand reviews to identify opportunities to further reduce waiting times for colonoscopy including expanding the service delivery model, use of mobile services and additional weekend clinics.	✓ 85% of people accepted for an urgent diagnostic colonoscopy wait no more than 2 weeks and 100% no more than 30 days. ✓ 70% of people accepted for non-urgent diagnostic colonoscopy wait no more than 6 weeks and 100% no more than 90 days. ✓ 70% of people scheduled for a surveillance/follow-up colonoscopy wait no more than 12 weeks and 100% no more than 120 days.

6.18 Shorter waits for elective services

Elective services are non-urgent procedures and operations that improve people's quality of life by reducing pain or discomfort and improving independence and wellbeing. Timely access to elective services is most often considered by the public to be a measure of the overall effectiveness of the health system. Government has also set clear expectations for DHBs to increase service delivery and reduce waiting times.

With the loss of hospital beds after the earthquakes, and a long and disruptive repair schedule ahead of us, delivering against the national health targets, is going to be a significant challenge. To maximise our available capacity we are improving our focus on the coordination and flow of patients by investing in our electives redesign 100-days Project and our new Project Realign Alliance workstreams across the Christchurch Hospital campus.

WHATS NEXT - OUR PERFORMANCE STORY FOR 2016/17		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCE OF SUCCESS
Increase planned care rates to support increased delivery of elective surgery.	▪ Maximise patient flow management and available capacity for first specialist assessments, follow-ups and treatments, through capacity planning, demand management and lean thinking techniques. ▪ Develop and implement a new shoulder pathway to increase access to alternative treatment when surgery is not the recommended option or capacity is constrained. ▪ Continue to invest in the delivery of alternative treatments in community settings using a combination of allied health and general practitioners – including the new Mobility Action Programme (MAP).[35] ▪ Monitor standardised intervention rates (SIR) and demand trends to assess areas of need and ensure equity of access for our population. ▪ Utilise private provider capacity where necessary, to maintain delivery. ▪ Continue to participate in the implementation of the National Patient Flow Project, include regular data collection and submission.	✓ New should pathway in operation Q1. ✓ Providers selected for the MAP Q2. ✓ Number of GPs trained in orthopaedic assessments. ✓ 20,982 elective surgical discharges delivered Q4.[36] ✓ 287 additional elective orthopaedic and general surgery discharges Q4. ✓ SIR per 10,000 people Major Joints: ≥21. Cataracts: ≥27.
Enhance the coordination and flow of patients to reduce wait times for treatment and make the best use of specialist resources.	▪ Continue to implement the electives redesign 100-days Project to ensure sustainable service delivery and provide certainty for patients. ▪ Work with two departments each quarter to review current practice, identify lean techniques and achieve the 100 day target. ▪ Support the development of the Surgical Services Redesign Alliance Workstream to support improvements in patient flow. ▪ Continue to use 'live' data to assist teams to monitor delivery and compliance with national surgery targets, predict demand trends and address capacity issues.	✓ Alliance in operation Q1. ✓ Alliance KPIs set Q2. ✓ Two department achieve 100 day target each quarter – 8 by year end. ✓ 100% of patients wait no more than 4 months for their First Specialist Assessment or treatment.
	▪ Review current theatre constraints and identify opportunities to maximise service delivery and reduce reliance on private providers. ▪ Embed Clinical Priority Access Criteria and national prioritisation tools for treatment through standardised triage processes – to support treatment of patients in order of priority. ▪ Use the Enhanced Recovery After Surgery and Frail Older Person's Pathways initiatives to reduce lengths of stay and enhance recovery.	✓ Elective theatre utilisation rate maintained at >85%. ✓ Standardised (100-days) FSA triage in place Q4. ✓ Elective inpatient average length of hospital stay maintained at <1.55 days.
Participate in the Regional Services Alliance to support specialist services delivery across the South Island.	▪ Continue with implementation of a Major Trauma Register and support regional timeframes to ensure the South Island DHBs contribute to the NZ Major Trauma Minimum Dataset. ▪ Develop and implement a co-joined vascular surgery service with Nelson Marlborough DHB, with local placement of vascular surgeon in Nelson with connections and support from Canterbury DHB.	✓ CDHB contributing data to Trauma Dataset. ✓ New vascular service developed Q1. ✓ Nelson-based vascular surgeon in place Q3.

[35] Current procedures include: acute demand service, skin lesion excisions, Mirena insertions, Pipelle biopsy and musculoskeletal injections.

[36] The South Island DHBs have agreed that while each DHB plans to deliver its share of the additional regional surgical discharges (which for Canterbury is 219 discharges), they will seek collegial support to deliver the volumes if that is required.

6.19 Shorter waits for cardiac services

Cardiovascular disease is the leading cause of death in New Zealand and along with cancer is responsible for two out of every three deaths. Improving access to cardiac services across the continuum will help our population to live longer, healthier and more independent lives.

The provision of timely cardiac services is closely intertwined with the delivery of the transalpine services to the West Coast DHB and activity through the South Island Regional Cardiac Workstream which is led by the Canterbury DHB.

WHATS NEXT - OUR PERFORMANCE STORY FOR 2016/17		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCE OF SUCCESS
Improve the response to cardiac events earlier in the continuum.	▪ Maintain direct GP access to Echocardiography and Exercise ECGs to improve referral quality and access to appropriate services. ▪ Continue to invest in the 'Heart Failure Initiative' to assist patients, GPs and ambulance staff to safely manage heart conditions in the community, and reduce avoidable hospital admissions.[37] ▪ Continue to support the regional implementation of the Accelerated Chest Pain Pathway in ED to reduce avoidable hospital admissions.	✓ GP access to diagnostics maintained. ✓ Review of Accelerated Chest Pain Pathway Q4.
Improve outcomes for patients presenting with Acute Coronary Syndrome (ACS).	▪ Maintain regionally agreed protocols and pathways for patients with ACS to ensure prompt risk stratification, stabilisation and transfer. ▪ Implement a common Percutaneous Coronary Intervention (PCI) HealthPathway for ACS patients and support same day discharge for appropriate patients undergoing PCIs. ▪ Support delivery of additional weekend lists, as needed, to reduce waiting times and meet national ACS targets. ▪ Continue to participate in the collection of data for the national Cardiac (ANZACS QI) and Cath/PCI Registers to enable monitoring of intervention rates and to identify quality improvements. ▪ Engage with the regional ANZAC QI Coordinator to help train staff on rotation in ACS protocols and the importance of recording ANZAC QI registry data in a timely manner.	✓ 70% of high-risk patients receive an angiogram within 3 days of admission. ✓ ACS HealthPathway in place Q3. ✓ Increased number of PCI patients with same day discharge Q4. ✓ Monthly reporting to ANZACS QI Register. ✓ 95% of ASC patients who undergo angiography have registry data collection completed within 30 days. ✓ Quarterly training for House Officers in the completion of registry data.
Maintain production capability for the delivery of cardiac surgery to our population.	▪ Maintain capacity to deliver cardiac surgery at 6.5 per 10,000, even if numbers of patients needing this type of surgery are below that rate. ▪ Monitor ESPI waiting time and intervention rates, to ensure equity of access and continued compliance with nationally agreed wait times. ▪ Continue to use national Clinical Priority Access Criteria tools and support treatment of patients in order of assigned priority. ▪ Continue to implement the 100 Days, Theatre Utilisation, ERAS, and Frail Elderly projects to improve the coordination and flow of patients and free-up capacity to deliver additional services.	✓ 95% of people receive their elective coronary angiograms within 90 days. ✓ 100% of patient wait no more than 4 months for their First Specialist Assessment or treatment. ✓ Waiting list for cardiac surgery remains between 5 and 7.5% of annual cardiac throughput. ✓ 348 cardiac surgery discharges delivered Q4. ✓ Percutaneous Revascularisation SIR: ≥12.5 per 10,000. ✓ Coronary Angiography SIR: ≥34.7 per 10,000.
Improve the consistency and quality of cardiac services across the South Island.	▪ Support the region approach to cardiology nurse training and development including quarterly meeting of cardiac nurse educators. ▪ Support the regional Cardiac Workstream to complete project work associated with the development of a South Island Cardiac Model of Care – including provision of data and expert advice.	

[37] *The Heart Failure Initiative is a best practice model of care implemented across primary and secondary services in Canterbury; similar to the successful COPD Initiative. A red card has been developed to guide patients with self-management and advise on when to access additional medical support. Ambulance staff are supported to identify people that can be safely managed in primary care and/or help them access a clinically appropriate level of care.*

6.20 Shorter waits for cancer treatment

Cancer is the second leading cause of death and a major driver of hospitalisation in New Zealand. While cancers attributable to tobacco smoking are expected to decline (with declining tobacco consumption), cancers related to poor diet, lack of physical activity and rising obesity levels are on the increase. The impact of cancer can be significantly reduced through early diagnosis and treatment.

Canterbury is participating in the national 'Faster Cancer Treatment' initiative to improve the timeliness of the patient journey from referral to treatment. This work requires a collaborative approach and commitment from a number of clinical specialties across the DHB. The key objective for the coming year is to improve the quality and consistency of service delivery by integrating the various project teams and initiatives under a single multi-disciplinary governance structure and to deliver marked improvements against the 31 and 62 day cancer targets for assessment and treatment.

WHATS NEXT - OUR PERFORMANCE STORY FOR 2016/17		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCE OF SUCCESS
Improve the quality and consistency of cancer services.	▪ Submit options for implementing recommendations from completed audits against head and neck, bowel and thyroid cancer tumour standards, to the new DHB cancer services governance group. ▪ Support the Southern Cancer Network to identify two new services for review in the coming year and provide data to support these reviews. ▪ Complete the implementation of the national prostate cancer management and referral guidelines.	✓ New service audit areas agreed Q1. ✓ Audit recommendation options presented Q2. ✓ Improvements in the prostate cancer journey monitored from Q3.
Facilitate timely access to cancer services to support earlier treatment and minimise the impact of Cancer.	▪ Enhance cancer services leadership with the introduction of a new multi-disciplinary governance structure to oversee and support delivery of the cancer improvement initiatives and national targets. ▪ Develop a 'live' monitoring and tracking system that prospectively identifies target breaches and opportunities for service improvement. ▪ Maintain appropriate outsourcing arrangement to ensure capacity is available to meet demand at peak times. ▪ Support the Southern Cancer Network to rollout the Psychosocial and Supportive Care Initiative across the South Island. ▪ Work closely with the Southern Cancer Network to implement service improvements across the following improvement initiative areas: Melanoma ▪ Develop pathways in primary care to enable faster diagnosis and referral of melanomas and support the roll out of dermatoscopy and dermatoscopy training to general practice. ▪ Instigate and monitor follow up regimes of melanoma by primary care. ▪ Engage with the South Island Consumer Group and the NZ Cancer Society to identify opportunities for targeting at risk populations. Head and Neck ▪ Work alongside the Nelson Marlborough DHB to improve the head and neck pathway, through process and value stream mapping. Gynaecology ▪ Apply the new definition to identify high suspicion of cancer (HSCAN) in gynaecology to a retrospective and prospective cohort of patients, to identify routes to diagnosis and validate the new HSCAN definition. ▪ Engage with representatives from patient groups, Māori health teams, primary referrers and the Te Waipounamu Māori Leadership Group to improve cervical screening rates and early detection for Māori. Data and Information Management ▪ Identify and progress actions to support regional implementation of the national Cancer Health Information Strategy. ▪ Continue to improve data collection activity and increase the number of records being submitted across faster cancer treatment indicators. ▪ Work with the Southern Cancer Network to undertake a review of ethnicity data and improve processes for coding of data.	✓ Governance leadership model implemented Q1. ✓ Programme of work to meet the national targets completed Q1. ✓ Cancer dashboard live Q1. ✓ Increased proportion of patients with a confirmed diagnosis receive their first cancer treatment (or other management) within 31 days Q1. ✓ 85% of patients (referred with a HSCAN and a need to be seen within two weeks) receive their first treatment within 62 days of referral Q4. ✓ 100% of patients ready for treatment wait less than 4 weeks for radiotherapy or chemotherapy. ✓ Pathway for melanoma follow up regimes live Q3. ✓ Reduced rate of benign lesion excision Q4. ✓ Number of patients assessed with HSCAN identified Q2. ✓ 10% increase in HSCAN patients who receive a confirmed diagnosis Q4. ✓ Monthly submission of data to national systems. ✓ Increased number of records being accepted.

6.21 Delivering organised stroke services

A stroke is the sudden interruption of the blood supply to the brain and can cause permanent damage. Strokes more often occur in older people, however around a quarter of all strokes in New Zealand happen to people of working age or younger. The best chance of full recovery from a stroke is getting medical attention early and through active management and rehabilitation we can support those experiencing a stroke to live well.

WHATS NEXT - OUR PERFORMANCE STORY FOR 2016/17		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCE OF SUCCESS
Develop and maintain a stroke service in Canterbury that meets the New Zealand Stroke Guidelines.	▪ Actively participate in the regional stroke network to ensure stroke services in the South Island meet the New Zealand Stroke Guidelines. ▪ Support regional DHBs with advice and training support. ▪ Support clinical leads in Canterbury to implement national guidelines and the regional stroke work plan to improve health system outcomes for stroke survivors. ▪ Maintain stroke thrombolysis quality assurance procedures, including training, audit and participation in the national thrombolysis register. ▪ Complete the reconfiguration of rehabilitation services to establish a single community-based service for rehabilitation after stroke. ▪ Enable the collection of data along the stroke pathway to establish baselines for transfer to community based rehabilitation and assessment within five working days post discharge. ▪ Support ongoing refinement and continuous quality improvement via monthly quality assurance and clinical audit meetings.	✓ Quarterly update on progress towards meeting guidelines. ✓ Community Stroke Rehabilitation Service includes all ages 18+ Q1. ✓ Stroke Pathway data capture evaluated Q2. ✓ 6% of potentially eligible stroke patient's thrombolysed. ✓ 80% of stroke patient admitted to an organised stroke service with demonstrated stroke pathways. ✓ 80% of patients with acute stroke who are transferred to in-patient rehabilitation service are transferred within 7 days of admission.

6.22 Developing a national hepatitis C pathway

Hepatitis C is a virus which that attacks the liver and can be passed on through contact with the blood of an affected person. The Ministry of Health estimates 50,000 New Zealanders are living with hepatitis C, many do not know they have it, and around two thirds of those people develop chronic hepatitis C and liver disease. The goal is to implement a single clinical pathway in order to provide consistent hepatitis C services and maximise the wellbeing of New Zealanders living with hepatitis C.

In the South Island this work will be driven through the South Island Alliance and involves the design and development of an integrated hepatitis C assessment and treatment service.

WHATS NEXT - OUR PERFORMANCE STORY FOR 2016/17		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCE OF SUCCESS
Improve the consistency of care delivered across the South Island.	▪ Support the regional alliance team to co-ordinate the development of a consistent South Island clinical pathway for people with hepatitis C. ▪ Develop an implementation plan to align Canterbury practice with the agreed South Island model.	✓ Hepatitis C programme group established Q1. ✓ Clinical pathway agreed Q4.

6.23 Implementing the national spinal cord impairment action plan

Spinal cord impairment is rare but complex. Every year in New Zealand around 80-100 people are diagnosed with spinal cord impairment through injury or medical/congenital causes. This affects their lives and those of many others, especially their families and whānau and can occur at any age. Due to medical advancements most people have a near normal life expectancy, but spinal cord impairment often involves progressive complexity and lifelong self-management.

In New Zealand, the current model of care for medical interventions and lifelong supports is seen as fragmented and in need of better coordination. Canterbury is working alongside Counties Manakau DHB, the Ministry of Health, ACC and St John Ambulance Service to implement a national Spinal Cord Impairment Action Plan. With a collaborative approach we aim to improve the coordination of services, enhance health outcomes and maximise the quality of people lives.

WHATS NEXT - OUR PERFORMANCE STORY FOR 2016/17		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCE OF SUCCESS
Improve information sharing.	▪ Implement and operationalise the recommended (Risk Hansen Institute) register for collection of data. ▪ Collaborate with Counties Manakau DHB to ensure consistency of data collection and reporting.	✓ Data points agreed Q1. ✓ Data collected Q2. ✓ Reports generated Q4.
Provide nationally consistent and high quality rehabilitation services.	▪ Identify and agree a quality framework for monitoring and strengthening services that could be used across Counties Manakau and Canterbury DHB spinal services. ▪ Develop an implementation plan for the agreed framework and begin implementation.	✓ Potential frameworks identified Q2. ✓ Framework agreed Q3. ✓ Implement plan Q4.
	▪ Implement a patient experience tool within the Burwood Spinal Unit that is consistent with Counties Manakau DHB tool.	✓ Patient experience tool identified and tested Q2. ✓ Data reported Q4.

Enhancing our organisational health and capability

6.24 Improving quality and patient safety

Patient safety is the cornerstone of high quality health care. The Canterbury DHB is committed to local, regional and national initiatives that encourage continuous quality improvement and support innovations that enhance service delivery. This includes a commitment to the NZ Business Excellence in Health Care Programme and delivery against the priority areas of the national Health Quality and Safety Commission (HQSC) including the Open for Better Care Programme and delivery against the national quality and safety markers. We will also support the development of a Quality and Safety Network under the umbrella of the CCN Alliance engaging PHOs, NGOs and the DHB in supporting improved quality and patient safety across the wider Canterbury health system.

Our performance against the key national quality and safety markers has improved over time, but we aim to focus on reducing hospital adverse events including falls and infections over the coming year. Patient experience is also an important factor in assessing the quality of care provided and is strongly linked to health outcomes. Patient-centred care is a strength of the Canterbury health system and we have begun reporting on a number of patient experience metrics to support better care across our hospitals. We will look to increase survey response rates in 2016/17 and report quarterly on the patient experience results. A national focus on patient experience metrics will also see further development and use of patient experience surveys across primary care.

WHATS NEXT - OUR PERFORMANCE STORY FOR 2016/17		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCE OF SUCCESS
Improve the patient experience of care across our services.	▪ Continue to support the use of the '4 Questions' at the bedside (what is happening today - when am I going home?) in medical services to increase patient involvement in decision-making about their care. ▪ Promote the Patient Experience Survey in discharge materials and patient publications to increase response levels. ▪ Use patient experience and stories to inform the design of service process improvements and to celebrate success.	✓ 90% completion of answers to 4 Questions. ✓ Quarterly reporting on Patient experience. ✓ Survey response levels increased to over 33%.
Increase the organisational focus on rapid cycle continuous improvement processes.	▪ Promote the use of the Health Excellence Criteria at team level to focus planning for improvement. ▪ Invest in the Elev8 training to support the use of the rapid cycle Plan-Do-Study-Act (PDSA) model for implementing service improvement. ▪ Embed the Releasing Time to Care programme by developing an improvement dashboard for use across the Christchurch Hospital.	✓ Participation in Health Excellence workshops Q1. ✓ Monthly Elev8 education programme in place Q2. ✓ Releasing Time to Care dashboard in place Q3.
Improve the quality of care delivered to reduce patient harm across our hospitals and improve local performance against the national Quality and Safety Markers.	▪ Integrate the use of the national Quality and Safety Markers (QSM) as key improvement indicators in appropriate improvement programmes. ▪ Complete the roll out of the electronic patient vital-signs early-warning E-observations application across Christchurch Hospital.	✓ Quarterly monitoring of progress against QSMs. ✓ E-observation application implemented Q4.
	▪ Promote prevention of healthcare associated infection through active participation in national Open for Better Care Campaign activities. ▪ Continue to improve '5 Moments in Hand Hygiene' practice and strengthen the organisation-wide leadership and audit programme. ▪ Continue to monitor and review hand hygiene audit results and support actions to improve quality and safety where identified. ▪ Report audit results through to the national quality database. ▪ Expand the Hand Hygiene New Zealand gold audit programme to all inpatient and procedure areas. ▪ Implement e-monitoring of inpatient peripheral IV line phlebitis. ▪ Review key process information collected for hip and knee data at a team level using the electronic scope form. ▪ Continue to work with Auckland DHB and the HQSC to support the national Surgical Site Infection Surveillance programme. ▪ Continue to disseminate surgical site infection surveillance results to all departments and take action to improve quality and safety.	✓ Hand hygiene results reported to the national database Q1. ✓ Auditor in place in all inpatient and procedure areas Q4. ✓ 80% compliance with good hand hygiene practice. ✓ 100% of inpatient IV lines sites recorded in the observation application. ✓ 95% of hip & knee replacement patients receive cefazolin ≥ 2g or cefuroxime ≥1.5g as surgical prophylaxis.

