

Canterbury DHB

Statement of Intent 2016/20

& Statement of Service Expectations 2016/2017



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

This Statement of Intent is extracted from the DHB's Annual Plan and presented to Parliament as a separate public accountability document. It 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 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 Statement of Intent present a picture of the collaborative activity that will be delivered by the Canterbury DHB and its Alliance partners.¹

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.

In signing this Statement of Intent, 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.²



Murray Cleverley
CHAIRMAN | CANTERBURY DHB



Steve Wakefield
DEPUTY CHAIRMAN | CANTERBURY DHB

November 2016

¹The 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.

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Part I

Overview

543,820
reasons to make
a difference



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 benchmarking 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 decisions 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 keep 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.



Murray Cleverley
CHAIRMAN

November 2016



David Meates
CHIEF EXECUTIVE

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 performed 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 \$1.660 billion to meet the needs of our population, which includes \$1.303 billion (10.85%) of the population based funding and subsequent new 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 document 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 10.4 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)

56

people have elective surgery



323



people are
discharged from
hospital



5,069

people are
supported in aged
resident care



1,753

outpatient
appointments

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

E8o

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 had been externally evaluated at well over \$100 million two years ago.

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.

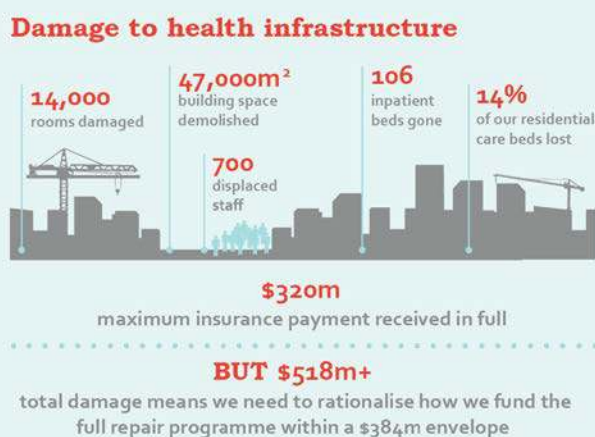
Population estimates do not fully account for the incoming rebuild population. Statistics New Zealand figures show 6,921 people coming into the city (net international migration) in the year to January 2016. In the year prior to earthquake it was 2,081. Changes to visa regulations have meant most of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

Our population growth

Our funded population has increased from 483,300 in 2006 to 529,905 in 2015. This is a growth rate of 9.6%.



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.

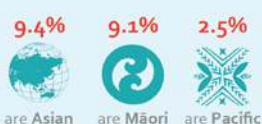
Our ageing population

Our population is older than the NZ average. By 2026, one in five people in Canterbury will be older than 65.



Our population diversity

Our population is becoming more diverse. In Canterbury, one person out of every five was born overseas.



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 Islands 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.

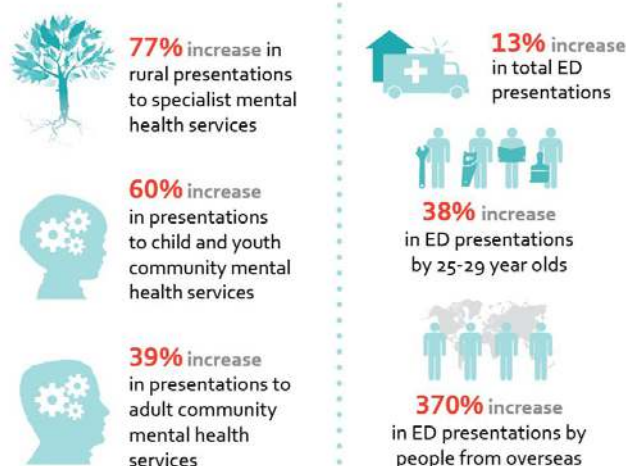
There are significant operational cost increases as a result of the earthquake including: the costs of responding to post-earthquake demand, outsourcing costs related to lost capacity, and unplanned capital and depreciation charges.

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.

Service demand

The earthquakes and rebuild have brought an unprecedented and unrelenting demand for mental health, emergency, and community services.



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 hospital 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

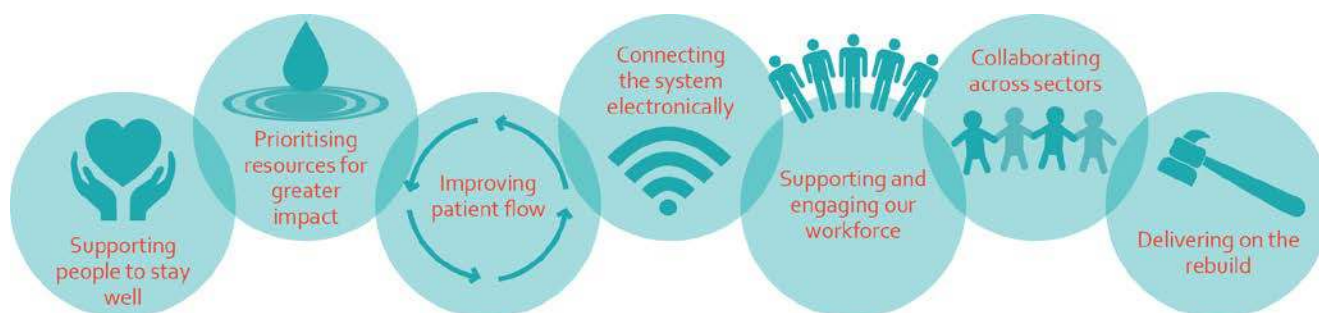
supports clinical decision-making and reduce waste and rework across our system. By providing the right care the first time, not only will we avoid unnecessary expenditure but people's experience and outcomes will be improved.

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

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 NZ'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 10.5 and 10.6 for 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

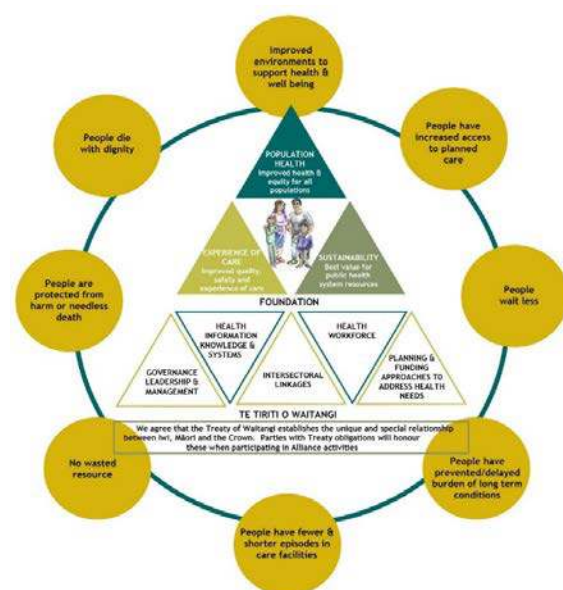
In delivering its commitment to better public services, and better, sooner, more convenient health services the Government has clear expectations of increased regional collaboration between DHBs.

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.

It's all about keeping people



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 (CCN) 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 10.7 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 strengthen 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 10.8 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 10.9 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 document. 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. Includes 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
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.	Obesity related services Smoking cessation services

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.

