Canterbury DHB

ANNUAL PLAN 2015/16

Incorporating the Statement of Intent 2015-2018
& Statement of Service Expectations 2015/2016

Statement of Responsibility

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

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

The Plan sets out the goals and objectives of the Canterbury DHB and describes what the DHB intends to achieve in terms of improving the health of its population and ensuring the sustainability of the health system. The Plan also contains service and financial forecast information for the current year 2015/16 and three subsequent out-years: 2016/17 to 2018/19.

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

The Minister of Health has been very clear in setting his annual expectations for 2015/16 that DHBs must focus on integration and strong clinical leadership. The Canterbury DHB has made a clear commitment to a 'whole of system' approach to 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 and the South Island Regional Alliance.

In line with this approach, the actions outlined in this Annual Plan present a picture of the joint commitment and activity that will be undertaken by the Canterbury DHB and its alliance partners to improve the health of the Canterbury community and deliver against the expectations of Government. [1]

The Canterbury DHB also has Māori Health Action Plan and Public Health Action Plans for 2015/16, both of which are companion documents to this Annual Plan. These Plans set out further actions and activity to improve population health and reduce inequalities in health status and outcomes. Both of these documents are available on the Canterbury DHB website: www.cdhb.health.nz.

In signing this Annual Plan, we are satisfied that it accurately represents the intentions and commitments of the Canterbury DHB and the wider Canterbury health system. Together, we will continue to strive to make real gains and improvements in the health of our population.

Murray Cleverley
CHAIRMAN | CANTERBURY DHB

Steve Wakefield
DEPUTY CHAIRMAN | CANTERBURY DHB

Honourable Jonathan Coleman
MINISTER OF HEALTH

Honourable Bill English
MINISTER OF FINANCE

March 2016

[1] *The CCN Work Plan and the South Island Regional Health Services Plan for 2015/2016 can be found on the Canterbury Clinical Network and South Island Alliance websites: www.ccnweb.org.nz and www.sialliance.health.nz.*

Approval of the Minister of Health

Office of Hon Dr Jonathan Coleman
Minister of Health
Minister for Sport and Recreation
Member of Parliament for Northcote

0 2 MAR 2016

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

Dear Mr Cleverley

Canterbury District Health Board 2015/16 Annual Plan

This letter is to advise you that together with the Minister of Finance, I have approved and signed Canterbury District Health Board's (DHB's) 2015/16 Annual Plan for one year.

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

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

As you are aware, a refresh of the New Zealand Health Strategy is currently under way. The Strategy will provide DHBs and the wider sector with a clear strategic direction and road map for the next three to five years for delivery of health services to New Zealanders. Thank you for your involvement to date and your continued input into the refresh.

Living Within our Means
The Government is determined to maintain rising surpluses in 2015/16. To assist with this, DHBs are required to budget and operate within allocated funding and to identify specific actions to improve year-on-year financial performance in order to live within their means. This includes seeking efficiency gains and improvements in purchasing, productivity and quality aspects of DHBs' operation and service delivery. Additionally, improvements through national, regional and sub-regional initiatives must continue to be a key focus for all DHBs.

I note that your DHB is planning to breakeven in 2015/16 and be in deficit for the following three years. As you are aware, I have asked the Director-General of Health to arrange for his officials to work with Canterbury DHB and the Treasury to update and remodel the assumptions of the Christchurch Hospital Redevelopment 2012 Detailed Business Case (DBC). This will allow both the DHB and Government to have confidence in the future forecasts of performance and position.

For 2015/16, I expect that you will have contingencies in place, should you need them, to ensure that you achieve your planned net result.

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Health Shared Services Programme
DHBs have committed to progress the shared service initiatives (Food Services, Linen and Laundry Services and National Infrastructure Platform business cases), and to include cost and benefit impacts for the Finance Procurement and Supply Chain Initiative in Annual Plans where these are available. I expect that DHBs will deliver on these business cases within their bottom lines.

With the establishment of NZ Health Partnerships Ltd, consistent with the shareholders' agreement, I expect all DHBs to work together to ensure successful implementation of the current programmes and to identify, develop and implement future opportunities.

National Health Targets
Your Annual Plan provides a good range of actions that I am confident will support strong health target performance when implemented in 2015/16. However, your recent results show continued attention to the More Heart and Diabetes Checks health target is needed. Please ensure all health target actions identified in your Annual Plan are fully implemented to help you to continue to deliver better outcomes for your population.

As you are aware, from quarter two of 2014/15, the 62 day Faster Cancer Treatment indicator became the cancer health target with a target achievement level of 85 percent by July 2016 and then increasing to 90 percent by July 2017. I am concerned that the pace of progress needs to improve if the 85 percent target is to be achieved by July 2016. Please ensure delivery of this target remains a key priority for your teams.

System Integration
As you are aware, DHBs are expected to continue focussing on integrated healthcare and to shift services closer to home in 2015/16. Shifting services is varied based on local need, context and scalability and can range from co-locating outpatient clinics in the community, through to redesign of services.

I understand that Canterbury DHB plans to maintain primary care access to radiology and its current extensive level of shifted services. It is encouraging to see that you will continue to further strengthen integration in 2015/16 by:

- increasing the number of clinical pathways
- embedding and improving IT enablers
- increasing referrals to CREST, spirometry and medication management services
- providing more than 25,000 urgent care packages.

I look forward to being advised of your progress with this throughout the year. Where these services trigger the service change protocols you will need to follow the normal service change process.

Better Public Services (BPS): Results for New Zealanders
Of the ten whole-of-government key result areas, the health service is leading the following areas:

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

It is important that DHBs continue to work closely with other social sector organisations, including non-governmental organisations, to achieve our sector goals in relation to these and other initiatives, such as Whānau Ora, Children's Action Plan and Youth Mental Health.

Tackling Obesity
I am pleased to note that your Annual Plan includes a focus on obesity, and identified a range of activities and initiatives to help tackle obesity. As you will be aware, the Childhood Obesity package of initiatives aims to prevent and manage obesity in children and young people up to 18

years of age. It has three focus areas made up of 22 initiatives that are either new or an expansion of existing initiatives:

1. targeted interventions for those who are obese
2. increased support for those at risk of becoming obese
3. broad approaches to make healthier choices easier for all New Zealanders.

The focus is on food, the environment and being active at each life stage, starting during pregnancy and early childhood. The package brings together initiatives across government agencies, the private sector, communities, schools, families and whanau.

The actions you have outlined in your plan to support the Healthy Families Spreydon-Heathcote initiative will also enhance efforts in this area. DHB participation in the Healthy Families NZ initiatives will help ensure that a co-ordinated approach to obesity and other drivers of chronic disease is taken across the sector.

Annual Plan Approval

My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the National Health Board. I am aware you have a number of service reviews under way. I have asked the National Health Board to ensure regular updates are provided as these reviews progress. Please ensure that you advise the National Health Board as early as possible of any proposals for service change that may require Ministerial approval. Approval of the Plan also does not constitute approval of any capital business cases that have not been approved through the normal process.

I would like to thank you, your staff, and your Board for your valuable contribution and continued commitment to delivering quality health care to your population, and wish you every success with the implementation of your 2015/16 Annual Plan. I look forward to seeing your achievements.

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

Yours sincerely

Hon Dr Jonathan Coleman
Minister of Health

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Part I – Overview

Foreword from the Chairman and Chief Executive

KEEPING CANTABRIANS WELL AND HEALTHY AND IN THEIR OWN HOMES AND COMMUNITIES.

As both the major funder and provider of health and disability services in Canterbury, we are strongly motivated to do the very best we can to deliver the most efficient services possible and to ensure those services are effective in improving the health and well-being of the people living in our community.

Our vision is a truly integrated health and social services system that keeps people healthy and well in their own homes by ensuring the right care and support is provided to the right person, at the right time and in the right place.

At its core, our vision is dependent on achieving a 'whole of system' approach where everyone in the health system works together to do the right thing for people, their Whanua and the system.

We collaborate with our health system alliance partners and under the Canterbury Clinical Network Alliance work closely with key stakeholders, agencies, provider organisations and our community. Together we decide what services are needed and how best to use the funding we receive to improve the health of our population and enhance efficiencies across the whole of the Canterbury health system.

We also work closely with our five colleague District Health Boards from the South Island, and collaborate under the South Island Regional Alliance to streamline patient pathways and improve the quality and coordination of care.

We have a particular focus on connecting with the West Coast DHB. Shared executive functions and an integrated clinical workforce, enabled through the development of Transalpine Services, are improving the sustainability of health services for the West Coast population and enhancing efficiencies across both of our health systems.

We also work with the Ministry of Health and national entities including Health Workforce NZ, the Health Quality & Safety Commission and the National Health Committee to develop and implement national initiatives to improve outcomes for patients and the system.

In the coming year we will expand our activity to encompass work with ACC with a focus on prevention and rehabilitation – particularly around spinal cord injuries. We will also work with our Government Sector colleagues (Ministry of Social Development, Education, Te Puni Kokeri, Justice and Police) and other social sector organisations to build better services for children and young people.

OUR REALITY

Like all health systems world-wide we are facing the challenges of increasing demand, rising treatment costs and workforce shortages with both an ageing population and an ageing work force.

In Canterbury we are also contending with the impacts of New Zealand largest natural disaster and the unintended consequences of dynamic shifts in our population's health profile and health need.

This puts us in a unique position: facing dynamic population and demand changes coupled with the inflow of a temporary rebuild population, as well as the consequences of forced migration distorting the factors our funding is based on.

We are now meeting the needs of quite a different population including a large migrant population, not funded in our population base, but entitled to free health care. Due to a lag effect in population estimates, it will take some time for funding to catch up with our rapidly growing population.

Our population's needs have also changed dramatically. The long term impacts on people's health and well-being cannot be accurately predicted because our experience is so unique, particularly in terms of the extended nature of the crisis. However worrying trends are evident, with increasing demand for mental health services right across our system.

Our infrastructure has also been severely damaged. While a significant rebuild and recovery programme is underway, we are running at the edge of our physical capacity. Any delays in the building programme will compound the challenges we face.

OUR RESPONSE

Responding to these multiple challenges has required Canterbury to focus on the short term management of our resources and capacity—whilst at the same time maintaining a longer term strategic vision.

We have been able to harness an internal capability to innovate to meet immediate challenges and enable continual improvement of our systems and services.

Canterbury's innovation and system transformation has been recognised nationally and internationally, with health leaders from Qatar, Canada, the Isle of Man and Australia travelling to Christchurch to see and understand what is happening here.

Canterbury's HealthPathways system is now being used in 24 health systems across Australia and New Zealand covering more than 20 million people. Our Design Lab is used by many Canterbury based organisations and agencies as a place to develop new

ideas and test solutions that meet the Government's desire for Better Public Services.

Recent developments in data and business intelligence tools have allowed Canterbury clinicians to rapidly develop and test new models of care which focus on delivering the best possible patient journey. Canterbury was recently recognised by the Innovation Partnership for its data driven innovation helping to improve patient outcomes. Data is being used to understand flow, reduce the time people waste waiting for care in our health system and taking many days out of hospital stays for our older population.

Canterbury was recently recognised for its achievements in integration. The Canterbury Clinical Network District Alliance won the Treasury Award for Excellence in Improving Public Value through Business Transformation, as well as the Prime Minister's Award for Public Sector Excellence in 2015.

We can see the impact of our approach in the reduction in the number of older people requiring hospital and aged residential care. In the last year more than 30,000 people received acute care free in the community rather than in a hospital setting. Analysis shows that Canterbury's acute hospital admissions were 15,000 less than would be expected if we were at the New Zealand average.

THE FUTURE

The health and cost impacts of the earthquakes will continue to influence and effect on our service and financial results for the next several years.

However, Canterbury has a unique opportunity to create a health system purpose designed for the future and consistent with our vision. Rarely has a health system been given the opportunity to move past old constraints and build new infrastructure that clearly supports future service models.

Our holistic approach to health service design means that facility redevelopment is an integral part of the plan for the future of health care in Canterbury.

With the Government's support we are redeveloping facility capacity as an element of the wider plan for moving the whole of the Canterbury health system to a more productive and sustainable configuration.

With over 47,000m2 of building space being demolished and substantive repairs to be completed, we are taking the opportunity created by the insurance proceeds to rebuild broken infrastructure in a way that supports our vision.

Alongside the hospital redevelopments at Christchurch and Burwood we are working with general practices to facilitate the development of integrated family health services that will bring a new range of services closer to people and reduce the need for hospital visits and residential care. The communities of Kaikoura, Rangiora, Akaroa and Ashburton are also looking forward to their new purpose designed facilities that will better support service delivery in their communities.

However, while the development of modern, effective and purpose-built infrastructure will support the ongoing journey of transformation, we need the whole of the system to be working for the whole of the system to work.

In October 2015, in consideration of the exceptional issues faced by the Canterbury health system, the Government advised it would provide the DHB with an additional one-off payment of $16 million in revenue to enable the DHB to achieve a break-even position in the current financial year.

In light of our immediate challenges, we will increase our emphasis on our more vulnerable population groups. Particularly: children and adolescents, older people, those struggling with mental health issues, and those with more complex lives who need more support and intervention.

We will continue to reorient our service delivery around a single point of continuity to deliver a health system capable of meeting future demand. We seek further opportunities to connect our system to minimise duplication, waste, and reduce the time people spend waiting.

We will also work across our system to achieve the expectations of government for better public health services. We remain committed to improving our performance, meeting national targets, living within our means and, most importantly, ensuring the ongoing delivery of efficient and effective health services to our population.

In the next twelve months, there will be a particular emphasis on developing clinically and financially sustainable services for our rural populations and continuing the development of the Integrated Family Health Service model.

While we make these commitments, we are conscious of the fragility of our system and the pressure we are under. Now, more than ever, we will be focused on not just delivering more services, but delivering more of the right services, in the right place, at the right time, by the right person.

Murray Cleverley
CHAIRMAN | CANTERBURY DHB

David Meates
CHIEF EXECUTIVE | CANTERBURY DHB

March 2016

Introducing the Canterbury DHB

1.1 Who are we

Canterbury is the second largest of New Zealand's 20 DHBs—by both geographical area and population size. We serve a population of 529,905 people (11.5% of the New Zealand population) and cover 26,881 square kilometres and six Territorial Local Authorities.

We manage a budget of approximately $1.6 billion which includes $1.24 billion (10.94%) of the total population based funding provided to DHBs.

As the single largest employer in the South Island, we employ more than 9,000 people across our hospitals and community bases. A similar number of people are employed in delivering health and disability services in Canterbury, funded either directly or indirectly by the Canterbury DHB.

We own and manage six major facilities: Christchurch, Christchurch Women's, Hillmorton, Burwood, Princess Margaret and Ashburton Hospitals, 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 elective surgery delivered in the South Island.

1.2 What do we do

The Canterbury DHB is charged by Government with improving, promoting and protecting the health and independence of the Canterbury population. 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 accordance with legislation we:

Plan the strategic direction of the Canterbury health system and determine the services required to meet the needs of our population. In alignment with our 'whole of system' approach we do not do this in isolation but in partnership with clinical leaders, alliance partners and service providers and in consultation with other DHBs and our community.

Fund the majority of the health services provided in Canterbury, and through our collaborative partnerships with other service providers, ensure services are responsive, coordinated and effective.

The DHB holds and monitors almost 1,000 service contracts and alliance agreements with organisations and individuals who provide health services to the Canterbury population. This includes the three Primary Health Organisations (PHOs), private hospitals, laboratories, pharmacies, mental health service providers, home based support services, residential care and rest home services, and our own Hospital and Specialist Services Division.

Provide the majority of specialist health and disability services for the population of Canterbury, and also for people referred from other DHBs where more specialised or higher-level services are not available.

As an 'owner' of hospital and specialist services the DHB provides a significant share of the health and disability services delivered in Canterbury. This is no small responsibility. In 2013/14 there were 94,010 presentations in our Emergency Departments, 116,167 inpatients discharged from our hospitals, 22,838 elective surgeries performed, 5,654 babies delivered, 166,991 consultations with our community based specialist mental health services and 640,678 specialist outpatient attendances.