WHATS NEXT - OUR PERFORMANCE STORY FOR 2016/17		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCE OF SUCCESS
	▪ Consolidate the use of visual cues, safe mobility plans and the post falls pathway to reduce the rate of falls across our hospitals. ▪ Implement the nursing InterRAI admission assessment (inclusive of the falls risk assessment).	✓ 100% of hip & knee replacement patients have appropriate skin prep. ✓ 100% of hip & knee replacement patients receive prophylactic antibiotic 0-60 minutes before incision. ✓ 90% of older patients are given a falls assessment. ✓ 98% of patients at risk of falls have an individual care plan addressing falls risk.
	▪ Complete the roll out of e-prescribing and e-administration and implement electronic medicines reconciliation (eMR) in inpatient services to improve medication safety. ▪ Consolidate Phase 2 of the roll out of Brief and Debrief and reinforce use of the Surgical Safety Checklist to support adherence to policy. ▪ Adopt and begin monitoring against the new Safe Surgery Marker measuring the use of the checklist as a communication tool from July.	✓ 80% of prioritised patients have medicines reconciliation completed <24 hrs of admission. ✓ Quarterly reporting on Pressure Injuries to HQSC. ✓ Pressure Injury coding practises reviewed Q1. ✓ Workshop delivered promoting pressure injury awareness Q4. ✓ Use of the InterRAI assessment tool Q4.
	▪ Promote the use of ACC45 and ACC2152 treatment injury claim forms for all grades of pressure injury to improve statistical data gathering on prevalence of pressure injuries. ▪ Review coding practises to improve classification and recording of pressure injuries and ensure all grade 3 & 4 pressure injuries are reported as SAC 1 & 2 events. ▪ Report all grade 3 and above pressure injuries internally and to HQSC as serious adverse events. ▪ Undertake the annual pressure injury point prevalence survey. ▪ Implement the InterRAI evidence based structured risk assessment to support clinical judgement and implement effective prevention using the electronic patient observation application Patientrack.	

6.25 Supporting our health workforce

Continuing to support and develop our health workforce remains a critical factor in meeting our current challenges and ensuring a sustainable future for our health system. Staff resilience and wellbeing support programmes will continue to be a priority over the coming year. We are also redefining how we support workforce development, starting with building a career based framework that focuses on the employee lifecycle, alignment of priorities and development engagement.

We will continue to invest in leadership programmes, coaching and mentoring, peer support networks, learning events and professional development programmes. These opportunities help to enhance collective leadership and shared accountability throughout the system and support and enable people to work at the greatest extent of their scope.

The South Island Workforce Development Hub provides further opportunities for greater collaboration across the South Island and clinical networks are well established across nursing, allied health, midwifery and medicine. Critical role identification, piloting of new roles, clinical training placements and career planning will be supported by the DHB.

WHATS NEXT - OUR PERFORMANCE STORY FOR 2016/17		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCE OF SUCCESS
Value and support the wellbeing of our people.	▪ Maintain wellbeing initiatives and support the creation of collegial peer groups to support the wellbeing of our people. ▪ Develop and implement a Wellbeing Strategy for 2016 onwards. ▪ Complete a follow-up Staff and Family Wellbeing Survey.	✓ Strategy launched Q2. ✓ >30 wellbeing workshops delivered. ✓ Improved wellbeing outcomes evident.
Optimise the capability of our people.	▪ Redefine the organisations workforce development focus to enhance leadership capability and support succession planning. ▪ Continue to invest in programmes that build capability including the DHB's 2020 Leaders, Xcelr8, Particip8, and Collabor8 programmes. ▪ Support training, mentoring and credentialing processes that enable our nursing workforce to work to their full scope of practice including a South Island toolkit for the development of nurse practitioner roles. ▪ Support allied health advanced role development for allied health assistants and pharmacy technicians and maintain the Healthcare Assistant Development Programme. ▪ Maintain accreditation as a training centre from the Australasian College of Physical Scientists and Engineers in Medicine. ▪ Support Medical Council of NZ requirements for community based rotations by hosting PGY2s into general practice.	✓ Ongoing staff participation in Xcelr8, Particip8 and Collabor8 and Elev8 programmes. ✓ Healthcare and Allied Health assistants gaining the NZ Certificate in Health and Wellbeing (Level 3) qualification. ✓ 1.0 FTE Calderdale Practitioner in place. ✓ Prescribing pharmacist role established.
Grow the capacity and capability of Māori and Pacific People across our health workforce.	▪ Continue to lead the regional delivery of the Kia Ora Hauora Māori Workforce Development Service and invest in Māori and Pacific health scholarships to encourage more Māori and Pacific people into health. ▪ Continue to provide access to the Health Workforce NZ Hauora Māori funding pool to support Māori staff in our health system to upskill. ▪ Work with our tertiary education partners to reduce the barriers for Māori and Pacific people enrolling in health education programmes. ▪ Improve the recording of staff ethnicity data to better understand our workforce and develop Māori and Pacific leaders.	✓ Uptake of Hauora Māori scholarships. ✓ Uptake of DHB funded scholarships. ✓ Increase in ethnicity stated in our workforce stats. ✓ Minimum of 4 Tikanga and Treaty workshops run.
Expand the capacity of our workforce; in particular, the sustainability of priority (vulnerable) workforce groups.	▪ Continue to maximise clinical placement for undergraduate and graduate entry nursing trainees and NETP/NESP positions. ▪ Continue to train, recruit and develop medical physicists. ▪ Continue to work alongside the South Island Workforce Development Hub and private training providers to train and recruit sonographers. ▪ Work alongside the South Island Hub to expand the role of nurse practitioners, clinical nurse specialists and palliative care nurses and the role of specialist nurses to perform colonoscopies.	✓ >150 nurse positions within the NETP and NESP programmes. ✓ 4.0 FTE trainee sonographers in place. ✓ 4.0 FTE trainee Medical Physicists in place. ✓ Increase in nurse practitioner roles by minimum of 2.0 FTE.

6.26 Connecting our information systems

The Canterbury DHB is taking a lead in redesigning, developing and implementing information systems solutions to enable a more integrated health system and to support the development of more integrated service delivery models. We take this role not only across the Canterbury health system but across the DHB boundaries to support our partner DHBs.

Major systems solutions include: HealthPathways which provides current local assessment, management and referral information online, the Electronic Request Management System (ERMS) which enables GPs to refer patients to anywhere in the health system directly from their desktop and HealthOne which integrates core clinical information from multiple systems and makes it available to health professionals at the point of care.

We will continue in the coming year to support the South Island roll-out of systems that reduce duplication, save clinical time and improve patient safety. Continued development of these solutions will enable faster, more accurate referrals and safer, more efficient sharing of clinical information between health professionals across the South Island.

WHATS NEXT - OUR PERFORMANCE STORY FOR 2016/17		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCE OF SUCCESS
Deploy new systems to empower people to manage their own health.	▪ Continue to work with the three Canterbury PHOs to design and implement a Patient Portal to provide patients with access to their core health information.	✓ Procurement process complete Q1. ✓ Quarterly progress updates.
Enhance current information systems to support more integrated models of care and service delivery.	▪ Continue to invest in HealthPathways to support the delivery of the right care, at the right time, in the right place. ▪ Continue to support the development of electronic Standing Orders to expedite care and access to treatment in primary care settings. ▪ Complete implementation of eReferrals Stage 2 (via the Health Connect South Platform). ▪ Implement eReferrals Stage 3, providing triage and internal referrals functionality across all services. ▪ Complete the roll out clinical workstation under a Virtual Desktop Infrastructure (VDI) environment to allow more efficient capture of clinical notes in different locations.	✓ >500 Community HealthPathways available across the system. ✓ 90% of all services using eReferrals Stage 2 Q3. ✓ 60% of services using eReferrals triage functionality Q3. ✓ Installation of VDI at ChCh Hospital complete Q4.
Deploy new clinical information systems to improve patient safety.	▪ Support electronic medicines reconciliation (eMR) to reduce transcription errors and improve care communication with deployment of e-Discharge Summary MedCharts. ▪ Introduce the electronic nursing observation application to improve patient assessment screening and escalation of care. ▪ Replace the current maternity system (Caresys) to streamline systems and provide a complete set of maternity information. ▪ Extend RL6 software to encompass Risk Management.	✓ eMR deployed Q2. ✓ Nursing Observation application implemented in according to project plan. ✓ Replacement of Caresys Q3. ✓ RL6 live in all areas Q4.
Develop information infrastructure alongside new facilities.	▪ Establish a clear mobile device, application, and data strategy. ▪ Develop functional design for digital hospitals incorporating the Christchurch Hospital requirements.	✓ Mobile device strategy Q2. ✓ Christchurch digital design concepts complete Q3.
Rollout information solutions to enable seamless and transparent access to clinical information across the South Island.	▪ Continue to lead the rollout of Health Connect South (HCS) across the South Island, providing upgrades and support. ▪ Continue the deployment of HealthOne to the rest of the South Island to improve clinical decision-making. ▪ Implement the South Island Patient Information Care System (SI PICS) to further integrate systems regionally. ▪ Upgrade Canterbury's electrocardiogram (ECG) and Holter management systems for regional access. ▪ Deploy the Maximo EAM asset management system CDHB-wide and extend to West Coast and South Canterbury DHBs.	✓ NMDHB using the HCS portal Q1 and SDHB Q2. ✓ HealthOne deployed to NMDHB Q2. ✓ SI PICS in use in Burwood Hospital Q1. ✓ All captured ECGs and Holter reports available in HCS Q2. ✓ Maximo EAM deployed Q4.

6.27 Living within our means

We must ensure we are on a sustainable financial path into the future. However, this will be extremely challenging in our current fiscally constrained environment - characterised by increasing demand and earthquake-related operating costs that are growing at a faster pace than funding growth.

Since the establishment of our Vision in 2006, we have been committed to delivering an integrated system that supports people to stay well and provides the right service, in the right place at the right time. Improving the over-all health and wellbeing of our population is the only real way to get ahead of the demand curve. While these gains may be slow, they are already evident, and are the foundation from which we will build a more sustainable health system.

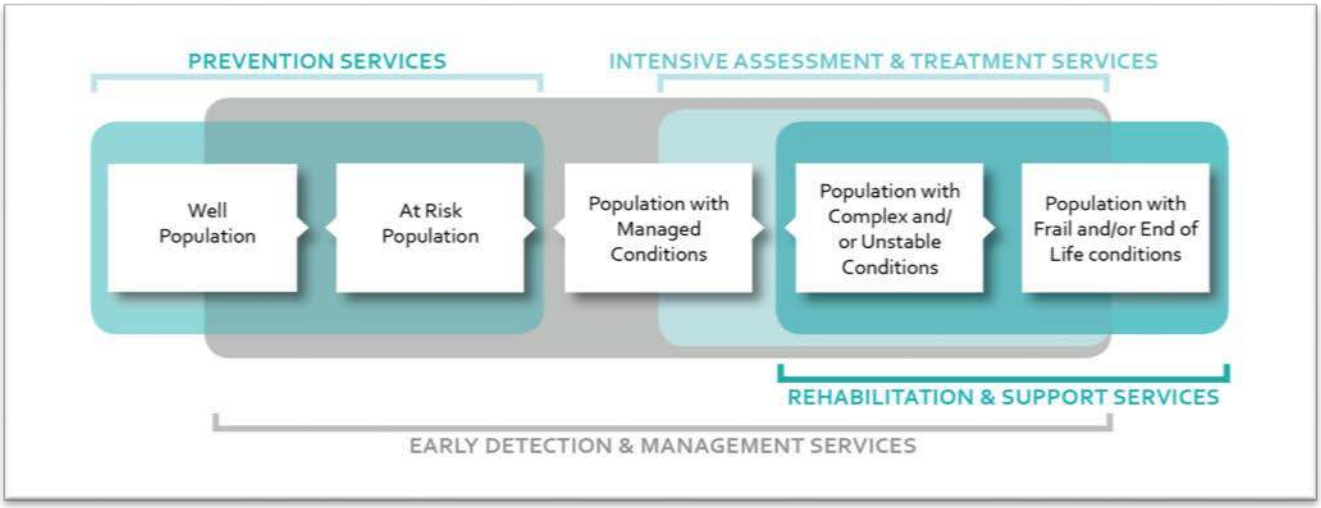
We will continue to focus on maximising value by delivering services in more effective and efficient ways and building on the incremental savings we have achieved to date. However, if an increasing proportion of our funding has to be directed into meeting additional earthquake-related costs or demand, it will begin to put continued service delivery at risk.

WHATS NEXT - OUR PERFORMANCE STORY FOR 2016/17		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCE OF SUCCESS
Support people to stay well and reduce unplanned or acute demand for hospital and specialist services.	▪ Maintain direct GP access to diagnostic services to support earlier intervention, without the need for specialist referral. ▪ Continued to invest in the delivery of community-based acute demand options and packages of care to reduce hospital admissions. ▪ Maintain CREST, falls prevention and medication review services to support people at risk of a hospital admission to stay safe and well. ▪ Review the stepped care model for mental health services to support earlier intervention and faster access to brief intervention and advice.	✓ >28,000 urgent care packages provided in the community. ✓ Rate of acute medical admissions maintained at <5,500 per 100,000.
Achieve technical and clinical efficiencies to reduce waste and duplication.	▪ Expand the use of HealthPathways across our hospital services. ▪ Continue to support the development of electronic Standing Orders to expedite care and access to treatment in primary care settings. ▪ Continue to support the use of the ERMS to streamline referrals and improve triaging capabilities within the system. ▪ Continue to support implementation of HealthOne, Health Connect South and PICs to support improved clinical decision.	✓ PICS live and running Q1. ✓ >100 Hospital HealthPathways in place. ✓ >20 Standing Orders available electronically. ✓ >90% of services use ERMS.
Maintain a focus on the efficient and effective use of specialist resources to minimise the cost of service delivery.	▪ Review and refine adult acute, patient overflow and theatre models to reduce the impact of acute demand variation of the delivery of elective surgery and seek to reduce outsourcing to pull back operational costs. ▪ Implement HQSC medication, infection control and surgical site infection initiatives to support safer and shorter patient stays. ▪ Continue to implement the national Enhanced Recovery After Surgery (ERAS) and Frail Older Person's Pathway initiatives to support earlier intervention, reduce lengths of stay and enhance recovery.	✓ Elective theatre utilisation maintained at >85%. ✓ Delivery in line with agreed production plans. ✓ Improved performance against the HQSC national quality markers. ✓ Elective inpatient average length of stay <1.55 days. ✓ Reduction in patients 75+ with a length-of-stay greater than 14 days – 2013 base 205.7. ✓ Readmission rates at or below current rates.
Maximise revenue to support the delivery of services.	▪ Apply scrutiny to contractual arrangements and ensure appropriate payment for Inter-district flows, insurance and ACC services. ▪ Maintain tight controls around the repair programme to ensure investment is not wasted on short-term fixes, delays are minimised and longer-term operational impacts are carefully considered. ▪ Actively engage in strategies to better identify and respond to the service demand created by unenrolled and overseas patients.	
Participate in regional initiatives focused on the more efficient and effective use of resources.	▪ Expand the use of telemedicine and virtual specialist assessments to reduce travel to and from the West Coast and Chatham Islands. ▪ Continue to support the Regional Support Services Alliance to achieve regional procurement and supply chain savings.	✓ Procurement and supply chain savings as agreed Q4. ✓ >1,700 telemedicine consultations between Canterbury and the Coast.
Participate as agreed in national entity initiatives focused on	▪ Work collaboratively with the National Health Promotion Agency to support the achievement of national health targets, particularly the national immunisation targets.	✓ Implementation of national promotion initiatives.

WHATS NEXT - OUR PERFORMANCE STORY FOR 2016/17		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCE OF SUCCESS
the efficient and effective use of resources.	▪ Support the promotion of alcohol screening, brief intervention and the provision of routine and consistent advice to women on alcohol and pregnancy in line with the National Health Promotion Agency work. ▪ Implement PHARMAC initiatives including national contracting for the procurement of hospital medical devices, management of hospital pharmaceuticals and product standardisation. ▪ Engage with the Ministry of Health on the work programme of the former National Health Committee (once confirmed).	✓ Progress against national health targets. ✓ Implementation of national PHARMAC initiatives.
Participate in the implementation of agreed Shared Services initiatives, aligned to the Health Partnership work programme.	▪ Commit resource where required to progress the National Oracle Solution (formerly the Finance, Procurement & Supply Chain) initiative. ▪ Consider the implementation of the national Food Services business case and commit appropriate resources where agreed. ▪ Work collaboratively with the NZ Health Partnership to progress the National Infrastructure Platform.	✓ Implementation of national shared services business cases are agreed. ✓ Resource commitments are fully factored into expected budgets. ✓ NZ Health Partnership benefits are realised.

Statement of Service Expectations

How will we demonstrate our success?



EVALUATING OUR PERFORMANCE

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

Understanding the dynamics of our population and the drivers of demand are key when making funding decisions. Just as fundamental is our ability to evaluate whether the services we are providing are making a measureable difference in people's lives.

Over the longer term, we evaluate the effectiveness of our decisions by tracking performance against a set of desired population health and service performance outcomes – highlighted earlier in section 5 of this document.

On an annual basis, we evaluate our performance by providing a forecast of the services we plan to deliver and the standards we expect to meet. We then report our actual performance against this forecast in our year-end Annual Report.[38] The following statement of service expectations presents the Canterbury DHB's planned performance for 2016/17.

Services have been grouped into four service (or output) classes that are a logical fit with the continuum care. These are: prevention services; early detection and management services; intensive assessment and treatment services; and rehabilitation and support services (illustrated above).

Because it would be overwhelming to measure every service delivered, we have chosen a set of indicators for each service class which we believe are important to our community and stakeholders, and provide a fair representation of how well the DHB is performing.

In presenting our performance picture, we cannot simply measure the volumes of services delivered. The number of people who receive a service is often less important, for example, than whether the service was delivered at the right time. We have chosen instead to present a mix of indicators that address four key aspects of performance: Volume (V), Timeliness (T), Coverage (C) and Quality (Q).

Wherever possible, past years baselines and national results are included to give context in terms of what we are trying to achieve and to support evaluation of our performance over time.

The DHB has a separate Māori Health Action Plan. Where the performance indicators align, these have been included in the statement of service expectations to highlight areas of particular priority in terms of improving health outcomes for Māori in Canterbury.

SETTING STANDARDS

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

Targets reflect the objective of increasing the coverage of prevention programmes, reducing acute or avoidable hospital admissions and maintaining service access - while reducing waiting times and delays in treatment.

[38] *The Annual Report is tabled in Parliament and is available on the DHB's website: www.cdhb.health.nz.*

While a healthier population and earlier intervention can reduce avoidable demand over time, there will always be some 'demand driven' services. These are services where the DHB must response to population need including: diagnostic tests, emergency care, maternity services, rehabilitation and respite services, dementia and palliative services.

It not appropriate to set targets for these services. Instead, previous years' volumes and estimates for the coming year have been provided to give context in terms of the use of resources across our health system.

EXPECTATIONS

With a growing Māori population and persistent inequalities amongst our population achieving equity of outcomes is an overarching priority. All of our targets are universal with the aim of bringing performance for all population groups to the same level, rather than accepting different standards for different populations.

In Canterbury we also continue to deal with the ongoing consequences of New Zealand's largest natural disaster. The impact is most markedly felt in an increase in demand for mental health and emergency services. It is also evident in terms of reduced capacity within our hospitals, the loss of space and buildings and the impact the constant disruption from repairs and construction is having on our staff and services.

A number of the standards set are based on national performance expectations for all DHBs. Some targets will be particularly challenging for Canterbury to meet as our population's needs continue to change and evolve. However we remain committed to maintaining high standards of service delivery and lifting the bar across all our indicators of performance.

WHERE DOES THE MONEY GO?

The table below presents a summary of the budgeted financial expectations for 2016/17, by output class.