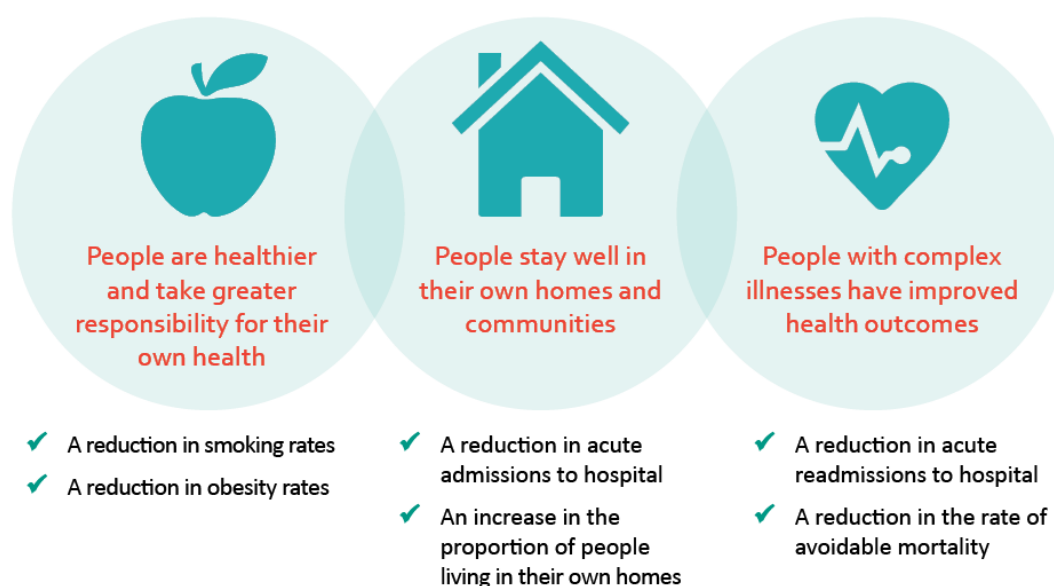
We have set local standards against these contributory measures in order to evaluate our performance annually. Performance expectations reflect the strategic objectives of our health system: increasing the effectiveness of prevention programmes; reducing acute or avoidable demand for hospital services; 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 10 for the DHB's Outcome Framework.

MINISTRY OF HEALTH SECTOR OUTCOMES

Health System Vision

All New Zealanders live well, stay well, get well.

New Zealanders are healthier & more independent

High-quality health & disability services are delivered in a timely & accessible manner

The future sustainability of the health system is assured

REGIONAL STRATEGIC GOALS

South Island Regional Vision

A sustainable South Island health & disability system, focused on keeping people well & providing equitable & timely access to safe, effective, high quality services, as close to people's homes as possible.

Population Health
Improved health & equity for all populations

Experience of Care
Improved quality, safety & experience of care

Sustainability
Best value from public health system resources

DHB LONG TERM OUTCOMES

What does success look like?

Canterbury DHB Vision

An integrated health system that keeps people healthy & well in their own homes & communities. A connected system, centered around the patient, that doesn't waste their time.

People are healthier & take greater responsibility for their own health.

- A reduction in smoking rates
- A reduction in obesity rates

People stay well, in their own homes & communities

- A reduction in the rate of acute admissions to hospital
- An increase in the proportion of people living in their own home

People with complex illness have improved health outcomes

- A reduction in the rate of acute readmissions to hospital
- A reduction in the rate of avoidable mortality

MEDIUM TERM IMPACTS

How will we know we are moving in the right direction?

- More babies are breastfed
- Children have improved oral health
- Fewer young people take up smoking

- People's conditions are diagnosed earlier
- Fewer people are admitted to hospital with avoidable or preventable conditions.
- Fewer people are admitted to hospital as a result of a fall

- People have shorter waits for urgent care
- People have increased access to planned care
- Fewer people experience adverse events in our hospitals

OUTPUTS

The services we deliver

Prevention & public health services

Early detection & management services

Intensive assessment & treatment services

Rehabilitation & support services

INPUTS

The resources we need

A skilled & engaged workforce

Strong alliances, networks & relationships

Sustainable financial resources

Appropriate quality systems & processes

Responsive IT & information systems

Fit for purpose assets & infrastructure

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.

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

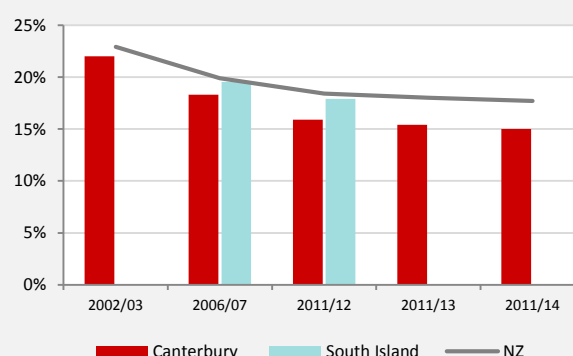
Tobacco smoking kills an estimated 5,000 people in NZ every year and is a major risk factor for six of the eight leading causes of death worldwide. Smoking is also a major contributor to preventable illness and long-term conditions, such as heart and respiratory disease and cancer.

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

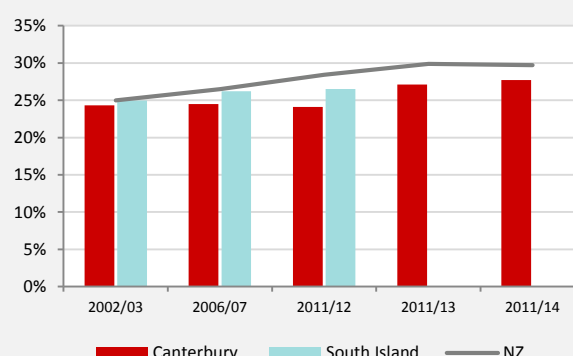
There has been a steady rise in obesity rates in New Zealand. The most recent NZ Health Survey found that 30% of adults and 10% of children are obese.

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.

INTERMEDIATE IMPACT INDICATORS | MAIN MEASURES OF PERFORMANCE

MORE BABIES ARE BREASTFED

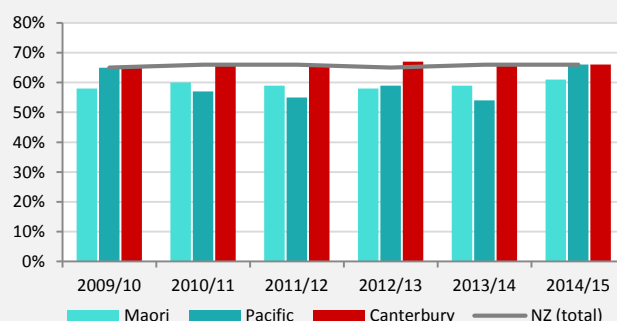
Breastfeeding helps lay the foundations for a healthy life, contributing positively to infant health and wellbeing and potentially reducing the likelihood of obesity later in life.

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 indicator of the impact of our health promotion and engagement activities.

Data source: Plunket⁹

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.

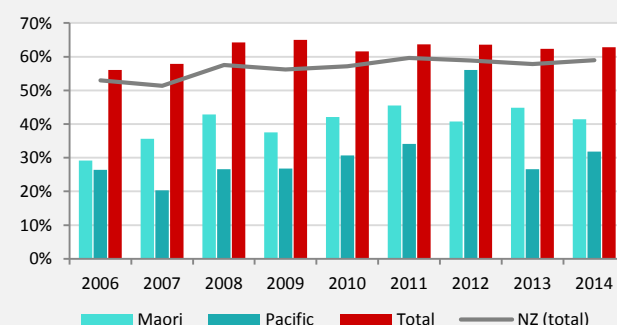
Good oral health not only reduces unnecessary hospital admission, but also signals a reduction in risk factors, such as poor diet, which have lasting benefits in terms of improved nutrition and health outcomes.

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 Services¹⁰

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

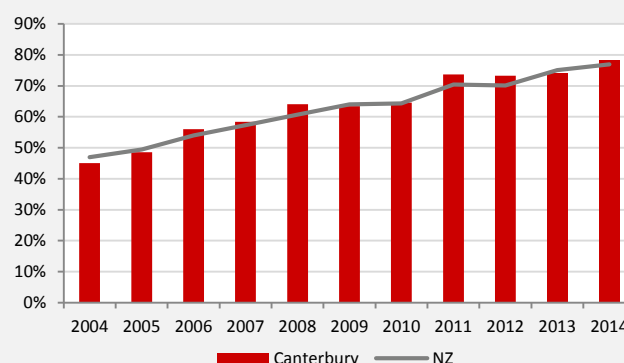
The highest prevalence of smoking is amongst younger people and preventing young people from taking up smoking is a key contributor to reducing smoking rates across the total population.