We provide these services through our Hospital and Specialist Services Division and while most secondary and specialist services are provided out of our hospitals, some are delivered from community bases, through outreach clinics in rural areas and in other DHB or private hospital facilities. The Canterbury DHB currently owns and manages 15 hospitals and more than 18 community bases. In 2015/16 we will also assume ownership of the health centre on Chatham Islands.

Promote and protect our population's health and wellbeing through investment in health promotion, education and evidence-based public health initiatives – including a major focus on community recovery strategies in the aftermath of the Canterbury earthquakes.

Our Community and Public Health Division takes the lead in providing public and population health services that focus on keeping people well. This work includes health promotion activity improving nutrition and physical activity levels, and reducing tobacco smoking and alcohol consumption. It also includes the provision of health protection services and collaboration on safeguarding water quality, bio-security (protection from disease carrying insects and other pests), the control of communicable diseases and planning to ensure preparedness for a natural or biological emergency.

1.3 Our operating structure

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

Four advisory committees assist the Board to meet its responsibilities. These committees are comprised 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 & patient safety.

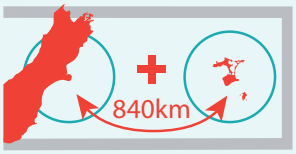
Since July 2010, Canterbury has provided executive and clinical services for the West Coast DHB. The two DHBs now share senior clinical and management expertise including: a joint Chief Executive, Executive Directors, Clinical Directors and Senior Medical Officers, as well as joint planning and funding,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

Canterbury also has in place a clinically-led District wide Health Alliance which was established in 2009. The Canterbury Clinical Network (CCN) is an alliance partnership of healthcare leaders, professionals and providers from across the Canterbury health system who provide the leadership needed to support the transformation of our health system.

Through the Alliance, we work with our alliance partners to enable collaborative service planning and determine and design the most appropriate models of service delivery for our health system. The collective work programme of the Alliance forms the basis of the DHB's Annual Plan and is reflected throughout this document.

Inclusion of the Chatham Islands

Canterbury is now responsible for the Chatham Islands population. The islands are Located 840km east of Christchurch with a population of 600 people.



1.4 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. Over 7,000 people from other DHBs were discharged from Canterbury hospitals in 2014 and over 11,000 people had outpatient visits.

These specialist services include: eating disorder services; brain injury rehabilitation; child and youth inpatient mental health services; forensic services; neonatal services; paediatric neurology; specialist diabetes and respiratory services; cardiothoracic; haematology; oncology; neurosurgery; plastics; gastroenterology; and ophthalmology services.

There are also some services we provide on a national or semi-national basis: including laboratory services; endocrinology; paediatric oncology; mental health forensic services and spinal services.

Every year, Canterbury delivers almost half of all the elective surgical services provided in the South Island and provides over $108m worth of tertiary and specialist services. The amount of work Canterbury does for other DHBs has continued to grow with a 45% increase in inpatient admissions between 2010 and 2014 and outpatient attendances up by 33%.

1.5 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. As required by legislation, we will engage with the Minister and seek prior approval before making any significant service change or capital investment or disposing of any Crown land.

The Canterbury DHB also strives to maintain open communication with the Minister and the Ministry of Health. This includes regular financial and performance reporting and a policy where early communication is provided with regard to any material or significant service transaction or issue of public interest - positive or negative.

- The DHB's reporting obligations include:
- Annual Reports and Audited Financial Statements
- Quarterly non-financial performance reports and health target reports
- Quarterly service delivery reports against plan
- Bi-annual risk reports
- Monthly financial reports and monthly wait time and ESPI compliance reporting.

The Crown Entities Act also requires DHBs to report annually to Parliament on their performance, as judged against our Statement of Intent. We publish this service and financial performance account as our Annual Report and also publish annual Quality Accounts, highlighting innovations and improvements in service delivery. Both are available on our website.

ON AN Average CANTERBURY DAY

16 babies are born in Canterbury hospitals

258 presentations to ED

442 consultations with our specialist mental health services

733 radiology tests are completed

16 children receive a Before School Check (B4SC)

318 people are discharged from hospital

46 people have elective surgery

3,618 people are supported in aged resident care

1,755 outpatient appointments

5,480 people visit their general practice team

12 older people received a comprehensive clinical assessment—using InterRAI

15 8-month-olds are fully vaccinated

105 people receive support and advice to quit smoking

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

91 women have a cervical smear

205 children have a free dental check+

57 people receive brief intervention counselling in primary care*

133 people have a cardiovascular disease risk assessment

5,139 laboratory tests are completed

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

+ represents the 2013 calendar year. All other figures are for the 2013/14 financial year and are based on the DHB's Annual Report.
** includes telephone consultations.*

Identifying Our Challenges

2.1 The Canterbury Dilemma

Like health systems world-wide the challenges we are facing are well understood. Our population is ageing and more people living with long-term conditions means increasing demand for services, rising treatment costs and workforce shortages.

However, Canterbury is also contending with the consequences of New Zealand's largest natural disaster.

While the full long-term outcomes of the earthquakes are hard to determine, international research points very strongly to ongoing impacts for portions of the population for upwards of a decade following the disaster. The long-term health impacts for children are particularly worrying for our population and concerning for our system.[2]

While it is difficult to quantify the increased transient population here for the rebuild, there has been a real and significant increase in demand for health services across our system, and worrying signs for the mental health and wellbeing of our population. Our health system is almost operating at full capacity, our resources are stretched, and our workforce is tired.

The operational and financial costs of the earthquake have already been considerable and evaluated at $106.8million. Even with the Government contribution of $84m the DHB has delivered over $50m in cost reductions over the past four years. We are also facing the challenge of making the best use of $384m of insurance proceeds and capital to manage $518m of earthquake damage.

Despite the dilemma we face we cannot step back and say this is all too hard. We have over half a million reasons to do the very best we can to deliver the best health service possible. This means sticking to our vision and continuing to transform the way we interact with each other and the people that we look after and providing not more of the same services – but more of the right services, in the right place at the right time.

In order to ensure the long-term sustainability of our health system, it is important we continue to invest in supporting people to remain healthy and well for as long as possible.

In the wake of the earthquakes, we must also consider the unique and emerging needs of our population in our planning, and better understand the constraints of our environment.

[2] *Professor Sir Peter Gluckman; Chief Science Advisor; Office of the Prime Minister's Science Advisory Committee: The psychosocial consequences of the Canterbury earthquakes – a briefing paper, 10 May 2011.*

2.2 Population profile

Based on Census 2013 projections, Canterbury remains the second largest DHB in New Zealand and in 2015/16 will be home to 529,905 people. While there was a short-term drop in our population after the earthquakes, census results shows that our population quickly recovered and continues to grow.

There has been a steady growth in our older population groups - one of the biggest ongoing challenges to our health system. Canterbury already had the largest total population aged over 65 of any DHB, and has the fourth faster rate of population growth in this age group in the country.

Latest population predictions indicate, 15.4% of our population (81,780 people) are aged over 65 - higher than the national rate (14.9%). Of those, 6.7% (35,365 people) are aged over 75. By 2026 one in every five people in Canterbury will be aged over 65.

As we age, we are likely to develop more complicated health needs and multiple conditions, meaning we are more likely to need specialised services and consume more health resources. Many long-term conditions become more common with age, including heart disease, stroke, cancer, respiratory disease and dementia. While more people living longer is a successful outcome in itself – the increasing average age of our population will put significant pressure on our workforce, infrastructure and finances.

While our younger population decreased slightly between the 2006 and 2013 Census, this group has grown rapidly as the rebuild gains momentum. There is a clear increase in the number of males compared to females in this age group, likely as a result of the rebuild. However, census numbers (on which our funding is based) are conservative. The census was not designed to allow for a spike in migration with the inflowing rebuild population, nor does it count people only working in Christchurch during the week.

Ministry of Business, Innovation and Employment figures suggest close to 28,000 people coming into Christchurch for the rebuild each rolling 12-months.

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

Many people do not realise that Canterbury has the 6th largest and 3rd fastest growing Māori population in New Zealand. By 2026, 9.3% of our population will be Māori, 2.7% Pacific and 11.7% Asian.

2.2 Health profile

The leading causes of death in Canterbury are cardiovascular diseases, including heart disease and stroke, followed by cancers and respiratory diseases such as Chronic Obstructive Pulmonary Disease. Diabetes is the ninth highest cause of death, but also an underlying factor for cardiovascular disease and contributes significantly to avoidable mortality.

Many of the leading causes of death are conditions for which a reduction of risk factors, earlier identification and improved management or treatment can dramatically reduce the impact of the disease and prevent deterioration or crisis resulting in hospital admissions.

The negative health outcomes associated with risk factors such as tobacco smoking, hazardous drinking poor diet and lack of physical activity place considerable pressure on our health system. All four risk factors have strong socio-economic gradients resulting in health inequalities.

Although our population continues to have a higher life expectancy than other parts of New Zealand, the most recent results from the combined 2011-2013 New Zealand Health Survey found that:

- 15% of our population are current smokers and while this is lower than the national average of 18%, and declining over time, smoking rates amongst our Māori and Pacific populations are significantly higher.
- 10% of our population is likely to drink in a hazardous manner and while lower than the national average (15%), this still amounts to one in every 10 adults.
- Our obesity rates are also lower than the national rate (31%) but over a quarter (27%) of our adult population are classified as obese.

Mental health and behavioural disorders are the sixth most common cause of death in Canterbury. While new research indicates some sections of our population are coping better with the psychological impact of the earthquakes, there are some whose situation and outcomes have worsened causing major areas of concern.

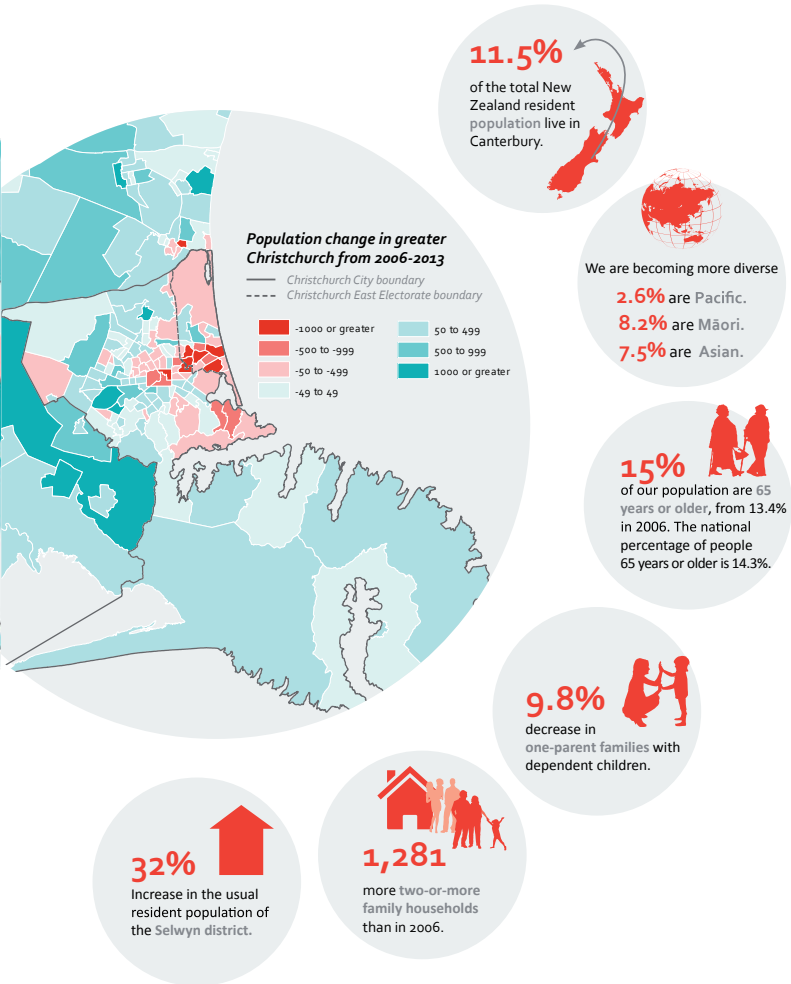
Since the earthquakes there has been a marked increase in demand for specialist mental health support with significant increases in new presentations to our emergency, adult and child & youth mental health services.

Over the last three years (to March 2015) there has been a 65% increase in rural presentations to specialist mental health services and a 69% increase in presentations to child & youth community services.

The 2011-2013 NZ Health Survey found that 20% of our population reported having been diagnosed with a common mental illness (such as depression or anxiety disorders) compared to 16% nationally.

The November 2014 All Right? Survey found that while fewer of the 800 respondents were struggling to deal with things than those surveyed two years ago for some there were significant and ongoing issues. Almost a third (32%) felt life was worse than before the earthquakes; 34% reported that they had more health issues; and 15% were finding it difficult to find appropriate accommodation.

Cross-sector and whole of system strategies are one of the most effective way to address this need. A focus on reducing alcohol harm is also an area where gains can be made in improving outcomes for our population. We are working closely with our community and primary care partners and the Ministry of Education to provide stress and anxiety support for young people in schools and to increase access to brief intervention counselling and specialist advice and support people who need additional help.



Data source: Statistics New Zealand, Census of Population and Dwellings, 2013.

2.3 Operating environment

DEMAND PRESSURES

Four years on from the earthquakes, a significant portion of our population remains unsettled. Many people are still living in temporary or crowded accommodation, moving about the city while they wait for repairs or unable to find permanent accommodation. Prolonged levels of stress, anxiety and poor living arrangements are exacerbating chronic illness and increasing demand.

Ongoing shortages of accommodation are hampering patient flow across our services, with patients sometimes 'stuck' in services with no place to go. This bed blockage restricts the next person coming in for treatment (particularly in mental health services) and increases waiting time for access to services. Prolonged hospital stays are associated with higher levels of dependence and poorer patient outcomes.

As highlighted, there is considerable uncertainty about the influx of people into Christchurch for the rebuild. Statistics projections do not 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 9% but emergency department presentations for this age group have grown by 37%. Over the same period there has been a 370% increase in the number of people from overseas presenting in our emergency department.

We are working hard to identify and quantify this new demand and to implement initiatives and strategies to reduce the pressure and the cost on our system.

FACILITIES PRESSURE

The environment in which the Canterbury DHB operates continues to be dominated by the damage inflicted by 2010 and 2011 earthquakes. Critical to the health systems recovery has been the Government's commitment to the redevelopment of the Burwood Heath Campus and the Acute Services and Outpatient Buildings on the Christchurch Hospital site scheduled for completion in 2016 and 2018.

However these redevelopments are only part of the picture. With over $518m worth of damage to over 200 buildings and 14,000 rooms, the DHB is engaged in a significant remediation and repair programme that will continue for over a decade. Major decisions need to be made with regards to the future use of almost every building across all of our sites. With a maximum insurance payment of $320m, carefully considered decisions are needed to ensure safety and service continuity while the repairs and redevelopments take place – without over-investing in facilities that do not have a future role.

While this work is underway our capacity is substantially reduced. Our staff continue to work out of wards, laboratories and clinical spaces converted from offices, temporary buildings and portacoms. There will be several years of major disruption as we shift and relocate wards and services to make repairs before the completion of the Burwood Campus and the Acute Services Building. Over 86% of the beds (and patients) in Christchurch Hospital have already been moved at least once.

With capacity tightly restricted, we have already had to increase inter-hospital transfers and contract private capacity for services, such as elective surgeries, while we manage repairs to our facilities. It is likely that the DHB will have to continue to outsource some services until we return to full capacity, however the increased service costs of this dependency are not sustainable - returning services in-house is a priority.

FISCAL PRESSURES

Government has given clear signals that DHBs need to operate within allocated funding and rethink how they deliver improved health outcomes in more cost-effective ways.

Numerous factors contribute to fiscal pressures including: the increasing demand for services including diagnostics and the risk of increasing aged residential care with an ageing population; rising treatment and infrastructure costs and the rising costs of wages and salaries. Our ability to contain cost growth within affordable levels is made more difficult by increasing expectations, the costs of new technology and the demand for seven-day-a-week service.