	2016/17
Revenue	**Total $'000**
Prevention	36,790
Early detection and management	344,516
Intensive assessment & treatment	1,034,575
Rehabilitation & Support	237,814
Total Revenue - $'000	**1,653,695**
Expenditure	**Total $'000**
Prevention	37,304
Early detection and management	352,851
Intensive assessment & treatment	1,058,826
Rehabilitation & Support	243,210
Total Expenditure - $'000	**1,692,191**
Surplus/(Deficit) - $'000	**(38,496)**

NOTES

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

E Services are demand driven and no targets have been set for these service lines.

Δ Performance data provided by external parties can be affected by a delay in invoicing and results are subject to change.

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

◇ National Health Targets are set for DHBs to achieve by the final quarter of the year. Performance data therefore refers to the fourth quarter result for any given year.

◆ This measure also appears in the DHB's Māori Health Action Plan for 2016-17.

OUTPUT CLASS

7.1 Prevention services

Preventative health services promote and protect the health of the population. They address individual behaviours by targeting changes to physical and social environments that influence and support people to make healthier choices and are in this way, distinct from treatment services. They include: health promotion and education programmes that raise awareness of risk behaviours and healthy choices; the use of legislation and policy to protect the public from environmental risks and communicable diseases; individual health protection services such as immunisation and screening that support early intervention and good health.

WHY IS THIS OUTPUT CLASS SIGNIFICANT?

The four leading long-term conditions: cancer, cardiovascular disease, diabetes and respiratory disease make up 80% of the disease burden for the total population.[39] These diseases are largely preventable. By supporting people to make healthier choices we can reduce the risk factors that contribute to these conditions. High-need population groups are also more likely to engage in risky behaviours, or live in environments less conducive to making healthier choices. Prevention services are therefore also our foremost opportunity to target improvements in the health of high-need populations and to reduce inequalities in health status and health outcomes. Prevention services are also designed to spread consistent messages to large numbers of people, and can therefore be very cost-effective.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Health Promotion and Education Services These services inform people about risks and support them to be healthy. Success begins with awareness and engagement, reinforced by education programmes and legislation that support people to make healthier choices.	Notes	2014/15 Result	2016/17 Target	2014/15 National Average
% of babies exclusively breastfeeding on hospital discharge	Q [40]	80%	≥75%	-
% of babies exclusive/fully breastfed at LMC discharge	Q [41]	71%	75%	78%
% of Māori babies exclusive/fully breastfed at LMC discharge	Q ◆	68%	75%	62%
Lactation support and specialist advice consults provided in community settings	A	1,058	>600	-
% of priority schools supported by the Health Promoting Schools framework	C [42]	91%	>70%	-
'Appetite for Life' nutrition courses provided in the community	A	59	>50	-
People provided with Green Prescriptions for additional physical activity support	A [43]	2,797	3,000	-
% of Green Prescription participants more active 6-8 months after referral	Q [44]	62%	>50%	-
% of women smokefree at two weeks postnatal	Q [41]	90%	95%	78%
% of Māori women smokefree at two weeks postnatal	Q ◆	72%	95%	62%
% of smokers enrolled with a PHO receiving advice and help to quit (ABC)	C ◇	89%	90%	90%
% of smokers identified in hospital receiving advice and help to quit (ABC)	C ◇	96%	95%	96%
% of Māori smokers identified in hospital receiving advice and help to quit (ABC)	C ◇	95%	95%	-

[39] World Health Organisation identifies the main non-communicable diseases are cancer, diabetes, cardiovascular and respiratory disease.

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

[41] Standards are set in alignment with the targets set under the national WellChild/Tamariki Ora (WCTO) Programme. Data is sourced from the national WCTO reports.

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

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

[44] Results are taken from national patient survey competed by Research NZ on behalf of the Ministry of Health. Standards are set nationally.

Population-Based Screening Services These services help to identify people at risk and pick up long-term conditions earlier. The DHB's role is to encourage uptake, as indicated by high coverage rates.	Notes	2014/15 Result	2016/17 Target	2014/15 National Average
% of four-year-olds provided with a B4 School Check	C [45]	91%	>90%	92%
% of 'high needs' four-year-olds provided with a B4 School Check	C [46]	92%	>90%	92%
% of four-year-olds (identified as obese at B4SC) offered a referral for clinical assessment and family based nutrition, activity and lifestyle intervention	Q [47]	new	95%	new
% of Year 9 students in decile 1-3 schools provided with a HEEADSSS assessment	C † [48]	98%	>95%	-
% of women aged 25-69 having a cervical cancer screen in the last 3 years	C [49]	75%	80%	77%
% of Māori women aged 25-69 having a cervical cancer screen in the last 3 years	C ◆	55%	80%	63%
% of women aged 50-69 having a breast cancer screen in the last 2 years	C [49]	79%	>70%	72%
% of Māori women aged 50-69 having a breast cancer screen in the last 2 years	C ◆	74%	>70%	64%

Immunisation Services These services reduce the transmission and impact of vaccine-preventable diseases. The DHB works with primary care and allied health professionals to improve the provision of immunisations both routinely and in response to specific risk. A high coverage rate is indicative of a well-coordinated, successful service.	Notes	2014/15 Result	2016/17 Target	2014/15 National Average
% of newborns enrolled on the National Immunisation Register at birth	C	98%	>95%	-
% of children fully immunised at eight months of age	C ◇	94%	95%	93%
% of Māori children fully immunised at eight months of age	C ◆	96%	95%	90%
% of eight-month-olds 'reached' by immunisation services	Q [50]	98%	95%	97%
% of eligible girls completing the HPV vaccination programme	C † [51]	38%	70%	61%
% of eligible Māori girls completing the HPV vaccination programme	C ◆	28%	70%	64%
% of older people (65+) receiving a free influenza ('flu') vaccination	C †	74%	75%	63%
% of older Māori (65+) receiving a free influenza ('flu') vaccination	C ◆	71%	75%	-

[45] The B4 School Check is the final core WellChild/Tamariki Ora check, which children receive at age four. It is free, and includes vision, hearing, oral health, height and weight. The check allows health concerns to be identified and addressed early in a child's development.

[46] The high needs grouping includes Māori, Pacific and children living in high deprivation areas.

[47] This measure is the newly introduced national Raising Healthy Kids health target.

[48] A HEEADSSS assessment is free and provided to Year 9 students to allow health concerns to be identified and addressed early and the assessment covers: Home, Education/Employment, Eating, Activities, Drugs, Sexuality, Suicide and Safety.

[49] These measures align to national screening programmes and national targets – reporting has been aligned to national screening reports and the cervical screening result differ slightly (1%) to that previously published due to rounding corrections.

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

[51] Results differ to those previously published due to alignment of age bands with the national target definition. The baseline is the percentage of girls born in 2001 receiving Dose 3 and the target for 2016/17 is girls born in 2003. The delivery of Canterbury's HPV programme differs to that provided in other regions being primarily a general practice based programme. A school-based programme was launched in February 2016 to complement and support the general practice programme.

OUTPUT CLASS

7.2 Early detection and management services

Early detection and management services help to maintain, improve and restore people's health by ensuring that those at risk, or with disease onset, are identified early and their condition is appropriately managed. These services are particularly important where people have multiple conditions requiring ongoing interventions or coordinated support.

WHY IS THIS OUTPUT CLASS SIGNIFICANT?

New Zealand is experiencing an increasing prevalence of long-term conditions, so called because once diagnosed people usually have them for the rest of their lives. Some population groups suffer from these conditions more than others do, and prevalence increases with age. By promoting regular engagement with health services, we can support people to maintain good health and, through earlier diagnosis and treatment, intervene in less invasive and more cost-effective ways with better long-term outcomes.

Our vision of a connected system presents a unique opportunity. By providing flexible and responsive services in the community, without the need for a hospital appointment, we are better supporting people to stay well and to manage their long-term conditions - reducing complications, acute illness or crises and therefore avoiding hospital admissions. Reducing avoidable and acute demand for hospital services frees up our hospital and specialist services capacity to enable the provision of more complex and planned interventions.

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Primary Health Care (GP) Services These services are offered in community settings by general practice teams and other primary healthcare professionals, to improve, maintain or restore people's health. High enrolment or access levels are indicative of a responsive system.	Notes	2014/15 Result	2016/17 Target	2014/15 National Average
% of the population enrolled with a Primary Health Organisation	C	95%	>95%	-
% of the Māori population enrolled with a Primary Health Organisation	C ◆	87%	95%	-
Number of Community HealthPathways in place	Q [52]	555	>500	-
Avoidable hospital admission rate for children aged 0-4	Q [53]	5,927	TBC	6,789
Avoidable hospital admission rate for Māori children aged 0-4	Q ◆	4,946	TBC	7,631
Young people (0-19) accessing Brief Intervention Counselling in primary care	A Δ,[54]	611	>500	-
Adults (20+) accessing Brief Intervention Counselling in primary care	A Δ	5,565	>3,500	-
Skin lesions (growths, including cancer) removed in primary care	A Δ	2,583	>2,000	-

Oral Health Services These services are provided by registered oral health professionals to help people maintain healthy teeth and gums. High enrolment indicates engagement, while timely examination and treatment indicates a well-functioning, efficient service.	Notes	2014 Result	2016/17 Target	2014 National Average
% of children (0-4) enrolled in DHB-funded oral health services	C †	69%	95%	76%
% of Māori children (0-4) enrolled in DHB-funded oral health services	C ◆	33%	95%	61%
% of enrolled children (0-12) examined according to planned recall	T †	86%	90%	-
% of enrolled Māori children (0-12) examined according to planned recall	C ◆	81%	90%	-
% of adolescents (13-17) accessing DHB-funded oral health services	C †	62%	85%	-

[52] HealthPathways support general practice teams to consistently assess and manage medical conditions, and provide the criteria for requesting health services and making secondary referrals in Canterbury. The total number is plateauing as pathways are reviewed, consolidated and refined and refers to clinical pathways on the Community HealthPathways site, not resource pages or Hospital HealthPathways.

[53] This measure is based on the national DHB performance indicator SI1, defined as the standardised rate per 100,000 population. The national definition for this measure was reset for 2017/18 and baselines are to March 2016. Targets will be agreed as part of the delivery of the Alliance System Level Improvement Plan due with the Ministry in October 2016.

[54] The Brief Intervention Coordination Service provides people with free support from their general practice teams for mild to moderate mental health issues including depression and anxiety. Results include face-2-face and phone consultations and excludes records with no identifier.

Long-term Conditions Programmes These services are targeted at people with high health need due to having a long-term condition. The aim is to reduce deterioration, crises and complications of those conditions through earlier identification, good management (and control) and monitoring of that condition and any possible side-effects.	Notes	2014/15 Result	2016/17 Target	2014/15 National Average
Spirometry tests provided in the community rather than hospital settings	A Δ [55]	1,682	>1,000	-
% of the eligible population having a CVD Risk Assessment in the last 5 years	C ◇ [56]	82%	90%	89%
% of the eligible Māori population having a CVD Risk Assessment in the last 5 years	C ◆	76%	90%	85%
% of the population identified with diabetes having an HbA1c test in the last year.	C Δ [57]	88%	>90%	-
% of the population identified with diabetes with acceptable glycaemic control.	Q Δ	77%	>75%	-
People receiving subsidised diabetes self-management support from their general practice team when newly diagnosed with Type 2 diabetes or starting insulin	A Δ	880	>800	-

Pharmacy and Referred Services These are services which a health professional may use to help diagnose a health condition, or as part of treatment. They are provided by allied health personnel such as laboratory technicians, medical radiation technologists and pharmacists. While services are largely demand driven, faster and more direct access aids clinical decision-making, improves referral processes and reduces the wait for treatment.	Notes	2014/15 Result	2016/17 Target	2014/15 National Average
Subsidised pharmaceutical items dispensed in the community	A Δ [58]	6.3m	E.<7m	-
Laboratory tests completed for the Canterbury population	A Δ	2.4m	E. <2.6m	-
People on multiple medications receiving medication support	A Δ [59]	1,430	2,000	-
GP requested Community Referred Radiology tests completed	A Δ	44,720	E. >30k	-
% of people receiving urgent diagnostic colonoscopy within 2 weeks	T [60]	96%	>85%	75%
% of people receiving Computed Tomography (CT) scans within 6 weeks	T	96%	95%	85%
% of people receiving Magnetic Resonance Imaging (MRI) within 6 weeks	T	75%	>85%	54%
% of people receiving elective coronary angiography within 3 months	T [61]	98%	>95%	94%

[55] Spirometry is a tool for measuring and assessing lung function for a range of respiratory conditions. Providing this service in the community means people do not need to wait for a hospital appointment and conditions can be identify earlier. Volumes include those delivered by general practice and mobile community respiratory providers.

[56] This measure refers to cardiovascular disease (CVD) risk assessments undertaken in primary care and was previously the national 'More heart and diabetes checks' health target. By identifying those at risk of CVD early, we can help them to change their lifestyle, improve their health and reduce the change that they develop a serious health condition. This intervention is expected to reduce the rate of avoidable CVD-related hospitalisation for our population.

[57] An annual HbA1c test of a diabetic patient's blood glucose levels is seen as a good means of assessing the management of their condition. An HbA1c level of less than 64mmol/mol reflects an acceptable blood glucose level. Numbers differ slightly (1%) due to rounding corrections.

[58] This measure may include some non-Canterbury residents who had prescriptions filled while in Canterbury.

[59] The Medical Management Reviews programmes has been expanded with the introduction of a new higher level service in May 2015, offering more intense medication therapy services for the most complex patients. The baseline and target includes patients receiving either Medical Management Reviews or Medical Therapy Assessments.

[60] The diagnostic measures are national performance measures (PP29) and baselines are as at the final month of the year (June) in line with national results published by the Ministry of Health. Standards are set nationally for all DHBs.

[61] This number differs to that previous published (95%) due to a transcribing error in the preparation of the Annual Report.

OUTPUT CLASS

7.3 Intensive assessment and treatment services

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

WHY IS THIS OUTPUT CLASS SIGNIFICANT?

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

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

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Quality and Patient Safety These quality and patient safety measures are national markers championed and monitored by the NZ Health Quality & Safety Commission. High compliance levels indicate robust quality processes and strong clinical engagement.[62]	Notes	2014/15 Result	2016/17 Target	2014/15 National Average
Rate of compliance with good hand hygiene practice	Q ◇[63]	77%	80%	80%
% of hip and knee replacement patients receiving cefazolin >2g	Q ◇[64]	98%	95%	96%
% of hip and knee replacement patients who have appropriate skin preparation	Q ◇	100%	100%	99%
% of inpatients (aged 75+) who received a falls assessment	Q ◇[65]	96%	90%	93%

Maternity Services These services are provided to women and their families through pre-conception, pregnancy, childbirth and the early months of a baby's life. Services are provided by a range of health professionals, including lead maternity carers, general practice teams and obstetricians. Utilisation is monitored to ensure service levels are maintained and to demonstrate responsiveness to need.	Notes	2014/15 Result	2016/17 Target	2014/15 National Average
% of women registered with an LMC by 12 weeks of pregnancy	C †	77%	80%	-
Maternity deliveries in Canterbury DHB facilities	A	5,895	E. 6,000	-
% of total deliveries made in Primary Birthing Units	A Δ [66]	12%	13%	-

[62] *All of the HQSC quality and safety measures have been updated in alignment with new national reporting timeframes and definitions, results differ slightly from those previous published and relate to the final 2014/15 quarter.*

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

[64] *Cefazolin ≥2g is an antibiotic recommended as routine for hip and knee replacements to prevent infection complications.*

[65] *While there is no single solution to reducing falls, an essential first step is to assess each individual's risk of falling, and acting accordingly.*

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

Acute/Urgent Services These are medical or surgical services for illnesses that have an abrupt onset or progress rapidly (they may or may not lead to hospital admission). Services include accident and emergency responses, short-stay observation, acute care packages, acute medical and surgical treatment and intensive care services.	Notes	2014/15 Result	2016/17 Target	2014/15 National Average
% of children under thirteen with access to free primary care after hours	A [67]	new	100%	-
% of general practices providing telephone triage outside business hours	A	92%	95%	-
Acute demand packages of care provided in community settings	A Δ [68]	31,182	>28,000	-
Attendances at Canterbury Emergency Departments	A [69]	91,253	E. <96k	-
% of people waiting less than 4 weeks for radiotherapy or chemotherapy	T ◇ [70]	100%	100%	-
% of patients (referred with a high suspicion of cancer and a need to be seen within two weeks) who receive their first treatment within 62 days of referral.	T ◇ [71]	73%	90%	68%
Acute inpatient average length of hospital stay (standardised)	Q [72]	2.40	<2.35	2.60

Elective/Arranged Services These are services for people who do not need immediate hospital treatment and are 'booked' or 'arranged' services. They include elective surgery, but also non-surgical interventions (such as coronary angioplasty) and specialist assessments (either first assessments, follow-ups or preadmission assessments).	Notes	2014/15 Result	2016/17 Target	2014/15 National Average
First Specialist Assessments provided (medical and surgical)	A [73]	69,199	E.>60k	-
% of First Specialist Assessments that were non-contact (virtual)	Q [74]	15.6%	>10%	-
Elective/arranged surgical discharges (surgeries provided)	A ◇ [75]	20,353	20,982	-
% of elective/arranged surgeries provided as day cases	Q [76]	58%	≥57%	-
% of people who receive their surgery on the day of admission	Q [76]	91%	≥90%	-
Elective inpatient average length of hospital stay (standardised)	Q [72]	1.57	<1.55	1.64
Outpatient attendances	V [77]	639,232	E.>600k	-
Outpatient 'Did not Attend' rates (total population)	Q [78]	5.4%	<5%	-
Outpatient 'Did not Attend' rates (Māori)	Q	10.7%	<5%	-

[67] This measure was previously related to children under six — Canterbury consistently achieved 100% against this measure.

[68] Acute demand packages support people to be treated in their own homes or community (rather than in hospital) and are provided through Canterbury's Acute Demand Management Service. Results differ to those previously published due to the inclusion of late invoices.

[69] This measure relates to the national shorter stays in ED health target and counts presentations to Christchurch and Ashburton Hospitals. The baseline differs to that previously published due to a change in the national definition for this measure.

[70] This measure is a national performance measure (PP30) and refers to all people 'ready for treatment' excluding Category D patients, whose treatment is scheduled with other treatments or part of a trial.

[71] This measure is the national Faster Cancer Track Health Target which was introduced in Q2 of 2014/15.

[72] This measure is a national performance measure (OS3). When seeking to reduce average length of hospital stay performance should be balanced against readmissions rates to ensure earlier discharge is appropriate and service quality remains high. The baseline differs to that previously published due to a change in the national definition for this measure – day stays are now included in the count.

[73] This measure counts both medical and surgical assessments but counts only the first assessments (where treatment is determined) and not the follow-up assessments or consultations after treatment has occurred. The FSA results differ slightly from those previously published (70,151 and 15.4%) due to alignment of service codes as the DHB moves to the new South Island Patient Information Care System (PICS).

[74] Non-contact FSAs are those where specialist advice and assessment is provided without the need (or the wait) for a hospital appointment.

[75] This measure is the national electives health target. The baseline differs to that previously published due to a change in the definition – this now includes inpatient surgical discharges, from both surgical and non-surgical speciality and both 'elective' and 'arranged' admissions.

[76] When elective surgery is delivered as a day case or on the day of admission, it makes surgery less disruptive for patients, who can spend the night before in their own home.

[77] The outpatient baselines differ slightly from those previously published due to alignment of definitions and service codes as the DHB moves to the new South Island Patient Information Care System (PICS). This adjustment has similarly impacted on outpatient DNA rates.

[78] The DNA rate is calculated as the proportion of all outpatient appointments where the patient was expected to attend but did not. Reducing these rates in an important factor in ensuring patients get the treatment they needs as early as possible but also reduces the waste of resource when a patient does not turn up for an appointment.