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 Survey¹¹

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

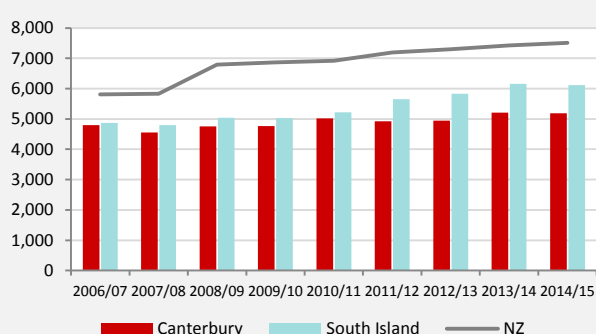
Long-term conditions have a significant impact on the quality of a person's life. However, with the right approach, people can live healthier lives and avoid the deterioration of their condition that leads to acute illness, hospital admission, complications and even premature death.

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

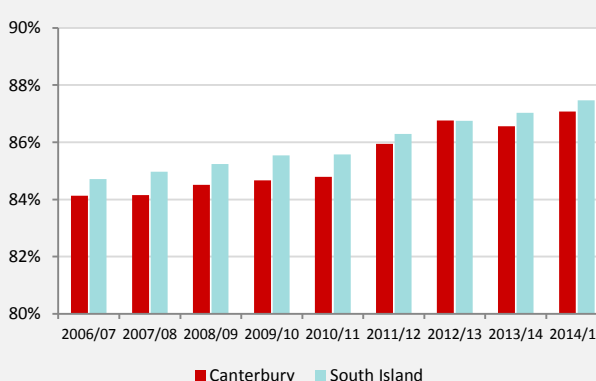
While living in residential care is appropriate for a small proportion of our population, studies have shown a higher level of satisfaction and better long-term outcomes, when people remain in their own homes and positively connected to their local communities.

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



INTERMEDIATE IMPACT INDICATORS | MAIN MEASURES OF PERFORMANCE

CONDITIONS ARE DIAGNOSED EARLIER

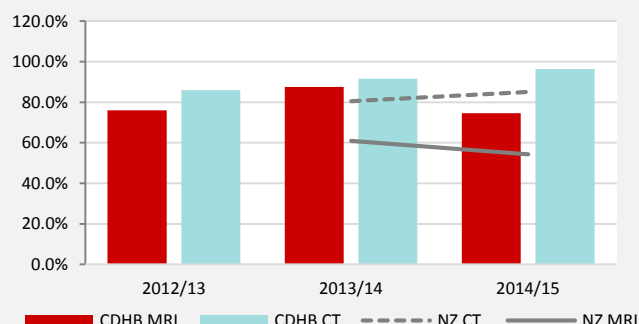
Timely access to diagnostics, by improving clinical decision-making, enables early and more appropriate intervention. This contributes to both improved quality of care and improved health outcomes.

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

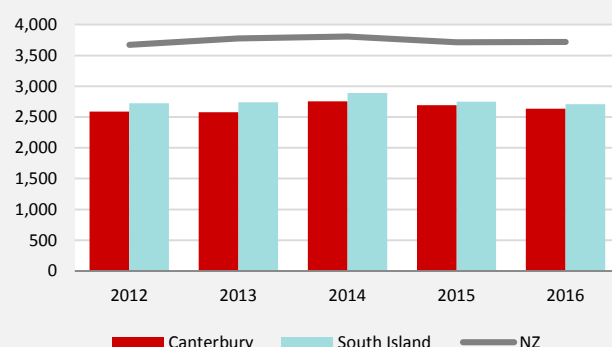
A number of admissions to hospital are for conditions which are seen as preventable through lifestyle change, early intervention and the effective management of long-term conditions - including improved coordination of care across primary and secondary services.

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.

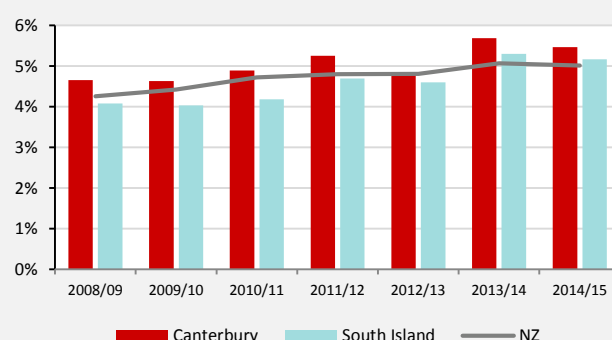
With an ageing population, our focus on reducing falls will help people to stay well and independent and reduce the demand on acute and residential care services.

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

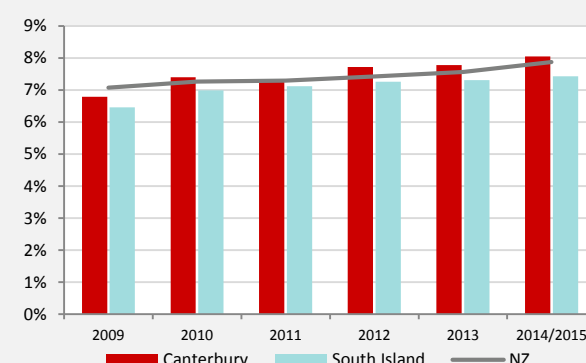
As well as reducing public confidence and driving unnecessary costs - patients who are readmitted to hospital are more likely to experience negative longer-term outcomes and a loss of confidence in the system.

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

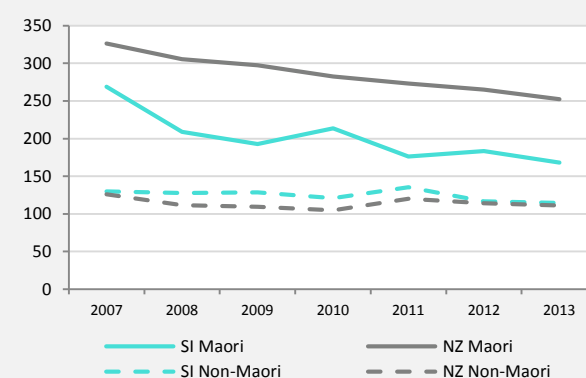
There are many upstream determinants of health, such as economic, social and environmental factors that have an influence on people's life expectancy. However premature mortality (death before age 65) is still partly preventable through lifestyle change, earlier intervention and the effective management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

INTERMEDIATE IMPACT INDICATORS | MAIN MEASURES OF PERFORMANCE

SHORTER WAITS FOR URGENT CARE

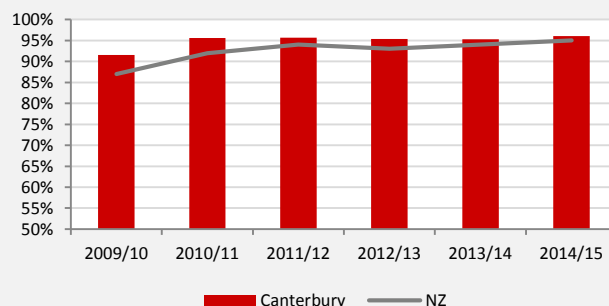
Emergency Departments (EDs) are often seen as a barometer of the efficiency and responsiveness of both the hospital and the wider health system.

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

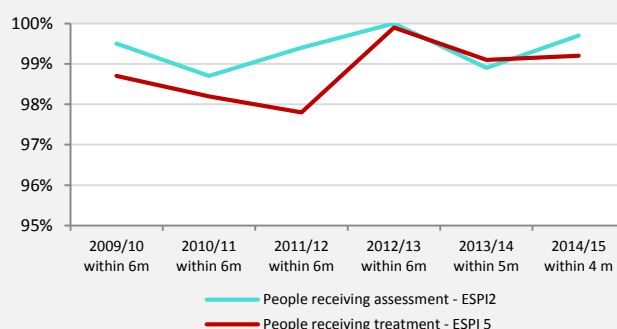
Access to elective services (including specialist assessment, treatment and surgery) improves the quality of people's lives by removing pain or discomfort, slowing the progression of disease and contributes to restoring independence and wellbeing.