The total overall cost of the earthquake repairs to our facilities remains an unknown factor. We are still unable to determine the final impact of new building codes and construction cost escalations however, it is apparent that a considerable amount of work will not be covered by our insurance proceeds.

There are also other significant financial impacts of the earthquake including: inter-hospital transfers, outsourcing and temporary accommodation costs related to lost capacity, increased staff sickness and allowances and the costs of developing and expanding community-based services to respond to increased need in our community. The total operational earthquake costs have been externally reviewed at $106.8 million to July 2014.

The Canterbury DHB is committed to operating within our funding allocations, with reduced reliance on earthquake funding support from the Ministry of Health — however this will be challenging.

In October of 2015, in consideration of the exceptional issues faced by Canterbury, Government has provided the DHB with an additional one-off payment of $16 million in revenue. This will enable the DHB to achieve a break-even position in the current financial year.

However, if the DHB is to ensure the sustainability of the Canterbury health system, solutions need to be found for meeting the increased costs associated with

the impact of the earthquakes and the increased demand from the rebuild population.

2.4 Critical success factors

Over the next year, the Canterbury health system faces a number of clear and unprecedented challenges. The following are areas where the greatest gains can be made in terms of improving health 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 viability of our health system.

DOING THE RIGHT THING

Supporting people to stay well - The prevalence of long-term conditions (such as diabetes, heart disease and depression) continues to increase. This is a worldwide pattern associated with lifestyle and an ageing population. If demand patterns continue as they are we simply will not have the resources to meet future need. Improving the overall health and wellbeing of our population is the only way to get ahead of the demand curve and while these gains may be slow they are the foundation from which we will build a more effective and sustainable health system.

Reducing unplanned admissions - Unplanned (urgent or acute) admissions are a significant source of pressure on health resources. Unimpeded, acute demand can quickly 'crowd out' planned services, increase waiting lists and adversely affect service quality. It is critical that maintain our historical trend. By ensuring people have access to timely and effective care at the right time and in the right place, we can improve health outcomes and ensure more efficient use of our specialist resources.

Prioritising our resources - Because our resources are increasingly limited, we need to prioritise our investment and effort where it is most needed and in a way that will have the biggest impact. It is critical that we continue to support our most vulnerable population groups and actively evaluate our performance to ensure the initiatives we have in place are making a real difference in the health and wellbeing of our population.

DOING THINGS RIGHT

Improving the flow of patients within our hospitals - Long waits and long hospitals stays are linked to negative outcomes for patients and indicate less efficient and effective use of our resource. It is critical that we improve the flow of patients through our system – as improved flow leads to shorter stays, patient access is increased, health outcomes are better and public confidence and trust in the health system is increased.

Reducing variation, duplication and waste - If an increasing share of our funding is directed into meeting cost growth, our ability to invest in new technology or implement new services and initiatives to better respond to changing need will be severely restricted. It is critical that we focus on reducing waste and rework across our system. By providing the right care the first time, not only will we avoid unnecessary expenditure but the patient experience and outcome can be improved.

Keeping our staff motivated and well - Recent staff surveys indicate that while people want to be here, they are exhausted. More than 20% feel their disrupted working environment is having a negative impact on their wellbeing. Without a motivated, 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 a place people want to be.

RESPONDING TO THE EARTHQUAKE IMPACTS

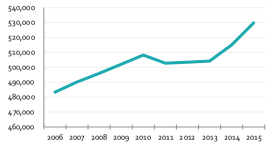
Responding to rebuild demand - If we are to ensure the sustainability of the Canterbury health system, solutions need to be found for meeting the costs associated with increased service demand from the rebuild population. It is critical that we implement strategies to encourage people to link with general practice rather than present to the emergency department. We also need to improve the identification of out of town patients to ensure we are appropriate reimbursed for services provided.

Delivering to rebuild timeframes - Canterbury is in the midst of the largest and most complex building project in history of New Zealand's public health service. Any delays to the timeframes set for construction of the new Burwood Campus and Christchurch Hospital Acute Services and Outpatient Buildings will create additional financial pressure and waste resources that could be better invested into patient services. It is critical the building programme delivers against the agreed timeframes and budgets.

THE IMPACT OF THE CANTERBURY EARTHQUAKES

Population growth

Canterbury's funded population has grown since the earthquakes.



510,915 people 2010-11

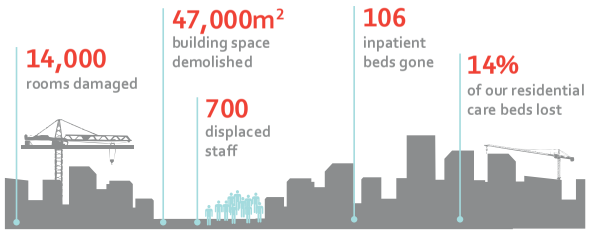
529,905 people 2015-16

+ Rebuild population

Current policies do not account for our unusual pattern of migration.

28,800
additional people working in Canterbury
in the year to June 2014[1]

Damage to health infrastructure



$320m
maximum insurance payment received in full

BUT $518m+
total damage means we need to rationalise how we fund the full repair programme within a $384m envelope

Community wellbeing

The CERA Wellbeing Survey[4] shows a substantial group within our population are still struggling.

21% stressed most, or all, of the time

15% relationship problems from the earthquake

19% quality of life had decreased in the past year

10% frightened, upset or unsettled children

Staff wellbeing

We also need to be concerned for the wellbeing of our own staff.[6]

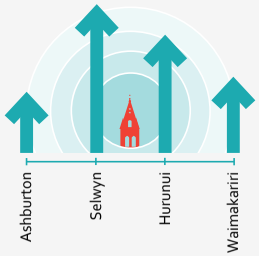
56% are still dealing with EQC and insurance issues

34% feel excessive workload is a main stress factor

21% feel their physical working environment is having a negative impact on their wellbeing

Population spread

People have spread out across Canterbury. Selwyn is the fastest growing district in New Zealand.



Ageing population

Canterbury has the largest 75+ population of any DHB.

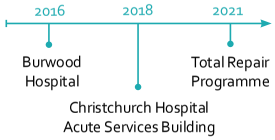
Rebuild disruptions

Disruption is constant as we repair wards and buildings.

86%
of our beds (and patients!) have been moved out and back again

Rebuild timeframes

Repairs and rebuilds will not happen overnight and any delays put further pressure in the system.



Service demand

The earthquakes and rebuild have brought an unprecedented and unrelenting demand for emergency, mental health and community services.[5]

13% increase
in total ED presentations

37% increase
in ED presentations by 25-29 year olds

370% increase
in ED presentations by people from overseas

> '...about **5%** [of the Canterbury population] ... will have **ongoing significant psychological morbidity** requiring professional help'
>
> – Sir Peter Gluckman[7]

Mental health services[8]

65% increase in rural presentations to specialist mental health services

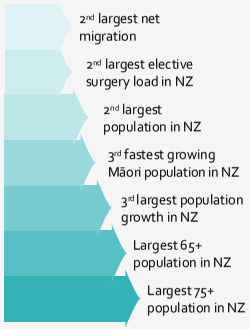
69% increase in presentations to child and youth community services

43% increase in presentations to adult community mental health services

50% of acute inpatients in our mental health services have housing issues

Our population

How do we stack up?



Housing shortages

The solution for housing issues sits outside the health system, but has a huge impact on health and wellbeing.[2]

39% increase
in median rent for one family households

56.5% increase
in the number of motor camp dwellings, compared to 6.1% nationally

35.4% increase
in the number of improvised dwellings compared to 9.3% increase nationally

Financial impact

Millions have already been spent on responding to the earthquakes and emerging health needs.[3]

Earthquake costs	= $106.8m
Other impacts	= $46m
Government contribution	= $84m
DHB cost reduction	= $22.8m

Funding comparisons

Population growth is outstripping funding. We must continue to respond to emerging needs – this means doing more with less.

1.5%
increase
in total funding

but fewer $ per person

$2,389 2014-15

$2,345 2015-16

1. MBIE, Canterbury Quarterly Job-matching Report, June 2014
2. Statistics NZ Census, 2013
3. CDHB, between 2011/12 and 2013/14
4. CERA Wellbeing Survey, 2014
5. SFN, between 2011/12 and 2014/15 (inc. end of year projections)
6. CDHB staff and family wellbeing survey report, August 2014
7. 'The psychosocial consequences of the Canterbury earthquakes', May 2011
8. Specialist mental health services, March 2012 - March 2015

Part II – Long-Term Outlook

Setting Our Strategic Direction

WHAT ARE WE TRYING TO ACHIEVE?

Although they differ in size, structure and approach, DHBs have a common goal: to improve the health and wellbeing of their populations by delivering high quality and accessible health care. A growing prevalence of long-term conditions, increasing demand for services, workforce shortages, rising treatment costs and tighter financial constraints make this increasingly challenging

3.1 Strategic context

In 2010, the National Health Board released Trends in Service Design and New Models of Care. [3] This document provided a summary of international responses to the same pressures and challenges facing the New Zealand health sector, to help guide DHBs in their service planning.

International direction emphasises that a 'whole of system' approach is required to improve health outcomes and ensure the sustainability of high quality health services. This approach entails four major service shifts:

- Early intervention, targeted prevention, self-management and more home-based care
- A connected system, integrated services and more services provided in community settings
- Regional collaboration, clusters and clinical networks, and more regional service provision
- Managed specialisation, with a shift to consolidate the number of tertiary centre/hubs.

Hospitals continue to be a key support and a setting for highly specialised care, with the importance of timely access to care being paramount. However, the prevalence of long-term conditions and the ageing of our population means we need to move away from the traditional health model in order to support our population to maintain good health for longer.

Rather than wait for people to become acutely unwell or require institutionalised care, the whole of the health system needs to works in partnership to deliver accessible and effective services that support people to stay well and in their own homes for as long as possible.

3.2 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 other stakeholders came together to rethink the future of our health system. The challenges we faced were well understood. There were growing numbers of older people and people living with long-term conditions and disabilities, capacity all across our health system was stretched. At the same time health budgets were under increasing pressure. We knew if we didn't actively transform the way we delivered health services, by 2020 Canterbury would need 2,000 more aged residential care beds, 20% more GPs and another Christchurch hospital.

If we were going to deliver high quality care and provide our population with the best possible quality of life we needed to rethink our relationships with each other and with the people we cared for. We needed to do things differently. Together we developed a vision for the future that at its heart involved a fundamental reorientation of the Canterbury health system around the needs of our patients and our population.

"A truly integrated health system that keeps people healthy and well in their own homes by ensuring the right care and support is provided in the right place at the right time 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 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 home.

In achieving our vision, we are focused on the delivery of three clear strategic objectives:

- The development of services that support people/whānau to stay well and take greater responsibility for their own health and wellbeing.
- The development of primary and community-based services that support people/whānau in the community and provide a point of ongoing

[3] *Ministry of Health. 2010. Trends in Service Design and New Models of Care. Wellington: Ministry of Health*

continuity (which for most will be general practice).

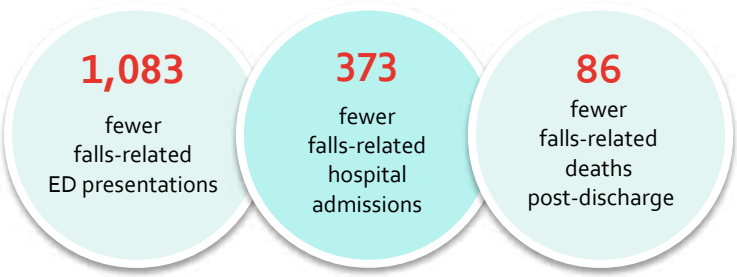
- The freeing-up of hospital-based specialist resources to be responsive to episodic events, provide complex care and provide specialist advice to primary care.

In line with this direction, health professionals from across Canterbury have spent the last several years working together to redesign the way we deliver health services, connecting the system, putting the patient at the centre, reducing the time people spend waiting and moving services closer to home.

Our Canterbury Clinical Network (CCN) Alliance embodies our commitment to this whole of system approach and through our Alliance we have been driving much of the system transformations across our health system. The health and system outcomes we are seeing as a result of this commitment have been striking and have demonstrated in a relatively short period of time how effective a whole of system response can be.

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 service quality.

Our community-based falls prevention programme, is a new service model led by clinical falls champions, focused on improving the strength and balance of people at risk of falling in their home and supporting their recovery. Evaluation of this small programme has demonstrated remarkable results.



In the first three years since the community-based falls prevention programme was established, there have been 1,083 fewer falls-related ED presentations, 373 fewer falls-related hospital admissions and 86 fewer deaths at six months post discharge.

Across our hospitals we are also harnessing innovation and empowering people to improve pathways and processes to delivering better outcomes both for the patient and for the system.

For those people who do fall and fracture their Neck-a-Femur (NOF) we have created a Fast Track NOF Pathway to improve the 'flow of patients through our hospital and to enable their early recovery and discharge. This coincides with our commitment to the Government's Enhanced Recovery After Surgery (ERAS) Initiative which we are also implementing.

30% reduction
in average rehabilitation wait time
for rehabilitation, in the first five months of implementing the NOF pathway

In the first five months since the implementation of the NOF Pathway patient's overall length of stay has reduced from 23.5 to 20.5 days – a saving of 480 bed days. The average time patients spent waiting in the emergency department has dropped from 3.6 hours to 2.8 and their average wait for rehabilitation has dropped 30% from 164 hours to 114 hours.

Good data is also a key enabler of change and real-time data is now helping us improve the quality and safety of care – and more importantly save patients time. The use of data raised awareness of the fact that in winter, patients with Chronic Obstructive Pulmonary Disease (COPD) were unnecessarily occupying up to 60 hospital beds.

>30% reduction
in COPD hospital bed days
and happier patients receiving care in their own homes.

The introduction of an integrated, clinically designed COPD service model has meant an over 30% reduction in COPD hospital bed days and happier patients receiving care in their own homes.

The importance of clinical leadership and engagement across the system in the success of our vision cannot be overstated. It is with a foundation of strong clinical leadership and the establishment of our District Alliance that we have been able to drive much of the considerable transformation across our health system. When the earthquakes struck, we were extremely fortunate to have such a strong collective vision andan effective system-wide clinical alliance. These collaborative partnerships kept our health system together through one of the worst natural disasters in our country's history.

The next few years will continue to be challenging as we respond to the evolving needs of a more vulnerable population and balance service delivery with ongoing infrastructure repairs. Despite these new challenges, our Board have recommitted to our vision and strategic direction and we are determine to continue the transformation of our health system.

3.3 National alignment

At the highest level, DHBs are guided by the New Zealand Health Strategy, Disability Strategy, Māori Health Strategy (He Korowai Oranga) and the New Zealand Public Health and Disability Act.

The ultimate high-level health system outcomes are that all New Zealanders lead longer, healthier and more independent lives and the health system is cost-effective and supports a productive economy.

DHBs are expected to contribute to meeting these system outcomes and the commitment of Government to provide 'better public services' and 'better, sooner, more convenient health services' by: increasing access to services; improving quality and patient safety; supporting the health of children, older people and those with mental illness; making the best use of information technology; and strengthening our health workforce. [4]

Alongside these longer-term goals and commitments, the Minister of Health's annual 'Letter of Expectations' signals annual priorities for the health sector. The 2015/16 focus is on: clinical leadership; integration between primary and secondary care; tackling the key drivers of morbidity; delivery of national health targets; fiscal discipline and performance management.

The Canterbury DHB is committed to playing its part in the delivery of longer-term health system outcomes and progress against national goals. Activity planned and prioritised in the coming year is in line with our strategic direction and goals and the priorities expressed by the Minister of Health and is highlighted in Part III of our Annual Plan - Delivering Our Service Priorities.

3.4 Regional commitment

In setting its expectations for better public services and better, sooner, more convenient health services, the Government also has clear expectations of increased regional collaboration and alignment between DHBs.