Specialist Mental Health Services These are services for those most severely affected by mental illness or addictions. They include assessment, diagnosis, treatment, rehabilitation and crisis response when needed. Utilisation and wait times are monitored to ensure service levels are maintained and to demonstrate the systems responsiveness to people's need.	Notes	2014/15 Result	2016/17 Target	2014/15 National Average
% of young people (0-19) accessing specialist mental health services	C Δ[79]	3.5%	>3.1%	3.5%
% of adults (20-64) accessing to specialist mental health services	C Δ	3.2%	>3.1%	3.8%
% of people referred for non-urgent MH and AOD services seen within 3 weeks	T [80]	73%	80%	80%
% of people referred for non-urgent MH and AOD services seen within 8 weeks	T	90%	95%	93%

Assessment, Treatment and Rehabilitation Services (AT&R) These are services provided to restore functional ability and enable people to live as independently as possible. Services are delivered in specialist inpatient units and outpatient clinics. An increase in the proportion of older people discharged home, rather than into residential care or hospital environments reflects a successful outcome for the patient and the service.	Notes	2014/15 Result	2016/17 Target	2014/15 National Average
Admissions into inpatient all AT&R services	A Δ [81]	3,462	E.>3,000	-
% of admissions into OPH AT&R made by direct community referral	Q [82]	21%	20%	-
% of OPH AT&R inpatients discharged to their own home rather than into ARC	Q Δ [83]	87%	>80%	-

[79] This measure is a national performance measure (PP6) and standards are set based on the expectation that 3% of the population will need access to specialist level mental health services. Results reflect only those services reporting through to the national PRIMHD database and may undercount service provision - with a number of local providers not currently set up to report to the national system.

[80] This measure is a national performance measure (PP8). Results are provided three months in arrears to March 2015 and the national average differs 1% to that previously published due to rounding.

[81] This result differs slightly to that previously published (3,450) due to the inclusion of 12 late invoices.

[82] This is a subset of the total AT&R services and relates to aged related AT&R services provided by the Older Person's Health Division of the DHB at Princess Margaret Hospital (soon to transfer to Burwood Hospital).

[83] A discharge from AT&R to home (rather than ARC) reflects the quality of AT&R and community support services in terms of assisting that person to regain their functional independence so that, with appropriate community supports, the person is able to safely 'age in place'.

OUTPUT CLASS

7.4 Rehabilitation and support services

Rehabilitation and support services provide people with the assistance they need to maintain or regain maximum functional independence often after illness or disability. These services are delivered after a clinical assessment of people's needs and include: domestic support, personal care, community nursing, respite and residential care. Services are primarily for older people, mental health clients and people with complex conditions.

WHY IS THIS OUTPUT CLASS SIGNIFICANT?

Services that support people to live safely and independently in their own homes are considered to provide a much higher quality of life, as a result of them staying active and positively connected to their communities. This is evident by less dependence on hospital and residential services and a reduction in acute illness, crisis or deterioration leading to acute admission or readmission into hospital services.

Even when returning to full health is not possible, timely access to assessment, advice and support enables people to maximise their function and independence. In preventing deterioration and crisis, these services have a major impact on the sustainability of the health system by reducing acute demand, avoidable hospital admissions and the need for more complex intervention. These services also support the flow of patients by enabling them to go home earlier and improve recovery after an acute illness or hospital admission – helping to reduce readmission rates.

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

HOW WILL WE DEMONSTRATE OUR SUCCESS?

Rehabilitation Services These services restore or maximise people's health or functional ability following a health-related event and success is often measured through increased referral to appropriate services following an acute event such as a heart attack or stroke.	Notes	2014/15 Result	2016/17 Target	2014/15 National Average
% of people accessing cardiac rehabilitation services after an acute event	Q [84]	15%	30%	-
% of people referred to an organised stroke service (with demonstrated stroke pathway) after an acute event	Q	80%	80%	-
People accessing pulmonary rehabilitation courses	A [85]	222	>200	-
People (65+) accessing community-based falls prevention programmes	A	1,686	>1,500	-

Home and Community-Based Support Services These are services designed to support people to continue living in their own homes and to restore functional independence. An increase in the number of people being supported is indicative of the capacity in the system, and success is determined as more people are supported to live longer in their own homes.	Notes	2014/15 Result	2016/17 Target	2014/15 National Average
% of older people (65+) receiving long-term home and community support services who have had a clinical assessment of need using the InterRAI assessment tool	Q Δ [86]	94%	95%	-
People accessing CREST services, on hospital discharge or GP referral	A Δ [87]	1,770	>1,500	-
People supported by district nursing services	A Δ	7,765	E.>7,000	-
People supported by long-term home-based support services	A Δ	8,641	E.<8,000	-

[84] *This measure counts those accessing Phase 2 (outpatient) cardiac rehabilitation on discharge.*

[85] *This measure includes people attending DHB funded pulmonary rehabilitation programmes (Ashburton, Christchurch, community-based).*

[86] *InterRAI is an evidence based geriatric assessment tool the use of which ensures assessments are high quality and consistent and that people receive appropriate and equitable access to support and care.*

[87] *The CREST service provides a range of home-based rehabilitation services to facilitate early discharge from hospital or avoid admission entirely via pro-active GP referral. The measure is the number of clients having received unique packages of care.*

Respite and Day Services These services provide people with a break from a routine or regimented programme so that crisis can be averted or so that a specific health need can be addressed. Services are provided by specialised organisations and are usually short-term or temporary in nature. Access to services are expected to increase over time, as more people are supported to remain in their own homes.	Notes	2014/15 Result	2016/17 Target	2014/15 National Average
People supported by day services	A Δ	832	E.>750	-
People accessing mental health planned and crisis respite	A Δ	935	E.>850	-
Occupancy rate of mental health planned and crisis respite beds	A Δ[88]	76%	85%	-
People supported with aged care respite services	A Δ	1,424	E.>1,200	-

Palliative Care Services These are services that improve the quality of life for patients facing end of life and their families, through the prevention and relief of suffering, treatment of pain and other supports. Services are demand driven.	Notes	2014/15 Result	2016/17 Target	2014/15 National Average
People supported by hospice or home-based palliative services	A Δ	3,934	E.>3,000	-

Residential Care Services These services are provided to meet the needs of a person who has been assessed as requiring long-term residential care in a hospital or rest home indefinitely. With an ageing population, a decrease in the number of subsidised bed days for lower-level aged residential care (ARC) is seen as indicative of more people being successfully supported to continue living in their own homes and is balanced against an increase in the level of home and community-based support.	Notes	2014/15 Result	2016/17 Target	2014/15 National Average
% of people entering ARC having had a clinical assessment using the InterRAI tool	Q Δ[86]	99%	95%	-
Subsidised ARC rest home beds provided (days)	A Δ [89]	528,795	E.<620k	-
Subsidised ARC hospital beds provided (days)	A Δ	471,724	E.<510k	-
Subsidised ARC dementia beds provided (days)	A Δ	231,066	E.>220k	-
Subsidised ARC psycho-geriatric beds provided (days)	A Δ	67,833	E.>65k	-

[88] Occupancy rates provide an indication of a service's 'capacity'. The aim is to maintain enough beds to meet demand requirements (with some space to flex) but not too many to imply that resources are underutilised and could be better directed to other areas. The 2014/15 baseline differs to that previously published reflecting 3 additional beds contacted mid-way through the year - there are 26 beds in total.

[89] Baselines for the ARC bed day have been revised to reflect improved data recording and calculations around start and end dates of stay.

Meeting Our Financial Challenges

8.1 Canterbury's financial outlook

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

While health continues to receive a large share of national funding, clear signals have been given that the health sector must rethink how it will meet the needs of the population with a more moderate growth platform. The Minister of Health has made it clear that DHBs are expected to operate within existing resources and approved financial budgets.

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

However, unlike other DHBs, we are also having to manage the extraordinary impacts of the country's largest natural disaster including: population funding shifts, increased service demand and the operational challenges of a significant repair programme.

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

In the past six years, we have been able to absorb $89 million in revenue and cost impacts related to the earthquakes, over and above the $100.4 million revenue deficit and $12.5 million equity deficit funding received from the Government over the same period.

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

However is becoming increasingly challenging to meet financial expectations, while we continue to address the needs of a more vulnerable population and at the same time rebuild almost all of our infrastructure.

UNAVOIDABLE COSTS

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

A significant proportion of our repair work is not covered by our insurance proceeds. While we received the maximum $320 million insurance pay-out under our collective sector policy, damage estimates were over $518 million. Our recovery programme will require ruthless prioritisation in order for it to remain affordable as we navigate the uncertainties of escalating repair costs.

The Burwood Hospital redevelopment was behind schedule and we are yet to see savings from the consolidation of services anticipated in the detailed business case. Our theatre and bed capacity is reduced and until our new facilities are completed we will have to carry significant additional costs for hiring theatres and outsourcing surgeries.

Included in the unplanned costs related to the earthquakes are the interest, depreciation and capital charges the DHB must pay to the Crown. Because these are driven off upward movements in asset valuations the repair work (on top of planned redevelopment) results in significant annual charges. In 2016/17 Canterbury will pay an estimated $22.6 million in interest and capital charges to the Crown, adding additional pressure to our already tight fiscal environment.

Demand patterns also continue to change. In line with other international recovery profiles, the post-disaster impacts on the health and well-being of our population are being acutely felt. This is particularly evident in the increased demand for mental health services with new presentations to children's services especially high. International evidence would suggest we can expect continued population impacts for up to a decade.

Our situation is further exacerbated by the interplay between local population fluctuations and the national population based funding mechanism.

The funding formula was never designed to deal with the kind of dynamic population shifts and demand changes we are experiencing. From Canterbury's perspective, the funding formula has the wrong inputs and is not proving to be a flexible or sensitive enough mechanism in a post-quake environment.

8.2 Planned results

In 2016/17 the Canterbury DHB will receive $1.654 billion in revenue with which to meet the needs of our population, including $1.303 billion (10.85%) of the population based funding and subsequent new funding provided by the Ministry of Health.

This $1.303 billion population based funding represents a net 1.7% increase on the previous year. Whilst this equates to a net $21.6 million increase in funding, this reflects the minimum percentage funding increase available to DHBs in 2016/17 and was lower than anticipated by the Canterbury DHB. The 2016/17 increase of $21.6m subsumes the additional $16m deficit funding received in 2015/16 leaving a net

increase of just over $5m which is free to be applied against in the coming year.

The DHB was separately funded ($4 million) for the provision of services to the population of the Chatham Islands in the previous year and designed to be cost neutral to the DHB. For the 2016/17 year, this $4 million funding is part of the $1.303 billion population based funding received by the DHB and the net 1.7% increase takes into account this funding switch.

The Canterbury DHB is predicting a $38.5 million deficit result for the 2016/17 year.

The $38.5 million forecast deficit for 2016/17 takes into account the net effect of the Canterbury DHB's share of the subsequent 'demographic and cost pressures' and 'pharmaceutical investment' funding provided to all DHBs by the Ministry of Health.

In addition, further to the funding for 2016/17, acknowledging the increased demand for mental health services following the earthquakes, the Government will provide an extra $5.5 million per annum for a fixed three year period to increase mental health support for people in Canterbury.

This additional funding will allow us to further respond to changing mental health demand patterns by investing in a range of targeted initiatives and boosting services where demand is highest. We will be able to invest further in extra primary care and community based mental health workers and confirm funding for community and workforce wellbeing programmes where resources are strained.

While this package does not address all of Canterbury's earthquake related challenges, it does acknowledge the sustained pressure on our mental health services, and the additional load being put on all those who work in these services. This $5.5 million per annum will make an important contribution to our health system over the next three years and will help us to improve access to a range of services.

OUT-YEARS SCENARIO

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

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

The bulk of our earthquake insurance proceeds are now held by the Crown on behalf of the DHB. We are able to draw down these proceeds as revenue to offset earthquake operating repair costs and as equity to offset capitalised repair costs. But equity drawdowns incur a capital charge in addition to the operational impact of depreciation.

Interest, depreciation and capital charge costs arising from the earthquake repair programme, assets revaluation and the new Burwood and Christchurch Hospital facilities will have a significant impact on our out-year financials. These costs will increase by approximately $78 million (from $69 million per annum in 2015/16 to approximately $147 million in 2019/20).

Whilst independent cost assessments have been received for a number of earthquake repair projects, the final interplay between the nature of repairs, new building codes and construction cost escalation is dynamic. Estimates of the anticipated costs have been included but an accurate total overall cost is still difficult to pre-determine.

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

8.3 Major assumptions

Revenue and expenditure estimates for out-years have been based on current government policy settings, services delivery models and demand patterns. Changes in the complex mix of any of the contributing factors will impact on our results.

In preparing our financial forecasts, we have made the following assumptions:

- Out-years funding is assumed at the Treasury's mid-scenario forecasts for Canterbury DHB.
- The DHB will retain early payment arrangements.
- The DHB will receive deficit funding equivalent to forecast operating deficits.
- Capital charge for out-years is based on the existing rate of 7%, any rate change in the future is assumed to be financially neutral to the DHB.
- Any targeted funding to meet additional mental health service provision will be sustainable over the longer-term.
- Costs of compliance with any new national expectations will be cost neutral or fully funded, as will any legislative changes, sector reorganisation or service devolvement. This includes assumption of responsibility for the population of the Chatham Islands which was to be cost neutral.
- $290 million, being the balance of Canterbury's $320 million earthquake settlement proceeds (transferred to the Crown to minimise capital charge expenses) will be available to the DHB to be drawn down as required to fund the DHB's earthquake repair and reinstatement programme.

- As agreed with the Ministry of Health, the revenue and equity mix of the draw down will be flexible and based on DHB requests rather than necessarily matching the earthquake capital and operating repair spend for a particular year.
- Work will continue on the redevelopment of Canterbury facilities in accordance with the detailed business case agreed with the Ministry and Cabinet. Capital expenditure associated with the redevelopment that will take place during the term of this Plan has been included.
- Revaluations of land and buildings will continue and will impact on asset values. In addition to regular periodic revaluations, further impairment in relation to earthquakes may be necessary.
- Employee cost increases for expired wage agreements will be settled on fiscally sustainable terms, inclusive of step increases and the impact of accumulated leave revaluation. External provider increases will also be settled within available funding levels.
- Treatment related costs will increase in line with known inflation factors, reasonable price charge impacts on providers and foreseen adjustments for the impact of growth within services.
- National and regional savings initiatives and benefits will be achieved as planned.
- Transformation strategies will not be delayed or derailed due to sector or legislative changes and investment to meet increased earthquake related demand will be prioritised and approved, in line with the Board's strategy.
- There will be no further disruptions associated with natural disasters or pandemics. Revenue and expenditure have been budgeted on current and expected operations with no disaster.

8.4 Bridging the gap

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

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

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

Alongside the effective transformation of our health system we are also focused on delivering efficiency and quality improvements to take the wait and waste out of our system.

In the coming year, we will consider all options and opportunities to bridge the gap between revenue and expenditure including:

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

Anticipated service changes already identified for 2016/17 are outlined under Service Reconfiguration (section 5.13).

NATIONAL SUPPORT

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

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

8.5 Capital investment

NATIONAL BUSINESS CASES

The detailed business case for the redevelopment of Burwood and Christchurch Hospital sites was approved by Cabinet and the Capital Investment Committee in March 2013. The timelines for completion of the Burwood redevelopment was extended from 2015 to 2016. The Acute Services Building on the Christchurch Hospital campus is scheduled for completion in 2018.

The business case and detailed implementation plan for replacement of our legacy patient administration systems with one South Island Patient Information Care System (PICS) was approved by Cabinet in 2014. Burwood was the first go-live site and we are currently progressing with the staged implementation in alignment with the new facility timeframe.

The DHB is also currently developing an indicative business case for the relocation of mental health services currently on the Princess Margaret Hospital site. These services were originally destined to be migrated to Christchurch Hospital, as part of that earlier detailed business case.

CAPITAL EXPENDITURE

Subject to the appropriate approvals, Canterbury's capital expenditure budget totals $281 million for the 2016/17 year, and is comprised of:

- $215 million new Burwood facility (cost of asset to be transferred from the Crown to the DHB).
- $14 million strategic earthquake programme of works (capital expenditure portion).
- $4 million Patient Information Care System.
- $2 million Electronic Medication Management.
- $40 million other new/replacement assets.
- $3 million replacement Linear Accelerator.
- $3 million replacement national finance system implementation.

Anticipated investment for 2017-2019 includes:

- Strategic information technology developments, including implementation of PICS, roll-out of e-Medicines, HealthOne and the patient portal and investment in moving towards a digital hospital.
- Completion of the facilities redevelopment on the Christchurch Hospital site (Acute Services Building) in line with the approved detailed business case.
- Repair and reinstatement of the Christchurch Hospital Energy Centre, Carpark, Tunnel and Outpatient Building.
- Completion of the Rangiora and Akaroa IFHC redevelopments in line with approvals.
- Continued repair and reinstatement of assets under the DHB's 10 year earthquake repair programme of works.
- Relocation of mental health services currently sited on the Princess Margaret Hospital site.

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

8.6 Debt and equity

The Canterbury DHB has total loans of $146 million with the Ministry of Health.

The DHB's total term debt as at June 2016 was $146 million rising to $231 million in August 2016, with the $85 million new loan for the new Burwood facility.

In February 2017, all existing DHB debts will be converted to equity as part of the Crown's debt/equity translation process. In addition, the pre-approved debt for the new Acute Services Building will also be translated to equity (i.e. effectively from February 2017 there will be no debt). Any cost differential between increased capital charge and reduced interest expense, arising from the debt/equity conversion, will be adjusted for in the funding (i.e. neutral impact to the DHB's operating result).

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

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

In June 2014 we paid $290 million of our earthquake settlement proceeds to the Crown to minimise capital charge expenses. As agreed with the Ministry of Health, the $290 million will be progressively drawn down to fund future earthquake repair work. As at 30 June 2016 we have drawn down $76 million, leaving a balance of $214 million yet to be drawn as either revenue or equity depending on the type of repairs.

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

Taking into account the equity movements over the next four years (earthquake proceeds redrawn as equity, debt to equity conversion, equity for the Acute Services Building and deficit funding), the Crown's equity in the DHB will rise from $199.9 million as at June 2016 to $1.14 billion by June 2020.

8.7 Additional considerations

DISPOSAL OF LAND

Due process will be undertaken with regard to the sale of any DHB land. Normal policy is that DHBs 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.

Anticipated activity for 2016-2019 includes:

- Sale of two parcels of land on Tuam Street to accommodate a bus super stop.
- Sale of a parcel of land on Antigua Street to accommodate development of a health research and education facility within the Health Precinct.

We are considering the future use of the former Christchurch Women's Hospital in the central city and the Princess Margaret Hospital in Cashmere. The future use of these sites will be determined following completion of the Acute Services Building and Outpatients Building and the decanting of services from the Princess Margaret Hospital.

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

We are also in discussions with Otakaro (formerly CERA) and the Christchurch City Council regarding a number of sites in the area adjacent to the Metro Sports Facility and Health Precinct sites in the city centre.

ACTIVITIES FOR WHICH COMPENSATION IS SOUGHT

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

ACQUISITION OF SHARES

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

ACCOUNTING POLICIES

The accounting policies adopted are consistent with those in the prior year. For a full statement of accounting policies, refer to Appendix 10.13.

Statement of Financial Expectations

Where will our funding go?

9.1 Group statement of comprehensive revenue and expense

For the years ending 2014/15 to 2019/20

In thousands of New Zealand dollars

	2014/15 Actual $'000	2015/16 Actual $'000	2016/17 Plan $'000	2017/18 Plan $'000	2018/19 Plan $'000	2019/20 Plan $'000
Revenue						
Patient care revenue	1,512,862	1,558,555	1,609,364	1,669,818	1,721,123	1,766,460
Other revenue	27,379	35,216	28,840	30,173	31,512	42,775
Earthquake repair revenue redrawn	13,150	9,882	12,600	15,400	19,300	7,700
Interest revenue	5,260	2,463	2,891	3,424	4,081	4,677
Total Revenue	1,558,651	1,606,116	1,653,695	1,718,815	1,776,016	1,821,612
Expense						
Employee benefit costs	659,665	693,369	717,621	739,797	762,956	788,644
Treatment related costs	144,564	142,198	149,352	153,145	157,293	162,767
External service providers	583,038	606,747	629,034	638,475	646,751	650,994
Depreciation and amortisation	61,135	57,740	59,151	62,220	67,740	69,090
Finance costs	5,886	5,575	4,400	-	-	-
Other expenses	96,303	101,728	101,802	104,806	105,871	105,094
Earthquake building repair costs	13,150	9,882	12,600	15,400	19,300	7,700
Capital charge expense	12,846	5,726	18,231	39,962	49,086	78,318
Total Operating Expenses	1,576,587	1,622,965	1,692,191	1,753,805	1,808,997	1,862,607
Surplus/(Deficit) before deficit funding	(17,936)	(16,849)	(38,496)	(34,990)	(32,981)	(40,995)
Deficit funding revenue	-	16,376	-	-	-	-
Surplus/(Deficit) after deficit funding	**(17,936)**	**(473)**	**(38,496)**	**(34,990)**	**(32,981)**	**(40,995)**
Other comprehensive revenue and expense	(62)	91,753	(0)	(0)	(0)	(0)
Total Comprehensive Revenue and Expense	**(17,998)**	**91,280**	**(38,496)**	**(34,990)**	**(32,981)**	**(40,995)**

Note 1: The 2016/17 forecast net result reflects the PWC financial report. Out-year forecasts are notional and subject to confirmation of 2017/18 funding advice, general assumptions and other outstanding matters under discussion.