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
ESPI ₂	99.7%	100%	100%	100%	100%
ESPI ₅	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.

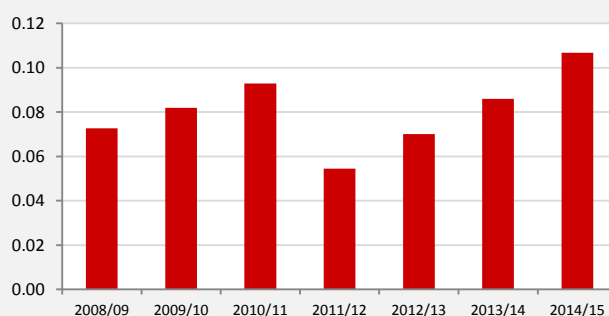
The rate of falls is particularly important, as patients who experience a serious fall are more likely to have prolonged hospital stays, loss of confidence, conditioning and independence and an increased risk of institutional care.

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.

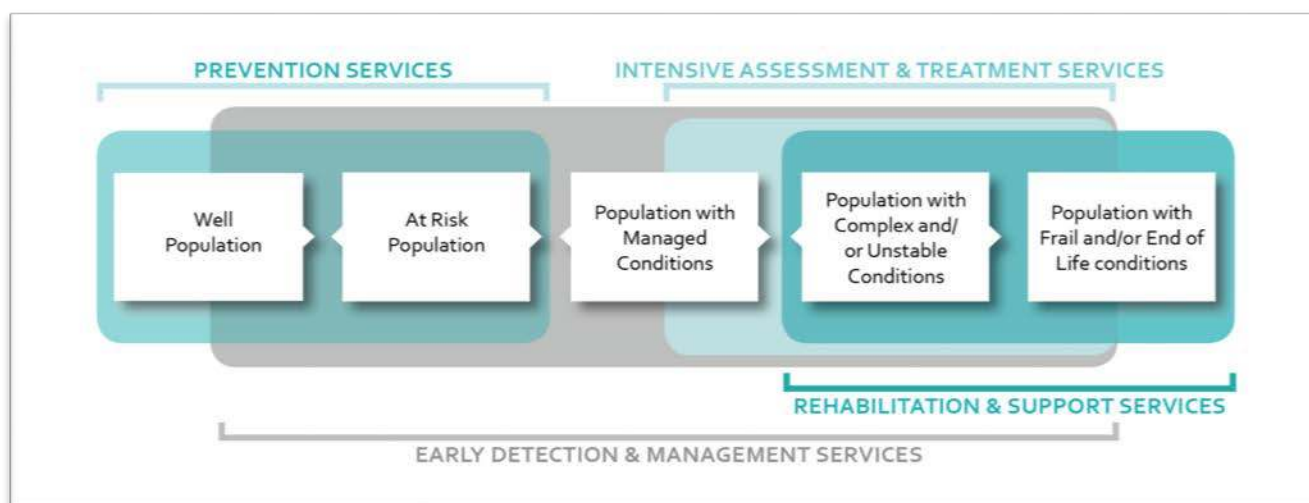
¹⁸ The Severity Assessment Code (SAC) is a numerical score given to an incident based on the outcome of the incident and the likelihood that it will recur. Level 1 and 2 incidents are those with both the highest likelihood and consequence. The rate is per 1,000 inpatient beds.

Part III

Annual Operating Intentions

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.¹⁹ 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

¹⁹ The Annual Report is tabled in Parliament and is available on the DHB's website: www.cdhb.health.nz.

or avoidable hospital admissions and maintaining service access - while reducing waiting times and delays in treatment.

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 respond 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

	2016/17
Revenue	Total \$'000
Prevention	35,551
Early detection and management	333,994
Intensive assessment & treatment	1,045,285
Rehabilitation & Support	245,580
Total Revenue - \$'000	1,660,410

Expenditure	Total \$'000
Prevention	35,948
Early detection and management	340,357
Intensive assessment & treatment	1,071,287
Rehabilitation & Support	249,882
Total Expenditure - \$'000	1,697,474

Surplus/(Deficit) - \$'000	(37,064)
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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.
- △ 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.²⁰ 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 ²¹	80%	≥75%	-
% of babies exclusive/fully breastfed at LMC discharge	Q ²²	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 ²³	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 ²⁴	2,797	3,000	-
% of Green Prescription participants more active 6-8 months after referral	Q ²⁵	62%	>50%	-
% of women smokefree at two weeks postnatal	Q ²²	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%	-

²⁰ World Health Organisation identifies the main non-communicable diseases are cancer, diabetes, cardiovascular and respiratory disease.

²¹ 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.

²² 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.

²³ 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.

²⁴ A Green Prescription is a health professional's written advice to a patient to be physically active, as part of their health management.

²⁵ Results are taken from national patient survey completed 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 ²⁶	91%	>90%	92%
% of 'high needs' four-year-olds provided with a B4 School Check	C ²⁷	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 ²⁸	new	95%	new
% of Year 9 students in decile 1-3 schools provided with a HEEADSSS assessment	C † ²⁹	98%	>95%	-
% of women aged 25-69 having a cervical cancer screen in the last 3 years	C ³⁰	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 ³⁰	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 ³¹	98%	95%	97%
% of eligible girls completing the HPV vaccination programme	C † ³²	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%	-

²⁶ 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.

²⁷ The high needs grouping includes Māori, Pacific and children living in high deprivation areas.

²⁸ This measure is the newly introduced national Raising Healthy Kids health target.

²⁹ 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.

³⁰ 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.

³¹ '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.

³² 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 ³³		555	>500	-
Avoidable hospital admission rate for children aged 0-4	Q ³⁴		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 ³⁵		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%	-

³³ 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.

³⁴ 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.

³⁵ 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 ³⁶	1,682	>1,000	
% of the eligible population having a CVD Risk Assessment in the last 5 years	C ◇ ³⁷	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 ³⁸	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 ³⁹	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 ⁴⁰	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 ⁴¹	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 ⁴²	98%	>95%	94%

³⁶ 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.

³⁷ 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.

³⁸ 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.

³⁹ This measure may include some non-Canterbury residents who had prescriptions filled while in Canterbury.

⁴⁰ 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.

⁴¹ 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.

⁴² 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. ⁴³	Notes	2014/15 Result	2016/17 Target	2014/15 National Average
Rate of compliance with good hand hygiene practice	Q \diamond ⁴⁴	77%	80%	80%
% of hip and knee replacement patients receiving cefazolin $\geq 2g$	Q \diamond ⁴⁵	98%	95%	96%
% of hip and knee replacement patients who have appropriate skin preparation	Q \diamond	100%	100%	99%
% of inpatients (aged 75+) who received a falls assessment	Q \diamond ⁴⁶	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 ⁴⁷	12%	13%	-

⁴³ 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 previously published and relate to the final 2014/15 quarter.

⁴⁴ This measure is based on ward audits of medical and surgical wards conducted according to Hand Hygiene NZ standards.

⁴⁵ Cefazolin $\geq 2g$ is an antibiotic recommended as routine for hip and knee replacements to prevent infection complications.

⁴⁶ 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.

⁴⁷ 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 ⁴⁸	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 ⁴⁹	31,182	>28,000	-
Attendances at Canterbury Emergency Departments	A ⁵⁰	91,253	E. <96k	-
% of people waiting less than 4 weeks for radiotherapy or chemotherapy	T ◇ ⁵¹	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 ◇ ⁵²	73%	90%	68%
Acute inpatient average length of hospital stay (standardised)	Q ⁵³	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 ⁵⁴	69,199	E.>60k	-
% of First Specialist Assessments that were non-contact (virtual)	Q ⁵⁵	15.6%	>10%	-
Elective/arranged surgical discharges (surgeries provided)	A ◇ ⁵⁶	20,353	20,982	-
% of elective/arranged surgeries provided as day cases	Q ⁵⁷	58%	≥57%	-
% of people who receive their surgery on the day of admission	Q ⁵⁷	91%	≥90%	-
Elective inpatient average length of hospital stay (standardised)	Q ⁵³	1.57	<1.55	1.64
Outpatient attendances	V ⁵⁸	639,232	E.>600k	-
Outpatient 'Did not Attend' rates (total population)	Q ⁵⁹	5.4%	<5%	-
Outpatient 'Did not Attend' rates (Māori)	Q	10.7%	<5%	-

⁴⁸ This measure was previously related to children under six — Canterbury consistently achieved 100% against this measure.