The Nelson Marlborough, Canterbury, West Coast, South Canterbury and Southern DHBs form the South Island Alliance - together providing services for 1,081,953 people or 23.5% of the total NZ population. [5]

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. Together we are committed to delivering a sustainable South Island health system, focused on keeping people well, and providing equitable and timely access to safe, effective, high-quality services - as close to people's homes as possible.

The success of the Alliance relies on improving patient flow and the coordination of services across the South Island by: agreeing and aligning patient pathways; introducing more flexible workforce models; improving patient information systems to better connect services and the clinical teams involved in a patient's care.

Closely aligned to the national direction, and operating under a 'Best for People, Best for System' framework, the shared outcomes goals of the South Island Alliance are: improved health and equity for all populations; improved quality, safety and experience of care; and best value from public health system resources.

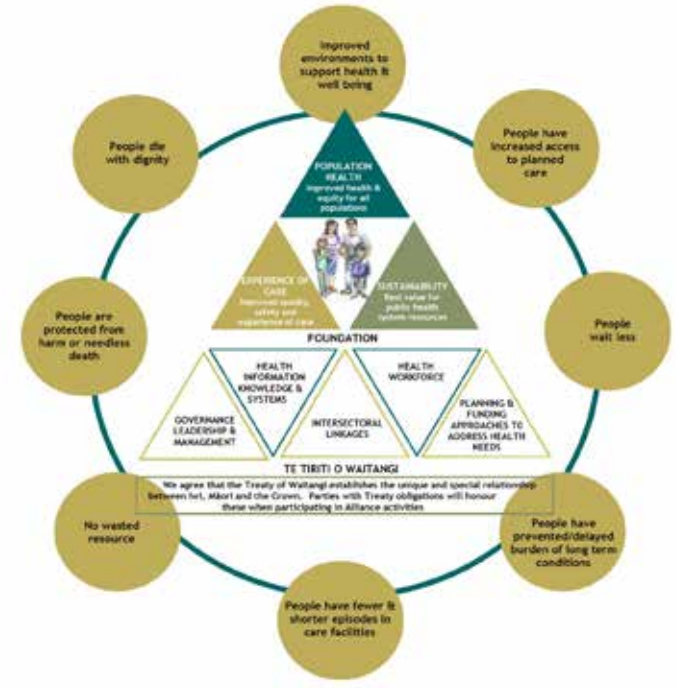
A set of high level outcomes sit alongside the 'Best for People, Best for System' framework and enable evaluation of regional activity at a population level. These are highlighted in the outer circles in figure 1.

The South Island Health Services Plan highlights the agreed regional activity to be implemented through our service level alliances and work streams in seven priority service areas: Cancer, Child Health, Health of Older People, Mental Health, Information Services, Support Services and Quality and Safety.

Regional activity in the coming year will also focus on cardiac services, elective surgery, palliative care, public health, stroke and major trauma services. Workforce planning, through the South Island Regional Training Hub and regional asset planning, will contribute to improved delivery in all service areas.

Canterbury's commitment in terms of the regional direction is outlined in the South Island Health Services Plan, and key deliverables are also highlighted in Part III of our Annual Plan. [6]

Figure 1. ***S***



[4] *For further detail refer to the Ministry of Health's Statement of Intent 2014-2018.*

[5] *2015/16 Population Based Funding Projection provided to the Ministry of Health by Stats NZ, based off the 2013 Census.*

[6] *For further detail refer to the Regional Health Services Plan on the South Island Alliance website: www.sialliance.health.nz.*

Measuring Our Progress

HOW WILL WE KNOW IF WE ARE MAKING A DIFFERENCE?

DHBs are expected to deliver against the national health system outcomes: 'All New Zealanders lead longer, healthier and more independent lives' and 'The health system is cost effective and supports a productive economy' and to meet their objectives under the New Zealand Public Health and Disability Act to 'improve, promote and protect the health of people and communities'.

As part of this accountability, DHBs need to demonstrate whether they are succeeding in achieving these goals and improving the health and wellbeing of their populations. There is no single indicator that can demonstrate the impact of the work DHBs do. Instead, the South Island DHBs have collectively chosen a mix of population health and service performance indicators that we believe are important to our stakeholders and that together, provide an insight into how well the health system and the DHBs are performing.

In developing our strategic framework, the South Island DHBs identified three shared high-level strategic objectives where collectively we can influence change and deliver on the expectations of Government, our communities and our patients by making a positive change in the health of our populations.

Alongside these strategic objectives (or goals) are six associated outcomes indicators, which will enable us to evaluate success. These are long-term indicators and, as such, the aim is for a measurable change in health status over time, rather than a fixed target.

The South Island DHBs have also identified a core set of associated medium-term indicators. Because change will be evident over a shorter period of time, these indicators have been identified as the headline or main measures of performance. Each DHB has set local targets in order to evaluate their performance

over the next four years and determine whether they are moving in the right direction. These impact indicators will sit alongside each DHB's Statement of Performance Expectations and be reported against in the DHB's Annual Report at the end of every year.

The following intervention logic diagram demonstrates the value chain. It shows how the services that an individual DHB chooses to fund or provide (outputs) will have an impact on the health of their population and result in achievement of the desired longer-term outcomes and the expectations and priorities of Government.

The outcome and impact indicators were specifically chosen from existing data sources and reporting frameworks. This approach enables regular monitoring and comparison, without placing additional reporting burden on the DHBs or other providers. As part of their obligations DHBs must also work towards achieving equity and to promote this, the targets for each of the impact indicators are the same across all ethnic groups.

Outcome 1:

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

- ✓ A reduction in smoking rates.
- ✓ A reduction in obesity rates.

Outcome 2:

People stay well in their own homes and communities.

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

Outcome 3:

People with complex illnesses have improved health outcomes.

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

Overarching Intervention Logic

MINISTRY OF HEALTH HIGH LEVEL OUTCOMES

Health System Vision

All New Zealanders to live longer, healthier & more independent lives, & the health system is cost effective & supports a productive economy.

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 HIGH LEVEL OUTCOMES

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

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.

DHB STRATEGIC OBJECTIVES

What does success look like?

People are healthier & take greater responsibility for their own health.	People stay well, in their own homes & communities	People with complex illness have improved health outcomes
▪ *A reduction in smoking rates* ▪ *A reduction in obesity rates*	▪ *A reduction in the rate of acute admissions to hospital* ▪ *An increase in the proportion of people living in their own home*	▪ *A reduction in the rate of acute readmissions to hospital* ▪ *A reduction in the rate of avoidable mortality*

IMPACT MEASURES

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 specialist 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

Strategic Outcome Goal 1

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

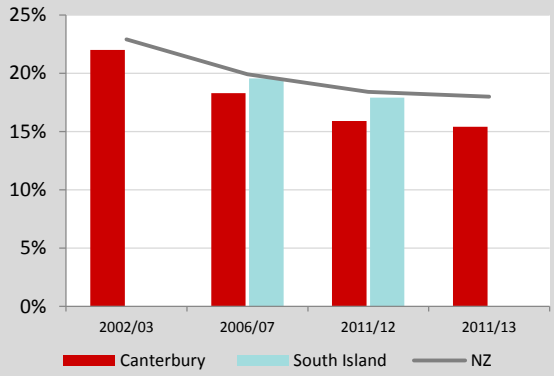
WHY IS THIS OUTCOME A PRIORITY?

New Zealand is experiencing a growing prevalence of long-term conditions such as diabetes and cardiovascular disease, which are major drivers of poor health and account for a significant number of presentations across primary care and hospital and specialist services. The likelihood of developing long-term conditions increases with age, and with an ageing population, the burden of long-term conditions will grow. The World Health Organisation (WHO) estimates more than 70% of all health funding is spent on managing long-term conditions. These conditions are also more prevalent amongst Māori and Pacific Islanders and are closely associated with significant disparities in health outcomes across population groups.

Tobacco smoking, inactivity, poor nutrition and rising obesity rates are major contributors to a number of the most prevalent long-term conditions. These are avoidable risk factors, preventable through a supportive environment, improved awareness and personal responsibility for health and wellbeing. Public health and prevention services that support people to make healthy choices will help to decrease future demand for care and treatment and improve the quality of life and health status of our population.

OVERARCHING OUTCOME INDICATORS

MEASURE: % OF THE POPULATION (15+) WHO SMOKE



Outcome: A reduction in smoking rates

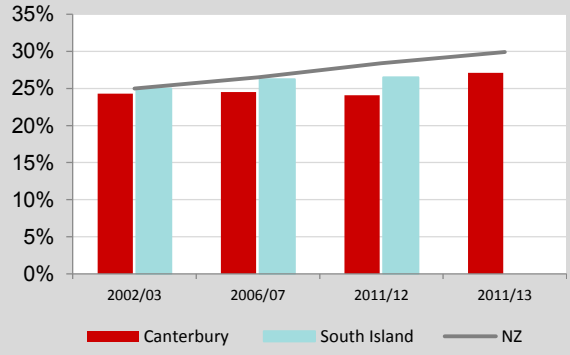
Tobacco smoking kills an estimated 5,000 people in NZ every year. Smoking is also a major contributor to preventable illness and long-term conditions, such as cancer, respiratory disease, heart disease and stroke and a risk factor for six of the eight leading causes of death worldwide.

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 to not only improve overall health outcomes but also reduce inequalities in the health of our population.

Data source: National NZ Health Survey[7]

MEASURE: % OF THE POPULATION (15+) WHO ARE OBESE



Outcome: A reduction in obesity rates

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

This has significant implications for rates of cardiovascular and respiratory disease, diabetes and some cancers, as well as poor psychosocial outcomes and reduced life expectancy.

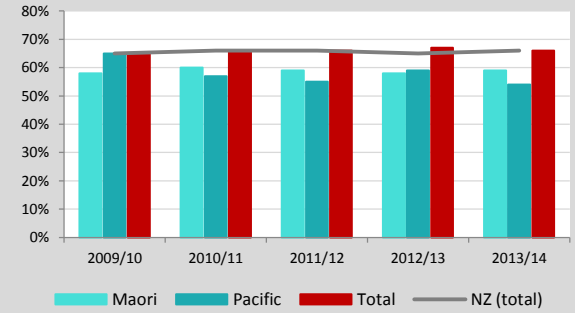
Supporting our population to achieve healthier body weights through improved nutrition and physical activity levels is fundamental to improving their health and wellbeing and to preventing and better managing long-term conditions and disability at all ages.

Data source: National NZ Health Survey[8]

[7] *The NZ Health Survey is completed by the Ministry of Health and results are subject to availability. From 2011/12 surveys were combined year-on-year in order to provide more robust results for smaller DHBs – hence the different time periods presented. Results are unavailable by ethnicity and by region. The 2013 Census results for smoking (while not directly comparable) demonstrates that while rates for Māori are improving they are still high; 30.7% of Canterbury Māori (15+) identified as regular smokers down from 40.2% in 2006 but high compared to 14.5% of the total population.*

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

MEASURE: % OF BABIES EXCLUSIVELY OR FULLY BREASTFED AT SIX WEEKS



2013/14	2015/16	2016/17	2017/18	2018/19
Actual: 66%	Target: 70%	>72%	>74%	>75%

Impact: More babies are breastfed

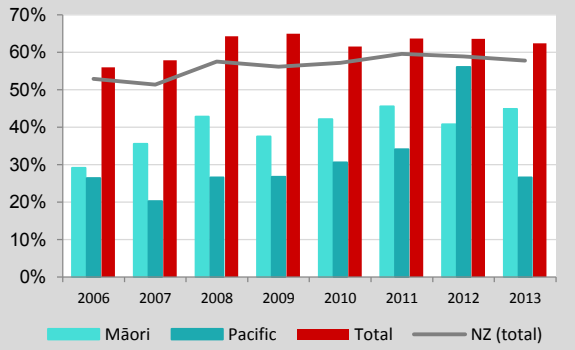
Breastfeeding helps lay the foundations for a healthy life, contributing positively to infant health and wellbeing and potentially reducing the likelihood of obesity later in life.

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

An increase in breastfeeding rates is seen as a proxy indictor of the success of health promotion and engagement activity. Appropriate access to support services and a change in both social and environmental factors influence breastfeeding behaviour and support healthier lifestyle choices.

Data source: Plunket via the Ministry of Health[9]

MEASURE: % OF FIVE-YEAR-OLDS CARIES FREE (NO HOLES OR FILLINGS)



2013	2015	2016	2017	2018
Base: 62%	Target: 65%	>65%	>65%	>65%

Impact: More children have improved oral health

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

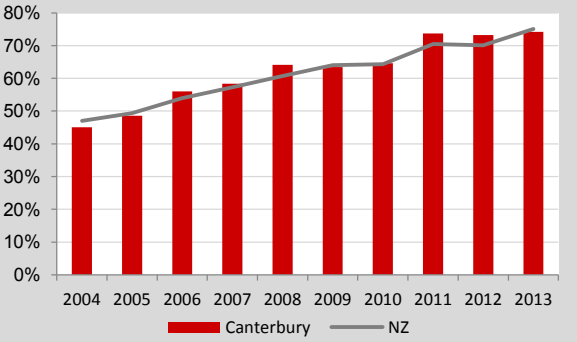
Good oral health not only reduces unnecessary hospital admissions, but also signals a reduction in a number of risk factors, such as poor diet, which then has lasting benefits in terms of improved nutrition and health outcomes.

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

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

Data Source: Ministry of Health Oral Health Team[10]

MEASURE: % OF 'NEVER SMOKERS' AMONG YEAR 10 STUDENTS



2013	2015	2016	2017	2018
Base: 74%%	Target: >75%	>75%	>75%	>75%

Impact: Fewer young people take up smoking

The highest prevalence of smoking amongst younger people and reducing smoking prevalence across the total population is largely dependent on preventing young people from taking up smoking.

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

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

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

[9] Provider 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 local WellChild/Tamariki Ora providers primarily target Maori and Pacific mothers - results for these ethnicities are likely to be under-stated. The target is based on national Well-Child standards for breastfeeding at 6 weeks.

[10] This measure is a national 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 and 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.

Strategic Outcome Goal 2

4.2 People stay well in their own homes and communities

WHY IS THIS OUTCOME A PRIORITY?

When people are supported to stay well in the community, they need fewer 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 on specialist level care.

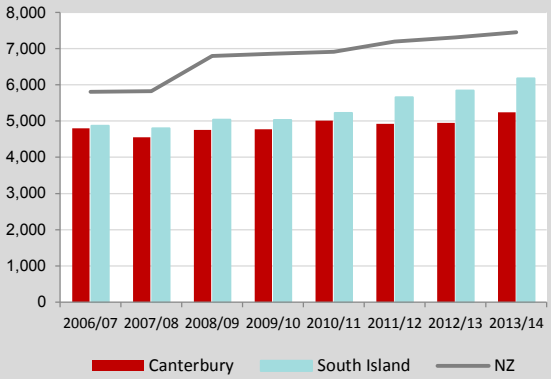
General practice can deliver services sooner and closer to home, and through early detection, diagnosis and treatment, deliver improved health outcomes. The general practice team is also vital as a point of continuity, particularly in terms of improving the management of care for people with long-term conditions and reducing the likelihood of acute exacerbations of those conditions resulting in complications of injury and illness.

Health services also play an important role in supporting people to regain their functionality after illness and to remain healthy and independent. Supporting general practice are a range of other health professionals including midwives, community nurses, social workers, allied and personal health providers and pharmacists. These providers also have prevention, early intervention and restorative perspectives and link people with other social services that can further support them to stay well and out of hospital.

Even where returning to full health is not possible, access to responsive, needs-based pain management and palliative services (closer to home and families) can help to improve the quality of people's lives.

OVERARCHING OUTCOME INDICATORS

MEASURE: RATE OF ACUTE (URGENT) MEDICAL ADMISSIONS TO HOSPITAL *(AGE STANDARDISED, PER 100,000)*



Outcome: A reduction in acute medical admission rates.