9.2 Group statement of financial position

As at 30 June for the years ending 2014/15 to 2019/20

In thousands of New Zealand dollars

	30/06/15 Actual $'000	30/06/16 Actual $'000	30/06/17 Plan $'000	30/06/18 Plan $'000	30/06/19 Plan $'000	30/06/20 Plan $'000
CROWN EQUITY						
Contributed capital (Note 2)	(313,790)	(282,151)	131,468	173,597	741,717	806,851
Revaluation reserve	199,096	290,849	290,850	290,850	290,850	290,850
Accumulated surpluses	191,708	191,235	152,739	117,749	84,768	43,773
TOTAL EQUITY	**77,014**	**199,933**	**575,057**	**582,196**	**1,117,335**	**1,141,474**
REPRESENTED BY:						
CURRENT ASSETS						
Cash & cash equivalents	3,640	13,546	(11,505)	20,372	56,000	54,211
Trade & other receivables	56,827	69,349	107,846	104,340	102,331	110,345
Inventories	8,593	9,432	9,432	9,432	9,432	9,432
Restricted assets	13,769	8,060	8,060	8,060	8,060	8,060
Assets held for sale	-	540	540	540	540	540
Investments	400	1,000	1,000	1,000	1,000	1,000
TOTAL CURRENT ASSETS	83,229	101,927	115,373	143,744	177,363	183,588
CURRENT LIABILITIES						
NZHPL sweep bank account	9,278	-	-	-	-	-
Trade & other payables	83,554	100,886	106,887	106,887	106,887	106,887
Employee benefits	160,732	154,321	154,321	154,321	154,321	154,321
Restricted funds	14,049	14,297	14,297	14,297	14,297	14,297
TOTAL CURRENT LIABILITIES	267,613	269,504	275,505	275,505	275,505	275,505
NET WORKING CAPITAL	(184,384)	(167,577)	(160,132)	(131,761)	(98,142)	(91,917)
NON CURRENT ASSETS						
Property, plant, & equipment	401,277	499,233	711,063	679,067	1,177,906	1,191,156
Intangible assets	12,284	14,386	24,250	35,014	37,695	42,359
Restricted assets	280	6,237	6,237	6,237	6,237	6,237
TOTAL NON CURRENT ASSETS	413,841	519,856	741,550	720,318	1,221,838	1,239,752
NON CURRENT LIABILITIES						
Employee benefits	6,458	6,361	6,361	6,361	6,361	6,361
Borrowings (Note 2)	145,985	145,985	-	-	-	-
TOTAL NON CURRENT LIABILITIES	152,443	152,346	6,361	6,361	6,361	6,361
NET ASSETS	**77,014**	**199,933**	**575,057**	**582,196**	**1,117,335**	**1,141,474**

Note 2: Effective 15 February 2017, all existing borrowings from the Crown will be translated to equity. The total borrowings as at 15 February 2017 were $230.985M (being $145.985M as at June 2016 plus $85.0M new debt associated with the new Burwood hospital facility transferred from the Crown to the DHB in August 2016). In out-years, the preapproved debt funding for the new Acute Services Building (ASB) will also be converted to equity. It is assumed that any difference between capital charge and interest expense arising from the debt to equity swap will result in a corresponding funding adjustment i.e. financially neutral to the DHB.

9.3 Group statement of movements in equity

For the years ending 2014/15 to 2019/20

In thousands of New Zealand dollars

	2014/15 Actual $'000	2015/16 Actual $'000	2016/17 Plan $'000	2017/18 Plan $'000	2018/19 Plan $'000	2019/20 Plan $'000
Total equity at beginning of the year	204,373	77,014	199,933	575,057	582,196	1,117,335
Total comprehensive revenue and expense for the year	(17,998)	91,280	(38,496)	(34,990)	(32,981)	(40,995)
Other Movements						
Equity Repayments						
Contribution towards new facilities redevelopment	(120,000)	-	-	-	-	-
Assets disposal net proceeds remitted to Crown	-	-	-	-	-	(20,000)
Annual depreciation funding repayment	(1,861)	(1,861)	(1,861)	(1,861)	(1,861)	(1,861)
Equity Injections						
Earthquake repair capital redrawn	-	33,500	16,000	9,000	56,000	46,000
Operating deficit support	12,500	-	38,496	34,990	32,981	40,995
New facilities redevelopment assets transferred from the Crown (original equity value)	-	-	130,000	-	256,400	-
Debt to Equity Swap - New facilities redevelopment assets related (Note 3)	-	-	85,000	-	224,600	-
Debt to Equity Swap - debt as at June 2016	-	-	145,985	-	-	-
Total Equity at End of the Year	**77,014**	**199,933**	**575,057**	**582,196**	**1,117,335**	**1,141,474**

Note 3: The 2018/19 debt figure is an indicative amount provided by Ministry of Health and subject to further discussion between the DHB and the Ministry.

9.4 Group statement of cash flow

For the years ending 2014/15 to 2019/20

In thousands of New Zealand dollars

	2014/15 Actual $'000	2015/16 Actual $'000	2016/17 Plan $'000	2017/18 Plan $'000	2018/19 Plan $'000	2019/20 Plan $'000
CASH FLOW FROM OPERATING ACTIVITIES						
Cash provided from:						
Receipts from Ministry of Health	1,468,333	1,554,809	1,550,765	1,609,347	1,658,849	1,702,330
Earthquake repair revenue redrawn	12,300	9,882	12,600	15,400	19,300	7,700
Other receipts	104,369	30,316	87,439	90,644	93,786	97,005
Interest received	5,260	2,463	2,891	3,424	4,081	4,677
	1,590,262	1,597,470	1,653,695	1,718,815	1,776,016	1,811,712
Cash applied to:						
Payments to employees	657,120	699,786	717,621	739,797	762,956	788,644
Payments to suppliers	862,298	844,786	886,788	911,826	929,215	926,555
Interest paid	5,907	4,910	4,400	-	-	-
Capital charge	12,845	5,726	18,231	39,962	49,086	78,318
GST - net	5,137	639	-	-	-	-
	1,543,307	1,555,847	1,627,040	1,691,585	1,741,257	1,793,517
Net Cash Flow from Operating Activities	**46,955**	**41,623**	**26,655**	**27,230**	**34,759**	**18,195**
CASH FLOW FROM INVESTING ACTIVITIES						
Cash provided from:						
Sale of property, plant, & equipment	10	(22)	-	-	-	20,000
Receipt from investments and restricted assets	50,998	14,148	-	-	-	-
	51,008	14,126	-	-	-	20,000
Cash applied to:						
Purchase of investments & restricted assets	14,657	13,775	-	-	-	-
Purchase of property, plant, & equipment	57,127	66,929	280,845	40,988	569,260	97,104
	71,784	80,704	280,845	40,988	569,260	97,104
Net Cash Flow from Investing Activities	**(20,776)**	**(66,578)**	**(280,845)**	**(40,988)**	**(569,260)**	**(77,104)**
CASH FLOW FROM FINANCING ACTIVITIES						
Cash provided from:						
Loans raised	15,000	-	85,000	-	-	-
Equity Injections						
Earthquake repair capital redrawn	-	33,500	16,000	9,000	56,000	46,000
Operating deficit support	-	12,500	-	38,496	34,990	32,981
Equity value of redeveloped Burwood and ASB facilities transferred from the Crown	-	-	130,000	-	481,000	-
Debt to Equity Swap(Note 4)	-	-	230,985	-	-	-
	15,000	46,000	461,985	47,496	571,990	78,981
Cash applied to:						
Loans repaid (Note 4)	15,000	-	230,985	-	-	-
Contribution towards Burwood and Christchurch facilities redevelopment	120,000	-	-	-	-	-
Asset disposal proceeds remitted to Crown	-	-	-	-	-	20,000
Annual depreciation funding repayment	1,861	1,861	1,861	1,861	1,861	1,861
	136,861	1,861	232,846	1,861	1,861	21,861
Net Cash Flow from Financing Activities	**(121,861)**	**44,139**	**229,139**	**45,635**	**570,129**	**57,120**
Net increase/(decrease) in cash and cash equivalents	(95,682)	19,184	(25,051)	31,877	35,628	(1,789)
Cash and cash equivalents at beginning of year	90,044	(5,638)	13,546	(11,505)	20,372	56,000
CASH & CASH EQUIVALENTS AT END OF YEAR	**(5,638)**	**13,546**	**(11,505)**	**20,372**	**56,000**	**54,211**

Note 4: 2016/17 amounts relate to translation of debt to equity and shown separately for transparency only.

9.5 Summary of revenue and expenses by arm

Forecast Operating Statement Years ending 2014/15 to 2019/20

In thousands of New Zealand dollars

	2014/15 Actual $'000	2015/16 Actual $'000	2016/17 Plan $'000	2017/18 Plan $'000	2018/19 Plan $'000	2019/20 Plan $'000
Funding Arm						
Revenue						
Patient care revenue	1,411,650	1,461,831	1,495,908	1,552,820	1,600,765	1,642,713
Other revenue	250	1,417	-	-	-	-
Total Revenue	1,411,900	1,463,248	1,495,908	1,552,820	1,600,765	1,642,713
Expense						
Personal Health	1,020,903	1,061,537	1,095,179	1,133,662	1,172,986	1,210,051
Mental Health	144,415	146,326	151,721	157,273	162,949	162,684
Disability Support	239,661	243,760	248,470	253,839	259,307	264,644
Public Health	2,484	3,506	4,121	4,190	4,258	4,326
Maori Health	2,041	2,210	2,029	2,059	2,091	2,123
Total Operating Expenses	1,409,504	1,457,339	1,501,520	1,551,023	1,601,591	1,643,828
Surplus/(Deficit) before deficit funding	2,396	5,909	(5,612)	1,797	(826)	(1,115)
Deficit funding revenue	-	16,376	-	-	-	-
Surplus/(Deficit) after deficit funding	**2,396**	**22,285**	**(5,612)**	**1,797**	**(826)**	**(1,115)**
Other comprehensive revenue and expense	-	-	-	-	-	-
Total Comprehensive Revenue & Expense	**2,396**	**22,285**	**(5,612)**	**1,797**	**(826)**	**(1,115)**
Governance & Funder Admin						
Revenue						
Patient care revenue	2,585	2,810	3,500	3,548	3,597	3,647
Other revenue	556	194	820	841	862	884
Total Revenue	3,141	3,004	4,320	4,389	4,459	4,531
Expense						
Employee benefit costs	7,136	8,214	8,736	8,902	9,075	9,348
Treatment related costs	763	1,305	1,632	1,632	1,632	1,632
Depreciation and amortisation	31	43	44	44	44	44
Interest expenses on loans	-	-	-	-	-	-
Other expenses	(4,789)	(5,522)	(6,092)	(6,189)	(6,292)	(6,493)
Capital charge expense	-	-	-	-	-	-
Total Operating Expenses	3,141	4,040	4,320	4,389	4,459	4,531
Surplus/(Deficit) before deficit funding	-	**(1,036)**	-	-	-	-
Deficit funding revenue	-	-	-	-	-	-
Surplus/(Deficit) after deficit funding	-	**(1,036)**	-	-	-	-
Other comprehensive revenue and expense	-	-	-	-	-	-
Total Comprehensive Revenue & Expense	-	**(1,036)**	-	-	-	-

9.5 Summary of revenue and expenses by arm—continued

Forecast Operating Statement Years ending 2014/15 to 2019/20

In thousands of New Zealand dollars

	2014/15 Actual $'000	2015/16 Actual $'000	2016/17 Plan $'000	2017/18 Plan $'000	2018/19 Plan $'000	2019/20 Plan $'000
Provider Arm						
Revenue						
Patient care revenue	925,093	944,506	982,442	1,025,998	1,071,601	1,112,934
Other revenue	26,573	33,605	28,020	29,332	30,650	41,891
Earthquake repair revenue redrawn	13,150	9,882	12,600	15,400	19,300	7,700
Interest revenue	5,260	2,463	2,891	3,424	4,081	4,677
Total Revenue	970,076	990,456	1,025,953	1,074,154	1,125,632	1,167,202
Expense						
Employee benefit costs	652,529	685,155	708,885	730,895	753,881	779,296
Treatment related costs	143,801	140,893	147,720	151,513	155,661	161,135
Depreciation and amortisation	61,104	57,697	59,107	62,176	67,696	69,046
Interest expenses on loans	5,886	5,575	4,400	-	-	-
Other expenses	101,092	107,250	107,894	110,995	112,163	111,587
Earthquake building repair costs	13,150	9,882	12,600	15,400	19,300	7,700
Capital charge expense	12,846	5,726	18,231	39,962	49,086	78,318
Total Operating Expenses	990,408	1,012,178	1,058,837	1,110,941	1,157,787	1,207,082
Surplus/(Deficit) before deficit funding	(20,332)	(21,722)	(32,884)	(36,787)	(32,155)	(39,880)
Deficit funding revenue	-	-	-	-	-	-
Surplus/(Deficit) after deficit funding	**(20,332)**	**(21,722)**	**(32,884)**	**(36,787)**	**(32,155)**	**(39,880)**
Other comprehensive revenue and expense	(62)	91,753	(0)	(0)	(0)	(0)
Total Comprehensive Revenue & Expense	**(20,394)**	**70,031**	**(32,884)**	**(36,787)**	**(32,155)**	**(39,880)**
In House Elimination						
Revenue						
Patient care revenue	(826,466)	(850,592)	(872,486)	(912,548)	(954,840)	(992,834)
Total Revenue	(826,466)	(850,592)	(872,486)	(912,548)	(954,840)	(992,834)
Expense						
Other expenses	(826,466)	(850,592)	(872,486)	(912,548)	(954,840)	(992,834)
Total Operating Expenses	(826,466)	(850,592)	(872,486)	(912,548)	(954,840)	(992,834)
Surplus/(Deficit) before deficit funding	-	-	-	-	-	-
Deficit funding revenue	-	-	-	-	-	-
Surplus/(Deficit) after deficit funding	-	-	-	-	-	-
Other comprehensive revenue and expense	-	-	-	-	-	-
Total Comprehensive Revenue & Expense	-	-	-	-	-	-

9.5 Summary of revenue and expenses by arm—continued

Forecast Operating Statement Years ending 2014/15 to 2019/20

In thousands of New Zealand dollars

	2014/15 Actual $'000	2015/16 Actual $'000	2016/17 Plan $'000	2017/18 Plan $'000	2018/19 Plan $'000	2019/20 Plan $'000
CONSOLIDATED						
Revenue						
Patient care revenue	1,512,862	1,558,555	1,609,364	1,669,818	1,721,123	1,766,460
Other revenue	27,379	35,216	28,840	30,173	31,512	42,775
Earthquake repair revenue redrawn	13,150	9,882	12,600	15,400	19,300	7,700
Interest revenue	5,260	2,463	2,891	3,424	4,081	4,677
Total Revenue	1,558,651	1,606,116	1,653,695	1,718,815	1,776,016	1,821,612
Expense						
Employee benefit costs	659,665	693,369	717,621	739,797	762,956	788,644
Treatment related costs	144,564	142,198	149,352	153,145	157,293	162,767
External service providers	583,038	606,747	629,034	638,475	646,751	650,994
Depreciation and amortisation	61,135	57,740	59,151	62,220	67,740	69,090
Finance costs	5,886	5,575	4,400	-	-	-
Other expenses	96,303	101,728	101,802	104,806	105,871	105,094
Earthquake building repair costs	13,150	9,882	12,600	15,400	19,300	7,700
Capital charge expense	12,846	5,726	18,231	39,962	49,086	78,318
Total Operating Expenses	1,576,587	1,622,965	1,692,191	1,753,805	1,808,997	1,862,607
Surplus/(Deficit) before deficit funding	(17,936)	(16,849)	(38,496)	(34,990)	(32,981)	(40,995)
Deficit funding revenue	-	16,376	-	-	-	-
Surplus/(Deficit) after deficit funding	**(17,936)**	**(473)**	**(38,496)**	**(34,990)**	**(32,981)**	**(40,995)**
Other comprehensive revenue and expense	(62)	91,753	(0)	(0)	(0)	(0)
Total Comprehensive Revenue & Expense	**(17,998)**	**91,280**	**(38,496)**	**(34,990)**	**(32,981)**	**(40,995)**

Part IV

Further Information for the Reader

Appendices

Appendix 10.1	Glossary of Terms
Appendix 10.2	Organisational and System Governance Structure
Appendix 10.3	Overview of Hospital and Specialist Services
Appendix 10.4	Legislative Objectives of a DHB: New Zealand Public Health and Disability Act (2000)
Appendix 10.5	Minister of Health's Letter of Expectations
Appendix 10.6	Canterbury's Commitment to National Health Targets
Appendix 10.7	NZ Health Strategy – Canterbury's Roadmap of Actions 2016/17
Appendix 10.8	Canterbury Clinical Network - Strategic Focus 2016/18
Appendix 10.9	Information Systems Overview
Appendix 10.10	Asset Performance Indicators
Appendix 10.11	Canterbury's Outcomes Framework
Appendix 10.12	DHB Performance Monitoring Framework 2016/17
Appendix 10.13	Statement of Accounting Policies

References

Unless specifically stated, all Canterbury DHB documents referenced in this document are available on the Canterbury DHB website www.cdhb.health.nz.

All referenced Ministry of Health documents are available on the Ministry's website www.health.govt.nz.

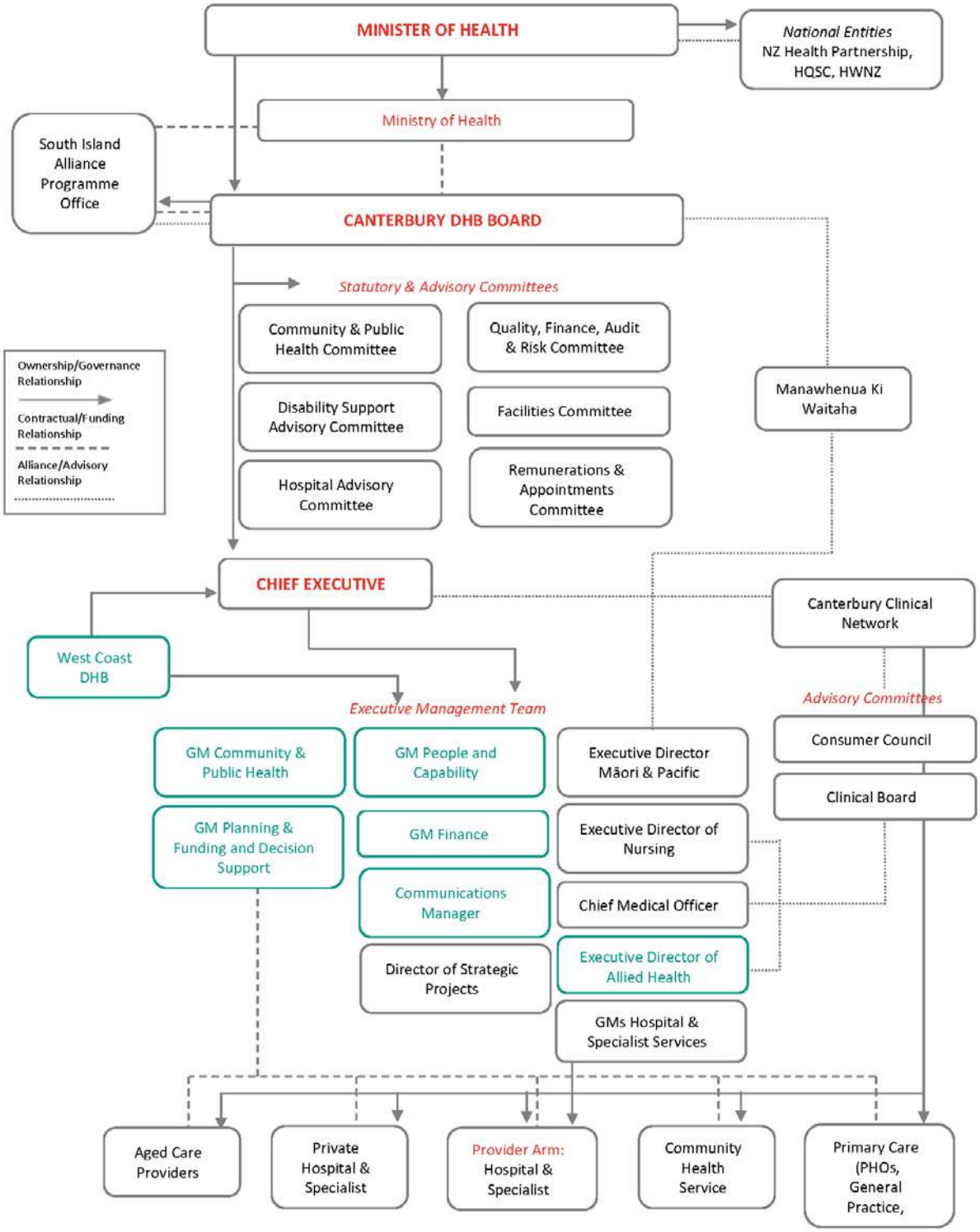
The Crown Entities Act 2004 and the Public Finance Act 1989, both referenced in this document, are available on the Treasury website www.treasury.govt.nz.