⁴⁹ 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.

⁵⁰ 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.

⁵¹ 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.

⁵² This measure is the national Faster Cancer Track Health Target which was introduced in Q2 of 2014/15.

⁵³ 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.

⁵⁴ 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).

⁵⁵ Non-contact FSAs are those where specialist advice and assessment is provided without the need (or the wait) for a hospital appointment.

⁵⁶ 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.

⁵⁷ 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.

⁵⁸ 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.

⁵⁹ 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 is an important factor in ensuring patients get the treatment they need 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 ⁶⁰		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 ⁶¹		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 ⁶²		3,462	E.>3,000	-
% of admissions into OPH AT&R made by direct community referral	Q ⁶³		21%	20%	-
% of OPH AT&R inpatients discharged to their own home rather than into ARC	Q Δ ⁶⁴		87%	>80%	-

⁶⁰ 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.

⁶¹ 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.

⁶² This result differs slightly to that previously published (3,450) due to the inclusion of 12 late invoices.

⁶³ 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).

⁶⁴ 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 ⁶⁵	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 ⁶⁶	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 ⁶⁷	94%	95%	-
People accessing CREST services, on hospital discharge or GP referral	A Δ ⁶⁸	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	-

⁶⁵ This measure counts those accessing Phase 2 (outpatient) cardiac rehabilitation on discharge.

⁶⁶ This measure includes people attending DHB funded pulmonary rehabilitation programmes (Ashburton, Christchurch, community-based).

⁶⁷ 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.

⁶⁸ 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 ⁶⁹	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 ⁶⁷	99%	95%	-
Subsidised ARC rest home beds provided (days)	A Δ ⁷⁰	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	-

⁶⁹ 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.

⁷⁰ Baselines for the ARC bed day have been revised to reflect improved data recording and calculations around start and end dates of stay.

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 the \$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 it 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

Earthquake 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 \$29.6 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 \$1.660 billion 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 \$37 million deficit result for the 2016/17 year.

The \$37 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 uncertainty 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 \$71 million per annum (from \$69 million per annum in 2015/16 to approximately \$140 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 NZ accounting standards) some future costs are not able to be offset with the corresponding inflow of insurance proceeds. This creates a detrimental 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.
- 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 assumptions.
- 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.

8.4 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:

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 is 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 includes:

- \$215 million new Burwood facility (cost of asset to be transferred from the Crown).
- \$15 million strategic earthquake programme of works (capital expenditure portion).
- \$4 million Patient Information Care System.
- \$2 million Electronic Medication Management.
- \$39 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 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 is expected to rise from \$146 million to \$232 million as at June 2017. The increase being the estimated loan for the new Burwood facility. This assumes a split for the \$215 million redevelopment, which differs from the 60% debt and 40% equity split indicated in the detailed business case.

By June 2019, the debt level is expected to be \$521 million to take into account the additional loan for the new Christchurch Hospital Acute Services Building. The timing of the respective loans will be aligned with the asset transfer dates.

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 Crown is proposing to translate all loans into equity, however, as this proposal is yet to be finalised and formally advised to the DHBs, we have not adjusted our financials to reflect the impact of this proposal.

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.

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.

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 10.11.

Statement of Financial Expectations

E8o

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	1,613,679	1,662,826	1,708,699	1,748,382
Other revenue	27,379	35,216	29,872	31,205	32,545	43,809
Earthquake repair revenue redrawn	13,150	9,882	14,000	11,600	2,900	2,100
Interest revenue	5,260	2,463	2,859	3,410	4,052	4,636
Total Revenue	1,558,651	1,606,116	1,660,410	1,709,041	1,748,196	1,798,927
Expense						
Employee benefit costs	659,665	693,369	714,276	736,047	756,496	779,984
Treatment related costs	144,564	142,198	149,352	153,147	156,595	162,068
External service providers	583,038	606,747	628,064	636,890	644,208	646,819
Depreciation and amortisation	61,135	57,739	59,151	62,433	67,954	68,623
Finance costs	5,886	5,575	8,728	9,015	15,028	23,446
Other expenses	96,303	101,729	103,069	106,101	107,855	107,068
Earthquake building repair costs	13,150	9,882	14,000	11,600	2,900	2,100
Capital charge expense	12,846	5,726	20,834	26,856	28,193	47,815
Total Operating Expenses	1,576,587	1,622,965	1,697,474	1,742,089	1,779,229	1,837,923
Surplus/(Deficit) before deficit funding	(17,936)	(16,849)	(37,064)	(33,048)	(31,033)	(38,996)
Deficit funding revenue	-	16,376	-	-	-	-
Surplus/(Deficit) after deficit funding	(17,936)	(473)	(37,064)	(33,048)	(31,033)	(38,996)
Other comprehensive revenue and expense	(62)	91,753	-	-	-	-
Total Comprehensive Revenue and Expense	(17,998)	91,280	(37,064)	(33,048)	(31,033)	(38,996)

Note: We have aligned our out-years forecast to reflect the current PWC modelling, adjusted for assumptions that have not been formally advised to the DHB e.g. reduction in capital charge (2017/18 \$5.8 million, 2018/19 \$11.9 million, and 2019/20 \$15 million). We have also adjusted for the depreciation impact differential due to increased asset values arising from revaluation.

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	(313,790)	(282,151)	(104,949)	(68,762)	211,810	289,945
Revaluation reserve	199,096	290,849	290,850	290,850	290,850	290,850
Accumulated surpluses	191,708	191,235	154,171	121,123	90,090	51,094
TOTAL EQUITY	77,014	199,933	340,072	343,211	592,750	631,889
REPRESENTED BY:						
CURRENT ASSETS						
Cash & cash equivalents	3,640	13,546	(13,733)	14,633	44,132	47,453
Trade & other receivables	56,827	69,349	106,414	102,398	100,383	108,346
Inventories	8,593	9,432	9,972	9,972	9,972	9,972
Restricted assets	13,769	8,060	8,060	8,060	8,060	8,060
Assets held for sale	-	540	-	-	-	-
Investments	400	1,000	1,000	1,000	1,000	1,000
TOTAL CURRENT ASSETS	83,229	101,927	111,713	136,063	163,547	174,831
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)	(163,792)	(139,442)	(111,958)	(100,674)
NON CURRENT ASSETS						
Property, plant, & equipment	401,277	499,233	711,723	679,748	1,187,722	1,210,913
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	742,210	720,999	1,231,654	1,259,509
NON CURRENT LIABILITIES						
Employee benefits	6,458	6,361	6,361	6,361	6,361	6,361
Borrowings	145,985	145,985	231,985	231,985	520,585	520,585
TOTAL NON CURRENT LIABILITIES	152,443	152,346	238,346	238,346	526,946	526,946
NET ASSETS	77,014	199,933	340,072	343,211	592,750	631,889

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	340,072	343,211	592,750
Total comprehensive revenue and expense for the year	(17,998)	91,280	(37,064)	(33,048)	(31,033)	(38,996)
Other Movements						
Equity Repayments						
<i>Contribution towards new facilities redevelopment</i>	(120,000)	-	-	-	-	-
<i>Assets disposal net proceeds remitted to Crown</i>	-	-	-	-	-	(20,000)
<i>Annual depreciation funding repayment</i>	(1,861)	(1,861)	(1,861)	(1,861)	(1,861)	(1,861)
Equity Injections						
<i>Earthquake repair capital redrawn</i>	-	33,500	13,000	5,000	59,000	61,000
<i>Operating deficit support</i>	12,500	-	37,064	33,048	31,033	38,996
<i>New facilities redevelopment assets transferred from the Crown (equity value)</i>	-	-	129,000	-	192,400	-
Total Equity at End of the Year	77,014	199,933	340,072	343,211	592,750	631,889