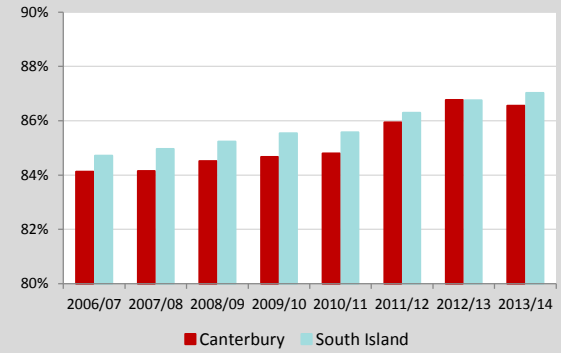
Long-term conditions have a significant impact on the quality of a person's life. However, with the right approach, people can live healthier lives and avoid the deterioration of their condition that leads to acute illness, hospital admission, complications and premature death.

Lower acute admission rates can be used as a proxy indicator of improved management and to indicate the accessibility of timely and effective care and treatment in the community.

Reducing acute admissions also has a positive effect by enabling more efficient use of specialist resources that would otherwise be taken up by reacting to demand for urgent care.

Data Source: National Minimum Data Set

MEASURE: % OF THE POPULATION (75+) LIVING IN THEIR OWN HOME



Outcome: More people living in their own home

While living in Aged Residential Care (ARC) is appropriate for a small proportion of our population, studies have shown a higher level of satisfaction and better long-term outcomes where people remain in their own homes and positively connected to their communities.

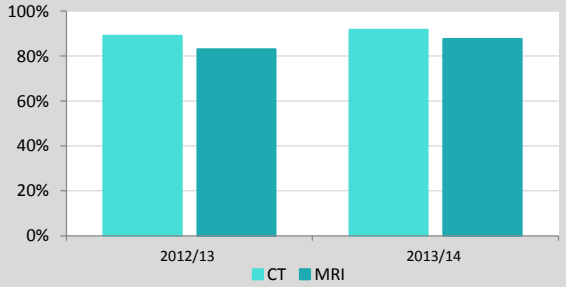
Living in ARC is also a more expensive option, and resources could be better spent providing appropriate levels of home-based support to help people stay well in their own homes.

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

Data Source: SIAPO Client Claims Payment System[12]

[12] *Updated Census population estimates used for the 2013/14 year have had a noticeable impact on the results for this measure with the total 75+ populations previously over counted – the actual number of people living in ARC has dropped from 4,608 (2012/13) to 4,442.*

MEASURE: % OF PEOPLE WAITING LESS THAN SIX WEEKS FOR CT/MRI SCANS



2013/14	2015/16	2016/17	2017/18	2018/19
CT Base: 92%	Target: 95%	95%	95%	95%
MRI Base: 88%	Target: 85%	85%	85%	85%

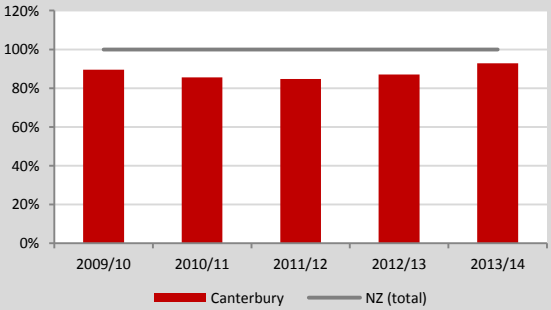
Impact: People's conditions are diagnosed earlier

Diagnostics are an important part of the healthcare system and timely access to diagnostics, by improving clinical decision making, enables early and appropriate intervention improving quality of care and outcomes for our population.

Timely access to diagnostics can be seen as a proxy indicator of system effectiveness where effective use of resources is needed to minimise wait times while meeting increasing demand.

Data Source: Individual DHB Patient Management Systems

MEASURE: RATIO OF ACTUAL VS EXPECTED AVOIDABLE HOSPITAL ADMISSIONS FOR THOSE AGED UNDER 75



2013/14	2015/16	2016/17	2017/18	2018/19
Base: TBC	Target: TBC	TBC	TBC	TBC

Impact: Fewer avoidable hospitalisations

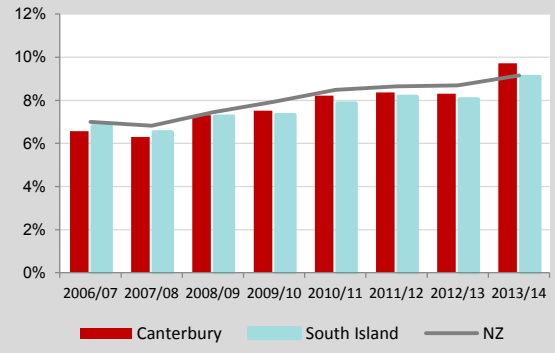
Given the increasing prevalence of chronic conditions, effective primary care provision is central to ensuring the long-term sustainability of our health system.

Keeping people well and supported to better manage their long-term conditions by providing appropriate and coordinated primary care should result in fewer hospital admissions - not only improving health outcomes for our population but also reducing unnecessary pressure on our hospital services.

Lower avoidable admission rates are therefore seen as a proxy indicator of the accessibility and quality of primary care services and mark a more integrated health system.

Data Source: Ministry of Health Performance Reporting[13]

MEASURE: % OF THE POPULATION (75+) ADMITTED TO HOSPITAL AS A RESULT OF A FALL



2013/14	2015/16	2016/17	2017/18	2018/19
Base: 9.7%	Target: 7.9%	<7.9%	<7.9%	<7.9%

Impact: Fewer falls-related hospitalisations

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

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

Solutions to reducing falls span both the health and social service sectors and include appropriate medications use, improved physical activity and nutrition, appropriate support and a reduction in personal and environmental hazards.

Lower falls rates can be seen as a proxy indicator of the responsiveness of the whole of the health 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[14]

[13] *This measure is a national DHB performance indicator (SI1) and covers hospitalisations for 26 identified conditions including asthma, diabetes, angina, vaccine-preventable diseases, dental conditions and gastroenteritis. It is defined as a rate per 100,000 people and the target is set to maintain performance below the national rate—which reflects less people presenting to hospital. The Ministry is working to resolve a definition issue with this measure and target setting for 2015/16 has been postponed while the definitions are reset. Data presented is the previous year's results under the old definition.*

[14] *The result for 2013/14 differs to that previously published due to the use of updated 2013 Census population numbers which have had a noticeable impact on the results for this measure — due to the total 75+ population previously being over counted. The actual number of people admitted as a result of a fall has risen from 2,890 (2012/13) to 3,211 (2013/14).*

Strategic Outcome Goal 3

4.3 People with complex illness have improved health outcomes

WHY IS THIS OUTCOME A PRIORITY?

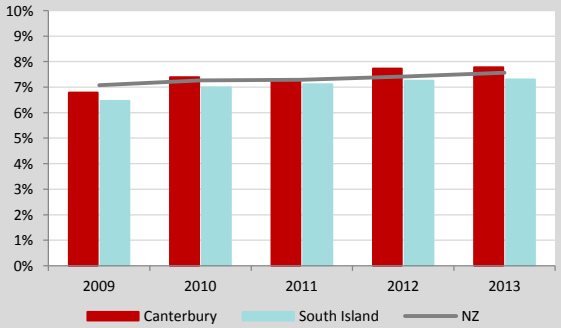
For people who do need a higher level of intervention, timely access to quality specialist care and treatment is crucial in supporting recovery or slowing the progression of illness. This leads to improved health outcomes with restored functionality and a better quality of life.

As providers of hospital and specialist services, DHBs are operating under growing demand and workforce pressures. At the same time, Government is concerned that patients wait too long for specialist assessments, cancer treatment and elective surgery. Shorter waiting lists and wait times are seen as indicative of a well-functioning system that matches capacity to demand by managing the flow of patients through its services and reduces demand by moving the point of intervention earlier in the path of illness.

This goal reflects the importance of ensuring that hospital and specialist services are sustainable and we have capacity to provide for the complex needs of our population now and into the future. It also reflects the importance of the quality of treatment. Adverse events, ineffective treatment or unnecessary waits can cause harm, resulting in longer hospital stays, readmissions and complications that have a negative impact on the health of our population.

OVERARCHING OUTCOME INDICATORS

MEASURE: RATE OF ACUTE READMISSIONS TO HOSPITAL WITHIN 28 DAYS OF DISCHARGE



Outcome: A Reduction in acute readmissions

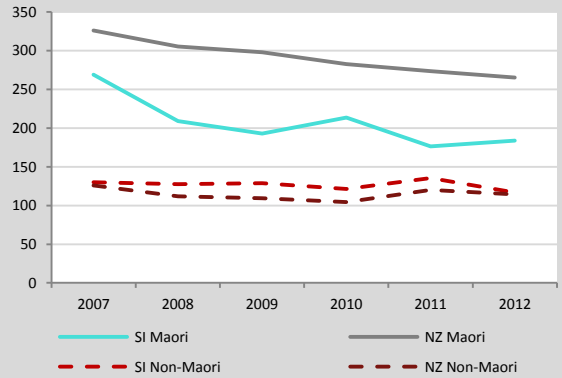
Unplanned hospital readmissions are largely (though not always) related to the care provided to the patient.

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

Because the key factors in reducing acute readmissions include safety and quality processes, effective treatment and appropriate support on discharge – they are a useful maker of the quality of care being provided and the level of integration between services.

Data Source: Ministry of Health Performance Data OS8[15]

MEASURE: RATE OF ALL-CAUSE MORTALITY FOR PEOPLE AGED UNDER 65 *(AGE STANDARDISED, PER 100,000 PEOPLE)*



Outcome: A reduction in avoidable mortality

Timely and effective diagnosis and treatment are crucial factors in improving survival rates for complex illnesses such as cancer and cardiovascular disease. Early detection increases treatment options and the chances of survival.

Premature mortality (death before age 65) is largely preventable through lifestyle change, intervention and safe and effective treatment. By detecting people at risk and improving the treatment and management of their condition, the serious impacts and complications of a number of complex illnesses can be reduced.

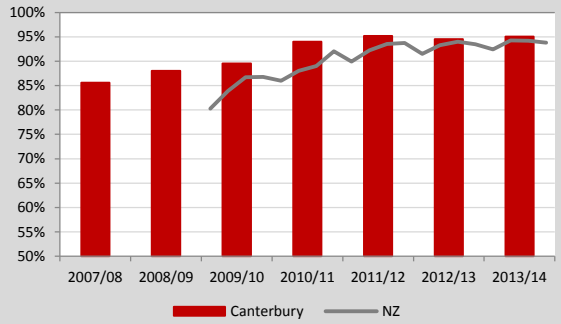
A reduction in avoidable mortality rates can be used as a proxy indicator of responsive specialist care & improved access to treatment for people with complex illness.

Data Source: National Mortality Collection[16]

[15] *This measure is a national performance indicator (OS8). A number of inconsistencies have been identified in comparison to local calculations—particularly patient transfers between hospitals being coded as readmissions. The Ministry of Health is currently reviewing the definition, and targets will be set once the definitions are confirmed. The DHB monitors readmission data internally to identify and target any areas of concern.*

[16] *The data presented is the most current available sourced from the national mortality collection which is three years in arrears.*

MEASURE: % OF PEOPLE PRESENTING IN ED ADMITTED, DISCHARGED OR TRANSFERRED WITHIN SIX HOURS



2013/14	2015/16	2016/17	2017/18	2018/19
Base: 95%	Target: 95%	95%	95%	95%

Impact: People have shorter waits for urgent care

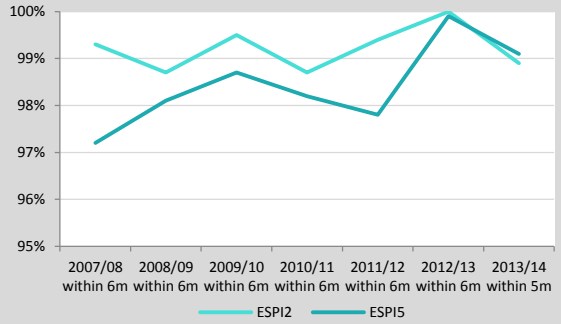
Emergency Departments (EDs) are important components of our health system and a barometer of the health of the hospital and the wider system.

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

Solutions to reducing ED wait times span not only the hospital but the whole health system. In this sense, this indicator is a marker of how responsive the whole system is to the urgent care needs of the population.

Data Source: Individual DHB Patient Management Systems[17]

MEASURE: % OF PEOPLE RECEIVING SPECIALIST ASSESSMENT (ESPI 2) OR TREATMENT (ESPI 5) WITHIN <4 MONTHS



2013/14	2015/16	2016/17	2017/18	2018/19
Base E2: 99%	Target: 100%	100%%	100%	100%
Base E5: 99%	Target: 100%	100%%	100%	100%

Impact: People have shorter waits for specialist care

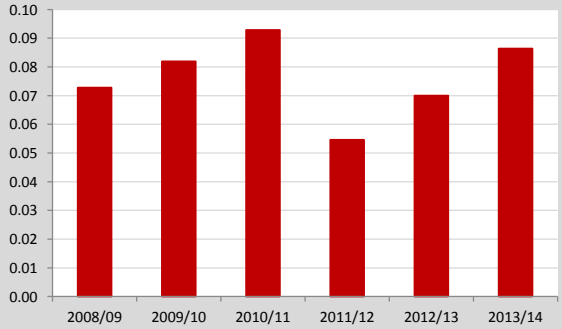
Planned services (including specialist assessment and elective surgery) are an important part of the healthcare system and improve people's quality of life by reducing pain or discomfort and improving independence and wellbeing.

Timely access to assessment and treatment is considered a measure of health system effectiveness and improves health outcomes by slowing the progression of disease and maximising people's functional capacity.

Improved performance against this measure requires effective use of resources so wait times are minimised, while a year-on-year increase in volumes is delivered. In this sense, this indicator is a marker of how responsive the system is to the needs of the population.

Data Source: Ministry of Health Quickplace Data Warehouse[18]

MEASURE: RATE OF SAC LEVEL 1 & 2 FALLS IN HOSPITAL *(PER 1,000 INPATIENT BED DAYS)*



2013/14	2015/16	2016/17	2017/18	2018/19
Base: 0.09	Target: 0.06	0.06	0.06	0.06

Impact: People experience fewer adverse events

Adverse events in hospital, as well as causing avoidable harm to patients, reduce public confidence and drive unnecessary costs. Fewer adverse events provide an indication of the quality of services and systems and improve outcomes for patients in our services.

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

Achievement against this measure is also seen as a proxy indicator of the engagement of staff and clinical leaders in improving processes and championing quality.

Data Source: Individual DHB Quality Systems[19]

[17] *This indicator is based on the national DHB Health Target 'Shorter Stays in ED' introduced in 2009.*

[18] *The Elective Services Patient Flow Indicators (ESPIs) have been established nationally to track system performance and DHB are provided with individual performance reports from the Ministry of Health on a monthly basis. In line with the ESPIs target reporting the annual results presented are those from the final quarter of the year.*

[19] *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 consequence and likelihood.*

Managing Our Business

WHAT DO WE NEED TO DELIVER OUR VISION?

The manner in which we work, the way we interact with each other and the values of our organisation are key factors in our success. Having already identified the challenges we face and set a collective vision for the Canterbury health system, this section highlights our organisational strengths and the way in which we will manage our business to support our transformation and deliver on our goals.

5.1 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. We need buy-in and support from our community and health professional working across our health system and we need the courage to do things differently.

Over the last six years, we have invested in leadership and engagement programmes that encourage our workforce to ask 'What is best for the patient?' and empower them to make changes to improve the effectiveness and efficiency of our health system.

The 'Xcelr8', 'Improving the Patient Journey' and the 'Canterbury Initiative' programmes promote lean thinking approaches to service and system redesign and support the development of a culture that focuses on the patient. 'Particip8' and 'Collabor8' are now offered alongside 'Xcelr8', and all three change leadership programmes are open to anyone in the Canterbury health system, not just DHB employees.

Our weekly CEO messages keep staff engaged in developments in Canterbury. 'Face-2-Face' rounds, community meetings and our HealthFirst community publications provide our community with updates, as well as a chance to provide feedback and input into the health system's direction.