10.1 Glossary of terms

ACC	Accident Compensation Corporation	Crown Entity set up to provide comprehensive no-fault personal accident cover for New Zealanders.
	Acute Care	Management of conditions with sudden onset and rapid progression.
ADMS	Acute Demand Management Service	General Practice and acute community nursing deliver packages of care that allow people who would otherwise need an Emergency Department visit and possible hospital admission to be treated in their own homes or community.
ARC	Aged Residential Care	Residential care for older people, including rest home, hospital, dementia and psycho-geriatric care.
B4SC	B4 School Check	The final core WCTO check, which children receive at age four. The free check allows health concerns to be identified and addressed early in a child's development.
CCN	Canterbury Clinical Network District Alliance	An alliance of Canterbury health professionals whose initial focus is the implementation of the 'Better, Sooner, More Convenient' business case, which began in 2009.
	Capability	What an organisation needs (in terms of access to people, resources, systems, structures, culture and relationships), to efficiently deliver outputs.
CVD	Cardiovascular Disease	Diseases affecting the heart and circulatory system including: ischaemic heart disease, rheumatic heart disease, cerebrovascular disease and other forms of vascular and heart disease.
COPD	Chronic Obstructive Pulmonary Disease	A progressive disease process that most commonly results from smoking. Chronic obstructive pulmonary disease is characterised by difficulty breathing, wheezing and a chronic cough.
	Continuum of Care	Services matched to the patient's level of need throughout their illness or recovery.
	Crown Entity	A generic term for a range of government entities that are legally separate from the Crown and operate at arm's length from the responsible or shareholding Minister, but are included in the financial statements of the Government.
CFA	Crown Funding Agreement	An agreement by the Crown to provide funding in return for the provision of, or arranging the provision of, specified services.
CREST	Community Rehabilitation Enablement and Support Team	This team supports the frail elderly who would otherwise be re-admitted to hospital or residential care. CREST is a collaboration across primary and secondary services.
	Determinants of Health	The range of personal, social, economic and environmental factors that determine the health status of individuals or populations.
ERMS	Electronic Request Management System	A system developed in Canterbury enabling referrals to public hospitals and private providers to be sent and received electronically from the GP desktop.
eSCRV	Electronic Shared Care Record View	A secure system for sharing core health information (such as allergies, dispensed medications and test results) between the health professionals involved in a person's care, no matter where they are based. Now rebranded as HealthOne.
ESPIs	Elective Services Patient flow Indicators	A set of indicators developed by the Ministry to monitor how patients are managed while waiting for elective (non-urgent) services.
FSA	First Specialist Assessment	(Outpatients only) The first time a patient is seen by a doctor for a consultation in that speciality. This does not include procedures, nurse or diagnostic appointments or pre-admission visits.
HbA1c	Haemoglobin A1c	Also known as glycated haemoglobin, HbA1c reflects average blood glucose level over the past 3 months.
HCS	Health Connect South	Regional clinical information system, a single repository for clinical records across the South Island.
HEEADSSS		An HEEADSSS assessment is free and provided to Year 9 students to allow health concerns to be identified and addressed early. The assessment covers: Home, Education/Employment, Eating, Activities, Drugs, Sexuality, Suicide and Safety.
IDFs	Inter District Flows	Services (outputs) provided by a DHB to a patient whose place of residence is in another DHB's region. Under PBF, each DHB is funded on the basis of its resident population; therefore, the DHB providing the IDF will recover the costs of that IDF from the DHB who was funded for that patient.
InterRAI	International Resident Assessment Instrument	A comprehensive geriatric assessment tool.

	Intervention logic model	A framework for describing the relationships between resources, activities and results, which provides a common approach for planning, implementation and evaluation. Intervention logic focuses on being accountable for what matters: impacts and outcomes.
LMC	Lead Maternity Carer	The health professional a woman chooses to provide and coordinate the majority of her maternity care. Most LMCs are midwives, though GPs and obstetricians may also be LMCs.
	Morbidity	Illness, sickness.
	Mortality	Death.
NHI	National Health Index	An NHI number is a unique identifier assigned to every person who uses health and disability services in NZ.
NGO	Non-Government Organisations	In the context of the relationship between Health and Disability NGOs and the Canterbury DHB, NGOs include independent community and iwi/Māori organisations operating on a not-for-profit basis, which bring a value to society that is distinct from both government and the market.
OPF	Operational Policy Framework	An annual document endorsed by the Minister of Health that sets out the operational-level accountabilities all DHBs must comply with, given effect through the CFA between the Minister and the DHB.
	Outcome	A state or condition of society, the economy or the environment, including a change in that state or condition. Outcomes are the impacts on the community of the outputs or activities (e.g. a change in the health status of a population).
	Output Class	An aggregation of outputs of a similar nature.
	Outputs	Final goods and services delivered to a third party outside of the DHB. Not to be confused with goods and services produced entirely for consumption within the DHB (internal outputs or inputs).
PBF	Population-Based Funding	Involves using a formula to allocate each DHB a fair share of the available resources so that each Board has an equal opportunity to meet the health and disability needs of its population.
	Primary Care	Professional health care received in the community, usually from a general practice, covering a broad range of health and preventative services. The first level of contact with the health system.
PHO	Primary Health Organisation	PHOs encompass the range of primary care practitioners and are funded by DHBs to provide of a set of essential primary healthcare services to the people enrolled with that PHO.
	Public Health	The science and art of preventing disease, prolonging life and promoting health and efficiency through organised community effort.
	Regional collaboration	Refers to DHBs across geographical 'regions' planning and delivering services (clinical and non-clinical). Four regions exist: Northern, Midland, Central and Southern. The Southern region includes all five South Island DHBs (Canterbury, Nelson Marlborough, South Canterbury, Southern and West Coast DHBs). Regional collaboration sometimes involves multiple regions, or may be 'sub-regional collaboration' (e.g. Canterbury and West Coast).
	Secondary Care	Specialist care that is typically provided in a hospital setting.
SIAPO	South Island Alliance Programme Office	A partnership between the five South Island DHBs working to support a clinically and financially sustainable South Island health system where services are as close as possible to people's homes.
SSP	Statement of Service Performance	Government departments, and Crown entities from which the Government purchases a significant quantity of goods and services, are required to include audited statements of service performance with their financial statements. These statements report whether the organisation has met its service objectives for the year.
	Tertiary Care	Very specialised care often only provided in a smaller number of locations
WCTO	WellChild/Tamariki Ora	A free service offering screening, education and support to NZ children from birth to age five.

10.2 Organisational and system governance structure



10.3 Overview of hospital and specialist services divisions

LABORATORY AND HOSPITAL SUPPORT SERVICES

Cover the provision of diagnostic services through Canterbury Health Laboratory and hospital support services such as: medical illustrations, specialist equipment maintenance, sterile supply, patient and staff food services, cleaning services and travel, transport, parking and waste contracts. These services are largely provided for patients under the care of the Canterbury DHB however Canterbury Health Laboratory (CHL) also offer a testing service for GPs and private specialists and all public and private laboratories throughout NZ refer samples to CHL for more specialised testing. CHL is recognised as an international referral centre.

MEDICAL AND SURGICAL SERVICES

Cover medical services: general medicine, cardiology/lipid disorders, endocrinology/diabetes, respiratory, rheumatology/immunology, infectious diseases, oncology, gastroenterology, clinical haematology, neurology, renal, palliative, hyperbaric medicine, dermatology, dental and sexual health. They also cover surgical services: general surgery, vascular, ENT, ophthalmology, cardiothoracic, orthopaedics, neurosurgery, urology, plastic, maxillofacial and cardiothoracic surgeries and the services of the day surgery unit. Medical and Surgical Services also 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 84,000 patients per annum.

OLDER PERSONS' SPECIALIST HEALTH AND REHABILITATION SERVICES

Cover assessment, treatment, rehabilitation and psychiatric services for the elderly in inpatient, outpatient, day services and community settings; specialist osteoporosis and memory clinics; inpatient and community stroke rehabilitation services and specialist under 65 assessment and treatment services for disability-funded clients. The DHB's School and Community Child and Adolescent Dental Service is also managed through this service area. Rehabilitation services (provided at Burwood Hospital) include spinal, brain injury, orthopaedic, chronic pain management services and a range of outpatient services. The majority of DHB elective orthopaedic surgery is undertaken at Burwood Hospital, as well as some general plastics lists. Located at the Burwood Procedure Unit is a 'see and treat' service for skin lesions in conjunction with primary care.

ASHBURTON AND RURAL HEALTH SERVICES

Covers a wide range of services provided in rural areas including rural hospital specialist medicine and community services. Ashburton Hospital provides secondary level hospital care, led by a specialist rural medical workforce, working closely with Christchurch tertiary services. There are also a number of smaller rural hospitals in Akaroa, Darfield, Oxford, Ellesmere, Kaikoura and Waikari, all of which work closely with local primary care services. Health services provided include: general medicine, day procedures, palliative care, maternity services, specialist outpatient services, and assessment, treatment and rehabilitation services, and long-term care for the elderly, including dementia care, diagnostic services, and meals on wheels. Also offered in Ashburton are rural community services: day care, district nursing, home support and clinical nurse specialist outreach services, including respiratory, cardiac, diabetes, wound care, urology, continence and stoma therapy. The division also operates Tuarangi Home, which provides hospital-level care for the elderly in Ashburton and in 2011 introduced rest home dementia care for the elderly.

WOMEN AND CHILDREN'S HEALTH SERVICES

Cover acute and elective gynaecology services: primary, secondary and tertiary obstetric services; neonatal intensive care services at Christchurch Women's Hospital; first trimester pregnancy terminations at Lyndhurst Hospital; and primary maternity services at Lincoln Maternity, Rangiora Hospital and the Burwood Birthing Unit. This service also covers: children's health; general paediatrics; paediatric oncology; paediatric surgery; child protection services; cot death/paediatric disordered breathing; community paediatrics and paediatric therapy; public health nursing services; and vision/hearing screening services. The services' neonatal intensive care is involved in world-leading research investigating improved care for pre-term babies, and child health specialists provide a Paediatric Neurology, Oncology and Surgery Outreach Service to DHBs in the South Island and lower half of the North Island.

SPECIALIST MENTAL HEALTH SERVICES

Cover specialist mental health services: adult community; adult acute; rehabilitation; child, adolescent and family (CAF); forensic; alcohol and drug; intellectually disabled persons' health; and other specialty services. Services are provided by a number of outpatient, inpatient, community-based and mobile services throughout Canterbury. The Forensic, Eating Disorders, Alcohol and Drug, and CAF Services provide regional inpatient beds and consultation liaison. Outreach clinics provide Rural Adult Community and CAF Services to Kaikoura and Ashburton.

10.4 Legislative objectives of a DHB

NEW ZEALAND PUBLIC HEALTH AND DISABILITY ACT (AMENDED 2012) - PART 3: SECTION 22

The New Zealand Public Health and Disability Act sets out the following objectives for DHBs:

- To improve, promote, and protect the health of people and communities
- To promote the integration of health services, especially primary and secondary health services
- To seek the optimum arrangement for the most effective and efficient delivery of health services in order to meet local, regional, and national needs
- To promote effective care or support for those in need of personal health services or disability support services
- To promote the inclusion and participation in society and independence of people with disabilities
- 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 within New Zealand 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 exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it 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 its operations
- To be a good employer in accordance with section 118 of the Crown Entities Act 2004.

10.5 Minister of Health's letter of expectations

Office of Hon Dr Jonathan Coleman

Minister of Health
Minister for Sport and Recreation
Member of Parliament for Northcote

22 DEC 2015

Mr Murray Cleverley
Chairperson
Canterbury District Health Board
PO Box 1600
CHRISTCHURCH 8140

Dear Mr Cleverley Murray

Letter of Expectations for DHBs and Subsidiary Entities 2016/17

The Government is committed to improving the health of New Zealanders and continues to invest in key health services. In Budget 2015 Vote Health received an additional $400 million, the largest share of new funding, demonstrating the Government's on-going commitment to protecting and growing our public health services.

Refreshed New Zealand Health Strategy

It is important that the health sector has a clear and unified direction. The refreshed New Zealand Health Strategy will provide DHBs and the wider sector with this direction, and sets a clear view of the future we want for our health system to ensure that all New Zealanders live well, stay well and get well.

While the Strategy is not yet finalised, DHBs need to be focussed on the critical areas to drive change that come out of the refreshed strategy. The draft covers five themes – people-powered, closer to home, value and high performance, one team, and smart system. The Strategy is supported by a Roadmap of Actions, which sets the direction for the next five years. I am aware that DHBs are already progressing work under some of the themes. I expect that this work will continue and, where possible, be accelerated over the coming year. If you are thinking about new initiatives, these should have a clear link to one or more of the five themes and the outcomes should be able to be clearly linked to the intent of the draft Strategy.

I thank you for your involvement to date in this work and finalised planning expectations will be provided to DHBs in the new year.

Living Within our Means

While the global economic environment continues to be challenging, DHB funding has been increased by around $3 billion over the last seven years. While the health system could always use more resources, DHBs need to budget and operate within allocated funding and must have detailed plans to improve year-on-year financial performance. As you are aware, I have asked the Director-General of Health to arrange for his officials to work with Canterbury DHB and the Treasury to update and remodel the assumptions of the Christchurch Hospital Redevelopment 2012 Detailed Business Case. This will allow both the DHB and Government to have confidence in the future forecasts of performance and position. I trust that you will continue to consider where your DHB can make efficiency gains. You and your Board must

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monitor and hold your Chief Executive accountable against these expectations as keeping to budget allows investment into new and more health initiatives.

Improvements through national, regional and sub-regional initiatives must continue to be a key focus for all DHBs. With the establishment of NZ Health Partnerships Ltd, consistent with the shareholders' agreement, I expect all DHBs to work together to ensure successful implementation of the current programmes and to identify, develop and implement future opportunities.

Working Across Government

Right now, a key focus of Government is vulnerable families. DHBs are already working closely with other social sector organisations to achieve sector goals in relation to the Government's Better Public Services initiatives, and other initiatives, such as Whānau Ora, Social Sector Trials, Prime Minister's Youth Mental Health Project and Healthy Housing. I expect DHBs to continue supporting cross-agency work that delivers outcomes for children and young people. I also expect that DHBs will keep me and the Ministry of Health informed of work they are undertaking with other sector agencies.

In line with this, the cross-government work programme on the Better Public Service Result One: Reducing long-term welfare dependence, is being expanded to include a focus on reducing unintended teenage pregnancies. I expect DHBs to commit to help deliver on this sub-focus in their 2016/17 annual plans.

National Health Targets

All of the national health targets are very important for driving overall hospital performance, and have resulted in major improvements in the health outcomes of New Zealanders. Health target performance continues to improve, but DHBs must remain focussed on achieving and improving performance against the targets, particularly the Faster Cancer Treatment target.

I remain concerned about the overall pace of progress nationally on the Faster Cancer Treatment health target. Locally, Canterbury DHB has shown good improvement since the target was introduced and this progress needs to continue to ensure that the DHB meets both the current year's goal of 85 percent and the increased goal of 90 percent by June 2017. Faster cancer treatment is a significant priority for the Government with almost $63 million invested over the last seven years to deliver better, faster cancer care. Please ensure delivery of this health target is a priority for your DHB.

Tackling Obesity

A key focus area for 2016/17 will be actions to reduce the incidence of obesity. The Childhood Obesity package of initiatives aims to prevent and manage obesity in children and young people up to 18 years of age, and includes a number of cross-agency activities. The core of the plan is the new childhood obesity health target, which is: by December 2017, 95 percent of obese children identified in the B4 School Check programme will be referred to a health professional for clinical assessment and other interventions.

I expect all DHBs to continue to show leadership in this area and to deliver on the new health target, and to identify other appropriate activities they can undertake to help reduce the incidence of obesity.

Shifting and Integrating Services

Integrating primary care with other parts of the health service is vital for better management of long-term conditions, mental health, an aging population and patients in general. The pathways to achieve better co-ordinated health and social services need to be developed and supported by clinical leaders in both community and hospital settings. I expect DHBs to continue to move services closer to home in 2016/17, and DHBs need to have clear evidence of how they plan to do this.

Health IT Programme 2015-2020

Health information systems have a crucial role to play to make the health system more sustainable, and to improve productivity, efficiency, and health outcomes. The Health IT Programme 2015–2020 begins with a design phase over the next nine months and I expect DHB, PHO and primary care representatives to be part of the co-design process. Meanwhile, DHBs will need to complete current regional and national IT investments, such as the foundation programmes currently under way.

Please note that all DHBs must refresh their statements of intent (SOIs) for tabling in 2016/17 to reflect the key priority areas outlined above, and a health equity focus, and build these SOIs into their annual plans.

Keep in mind that the Budget 2016 process will clarify the priorities outlined in this letter and other Government priorities, and more information will be provided when available. Please share this letter with your clinical leaders and local primary care networks.

Finally, please note that the provisions of the Enduring Letter of Expectations continue to apply. The Letter can be accessed on the State Services Commission's website.

I would like to thank you, your staff, and your Board for your continued commitment to delivering quality health care to your population. I look forward to seeing your achievements throughout 2016/17.

Yours sincerely

Hon Dr Jonathan Coleman
Minister of Health

10.6 Canterbury's commitment to the national health targets

BETTER HELP FOR SMOKERS TO QUIT

Expectation: PHO enrolled smokers and women at confirmation of pregnancy with general practice or a Lead Maternity Carer will be offered brief advice and support to quit smoking.

Commitment: 90% of PHO enrolled smokers and 90% of pregnant smokers will be offered advice and help to quit smoking.

Canterbury contribution – see section 6.8

INCREASED IMMUNISATION

Expectation: Eight-month-olds will have their full primary course of immunisation (six weeks, three months and five months immunisation events) on time.

Commitment: 95% of all eight-month-olds will be fully vaccinated.

Canterbury contribution – see section 6.2

RAISING HEALTHY KIDS

Expectation: Obese children identified in the B4SC programme will be offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions.

Commitment: 95% of obese children will be offered a referral to a health professional for clinical assessment and family-based intervention.

Canterbury contribution – see section 6.7

SHORTER STAYS IN EMERGENCY DEPARTMENTS

Expectation: Patients presenting at an Emergency Department (ED) will be admitted, discharged or transferred within six hours.

Commitment: 95% of people presenting at ED will be admitted, discharged or transferred within six hours.

Canterbury contribution – see section 6.13

IMPROVED ACCESS TO ELECTIVE SURGERY

Expectation: More New Zealanders have access to elective surgical services. Nationally, DHBs will deliver an increase in the volume of elective surgery by an average of 4,000 per year.