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	1,570,598	1,600,810	1,644,833	1,682,612
Earthquake repair revenue redrawn	12,300	9,882	14,000	11,600	2,900	2,100
Other receipts	104,369	30,316	72,953	93,221	96,411	99,679
Interest received	5,260	2,463	2,859	3,410	4,052	4,636
	1,590,262	1,597,470	1,660,410	1,709,041	1,748,196	1,789,027
Cash applied to:						
Payments to employees	657,120	699,786	714,276	736,047	756,496	779,984
Payments to suppliers	862,298	844,786	888,485	907,750	911,571	918,068
Interest paid	5,907	4,910	8,728	9,015	15,028	23,446
Capital charge	12,845	5,726	20,834	26,856	28,193	47,815
GST - net	5,137	639	-	-	-	-
	1,543,307	1,555,847	1,632,323	1,679,668	1,711,288	1,769,313
Net Cash Flow from Operating Activities	46,955	41,623	28,087	29,373	36,908	19,714
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	281,505	41,222	578,609	106,578
	71,784	80,704	281,505	41,222	578,609	106,578
Net Cash Flow from Investing Activities	(20,776)	(66,578)	(281,505)	(41,222)	(578,609)	(86,578)
CASH FLOW FROM FINANCING ACTIVITIES						
Cash provided from:						
Loans raised	15,000	-	86,000	-	288,600	-
Equity Injections						
Earthquake repair capital redrawn	-	33,500	13,000	5,000	59,000	61,000
Operating deficit support	-	12,500	-	37,076	33,061	31,046
Equity value of Burwood and Christchurch facilities redeveloped assets transferred from the Crown	-	-	129,000	-	192,400	-
	15,000	46,000	228,000	42,076	573,061	92,046
Cash applied to:						
Loans repaid	15,000	-	-	-	-	-
Equity Repayments						
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	1,861	1,861	1,861	21,861
Net Cash Flow from Financing Activities	(121,861)	44,139	226,139	40,215	571,200	70,185
Net increase/(decrease) in cash and cash equivalents	(95,682)	19,184	(27,279)	28,366	29,499	3,321
Cash and cash equivalents at beginning of year	90,044	(5,638)	13,546	(13,733)	14,633	44,132
CASH & CASH EQUIVALENTS AT END OF YEAR	(5,638)	13,546	(13,733)	14,633	44,132	47,453
REPRESENTED BY:						
Cash & cash equivalents	3,640	13,546	(13,733)	14,633	44,132	47,453
NZHPL sweep bank account	(9,278)	-	-	-	-	-
CASH & CASH EQUIVALENTS AT END OF YEAR	(5,638)	13,546	(13,733)	14,633	44,132	47,453

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	1,500,273	1,545,879	1,588,389	1,624,678
Other revenue	250	1,417	-	-	-	-
Total Revenue	1,411,900	1,463,248	1,500,273	1,545,879	1,588,389	1,624,678
Expense						
Personal Health	1,020,903	1,061,537	1,089,849	1,120,051	1,149,822	1,183,364
Mental Health	144,415	146,326	153,075	157,452	161,920	161,179
Disability Support	239,661	243,760	251,062	255,678	260,199	265,099
Public Health	2,484	3,506	3,702	3,752	3,798	3,844
Maori Health	2,041	2,210	2,153	2,184	2,213	2,242
Total Operating Expenses	1,409,504	1,457,339	1,499,841	1,539,117	1,577,952	1,615,728
Surplus/(Deficit) before deficit funding	2,396	5,909	432	6,762	10,437	8,950
Deficit funding revenue	-	16,376	-	-	-	-
Surplus/(Deficit) after deficit funding	2,396	22,285	432	6,762	10,437	8,950
Other comprehensive revenue and expense	-	-	-	-	-	-
Total Comprehensive Revenue & Expense	2,396	22,285	432	6,762	10,437	8,950
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	8,376	8,982	9,152	9,432
Treatment related costs	763	1,305	1,632	1,632	1,632	1,632
Depreciation and amortisation	31	42	44	44	44	44
Interest expenses on loans	-	-	-	-	-	-
Other expenses	(4,789)	(5,521)	(5,732)	(6,269)	(6,369)	(6,577)
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	981,683	1,015,626	1,050,457	1,088,966
Other revenue	26,573	33,605	29,052	30,364	31,683	42,925
Earthquake repair revenue redrawn	13,150	9,882	14,000	11,600	2,900	2,100
Interest revenue	5,260	2,463	2,859	3,410	4,052	4,636
Total Revenue	970,076	990,456	1,027,594	1,061,000	1,089,092	1,138,627
Expense						
Employee benefit costs	652,529	685,155	705,900	727,065	747,344	770,552
Treatment related costs	143,801	140,893	147,720	151,515	154,963	160,436
Depreciation and amortisation	61,104	57,697	59,107	62,389	67,910	68,579
Interest expenses on loans	5,886	5,575	8,728	9,015	15,028	23,446
Other expenses	101,092	107,250	108,801	112,370	114,224	113,645
Earthquake building repair costs	13,150	9,882	14,000	11,600	2,900	2,100
Capital charge expense	12,846	5,726	20,834	26,856	28,193	47,815
Total Operating Expenses	990,408	1,012,178	1,065,090	1,100,810	1,130,562	1,186,573
Surplus/(Deficit) before deficit funding	(20,332)	(21,722)	(37,496)	(39,810)	(41,470)	(47,946)
Deficit funding revenue	-	-	-	-	-	-
Surplus/(Deficit) after deficit funding	(20,332)	(21,722)	(37,496)	(39,810)	(41,470)	(47,946)
Other comprehensive revenue and expense	(62)	91,753	-	-	-	-
Total Comprehensive Revenue & Expense	(20,394)	70,031	(37,496)	(39,810)	(41,470)	(47,946)
In House Elimination						
Revenue						
Patient care revenue	(826,466)	(850,592)	(871,777)	(902,227)	(933,744)	(968,909)
Total Revenue	(826,466)	(850,592)	(871,777)	(902,227)	(933,744)	(968,909)
Expense						
Other expenses	(826,466)	(850,592)	(871,777)	(902,227)	(933,744)	(968,909)
Total Operating Expenses	(826,466)	(850,592)	(871,777)	(902,227)	(933,744)	(968,909)
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	1,613,679	1,662,826	1,708,699	1,748,382
Other revenue	27,379	35,216	29,872	31,205	32,545	43,809
Earthquake repair revenue redrawn	13,150	9,882	14,000	11,600	2,900	2,100
Interest revenue	5,260	2,463	2,859	3,410	4,052	4,636
Total Revenue	1,558,651	1,606,116	1,660,410	1,709,041	1,748,196	1,798,927
Expense						
Employee benefit costs	659,665	693,369	714,276	736,047	756,496	779,984
Treatment related costs	144,564	142,198	149,352	153,147	156,595	162,068
External service providers	583,038	606,747	628,064	636,890	644,208	646,819
Depreciation and amortisation	61,135	57,739	59,151	62,433	67,954	68,623
Finance costs	5,886	5,575	8,728	9,015	15,028	23,446
Other expenses	96,303	101,729	103,069	106,101	107,855	107,068
Earthquake building repair costs	13,150	9,882	14,000	11,600	2,900	2,100
Capital charge expense	12,846	5,726	20,834	26,856	28,193	47,815
Total Operating Expenses	1,576,587	1,622,965	1,697,474	1,742,089	1,779,229	1,837,923
Surplus/(Deficit) before deficit funding	(17,936)	(16,849)	(37,064)	(33,048)	(31,033)	(38,996)
Deficit funding revenue	-	16,376	-	-	-	-
Surplus/(Deficit) after deficit funding	(17,936)	(473)	(37,064)	(33,048)	(31,033)	(38,996)
Other comprehensive revenue and expense	(62)	91,753	-	-	-	-
Total Comprehensive Revenue & Expense	(17,998)	91,280	(37,064)	(33,048)	(31,033)	(38,996)

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	Canterbury's Commitment to National Health Targets
Appendix 10.6	NZ Health Strategy – Canterbury's Roadmap of Actions 2016/17
Appendix 10.7	Canterbury Clinical Network - Strategic Focus 2016/18
Appendix 10.8	Information Systems Overview
Appendix 10.9	Asset Performance Indicators
Appendix 10.10	Canterbury's Outcomes Framework
Appendix 10.11	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.