We further engage and empower the Canterbury health workforce to improve patient outcomes through our annual Quality Improvement and Innovation Awards, which recognise excellence in quality improvement across the system. The awards were introduced in 2003 and have run every year except for 2011 due to the Canterbury Earthquakes.

5.2 Effective governance 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 Board and committee meetings to provide advice and consultation as required.

To support good governance across our health system, we have a clear accountability and decision-making framework that enables our 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:

CONSUMER PARTICIPATION IN DECISION-MAKING

There are a number of consumer and community reference/advisory groups and working parties in place across the Canterbury health system. Their advice and input assists in the development of new models of care and individual service improvements.

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 for the Chief Executive, the Consumer Council supports a partnership model that ensures a strong and viable voice for consumers in health service planning.

CLINICAL PARTICIPATION IN DECISION-MAKING

Viewing clinical leadership as intrinsic to our success, 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.

Clinical input into decision-making is embedded in the DHB's shared clinical and management model - in place across all service divisions. This model is replicated across the wider health system, with whole of system clinical leadership helping to drive transformation through Canterbury's District and Regional Alliances and to support the redevelopment of our hospital facilities.

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 leadership is further facilitated by the DHB's 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.

MĀORI PARTICIPATION IN DECISION-MAKING

Through its partnership and formal Memorandum of Understanding with Manawhenua Ki Waitaha (representing the seven Ngāi Tahu Rūnanga), the Board is able to actively engage 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 PHO activity to improve outcomes for Māori and who provide advice and support to the PHOs and DHB. Canterbury also has a Māori and Pacific Provider Leadership Forum to improve collective 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.

DECISION-MAKING PRINCIPLES

The input and insight of these groups supports good decision-making, but the environment in which we operate still requires some hard decisions about which competing services or interventions to fund with the limited resources available. To support this, the DHB has established a prioritisation framework and a set of decision-making principles.

Based on best practice and consistent with our strategic direction; these principles assist us in making final decisions on whether to develop or implement new services. They are also applied when reviewing existing services or investments and help to support the reallocation of funding between services.

Effectiveness: Services should produce more of the outcomes desired, such as a reduction in pain, greater independence and improved quality of life.

Equity: Services should reduce inequalities in the health and independence of our population.

Value for money: Our population should receive the greatest possible value from public spending.

Whānau ora: Services should have a positive impact on the holistic health and wellbeing of the person and their family/whānau.

Acceptability: Services should be consistent with community values. Consideration will be given as to whether consumers or the community have had involvement in the development of the service.

Ability to implement: Implementation of the service is carefully considered, including the impact on the whole system, workforce considerations and any risk and change management requirements.

5.3 Successful alliance partnerships

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

THE CANTERBURY CLINICAL NETWORK

In 2009 we established the Canterbury Clinical Network (CNN) District Alliance. The CCN is the broadest health alliance in New Zealand with nine partner organisations including not only the DHB and Canterbury's three Primary Health Organisations, but also pharmacy, laboratory, radiology and community service providers – ensuring wide ranging clinical input. We share a joint vision for our health system and come together to improve the delivery of health care in Canterbury and realise opportunities to transform and integrate our health system.[20]

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 the establishment of Integrated Family Health Services, Integrated Family Health Centres and Community Hubs, 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 alliance 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 and the CCN Work Programme is reflected throughout this Plan.

CROSS-SECTORIAL PARTNERSHIPS

The Canterbury DHB works in partnership with organisations from other sectors - recognising the role we all play in shaping the health of our population, whether our focus education, employment, youth, environmental enhancement, transport, housing or any other aspect of life.

Healthy Families New Zealand (NZ) is a new initiative that aims to improve people's health where they live, learn, work and play in order to prevent chronic disease. The Spreydon-Heathcote Ward is one of 10 Healthy Families NZ communities, with Pacific Trust Canterbury being the Government-funded local lead provider responsible for bringing together a partnership of key organisations, and establishing a dedicated health promotion workforce. The DHB is actively involved in this initiative.

[20] *Refer to Appendix 5 for an overview of the structure of the CCN and its Workstreams and Service Level Alliances.*

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 including the DHB.

All Right? is a Healthy Christchurch initiative led by the DHB and the Mental Health Foundation of New Zealand. All Right? undertakes regular in-depth research into how Cantabrians are feeling and the hurdles they are facing. This research is used to raise awareness about how Cantabrians are coping and to create tools to help them improve their wellbeing.

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

The DHB is also developing a closer working relationship with the Ministry of Health's Department of Disability Services to improve service engagement, delivery and outcomes for people with disabilities. Supported by the DHB's Disability Support Advisory Committee the DHB is developing a Disability Action Plan which, following engagement with providers and consumers will be implemented in the coming year.

CANTERBURY - WEST COAST 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 clinical partnerships has allowed us to actively plan the assistance and services Canterbury provides 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 1,200 telemedicine consultations have taken place since 2010. Covering specialties including: oncology, paediatrics, general medicine, plastics, orthopaedics and general surgery – telehealth consultations provide 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.

Over the next year years there will be a focus on developing the transalpine approach across a broader range of areas including: anaesthesia, medical, surgical, mental health and older persons' health services. A key goal is to develop a support structure that provides sustainable and consistently high quality services on the Coast.

NATIONAL COLLABORATION AND PARTNERSHIPS

At a national level, we work with the Education, Social Development and Justice sectors to improve outcomes for our population and achieve shared goals. From this perspective we are committed to implementing national cross-agency programmes including: the rollout of the Prime Minister's Youth Mental Health Project, the Children's Action Plan and the national Whānau Ora programme.

Canterbury DHB is working nationally alongside other DHBs, the Ministry of Health and the Accident Compensation Corporation (ACC) 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.

Our ongoing leadership role in the Adverse Drug Event Collaborative in partnership with Counties Manukau and Capital and Coast DHBs will help us identify opportunities to improve medication safety.

Canterbury will also continue to actively participate in the delivery of national programmes led by the National Health IT Board, Health Quality & Safety Commission, Health Workforce NZ, the National Health Committee, Health Promotion Agency, PHARMAC and Health Partnership Limited (Health Benefits Limited) for the benefit of our population and the wider health system.

5.4 Research & innovation

A significant body of clinical research is 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. The Research Committee, a standing committee reporting to our Clinical Board, provides governance and advice on matters related to clinical research activities and develops research policy.

Canterbury is also one of the four founding DHBs of the national Health Innovation Hub - launched in late 2012. The focus of the Health Innovation Hub is to facilitate the flow and development of ideas with both a commercial potential and a positive impact on health care. In tandem, Canterbury has a strong health innovation environment. The Via Innovations brand, launched in late 2012, has strengths in health IT and service delivery improvement, and represents the Canterbury DHB's contribution to innovation.

Both the national Health Innovation Hub and Via Innovations are supported by the Canterbury Development Corporation, universities and other

tertiary providers. Through these regional and national networks, clinicians now have improved opportunities to access innovation support, with the aim of accelerating the rate of innovations focused on improved patient outcomes and health system improvements.

5.5 Subsidiary companies & partnerships

The Canterbury DHB has two operational subsidiary companies. 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.

Brackenridge Estate Limited was incorporated in 1998 and 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 Brackenridge Estate. The primary source of funding is service contracts with the Ministry of Health and as at December 2014; 137 clients were being supported. The DHB currently owns all shares, however Brackenridge is considering transitioning to non-DHB ownership in the future.

Canterbury Linen Services Limited was incorporated as a company in 1993 and 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 to the DHB. Plant and equipment, motor vehicles and the rental linen pool are the major fixed assets of the company. The key output for 2015/16 is the processing (collection, laundering and delivery) of 4.74 million kilos or 13.4 million items of laundry.

Alongside these two subsidiary companies:

New Zealand Health Innovation Hub is 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 service improvement initiatives that will deliver health and economic benefits to the health system. Structured as a limited partnership, with the four foundation DHBs each having 25% shareholding, further detail can be found at innovation.health.nz.

The Canterbury DHB is also a joint shareholder in the South Island Shared Services Agency Limited, wholly owned by the five South Island DHBs. While the company remains in existence, following the move to a regional alliance framework, the staff now operate as the ***South Island Alliance Programme Office*** delivering a service to the South Island DHBs from under the employment and ownership of Canterbury DHB. The Programme Office is jointly funded by the five South Island DHBs to provide services such as audit, regional service development and project management with an annual budget of just over $6m.

Canterbury DHB's contribution to the Regional Office for 2015/16 is $1.43 million.

5.6 Investment in people

Our ability to meet the future demand for health services relies on having the right people, with the right skills, working in the right place.

Like all DHBs, our workforce is ageing and we face shortages and difficulties in recruiting to some professional areas. Canterbury has the added challenges of attracting staff in in a post-earthquake period with its associated rebuild disruptions and housing shortage and supporting our workforce through a period of extraordinary stress and disruption.

Results from our staff engagement surveys demonstrated positive levels of engagement with the organisations goals but also showed that the post-earthquake stress that is increasingly evident across our community is also affecting our workforce. As well as dealing with unresolved personal issues resulting from the earthquakes, our staff are coping with workplace repairs and disruption including preparation for transitioning into new facilities - all while addressing the increasingly complex health issues experienced by the people in their care.

The 2014 Staff & Family Wellbeing Survey highlighted:

- Over one third of respondents had a WHO-5 Wellbeing Index score of less than 13, which is indicative of poor emotional wellbeing and can be an indicator of potential mental health risk. These staff have a reduced capacity to cope with stressors and an elevated degree of psychological burden.
- Only 18% reported achieving the minimum level of recommended physical activity (down from 22% in 2012) and 52% reported frequently or feeling fatigued in their daily lives.
- Of the staff who own properties, 56% reported having either partially resolved or unresolved 'earthquake issues'.
- Over 30% identified poor working conditions such as noise and overcrowding as a key stressor affecting them in their job and 20% identified disrupted work environments as having a negative impact on their wellbeing.
- Over 60% of managers reported feeling somewhat or extremely burdened by the responsibility to lead.

A significant commitment has been made to supporting staff wellbeing, acknowledging the links to engagement, productivity and the quality of patient care and. Our Wellbeing Programme took out top honours at the 2013 National Workplace Wellbeing Awards (best new programme category). We have also been named as a finalist in the NZ Workplace Health and Safety Awards 2015, for the programme of wellbeing workshops run for line mangers.

In April 2015 the DHB engaged Nigel Latta to present three one-hour sessions on self-care which were attended by 1,500 staff, with another 2,400 logging in to view the live stream. We are currently running another series of wellbeing workshops open to all staff, with the first 10 workshops being fully booked within three weeks of promotion. Over the next few years we will continue to implement our Wellbeing Programme focusing on building mental and physical resilience, identifying and supporting those at risk and improving the management of absenteeism.

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, 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.

In the past year the Canterbury DHB has reviewed its current Child Protection Policy against recent changes to Vulnerable Children's legislation and agree a phased implementation plan to meet the new requirements for worker safety checks as this comes into effect. Alongside the other 20 DHBs, Canterbury will implement safety checking requirements for recruiting workers in the children's workforce and ensure this information is available to the Director General of Health to meet the requirements in the Vulnerable Children's legislation. The DHB is also reviewing relevant contracts to ensure a clause relating to the need for contracted service providers to have a Child Protection Policy is included.

EXPANDING OUR WORKFORCE CAPACITY

From a recruitment perspective, (and in spite of the post-earthquake environment) Canterbury is able to attract health professionals to most positions due to our size and reputation. However, there are a few notable exceptions where workforce shortages affect capacity. In response, we have strengthened our interactive and targeted recruitment strategies, including branding, profiling and Facebook to keep people connected. We also tap into available talent through national and regional initiatives, links with the education sector, support for internships and increased clinical placements in our hospitals.

Canterbury employed over 190 new graduate nurses this year through the national Nursing Entry to Practice programme and the Nursing Entry to Specialist Practice Mental Health and Addictions Programme. The DHB has a collaborative partnership with Christchurch Polytechnic offering clinical placement for students undertaking Bachelors of Nursing and Diploma of Enrolled Nursing. We also work in partnership with the graduate entry Master of Health Sciences and Bachelor of Nursing programme which is a joint initiative between the University of Canterbury and CPIT.

We support the development of an appropriately skilled Māori 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 are 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.

ENHANCING OUR WORKFORCE CAPABILITY

Developing our existing staff is a key strategy for enhancing the capability of our system. We have recently strengthened our core development training calendar, which can be accessed by health professionals working anywhere in the Canterbury health system.

CANTERBURY DHB WORKFORCE		
DHB Total Headcount	Turnover	Sick Leave
9,608	7.9%	3.5%
81% female	8.9% nationally	3.7% nationally
Average Age	Largest Ethnic Group	Diversity
46 years	NZ European	98 ethnic groups
Oldest Workforce	Largest Workforce	FTE Terms
Nursing 4,485	Support	48% part time
47% of workforce	Avg. Age 52 years	80% permanent

A group of 24 participants from across Canterbury have been selected for targeted leadership development under our "20-20 leaders programme". We have also embedded formal performance appraisals into operational management, along with support for career plans and succession planning initiatives such as talent identification to reduce gaps across our organisation.

With the new facilities being built, new models of care, work processes, IT systems and ways of working are all part of the key strategy for workforce transition readiness. This will enable us to ensure that the right care is being delivered, in the right place, at the right time by the right person, with the right experience and provide a framework for standardised work practices across the care continuum.

The Professional Development Recognition Programme, the Credentialing Committee for Expanded Practice and the Regional Allied Health Assistant Training Programme highlight the focus on the expansion of the scope of existing roles (and the establishment of new ones). New advanced gerontology nurse specialist roles reflect a more connected and capable workforce.

There is an integrated palliative care service between Nurse Maude and Christchurch Hospital. The South

Island Palliative Care Regional work stream has also initiated planning and discussion around potentially extending palliative care specialist nurses to support the ARC sector across the South Island.

We have stepped up our participation in the Health Workforce NZ sponsored Regional Training Hubs to support critical role identification and expand workforce capability through sharing of training resources. The focus over the next few years will also be on, Sonographers, GPEP2 training for general practice registrars and implementation of the community component for PGY2s in the new Medical Council prevocational curriculum.

Aligned to the health system transformation across Canterbury we are investing in primary care education. This enables GPs, practice nurses and pharmacists to attend peer-led, evidence-based education sessions that promote the use of clinical best practice and integrated pathways and increase the capability of our system.

Canterbury is an active participant in the Regional Training Hub Nurse Practitioner Work Stream developing an implementation strategy and pathway to increase the number of nurse practitioner roles to better meet future health needs. The South Island Nursing Community of Practice Group has also been established to ensure a whole of system approach with consistent education and training resources developed to build a South Island Nursing workforce with transferable skills, which is fit for purpose, and working towards top of scope.

E-Learning also will continue to be incorporated in the developmental approach to building capability, and the number of clinical and non-clinical modules available to staff across the South Island will continue to grow in the coming year.

5.7 Investment in quality & safety

Our patient-focused, clinically led culture supports two of our system's greatest strengths: our commitment to 'zero harm' and continuous quality improvement. The DHB is utilising the NZ Business Excellence in Health Care criteria to guide the organisation's continuous improvement efforts. A staff perception survey and focus groups review has been completed and the information gained used to strengthen organisational processes.

Working with the South Island Quality and Safety Alliance we are implementing a regional incident and risk management system (Safety 1st) as part of our routine incident and risk management processes. This will provide ready access to trends in incidents and risks as well as support more timely completion of root cause analyses for sentinel events helping to improve process and reduce harm.

As part of our efforts to detect the deteriorating patient we will introduce an electronic patient-vital-sign early-warning system that will aid staff in detecting and communicating risk to the broader team via the patient portal. This system will significantly enhance clinical decision-making.

Canterbury is committed to progressing the Health Quality & Safety Commission's (HQSC) national priorities: reducing hospital-acquired infections, harm from falls and the risk of infection and improving medication and surgical safety. We will continue to monitor our performance using the national Quality and Safety Markers and work with the HQSC to implement the new perioperative harm measure in 2015/16. We will also continue to support local and national morbidity and mortality reviews.