Commitment: 20,982 elective surgical discharges will be delivered in 2016/17

Canterbury contribution – see section 6.18

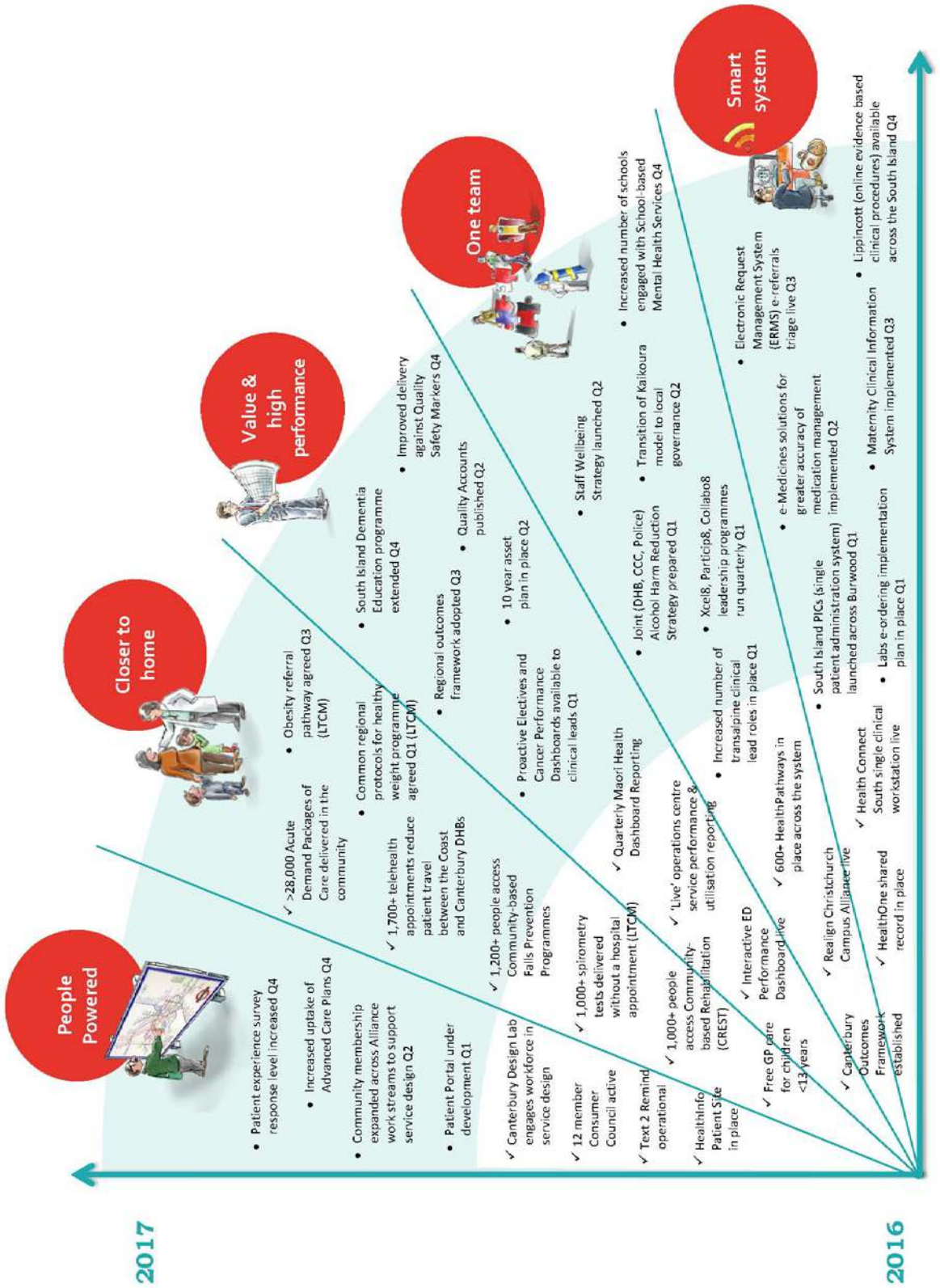
FASTER CANCER TREATMENT

Expectation: Patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.

Commitment: 85% of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks, by June 2017.

Canterbury contribution – see section 6.20

10.7 NZ health strategy – Canterbury's roadmap of actions 2016/17



Canterbury Clinical Network Strategic Focus 2016-18

OUR APPROACH

Within our alliance framework we will act in good faith to reach consensus decisions on the basis of 'best for patient, best for system.'

Our person centred approach includes:

- Taking a patient-centred, whole of **SYSTEM APPROACH** to make health and social services integrated and sustainable;
- **FOCUSING** on **PEOPLE**, their **FAMILIES** and communities, keeping them at the centre of everything we do;
- Enabling **CLINICALLY-LED** service development;
- Making the best use of our resources and capacity to achieve **IMPROVED HEALTH OUTCOMES** for our population.

OUR MISSION

We provide leadership to the transformation of the Canterbury Health System in collaboration with system partners and on behalf of the people of Canterbury.

STRATEGIC OBJECTIVES of the CANTERBURY HEALTH SYSTEM

The vision that underpins our leadership decisions:

People take greater responsibility for their own health.

The development of services that support people/whānau to stay well and take greater responsibility for their own health and wellbeing.

People stay well in their own homes and communities.

The development of primary care and community services to support people/whānau in a community based setting and provide a point of ongoing continuity, which for most people is general practice.

People receive timely and appropriate complex care.

The freeing-up of hospital based specialist resources to be responsive to episodic events and the provision of complex care and support and specialist advice to primary care.

www.ccn.health.nz

Canterbury Clinical Network
Transforming Health Care, Whanau Ora ki Waitaha.

AREAS OF ACTIVITY IN 2016/17

Workstreams
- Child & Youth Health
- Health of Older People
- Mental Health
- Rural Health

Service Level Alliances
- Community Services
- Flexible Funding Pool
- Immunisation
- Laboratory
- Pharmacy
- Ashburton
- Rural Funding
- Urgent Care
- Kaikoura

Enablers
- Collaborative Care
- Integrated Family Health Services
- Regional Standing Orders
- HealthInfo
- Community HealthPathways
- HealthOne
- Canterbury Initiative
- Electronic Request Management System

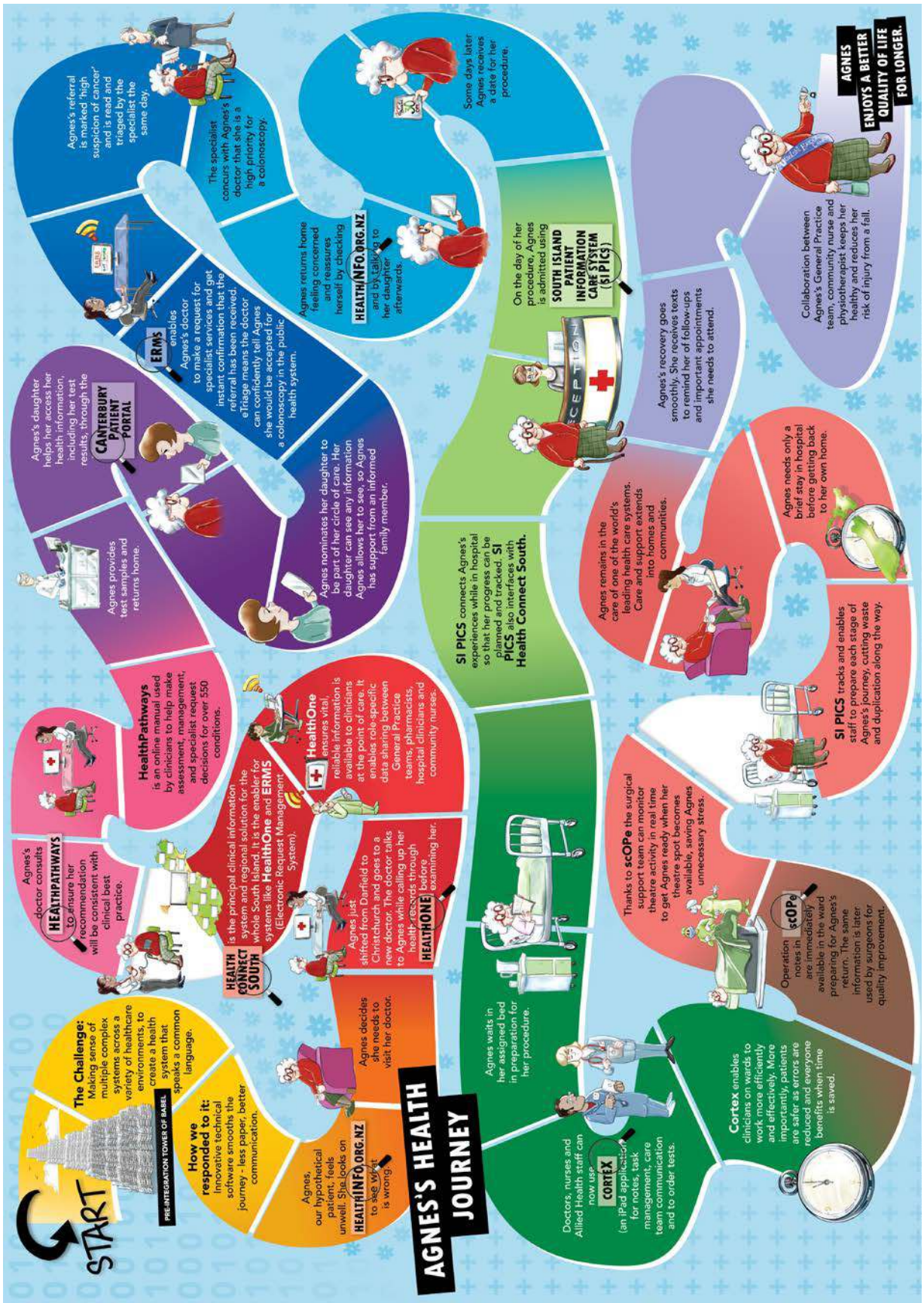
Service Development Groups
- Integrated Diabetes
- Integrated Respiratory
- Hurunui Health Services Development Group

Reference Groups
- Te Kahui o Papaki Ka Tai (TKOP)
- Pacific Reference Group
- Culturally & Linguistically Diverse Health Advisory Group
- CDHB Consumer Council

PRIORITIES FOR 2016-18

- **Equitable health outcomes:** Work towards equitable health outcomes for the Canterbury population, with a focus on Māori, rural and vulnerable people.
- **Management of complex patients:** Support vulnerable people and those with more complex health and social issues to keep healthy and well in their own homes.
- **A 'healthy health workforce':** Foster a highly valued and engaged health workforce and optimise workforce capacity and capability.
- **Tell our story:** Communicate and share our learnings and achievements with our community, health workforce and stakeholders.
- **Optimise leadership:** Further develop, regenerate and optimise strategic leadership across CCN.
- **Collaboration with social services:** Achieving collective impact through further collaboration with social services, addressing common issues and analysing shared data together.
- **Take action:** Focus on delivering and reporting on our activity, including showing the evaluations of our results.
- **Healthier environments:** Influence transparent urban design with a focus on wellness, including encouraging increased physical activity, better housing and reduced rates of obesity.
- **Further integration & rationalisation** Align, coordinate and consolidate work group activity while optimising activity that supports the patient's seamless journey through the health system.

10.9 Information systems overview



10.10 Asset performance indicators

To support asset performance monitoring and investment planning, we have aggregated our assets into three major portfolio areas which cover the majority of those assets considered significant (critical) in regard to the delivery of core health services.

Asset Portfolio	Asset Classes within Portfolios	Asset Purpose	2014/15 Net Book Value	2015/16 Net Book Value
Property	Land, buildings, furniture and fittings	To provide a base for the provision of health services	$326M	$412M
Clinical Equipment	Equipment and machinery	To enable the delivery of health services through diagnosis, monitoring or treatment	$35M	$41M
Information Communication Technology (ICT)	Computer hardware and computer software	To enable the delivery of core health service by aiding decision making at the point of care	$8M	$11M

The performance metrics for each asset portfolio are set out below, with associated standards. The majority of these standards have been set and agreed at clinical, management or governance levels throughout the DHB, as part of service level agreements, business cases and national performance expectations. These performance metrics are being reviewed as part of our long-term planning and in conjunction with the national long-term investment planning process and are subject to change.

Property Portfolio Performance

Asset Performance Indicators	Indicator Class	2014/15 Baseline	2015/16 Standard	2015/16 Result	2016/17 Standard
Percentage of buildings within the DHB's property portfolio with a current Building Warrant of Fitness	Condition	100%	100%	100%	100%
Percentage of the critical property portfolio with a National Building Standard greater than 34% [90]	Condition	-	100%	83%	100%
Number of patients presenting at the Christchurch Hospital Emergency Department [91]	Utilisation	86,035	<91,000	88,581	<91,000
Number of elective surgical discharges delivered [92]	Utilisation	20,353	>20,474	21,039	>20,982
Proportion of elective surgical discharges delivered in-house or using DHB resources	Utilisation	90%	>90%	90%	>90%
Acute inpatient average length of stay [93]	Functionality	3.42	<2.45	2.39	<2.35
Elective inpatient average length of stay [93]	Functionality	2.99	<1.59	1.54	<1.55
Energy consumption per sqm (kWh/sqm) [94]	Functionality	442	<500	413.8	<500

[90] *All critical property providing clinical services are to have an NBS greater than 34%.*
[91] *This measure is based on the national ED Health Target definition, but reflects Christchurch Hospital ED only, standards where set as part of the business case for the expansion of the Christchurch Hospital ED.*
[92] *The standard is based on the national Electives Health Target and includes surgeries outsourced to private providers. The second measure reflects the proportion of those surgeries delivered in DHB facilities or with DHB resources (DHB staff outplaced to other facilities). This proportion is expected to increase once the new Burwood facilities are up and running.*
[93] *The average length of stay measures sit under the national DHB performance set (OS3) standards are set nationally and are standardised.*
[94] *The Energy Consumption measure is based on the Code of Practice NZS4220: 1982 Energy Conservation standard which applies to Non-Residential Buildings and specifies targets for existing buildings. The 2014/15 result is at April 2015.*

Clinical Equipment Portfolio Performance

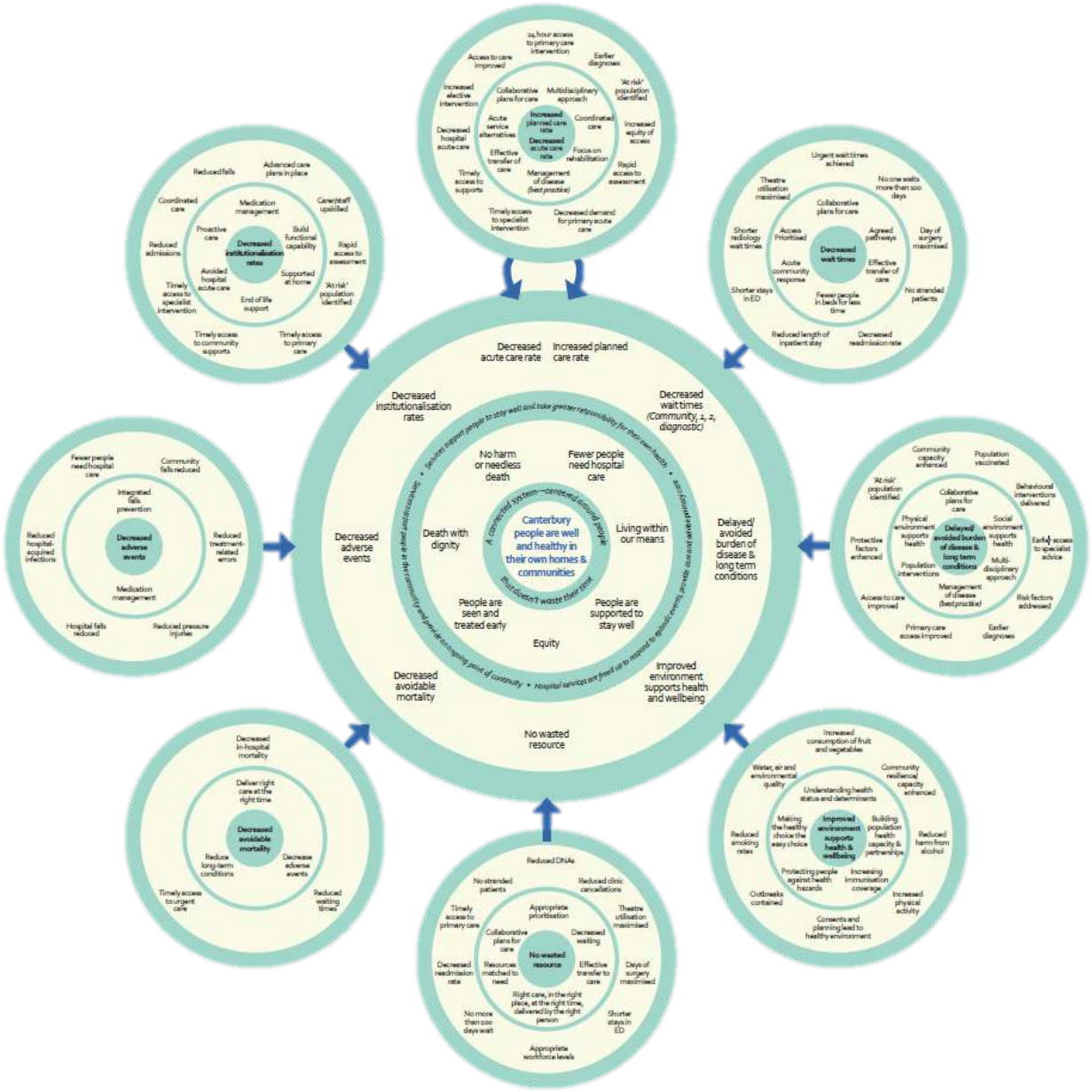
Asset Performance Indicators	Indicator Class	2014/15 Baseline	2015/16 Standard	2015/16 Actual	2016/17 Standard
Percentage of MRIs compliant with manufacturer specification standards	Condition	100%	100%	100%	100%
Percentage of CTs and Linacs compliant with the requirements of the Radiation Protection Act	Condition	100%	100%	100%	100%
Percentage of MRI uptime vs. operational hours [95]	Utilisation	-	>98%	100%	>98%
Percentage of CT uptime vs. operational hours [95]	Utilisation	-	>98%	100%	>98%
Percentage of Linac uptime vs. operational hours [96]	Utilisation	97%	>98%	98%	>98%
Percentage of people accepted for an urgent diagnostic colonoscopy receiving their procedure within 2 weeks [97]	Functionality	96%	>75%	92%	>85%
Percentage of patients with an accepted referral receiving an MRI scan within 6 weeks Error! Bookmark not defined.	Functionality	75%	>85%	59%	>85%
Percentage of patients with an accepted referral receiving CT scan within 6 weeks Error! Bookmark not defined.	Functionality	96%	>95%	75%	>95%
Percentage of patients receiving radiotherapy or chemotherapy within 4 week of the decision to treat Error! Bookmark not defined.	Functionality	100%	100%	100%	100%
Percentage of the anaesthetic machine fleet with appropriate patient monitoring functionality	Functionality	-	100%	100%	100%

Information Communication and Technology (ICT) Portfolio Performance

Asset Performance Indicators	Indicator Class	2014/15 Baseline	2015/16 Standard	2015/16 Actual	2016/17 Standard
Percentage of available capacity for storage [98]	Condition	-	>20%	35%	>20%
Percentage uptime for critical applications (Health Connect South, Rhapsody, Éclair, MedChart) [99]	Utilisation	-	>99%	100%	>99%
Percentage of GP utilising the Electronic Referral Management System (ERMS) for referrals	Utilisation	74%	>80%	79%	80%
Customer satisfaction level with service desk [100]	Functionality	-	>2.6	4.4	>2.6
Annual network penetration test risk level (5-critical, 4-high, 3-medium, 2-low, 1-informational) [101]	Functionality	-	<2	2	<2

[95] The MRI and CT uptime results are collated manually the 2015/16 results are for the year to June 2016.
[96] The Linac uptime results baseline is for the calendar year to June 2016.
[97] The diagnostic wait time measures are part of the national DHB performance measures set (PP29 and PP30), standards are set nationally and baselines results are for the month of June 2016.
[98] Live updates provide storage capacity results at a point in time – the results for 2015/16 is at May 2016.
[99] These results are captured at a point in time – the 2015/16 result is for six months January-June 2016.
[100] The Service Desk Customer Satisfaction Survey scores range from 1-5. The satisfactory threshold has been identified as an average score greater than 2.6. Live updates provide survey results at a point in time – the result for 2015/16 is at May 2016.
[101] The Network Security External Penetration Test is a new measure for the ICT component. This has a target identified by the CDHB Information Services Group management team. The result for 2014/15 is at April 2015.