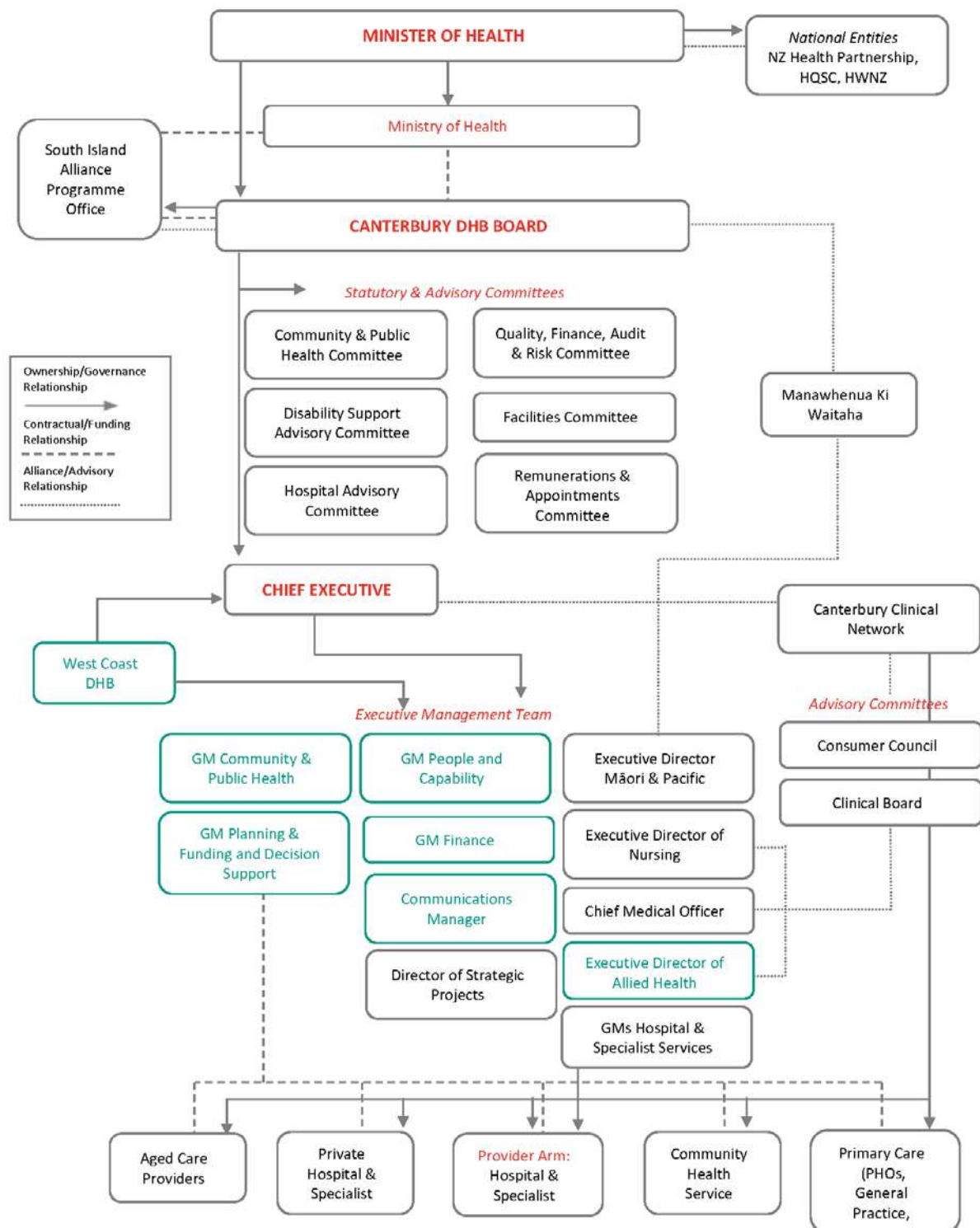
The Crown Entities Act 2004 and the Public Finance Act 1989, both referenced in this document, are available on the Treasury website www.treasury.govt.nz.

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 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



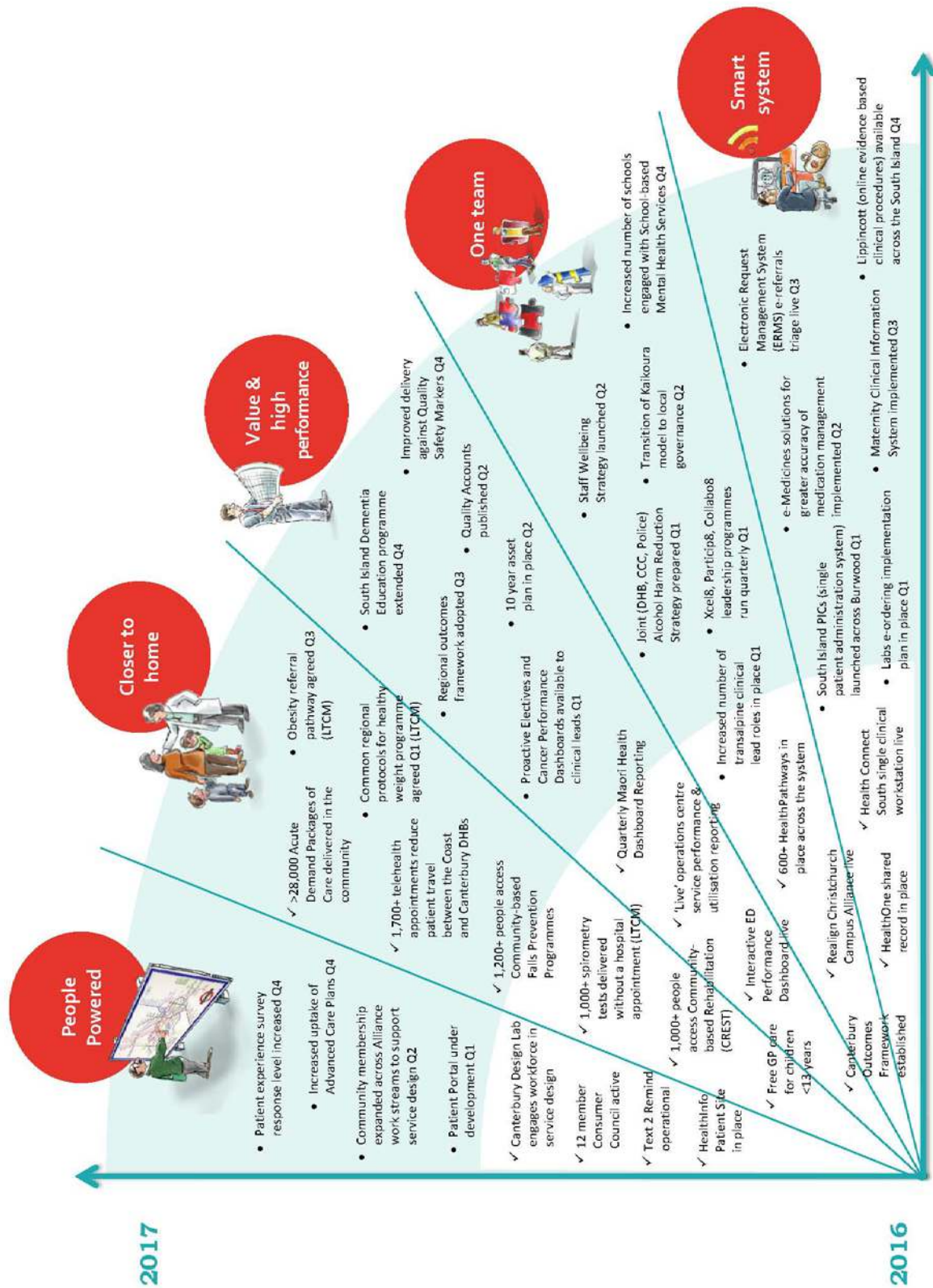
FASTER CANCER TREATMENT

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

10.6 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.