The DHB has a set of Quality Accounts which articulate how our patient-focused culture supports our commitment to zero harm and continuous quality improvement. The Accounts contain snapshots of activity and performance across the Canterbury health system, with particular emphasis on priority areas of the Clinical Board. The DHB uses HQSC guidelines and consumer feedback to review and develop the Accounts.

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

Improving the patient experience: We recognise that consumers have a unique perspective of health services and are able to provide important information about care they receive. By working in partnership, we will be able to improve their experience as well as their health and wellbeing. In collaboration with our Consumer Council, the DHB is facilitating consumer focus groups, gathering patient stories and identifying effective methods for gathering feedback. We are surveying patients fortnightly using the national survey methods and plan to increase the participation rates this year. The 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 and this is used by the teams in surveillance and management. We are committed to minimising risk in three specific areas: Hand Hygiene; Central-Line-Associated Bacteraemia; and Surgical Site Infections. The HQSC recently launched a programme aimed at reducing the rate of surgical site infections and we are working with Auckland DHB and the HQSC on the national Surgical Site Infection Surveillance Programme.

Preventing harm from falls: Reducing the number of and harm from falls is a key component in our strategies for improving the health of older people and reducing acute demand. We invest in a community model that focuses on the delivery of falls prevention in people's homes and communities and targets older people at risk of admission to hospital. In our hospital setting, we pay close attention to the evidence-based essentials of falls prevention and to the specific falls risk for each patient in our care. We have standardised falls alert visual cues across hospitals and introduced Safe Mobility plans for each patient that can be used

by the full team and family members. We will consolidate their use this year. An electronic nursing patient observation system is also being introduced to record falls risk and make data visible in real time, assisting with improving adherence to protocol and prevention activity.

Medication and surgical safety: The use of medications always carries the risk of a side effect, allergy or other adverse outcome. The DHBs is participating in the national medicine reconciliation, electronic medicines management and the opioid campaign initiatives being driven through the HQSC. We have also taken a lead role in supporting the New Zealand Universal List of Medicines (NZULM) fit for purpose in New Zealand.

We maintain an Adverse Drug Event Trigger Tool programme that provides valuable information about the severity and type of medication events occurring and helps to identify where to focus our safety improvement initiatives. This has led to our focus on improving the prescribing of opiates as part of the national campaign. We are also committed to ensuring the Safe Surgery Checklist is used in our operating theatres to promote better communication and teamwork in the operating room. We will also work with South Island colleagues to introduce the brief debrief approach in our theatres and use the measures to track and improvement performance over the coming year.

5.8 Investment in information systems

Information management is a national priority, and DHBs are taking a collective approach to implementing the Government's National Health Information Technology Plan. The South Island DHBs have collectively determined strategic actions to deliver on the national plan and Canterbury is committed to this approach.

Our major priority is to connect up the system enabling seamless access to clinical patient information at the point of care. This will benefit patients by enabling more effective clinical decision-making, improving standards of care and reducing the risks associated with missing important information.

Canterbury has already adopted several key information solutions which are now being rolled-out regionally, such as HealthPathways, the Electronic Request Management System, Health Connect South and HealthOne (formally eSCRV). Canterbury is also replacing its three hospital based Patient Administration Systems (PASs) with one new system in line with the rest of the country.

We will continue to work closely with clinicians and stakeholders to ensure that the right clinical information is provided in the right place, at the right time. Full details of the regional investment in information systems can be found in the South Island Regional Health Services Plan but includes the following major initiatives:

South Island Patient Information Care System (PICS) will be the new regional patient administration system, replacing Canterbury's three current patient administration systems with a single system and further integrating system throughout the South Island. Canterbury and the West Coast will upgrade their old legacy systems and implement the new PICS in 2016/17 and initial implementation at Burwood will commence 2015.

HealthPathways provides locally developed and agreed assessment, management, and referral information to health professionals across our system. Over 600 clinically-designed pathways and GP resource pages are now available and we are supporting the implementation of HealthPathways across the rest of the South Island.

HealthInfo is a more recently developed 'sister site' to HealthPathways that provides locally approved health information for consumers. The site has over 1,400 pages and we are expanding its content and visibility.

Health Connect South (HCS) is a clinical workstation and data repository (portal) that brings a patient's clinical information into one view, providing timely information at the point of care and supporting clinical decision making. Canterbury is leading the roll-out and a single HCS record now exists between Canterbury, West Coast and South Canterbury DHBs. This will be extended in 2015/16 to include both Nelson Marlborough and Southern DHBs establishing a single clinical record across the South Island.

HealthOne (formerly eSCRV) is a secure system for sharing core health information (such as allergies, dispensed medications and test results) between all the health professionals involved in a person's care, no matter where they are based. HealthOne enables faster, safer, more informed treatment. Canterbury is leading the rollout of HealthOne across the South Island with the West Coast live in early 2015 and South Canterbury to follow.

The Electronic Request Management System (ERMS) enables general practices to send referrals electronically from their desktops. Over 80% of GP referrals to Canterbury DHB are now sent via ERMS, which receives 12,000 to 14,000 referrals every month. Canterbury lead the rollout of ERMS across the South Island over the past year and all South Island DHBs are now using this system.

eMedications is a foundation system which promotes patient safety by improving medications management. The system has three components and is being rolled out regionally. In 2014/15 Canterbury implemented ePA (prescribing and administration) for Mental Health services with other sites to follow over 2015/16. The DHB will also implement eMedications Reconciliation across the DHB in the coming year.

The National Patient Flow 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 been implementing Phase I (collection of referrals to

specialists) and will begin Phase II (non-admitted and associated referral information including diagnostic tests) in 2015/16.

The Self-Care Patient 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 will work with the three Canterbury PHOs to further develop patient engagement platforms.

Safety 1st is a new incident and risk management system that enables the capture and reporting of incidents and risk. This system supports the DHB's drive for quality by allowing timely root cause analysis and opportunities for the organisation to learn.

5.9 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 $650 million redevelopment on the Burwood and Christchurch Hospital sites is the largest health-related building project in New Zealand's history and will allow us to regain a large part of the capacity lost after the earthquakes and support the very best patient care. However, it is important to note that the development will not resolve all of our facilities issues and it will not happen overnight.

Our health system will continue to have significant capacity challenges for a number of years. The Burwood Health Campus redevelopment will not be completed until 2016, and the new Acute Service Building at Christchurch Hospital not until 2018. In the meantime, we have to continue to maintain service delivery and operate safely with fewer hospital beds, severely damaged infrastructure and disruption for major repairs.

Our facilities suffered extensive damage in the earthquakes. Only the dedication of our maintenance and engineering team has kept our major sites going. 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 devised a 10 year recovery programme of earthquake repair. Damage estimates were over $518m and while the DHB negotiated the full insurance coverage – this was capped at $320m. Our recovery programme will require ruthless prioritisation in order for it to remain affordable as we navigate the uncertainties of escalating costs while maintaining a safe and effective environment for staff and patients.

In order to avoid costly and wasteful investment, close alignment and careful timing of the redevelopment and repair programmes is essential. We must make careful decisions about our short-term capital investment in repairs in the context of the longer-term direction, or health dollars will be wasted. The DHB is working with the Ministry of Health, through the nationally appointed Hospital Redevelopment Partnership Group, to ensure delays are minimised and programmes are closely aligned.

The DHB is also working closely with primary and community service providers to make the most of every opportunity as they look to repair and redevelop their own facilities. We will support the development of Community Hubs and Integrated Family Health Centres in key locations across Canterbury to further align community health facilities with the future model of care.

Anticipated activity for 2015-2018 includes:

Kaikoura: The Kaikoura Integrated Family Health Centre will replace the old hospital facilities and provide for primary care, acute care, aged care, maternity care, radiology and trauma stabilisation. Construction is well underway and the facility is scheduled for completion in 2016.

Rangiora: The Rangiora Community Hub will replace the old hospital facilities. The first phase of construction will provide maternity services and inpatient beds with completion expected mid-2015. Phase II is to include the relocation of the temporary outpatients building from Christchurch Hospital and is set to begin subject to the construction of the new Outpatient Building.

Ashburton Hospital: The construction of a new theatre block and acute admitting unit and various ward refurbishments will be completed in 2016.

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

The Acute Services Building: The construction of the new Acute Services Building at Christchurch Hospital is underway and scheduled for completion in 2018. The new building will provide: additional operating theatres; around 400 beds including purpose-designed spaces for children; an expanded intensive care unit; state-of-the-art radiology and emergency departments; and a rooftop helipad.

The Christchurch Hospital Intensive Care Unit: The interim expansion of the ICU is underway. This will provide the service with the capacity to response to demand until the new Acute Services Building is complete and is scheduled for completion in 2015.

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.

The Christchurch Health Precinct: This is a major anchor project under the Christchurch City Rebuild where the DHB is working in a partnership with the Christchurch Central Development Unit, Universities of Canterbury and Otago and the Christchurch Institute of Technology. Outpatient services, car parking, teaching, research facilities and an energy

centre are all being considered across this space and the DHB's St Asaph Street site.

Canterbury's Rural Hospitals: The DHB is also carefully considering the role of other rural hospitals, alongside strategies for the future sustainability of health services in rural communities.

5.10 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 exceptional circumstances, there are risks to service coverage in terms of short-term capacity constraints due to repairs, spikes in demand and stresses on other non-government and community providers. Our greatest service risk continues to be the increased vulnerability of our population and the unpredictable demand from the influx of workers for the rebuild with service demand in some areas increased markedly.

We are committed to continuing to manage and resolve any service coverage issues we encounter and at this stage are not seeking any formal exemptions to the Service Coverage Schedule for 2015/16.

SERVICE REDESIGN AND RECONFIGURATION

In line with our vision, we are continually working to transform the way we deliver health services in order to better meet the needs of our population, improve the quality of services delivery and ensure the sustainability of our health system. We anticipate that new models of care and service delivery will also continue to emerge as we respond to the evolving needs of our most vulnerable population groups.

However, the DHB recognises its obligations under our policy framework to notify the Minister of Health with respect to any significant service change and will continue to do so. In line with our shared decision-making principles, decisions regarding how a service is best delivered are made collectively and wherever possible under the leadership of the health professionals delivering the service.

Canterbury has a policy of ongoing participatory engagement, and we will keep a steady stream of information flowing across the sector on the planned transformation of any services. Any service changes will be carefully considered so as not to destabilise or negatively affect other providers or DHBs.

ANTICIPATED ACTIVITY FOR 2015-2018 INCLUDES:

Internal service shifts or reconfiguration to support the repair of infrastructure or the provision of services with reduced capacity while facilities are redeveloped including: service and ward reconfigurations in line with Canterbury programme of earthquake repair.

Internal service redesign to improve patient safety, system capacity and patient outcomes including: elective services redesign (100 Days Project), implementation of the Frail Older Person's Pathway, roll-out of the Enhanced Recovery After Surgery (ERAS) model, Faster Cancer Treatment track project, and the Electronic Incident Management System.

System-wide service integration to ensure capacity to meet immediate and future demand and to improve health outcomes including: implementation of extended treatment strategies for people with mental health needs, continued development of rural health models that provide people with care closer to their own homes and implementation of the IFHS models. The DHB will also be developing a Fracture Liaison Service and establishing a single community-based rehabilitation service for stroke patients.

Regionally driven service redesign or reconfiguration to support equity of access and the sustainability of vulnerable services including: a regional proposal for Fertility Services and the adoption of consistent and sustainable regional pathways for access to specialist services in line with the South Island Regional Health Services Plan.

Nationally driven service redesign or reconfiguration to align processes with national policy and implement Government strategies including: implementation of the Children's Action Team in line with the Vulnerable Children's Legislation, changes in line with national pharmacy and PHO agreements and key actions in relation to National Entity priorities.

At times, we may wish to enter into cooperative agreements and arrangements to assist in meeting our objectives to enhance health outcomes for our population and efficiencies in the health sector. In doing so (in accordance with Section 24(1) of the NZPHD Act 2000), we will ensure that any arrangements 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.

Part III – Annual Operating Intentions

Delivering Our Service Priorities

A fully integrated health system is one that provides a seamless flow of care rather than a series of isolated events. In a constrained environment, our focus on supporting people to stay well, reducing demand and managing patient flow becomes critical. The answer to improving the health of our population and meeting the demands on our system is not more of the same services, but more of the right services delivered in the right place, at the right time, by the right person.

Connecting our system

6.1 Service integration

Our approach to getting things right has been to bring health professionals and service managers from community services, general practice and hospital specialties together and give them the permission and the tools to improve the way they work and the way our health system responds.

By working alongside one another to design new models of care and patient pathways we have been able to improve the patient journey, streamline the interface between services and make better use of our system's resources. Together, under the banner of the Canterbury Clinical Network (CCN) Alliance, we have significantly improved outcomes for the Canterbury population.

By moving services closer to the patient and into the community we have improved service access and reduced waiting times. Clinically-designed HealthPathways, direct access to diagnostics, subsidised GP procedures and alternative ambulance pathways mean Canterbury patients spend less time waiting for treatment.

Strong clinical leadership, funded education programmes, a multi-disciplinary approach to care and access to acute care in the community, has meant Canterbury now has the 2nd lowest rate of acute medical admissions of any DHB in the country. If we admitted patients to hospital at the national average over 18,000 more acutely unwell people would have been admitted in the last year alone.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Engage the whole of the health system in the vision to support transformation and improve outcomes for our population.	▪ Continue to ensure system-wide participation, joint planning and clinically-led service development through the CCN Alliance. ▪ Maintain the range of partners within the CNN Alliance. [21] ▪ Continue to connect and align CCN workstreams and Service Level Alliance (SLA) activity with other system-level initiatives and where appropriate rationalise work group activity. ▪ Enhance CCN communications with a focus on redevelopment of the website and profiling of patient and provider stories to engage alliance stakeholders and proactive development. ▪ Identify opportunities for cross-sector alliances and enhanced involvement of social sector partners in CCN alliance activity.	✓ Quarterly activity and outcomes reporting to Alliance Leadership. ✓ CCN website enhanced Q1. ✓ Prioritisation of activity evidenced in the work programmes Q2. ✓ Joint CCN/DHB Annual Planning Workshop Q3. ✓ Increased visibility of CCN activity and system improvements through patient case studies Q4.
Support continued alignment of clinical information systems and technology to support the transformation of our system.	▪ Continue to review clinical HealthPathways to support the delivery of the right care, in the right place, at the right time. ▪ Continue to expand HealthInfo to provide people with the information they need to better manage their own health.	✓ >600 HealthPathways available across the Canterbury system. ✓ Increase number of visits to the HealthInfo site – base 43,696.
	▪ Continue to support the use of the Electronic Request Management System (ERMS) to streamline primary/secondary referrals and improve triaging capabilities within the system. ▪ Continue to support the development of HealthOne to provide secure access to key health information in any health setting.	✓ 95% of general practices and pharmacies have HealthOne access. ✓ >80% of all GP referrals to CHCH Hospital are e-Referrals via ERMS

[21] *There are currently nine signatories to the Alliance Partnership – the three Canterbury PHOs, the Canterbury DHB, Access Home Health, Nurse Maude Association, Health Care of NZ Limited, Canterbury Community Pharmacy Group and Christchurch Radiology.*