10.11 Canterbury's outcomes framework



10.12 DHB performance monitoring framework

PERFORMANCE MEASURE	PERFORMANCE EXPECTATION		CANTERBURY TARGET	NATIONAL TARGET	REPORTING FREQUENCY
PP6 Improving the health status of people with severe mental illness through improved access.	% of the population accessing specialist mental health services.	Age 0-19	>3.1%	3%	Quarterly
		Māori			
		Total			
		Age 20-64	>3.1%		
		Māori			
		Total			
		Age 65+	>3.0%		
PP7 Improving mental health services using transition (discharge) planning and employment.	% of clients discharged with a transition (discharge) plan.	Long term clients	Provide a report as specified		Quarterly
		Child & Youth	95%	95%	Quarterly
PP8 Shorter waits for non-urgent mental health and addiction services for 0-19 year olds.	% of young people (0-19) referred for non-urgent mental health services seen within 3 weeks and within 8 weeks.	3wks	80%	80%	Quarterly
		8wks	95%	95%	
	% of young people (0-19) referred for non-urgent addictions services seen within 3 weeks and within 8 weeks.	3wks	80%	80%	Quarterly
		8wks	95%	95%	
PP10 Oral Health DMFT Score at Year 8.	DMFT score at Year 8.	2016	0.82	0.82	Annual
		2017	0.80	0.80	
PP11 Children caries-free at age 5 years.	% caries-free at age 5.	2016	65%	65%	Annual
		2017	66%	66%	
PP12 Utilisation of DHB-funded dental services by adolescents.	School Year 9 up to and including age 17 years.	2016	85%	85%	Annual
		2017	85%	85%	
PP13 Improving the number of children enrolled in DHB-funded dental services.	% of children (age 0-4) enrolled.	2016	95%	95%	Annual
		2017	95%	95%	
	% of children (0-12) not examined according to planned recall.	2016	<10%	<10%	
		2017	<10%		
PP20 Improved management of LTC.					
Focus area 1: Long term conditions.	Report on delivery of the actions and milestone in the Annual Plan, six monthly teleconference.				Quarterly
Focus area 2: Diabetes Services.	% of enrolled people aged 15-74 with acceptable glycaemic control (HbA1c ≤64mmol/mol).		Improve or, where high, maintain percentages.		
	Narrative quarterly report on the implementation of actions in the Diabetes plan "Living Well with Diabetes" identified in the 2016/17 annual plans.				
Focus area 3: Cardiovascular (CVD) Health.	% of the eligible population will have had their cardiovascular risk assessed in the last five years.		90%	90%	
	% of 'eligible Māori men in the PHO aged 35-44 years' who have had their cardiovascular risk assessed in the past five years.		90%	90%	
	Narrative reporting on progress to date on deliverables for CVD identified in the 2016/17 annual plans.				
Focus area 4: Acute Heart Service.	% of high-risk patients receiving an angiogram within 3 days of admission (where the day of admission is day 0).		70%	70%	
	% of patients presenting with ACS who undergo angiography and have completion of registry data collection within 30 days.		≥95%	≥95%	

PERFORMANCE MEASURE	PERFORMANCE EXPECTATION	CANTERBURY TARGET	NATIONAL TARGET	REPORTING FREQUENCY
	% of patients undergoing cardiac surgery will have completion of Cardiac Surgery registry data collection with 30 days of discharge.	>95%	>95%	
	Report on delivery of the actions and milestones for acute heart services identified in the Annual Plan, and actions and progress in quality improvement initiatives to support the improvement of ACS indicators as reported in ANZACS-QI.			
Focus area 5: Stroke services.	% of potentially eligible stroke patient's thrombolysed.	6%	6%	Quarterly
	% of stroke patients admitted to a stroke unit or organised stroke service with a demonstrated stroke pathway.	80%	80%	
	% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission (and % of acute stroke patients transferred to inpatient rehab).	80%	80%	
	Report on delivery of the actions and milestones identified in the Annual Plan.			
PP21 Immunisation coverage.	% of two-year-olds fully immunised.	95%	95%	Quarterly
	% of five-year-olds fully immunised.	95%	95%	
	% of eligible girls immunised with HPV vaccine dose 3.	70%	70%	
PP22 Improving system integration.	Report on delivery of the actions and milestones identified in the Annual Plan. In relation to System Level Measures (SLM) – a jointly agreed (by the alliance) SLM improvement plan, including improvement milestones, will be provided at the end of quarter one 2016/17.			Quarterly
PP23 Improving wrap-around services – health of older people.	Report on delivery of the actions and milestones identified in the Annual Plan.			Quarterly
	% of older people receiving long-term home and community support that have a comprehensive clinical assessment and an individual care plan.	Demonstrate an improvement on current performance.		
	% of LTCF clients admitted to an Aged Residential Care (ARC) facility who had been assessed using an interRAI Home Care assessment tool in the six months prior to that first long term care facility (LTCF) assessment.	Demonstrate an improvement on current performance.		
	% of people in aged residential care by facility and by DHB who have a subsequent (LTCF) interRAI completed within 230 days of the previous assessment.	Demonstrate an improvement on current performance.		
PP25 Prime Minister's youth mental health project.				
Initiative 1: School Based Health Services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities.	Quarterly quantitative report on the implementation of SBHS, as per template.			Quarterly
	Provide quarterly narrative progress reports on actions undertaken to implement Youth Health Care in Secondary Schools: A framework for continuous quality improvement in each school (or group of schools) with SBHS.			
Initiative 3: Youth Primary Mental Health.	Provide quarterly narrative progress reports (as part of PP26 Primary Mental Health reporting) with actions undertaken in that quarter to improve and strengthen youth primary mental health (12-19 year olds with mild to moderate mental health and/or addiction issues) to achieve the following outcomes: ▪ early identification of mental health and/or addiction issues ▪ better access to timely and appropriate treatment and follow up ▪ equitable access for Māori, Pacific and low decile youth populations.			Quarterly
	Provide quantitative reports using the template provided under PP26.			
Initiative 5: Improve the responsiveness of primary care to youth.	Provide narrative reports with actions undertaken in that quarter to ensure the high performance of the youth SLAT(s) (or equivalent) in your local alliance.			Quarterly
	Provide quarterly narrative reports with actions the youth SLAT has undertaken in that quarter to improve the health of the DHB's youth population (for the 12-19 year age group at a minimum) by addressing identified gaps in responsiveness, access, service provision, clinical and financial sustainability for primary and community services for the young people, as per your SLAT(s) work programme.			
PP26 Rising to the Challenge: The Mental Health and Addiction Service Development Plan.				Quarterly

PERFORMANCE MEASURE	PERFORMANCE EXPECTATION		CANTERBURY TARGET	NATIONAL TARGET	REPORTING FREQUENCY
Focus Area 1: Primary Mental Health.	Reporting on the amount of service delivered including alcohol brief interventions (numbers of adults and youth (12-19) seen by ethnicity and services accessed).				Quarterly
Focus Area 2: District Suicide Prevention and Postvention.	Reporting on the highlights of implementation successes, expectations where actions are not being progressed and provide reasons and report on training; what groups have received training and how many have been trained.				
Focus Area 3: Improving Crisis Response Services.	Report on actions that have been undertaken to reduce the rate of known clients being referred to by police to crisis teams and what difference have the above actions made to police referrals.				
Focus Area 4: Improve outcomes for children.	Reporting required where actions identified in the annual plan for improving outcomes for children are not on track.				
Focus Area 5: improving employment & physical health needs of people with low prevalence conditions.	Reporting required where actions identified in the annual plan for improving the physical and employment outcom.es of people with low prevalence conditions are not on track.				
PP27: Supporting Vulnerable Children.	Progress on delivery of the actions/milestones identified in the Annual Plan to support implementation of the Children's Action Plan and Vulnerable Children Act 2014.				Quarterly
PP28: Reducing the Incidence of First Episode Rheumatic Fever.	Provide a progress report against the region's rheumatic fever prevention plan.				Quarterly
	Report on progress in following-up known risk factors and system failure points in cases of first episode and recurrent acute rheumatic fever.				
	Acute rheumatic fever rate of hospitalisation per 100,000.	South Island rate	< 0.2 per 100,000		
PP29: Improved waiting times for diagnostic services.	% of accepted referrals for elective coronary angiography will receive procedure within 3 months (90 days).		95%	95%	Monthly
	% of accepted referrals for CT and MRI scans receiving scans within 6 weeks (42 days).	CT Scan	95%	95%	
		MRI Scan	85%	85%	
	% of people accepted for an urgent diagnostic colonoscopy receive their procedure:	Within 14 days	85%	85%	
		Within 30 days	100%	100%	
	% of people accepted for a diagnostic colonoscopy receive their procedure:	Within 42 days	70%	70%	
		Within 90 days	100%	100%	
	% of people waiting for a surveillance colonoscopy beyond the planned date seen:	Within 84 days	70%	70%	
		Within 120 days	100%	100%	
PP30: Faster cancer treatment.	% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.		85%	85%	Quarterly
	% of people ready for treatment wait less than four weeks for radiotherapy or chemotherapy.		100%	100%	
PP31: Better help for smokers to quit in public hospitals.	% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking.		95%	95%	Quarterly
SI1 SLM Ambulatory sensitive (avoidable) hospital admissions.	DHB rate vs. national rate (per 100,000 people).	Age 0-4	TBC*	NA	Six-monthly
		Age 45-64	<2,637		
	* A jointly agreed (alliance) SLM improvement plan, including improvement milestones and targets, will be provided at the end of quarter one 2016/17 via PP22.				Quarterly
SI2 Delivery of regional service plan.	A single progress report on behalf of the region, agreed by all regional DHBs.				Quarterly
SI3 Ensuring delivery of service coverage.	Report progress achieved during the quarter towards resolution of exceptions to service coverage identified in the Annual Plan, and not approved as long-term exceptions, and any other gaps in service coverage.				Six-monthly
	Major joint replacement procedures (per 10,000).		21	21	Annual

PERFORMANCE MEASURE	PERFORMANCE EXPECTATION		CANTERBURY TARGET	NATIONAL TARGET	REPORTING FREQUENCY
SI4 Elective services standardised intervention rates.	Cataract Procedures (per 10,000).		27	27	
	Cardiac surgery (per 10,000).		6.5	6.5	Quarterly
	Percutaneous revascularisation (per 10,000).		12.5	12.5	
	Coronary angiography services (per 10,000).		34.7	34.7	
SI5 Delivery of Whānau Ora.	Performance expectations are met across all the measures associated with the five priority areas: Mental health, Asthma, and narrative reports cover all areas indicated, Obesity, Tobacco and narrative reports cover all areas indicated.				Annual
SI7: SLM total acute hospital bed days per capita.	A jointly agreed (by district alliances) SLM improvement plan, including improvement milestones, will be provided at the end of quarter one 2016/17 via measure PP22.				Quarterly
SI8: SLM patient experience of care.	Hospital	Provide a report each quarter as specified in the measure definition.			Quarterly
	Primary care	A jointly agreed (by district alliances) SLM improvement plan, including improvement milestones, will be provided at the end of quarter one 2016/17 via measure PP22.			
SI9: SLM amenable mortality.	A jointly agreed (by district alliances) SLM improvement plan, including improvement milestones, will be provided at the end of quarter one 2016/17 via measure PP22.				Quarterly
OS3 Inpatient length of stay (LOS).	Average Elective LOS.		≤1.55	1.55	Quarterly
	Average Acute LOS.		≤2.35	≤2.35	
OS8 Acute readmissions to hospital.	% total population.		Improvement on baseline performance		Quarterly
	% population aged 75+.				
OS10 Improving the quality of identity data within the national health index and data submitted to national collections.					
Focus area 1: Improving quality of identification data.	New NHI registrations in error (Group A).		>2% - ≤ 4%	>2% - ≤ 4%	Quarterly
	Recording on non-specific ethnicity (set to 'Not stated' or 'Response Unidentifiable').		>0.5% - ≤2%	>0.5% - ≤2%	
	Updating of specific ethnicity value in existing NHI record with a non-specific value.		>0.5% - ≤2%	>0.5% - ≤2%	
	Validated addresses excluding overseas, unknown and dot (.) in line 1.		>76% - ≤85%	>76% - ≤85%	
	Invalid NHI data updates.		TBC	TBC	
Focus are 2: Improving the quality of data submitted to National Collections.	NBRS links to NNPAC and NMDS.		≥97%-<99.5%	≥97% - <99.5%	Quarterly
	National collections file load success.		≥98% - <99.5%	≥98% - <99.5%	
	Assessment of data reported to the NMDS.		≥75%	≥75%	
	NNPAC timeliness.		≥95% - <98%	≥95% - <98%	
OP1 Mental health output delivery against plan.	Volume delivery for specialist Mental Health and Addiction services is within: a) five percent variance (+/-) of planned volumes for services measured by FTE, b) five percent variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day, and c) actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan.		Within 5% of plan	Within 5% of plan	Quarterly
DV6: SLM youth access to and utilisation of youth appropriate health services.	No performance target/ expectation set.				TBC
DV7: SLM number of babies who live in a smoke-free household at six weeks post-natal.	No performance target/ expectation set.				TBC

10.13 Statement of accounting policies

The prospective financial statements in this Annual Plan for the year ended 30 June 2017 are prepared in accordance with Section 38 of the Public Finance Act 1989 and they comply with NZ IFRS, as appropriate for public benefit entities. FRS-42 states that the (prospective) forecast statements for an upcoming financial year should be prepared using the same standards as the statements at the end of that financial year.

The following information is provided in respect of this Plan:

(i) Cautionary Note

The Annual Plan'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 Canterbury DHB expects to take place.

(iii) Assumptions

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

REPORTING ENTITY AND STATUTORY BASE

Canterbury DHB ("Canterbury DHB") is a Health Board established by the NZ Public Health and Disability Act 2000. The DHB is a Crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand.

Canterbury DHB has designated itself and its subsidiaries, as public benefit entities (PBEs) for financial reporting purposes.

The DHB's primary objective is to deliver health and disability services and mental health services in a variety of ways to the Canterbury community. Canterbury DHB does not operate to make a financial return.

The consolidated financial statements of Canterbury DHB consist of the DHB, its subsidiaries - Canterbury Linen Services Ltd (100% owned) and Brackenridge Estate Ltd (100% owned).

Canterbury DHB will adopt the following accounting policies consistently during the year and apply these policies for the Annual Accounts.

BASIS OF PREPARATION

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

Statement of compliance

The consolidated financial statements have been prepared in accordance with the requirements of the New Zealand Public Health and Disability Act 2000 and the Crown Entity Act 2004, which includes the requirement to comply with New Zealand generally accepted accounting practice (NZ GAAP).

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

Measurement basis

The financial statements are prepared on the historical cost basis except that the following assets and liabilities are stated at their fair value: land and buildings.

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

Functional and presentation currency

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

Changes in accounting policies

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

Transition to PBE accounting standards.

In May 2013, the External Reporting Board issued a new suite of PBE accounting standards for application by public sector entities for reporting periods beginning on or after 1 July 2014. Canterbury DHB has applied these standards in preparing the 30 June 2015 financial statements.

In October 2014, the PBE suite of accounting standards was updated to incorporate requirements and guidance for the not-for-profit sector. These updated standards apply to PBEs with reporting periods beginning on or after 1 April 2015. Canterbury DHB has applied these updated standards in preparing these prospective financial statements. Canterbury DHB expects there will be minimal or no change in applying these updated accounting standards.

SIGNIFICANT ACCOUNTING POLICIES

Basis for Consolidation

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

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

Subsidiaries

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

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

Associates

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

The consolidated financial statements include Canterbury DHB's share of the total recognised gains and losses of associates on an equity accounted basis, from the date that significant influence commences until the date that significant influence ceases. When Canterbury DHB's share of losses exceeds its interest in an associate, Canterbury DHB's carrying

amount is reduced to nil and recognition of further losses is discontinued except to the extent that Canterbury DHB has incurred legal or constructive obligations or made payments on behalf of an associate.

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

Transactions eliminated on consolidation

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 surplus /deficit.

Budget figures

The budget figures are those approved by Canterbury DHB in its Annual Plan (incorporating the Statement of Intent) which is tabled in parliament. The budget figures have been prepared in accordance with NZ GAAP, 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 buildings
- 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.

Revaluations

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

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

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

Additions

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

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

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

Subsequent costs

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

Disposal of Property, Plant and Equipment

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

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

Depreciation

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

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

Class of Asset	**Year**	**Dep Rate**
Freehold Buildings & Fitout	10 – 50 2 -	10%
Leasehold Buildings	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, resulting in new or substantially improved software and processes, is capitalised if the product or process is technically and operationally feasible and Canterbury DHB has sufficient resources to complete development. The expenditure capitalised includes the cost of materials, direct labour and an appropriate proportion of overheads. Staff training and other costs associated with maintaining computer software are recognised as an expense when incurred. Capitalised development expenditure is stated at cost less accumulated amortisation and impairment losses.

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

Amortisation

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

Type of asset	Estimated life	Amortisation rate
Software	2-10 years	10 - 50%

Investments

Bank term deposits

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

After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest method, less any provision for impairment.

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.

A receivable is considered impaired when there is evidence that Canterbury DHB will not be able to collect the amount due. The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

Inventories

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

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

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

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.

Capital charge

The capital charge is recognised as an expense in the financial year to which the charge relates.

Impairment

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

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

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

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

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

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

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

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

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

Impairment of property, plant, and equipment and intangible assets

Canterbury DHB does not hold any cash-generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return.

Non-cash-generating assets

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

Value in use is determined using an approach based on either a depreciated replacement cost approach, restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of information. If an asset's carrying amount exceeds its recoverable service amount, the

asset is regarded as impaired and the carrying amount is written-down to the recoverable amount. The total impairment loss is recognised in the surplus or deficit.

The reversal of an impairment loss is recognised in the surplus or deficit.

Borrowings

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

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

Employee entitlements

Defined contribution plans

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

Defined benefit plans

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

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

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

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

Annual leave, conference leave and medical education leave

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

Presentation of employee entitlements

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

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 Canterbury DHB is liable for all its claims costs for a period of five years up to a specified maximum. At the end of the five year period, Canterbury DHB pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC.

The liability for the ACC Partnership Programme is measured using actuarial techniques at the present value of expected future payments to be made in respect of the employee injuries and claims up to the reporting date. Consideration is given to anticipated future wage and salary levels and experience of employee claims and injuries. Expected future payments are discounted using market yields on government bonds at balance date with terms to maturity that match, as closely to possible, the estimated future cash outflows.

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.

Income tax

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

Equity

Equity is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into the following components.

- Contributed capital;
- Revaluation reserve; and
- Accumulated surpluses/deficits.

Revaluation reserve

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

Goods and services tax

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

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

Revenue

The specific accounting policies for significant revenue items are explained below.

Ministry of Health population-based revenue

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

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

Ministry of Health contract revenue

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

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

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

Inter-district flows

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

ACC contract revenue

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

Interest revenue

Interest revenue is recognised using the effective interest method.

Rental revenue

Lease revenue under an operating lease is recognised as revenue on a straight-line basis over the lease term.

Provision of other services

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

Donations and bequests

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

Vested or donated physical assets

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

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

Donated services

Volunteer services received are not recognised as revenue or expenses by the group.

Operating lease payments

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

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 surplus or deficit.

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

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

Borrowing costs

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

Critical accounting estimates and assumptions

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

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

- Physical inspection of assets
- Asset replacement programs
- Review of second hand market prices for similar assets

- Analysis of prior asset sales.

In light of the Canterbury earthquakes, Canterbury DHB has reviewed the carrying value of land and buildings, resulting in an impairment. . Other than this review, Canterbury DHB has not made any other significant changes to past assumptions 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.

Leases classification

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

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

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

Non-government grants

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

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