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.

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.

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.

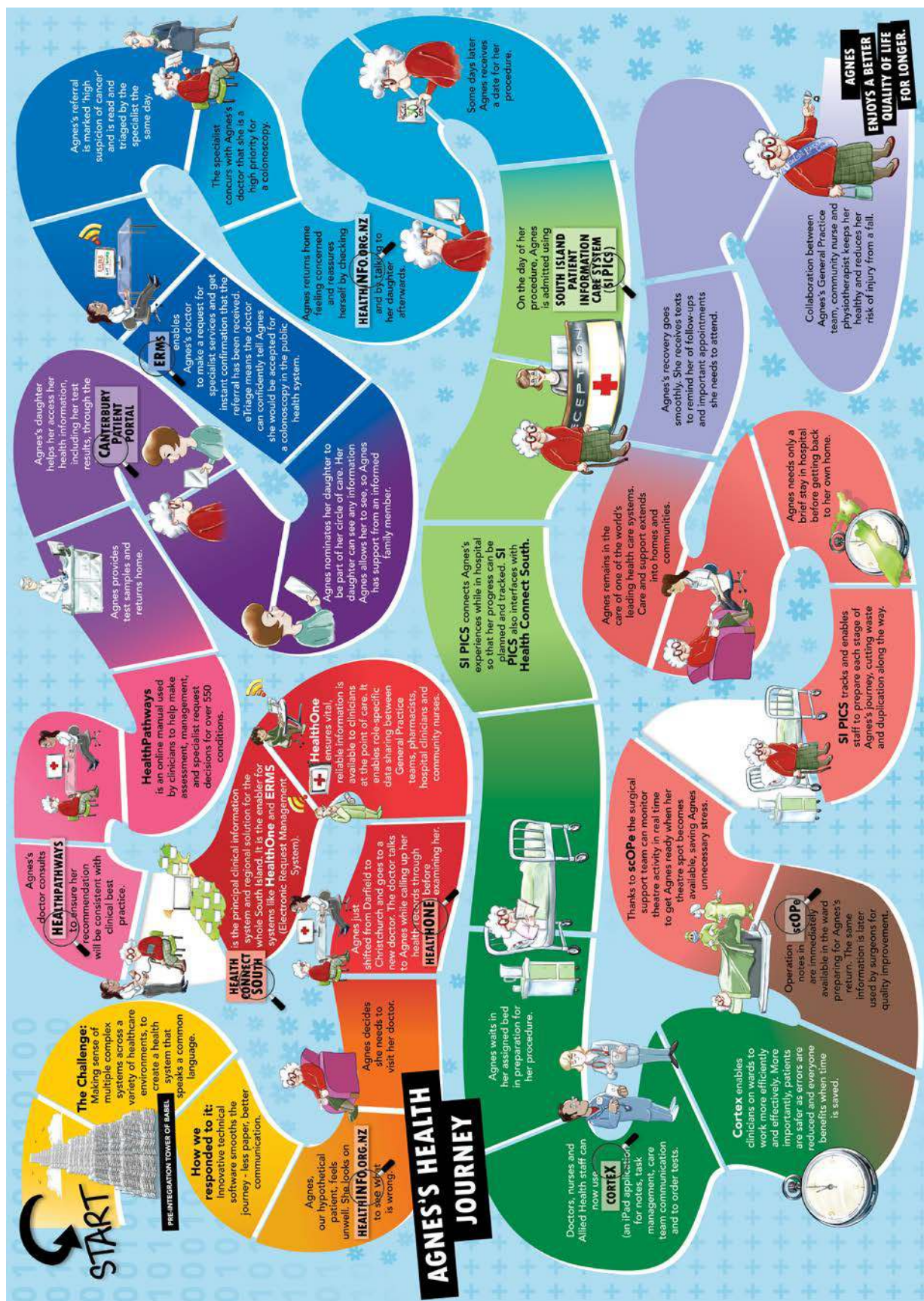
Healthier environments:
Influence transparent urban design with a focus on wellness, including encouraging increased physical activity, better housing and reduced rates of obesity.

Further integration & rationalisation
Align, coordinate and consolidate work group activity while optimising activity that supports the patient's seamless journey through the health system.

www.ccn.health.nz

Canterbury Clinical Network
Transforming Health Care. Whānau Ora ki Wāitaha.

10.8 Information systems overview



10.9 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% ⁷¹	Condition	-	100%	83%	100%
Number of patients presenting at the Christchurch Hospital Emergency Department ⁷²	Utilisation	86,035	<91,000	88,581	<91,000
Number of elective surgical discharges delivered ⁷³	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 ⁷⁴	Functionality	3.42	<2.45	2.39	<2.35
Elective inpatient average length of stay ⁷⁴	Functionality	2.99	<1.59	1.54	<1.55
Energy consumption per sqm (kWh/sqm) ⁷⁵	Functionality	442	<500	413.8	<500

⁷¹ All critical property providing clinical services are to have an NBS greater than 34%.

⁷² This measure is based on the national ED Health Target definition, but reflects Christchurch Hospital ED only, standards were set as part of the business case for the expansion of the Christchurch Hospital ED.

⁷³ 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.

⁷⁴ The average length of stay measures sit under the national DHB performance set (OS3) standards are set nationally and are standardised.

⁷⁵ 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 ⁷⁶	Utilisation	-	>98%	100%	>98%
Percentage of CT uptime vs. operational hours ⁷⁶	Utilisation	-	>98%	100%	>98%
Percentage of Linac uptime vs. operational hours ⁷⁷	Utilisation	97%	>98%	98%	>98%
Percentage of people accepted for an urgent diagnostic colonoscopy receiving their procedure within 2 weeks ⁷⁸	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 ⁷⁹	Condition	-	>20%	35%	>20%
Percentage uptime for critical applications (Health Connect South, Rhapsody, Éclair, MedChart) ⁸⁰	Utilisation	-	>99%	100%	>99%
Percentage of GPs utilising the Electronic Referral Management System (ERMS) for referrals	Utilisation		>80%	97%	80%
Customer satisfaction level with service desk ⁸¹	Functionality	-	>2.6	4.4	>2.6
Annual network penetration test risk level (5-critical, 4-high, 3-medium, 2-low, 1-informational) ⁸²	Functionality	-	<2	2	<2

⁷⁶ The MRI and CT uptime results are collated manually the 2015/16 results are for the year to June 2016.

⁷⁷ The Linac uptime results baseline is for the calendar year to June 2016.

⁷⁸ 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.

⁷⁹ Live updates provide storage capacity results at a point in time – the results for 2015/16 is at May 2016.

⁸⁰ These results are captured at a point in time – the 2015/16 result is for six months January-June 2016.

⁸¹ 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.

⁸² 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.

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10.11 Statement of accounting policies

The prospective financial statements in this Statement of Intent (SOI) 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 financial information in this document 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 this document.

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 as 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.

STATEMENT OF INTENT

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Whilst every intention is made to ensure the information in this plan is correct, the Canterbury DHB gives no guarantees as to its accuracy or with regards to the reliance placed on it. If you suspect an error in any of the data contained in the Statement of Intent (SOI), please contact the Planning & Funding Division of the DHB so this can be rectified.