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Continued support of key programmes to support people in the community and closer to their own homes.	▪ Maintain direct GP access to diagnostic services to support earlier intervention without the need for specialist referral. ▪ Continue to invest in services already shifted closer to home including mobile assessments, subsidised procedures with specialist advice and oversight and GP-2-GP referrals. [22] ▪ Continued to invest in the delivery of community-based acute demand services to better support people in the community rather than in our hospitals. ▪ Maintain direct GP access to CREST services to support people at risk of a hospital admission to stay well in their own home.	✓ >1,000 people referred to community-based spirometry. ✓ >8,000 subsidised procedures delivered in primary care. ✓ >28,000 urgent care packages provided in the community Q4. ✓ >1,500 people (65+) accessing CREST services.
Continued access to services that enable the improved management of patients across the system.	▪ Continue to support the Pharmacy Service Level Alliance to promote the role of the pharmacist in the multi-disciplinary team and in the management of long-term conditions. ▪ Continue to invest in the Medication Management Service (MMS) and Medication Therapy Assessments (MTA) to give people greater understanding of their medications and reduce the risk of harm from medications use.	✓ Medical Therapy Assessment service implemented Q2. ✓ >2,000 people referred to MMS or MTA.
	▪ Continue to support the Laboratory Service Level Alliance to implement a seamless and patient centre model that supports appropriate clinical intervention and treatment. ▪ Invest in Point of Care Testing (POCT) particularly within Integrated Family Health Services and associated pharmacies.	✓ E-ordering of lab tests live Q4. ✓ Increased number of IFHS and related pharmacies offering POCT Q4.
	▪ Support the Radiology Service Level Alliance to deliver a seamless service that provides radiology images and reports to clinicians in both public and private practice. ▪ Maintain direct GP access to Ultrasounds, X-ray, MRI and CT scans. ▪ Support continuous process improvement through service audits on wait times and service quality of contracted providers.	✓ 95% of accepted referrals for CT scans receive their scan within six weeks Q4. ✓ 85% of accepted referrals for MRI scans receive their scan within six weeks Q4.
Support implementation of the Integrated Performance and Incentive Framework (IPIF) and achievement against the system level measures.	▪ Work closely with the three Canterbury PHOs and the CCN Alliance to agree key programmes and initiatives to achieve the national measures and agree a streamlined process for reporting progress and performance. ▪ Support achievement of the Healthy Start measures through the Child and Youth Health Workstream and Immunisation Service Level Alliance. ▪ Support achievement of the Healthy Adult measures through the cross-sector Cervical Screening Action Group (refer to Māori Health Plan). ▪ Support achievement of the primary care health targets through implementation of the agreed DHB/PHO Recovery Plan. ▪ Support achievement of the Healthy Ageing (Polypharmacy) measure through the Pharmacy Service Level Alliance and the Medications Management Service.	✓ Quarterly performance reporting. ✓ 80% of pregnant women register with an LMC by week 12. ✓ 98% of new-borns enrolled with general practice within three months of birth. ✓ 95% of eight month olds are fully vaccinated. ✓ 95% of two year olds are fully immunised. ✓ 80% of eligible women have had a cervical screen in the last 3 years. ✓ No increase in the number of people aged 65+ dispensed 11 or more discrete medications.

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

6.2 Primary care

The next step in our journey will be ensuring that primary and community services have the right capacity and capability to play their part in this integrated system. Core to this direction is the continued investment in the CCN and the development of our Integrated Family Health Service (IFHS) programme. The DHB has invested in this programme, working alongside general practice, to support the reorganisation of their models of care, to ensure that they are ready to play their part in meeting the future challenges that our health system faces.

This programme (which is being described around the country as the Health Care Home) has been working with 40 practices across Canterbury who cover approximately 60% of the enrolled population. The current programme supports the integration of tools like collaborative care, electronic referral management and HealthOne into the general practice setting as enablers to support a change in their models of care. The IFHS programme, supported through the CCN, will evolve to incorporate the relevant standards of Health Care Home models from around the country and support primary care to take the next leap in transformation.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Support the continued transformation of general practice models.	▪ Continue to invest in the development of Integrated Family Health Services in Canterbury. ▪ Build on the engagement and success of the IFHS programme to support practices to implement the relevant standards of Health Care Home programme. ▪ Continue to invest in the supported primary care education programme for general practitioners, practice nurses and pharmacy to further support integration models.	✓ 70% of Canterbury's enrolled patients practices engaged in IFHS programme Q4. ✓ 10% of those practices have progressed onto the full model of care programme Q4.
Support implementation of national primary care policies across the Canterbury system.	▪ Support implementation of the National Enrolment Services to streamline PHO enrolment processes. ▪ Support implementation of the national policy — free day time and after-hours GP visits and prescriptions for all children <13. ▪ Support primary care to implement the Health Quality and Safety Commission Patient Experience Survey (to be developed).	✓ National Enrolment Service operational Q1. ✓ 100% of children <13 have access to free GP visits afterhours Q1. ✓ Quarterly updates on progress towards free <13 access.
Invest in the development of a sustainable Rural Health Strategy and tailored rural health solutions across rural Canterbury.	▪ Support the Rural Health Workstream to deliver sustainable health services for rural communities, including a staged approach to the completion and implementation of a fit for purpose vision and associated models of care. ▪ Ensure that retention and recruitment initiatives are aligned to the models to promote a full staffing complement in rural areas. ▪ Support the Rural Funding SLA to review and refine the model for the distribution of rural subsidies for the Canterbury region.	✓ First of the agreed rural strategies recommended to ALT Q2. ✓ Revised Rural Funding allocation model receives support is agreed and endorsed by the ALT Q3. ✓ Rural subsidies are allocated and distributed Q1 (2016/17).
	▪ Continue to consolidate, implement and fund models for sustainable after-hours services in rural areas. ▪ Support tailored strategies and initiatives to improve the mental health and wellbeing of our rural populations. ▪ Continue consolidation of wrap-around service and discharge management for older people in rural communities. ▪ Review the delivery of Radiology Services in rural areas to determine the most effective model for rural patients. ▪ Continue to support increased use of video conferencing (VC) technology for education, peer support, clinical supervision and clinical sessions to reduce the need for patients to travel.	✓ Kaikoura Youth Health Pathway developed and implemented Q3. ✓ Radiology model for Kaikoura reviewed Q4. ✓ Increased number of remote rural practices utilise video conferencing technology Q4.

Supporting people to stay well

6.3 Disease prevention

Our health is influenced by the environments in which we each live: 'Health starts where we live, learn, work and play'.[23] Environment in this context is meant in its broadest sense, and includes the built, natural, economic, social and cultural environments. In Canterbury, we must also take into account the earthquake recovery context and the changing impact that it has on these environments and on our health. We promote health and wellbeing by working with partners from both health and non-health organisations to improve our environments and make the healthy choice the easy choice.

Canterbury has a detailed Public Health Plan for 2015/16, which can be found at www.cdhb.govt.nz.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Positively influence the determinants of health via engagement with health and non-health organisations.	▪ Lead the intersectoral work of Healthy Christchurch. ▪ Promote the use of Health and Social Impact Assessments and deliver health and health promotion through joint workplans with the Christchurch City Council and Environment Canterbury. ▪ Engage with intersectoral partners to deliver recovery priorities i.e. the Programme of Action for the Community in Mind Strategy.	✓ A regular programme of Healthy Christchurch hui and lunchtime seminars, with 2 hui and 8 seminars held. ✓ 1-2 medium Health Impact Assessments completed Q4.
Promote the health and wellbeing of our population through specific settings and issues.	▪ Work alongside the Mental Health Foundation to lead the 'All Right?' social marketing wellbeing campaign. ▪ Participate as an active member of 'FlouriSH' the Governance Group for the Healthy Families NZ Spreydon Heathcote Initiative. ▪ Participate in the Prevention Partnership under the Healthy Families NZ Initiative, identifying opportunities to align health promotion activity and rollout successes to the wider population. ▪ Contribute to and/or lead other health promotion work in national priority issues and settings, including: Health Promoting Schools; Whanua Ora; and Smokefree Aotearoa 2025.	✓ 'All Right?' evaluation results available Q2. ✓ >70% of priority schools engaged in HPS Framework. ✓ >240 people enrolled in Aukati Kaipaipa Q4.
Contribute to programmes and initiatives that improve housing quality.	▪ Work alongside Community Energy Action encouraging referral of vulnerable people to services to improve housing quality. ▪ Contribute to the CERA-initiated Sustainable Homes Working Party to further enable sustainable home improvements — particularly promote and support 'Build Back Smarter' initiative. ▪ Continue to contribute to cross-sector initiatives to resolve housing issues, particularly for unwell and at-risk families and support health organisations to identify issues and locate help.	✓ Increased referrals to community agencies able to impact on housing quality Q4.
Enable prompt identification and analysis of emerging disease trends, clusters and outbreaks.	▪ Review, analyse and report on communicable diseases data, including via web applications and written reports. ▪ Produce disease-specific reports for communicable diseases of concern (i.e. Pertussis) and other diseases causing outbreaks. ▪ Review, analyse and report on other disease data (including alcohol-related harm).	✓ 'Public Health Information Quarterly' distributed. ✓ Timely and effective identification of and response to outbreaks and elevated disease incidence.
Implement programmes that reduce the harm caused by alcohol in line with the DHB Alcohol Position Statement.	▪ Develop an Alcohol Harm Reduction Strategy (AHRS), with associated outcomes framework. ▪ Develop and deliver training and new communication tools to engage and inform patients and professionals around alcohol misuse and improve the overall response of the health sector. ▪ Work with other agencies to deliver host responsibility training to improve the skills of Duty Managers in reducing alcohol harm. ▪ Assist Police with alcohol controlled purchase operations (CPOs) to reduce the supply of liquor to minors.	✓ AHRS framework agreed Q2. ✓ 16 host training sessions delivered Q4. ✓ All license applications responded to within 15 working days. ✓ 6 CPOs and 6 night-time visits completed Q4.

[23] *Robert Wood Johnson Foundation (2010) A New Way to Talk About the Social Determinants of Health. Princeton, New Jersey: Robert Wood Johnson Foundation.*

6.4 Smoking prevention

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Ensure an integrated system wide approach towards achieving Smokefree Aotearoa 2025.	▪ Work with the DHB Advisory Group and Smokefree Canterbury to update the DHB's Tobacco Control Plan. ▪ Update the Smokefree Canterbury's website with any changes to cessation services, policy templates and toolkits. ▪ Continue work with local councils to extend smokefree public spaces and further implement smokefree social housing. ▪ Continue to support social service organisations, schools and workplaces to establish smokefree policies and environments and support increased quit attempts.	✓ Updated Plan in place Q2. ✓ >4,000 Canterbury residents seek cessation support from Quitline. ✓ >75% of year 10 students have 'never smoked'. ✓ <5% of the population will be current smokers by 2025.
Support the provision of ABC advice and support to pregnant women who smoke. [24]	▪ Engage LMCs in delivering ABC and provide a feedback loop on performance against the targets. ▪ Provide Smokefree training to 3rd year midwives at CPIT. ▪ Offer ABC and Cessation training to LMCs, including sessions delivered with the DHB and externally in their practices. ▪ Work alongside LMCs, Whaea Manawa, Aukati Kaipipa and Pacific Quit Coaches to provide cessation support to pregnant women. ▪ Review the content of the parenting and pregnancy classes to ensure they include ABC and smoking cessation provision. ▪ Work with the Well Child Tamariki Ora Quality Improvement leaders to implement opportunities to increase the proportion of mothers smoke free at two weeks postnatal - particularly Māori.	✓ Quarterly monitoring of performance against the health target. ✓ 1 Smokefree session delivered to students at CPIT Q4. ✓ 8 training sessions offered to LMCs Q4. ✓ 90% of pregnant smokers are offered advice and support to quit. ✓ 86% of mothers smoke free at two weeks post natal.
Build on gains made in the delivery of the ABC programme within primary care with a continued focus on successful strategies to achieve and maintain the health target.	▪ Continue to support tracking of PHO and general practices health target results and follow-up where performance is low. ▪ Maintain the use of advanced IT tools in general practice that prompt and capture ABC activity including Text-2-Remind. ▪ Support the development of individual practice plans that include actions to achieve/maintain the health target. ▪ Continue to identify ABC champions within general practice. ▪ Supplement the support provided to practices by PHO liaison staff with specialist training from the ABC Smokefree team. ▪ Share primary and secondary ABC data to ensure follow-up of patients as clinically indicated and coding of this activity.	✓ Quarterly monitoring of performance against the health target. ✓ 10 ABC training sessions delivered in primary care by the ABC team Q4. ✓ 90% of enrolled patients seen in general practice being provided with advice and help to quit in the last 15 months.
Refine delivery of ABC programme in hospital settings to maintain performance against the health target.	▪ Maintain weekly feedback reports on performance and promote the use of online performance dashboards by individual wards. ▪ Continue to support Directors of Nursing and Lead Charge Nurses to champion the health target and monitor performance. ▪ Undertake audit/analysis of care pathways with no intervention is recorded and follow up to improve performance and systems. ▪ Maintain a Training Calendar for Smokefree education and continue to support e-learning ABC modules for staff. ▪ Progressively introduce 'ABC' to electronic documentation.	✓ Weekly monitoring of performance against the health target. ✓ >200 staff members receive ABC training Q4. ✓ 95% of all hospitalised smokers are provided with advice and support to quit.
Provide targeted community-based ABC and cessation support to high risk population groups.	▪ Continue to provide targeted cessation support through Pacific Trust Canterbury and the Aukati Kaipaipa cessation programme. ▪ Increase referrals from all sources to specialist cessation providers; Aukati Kaipaipa, Pacific Trust and Whaea Manawa.	✓ >120 people enrol with Pacific Trust cessation Q4. ✓ >240 people enrol with Aukati Kaipaipa Q4.

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

6.5 A whole of system approach to long-term conditions management

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

Our approach to the management of long-term conditions is to support systematic care at every point of the health continuum and to align service models and funding to facilitate earlier intervention and treatment.

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

Our 'whole of system' approach closely links with our disease and acute demand management programmes. Strong networks are also in place between general practice, ABC teams, public health and nutrition teams and community organisation, including Sports Canterbury and Smokefree Canterbury, to support our population to make healthier choices.

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

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Improve the identification and management of at risk populations.	▪ Coordinate across the Pharmacy, Collaborative Care and IFHS alliance streams to identify the poly pharmacy patient subset for review and care planning. ▪ Continue to maintain direct access to diagnostics in community settings rather than in hospital to support diagnosis of COPD. ▪ Continue to support the use of IT tools and dashboard in general practice for the identification of smoking status and CVD risk.	✓ At-risk poly-pharmacy subset identification underway Q4. ✓ >1,000 people referred to community-based spirometry testing Q4. ✓ 90% of the eligible population have had a CVDRA within the last 5 years.
Improve the coordination of care and support for patients identified with long term and complex health conditions.	▪ Encourage and support the identification and enrolment of patients with long-term conditions into the Collaborative Care Programme in line the development of the IFHS model. ▪ Support clinical teams to develop and refine collaborative care plans for complex patients via the shared care electronic platform. ▪ Align with the Integrated Family Health Services programme to ensure the coordination of care for patients with complex needs is a key consideration in the development of IFHS models of care. ▪ Continue to promote the use of Acute Care Plans to support frequently admitted patients and those at risk of hospital admission.	✓ 5% increase in the number of collaborative care plans. ✓ Patients report improved self-management and quality of life through EQ5D and PIH tools Q4.
	▪ Evaluate alternative mechanisms for distributing FFP funds that will enable general practice to more proactively coordinate the care of patients with complex health and social needs.	✓ Alternative mechanisms for funding distribution agreed Q2.
Support patients to take a more active role in the management of their own health and wellbeing.	▪ Promote programmes that encompass warmer homes and smoking cessation to support people at risk of long-term conditions. ▪ Support development of patient portals to enable patients to access their records and take a more active role in the management of their health and wellbeing.	✓ Quarterly progress in implementing patient portals. ✓ HealthInfo content reviewed annually. ✓ >3,000 people access

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
	▪ Support patients to receive clinically and culturally appropriate lifestyle information to support people to reduce risk factors. ▪ Encourage increased referrals to programmes that help improve overall health and wellbeing and reduce risk factors. ▪ Continue to support access to rehabilitation programmes and promote programmes amongst general practice to increase referrals and improve people's management of their condition.	Green prescriptions for additional physical activity support Q4. ✓ >200 people access pulmonary rehabilitation.
Improve the identification and management of people with diabetes.	▪ Continue to work with general practice to identify, code and manage their population with diabetes, including identification of high risk and high needs patients. ▪ Continue to provide information to general practice about their enrolled population with diabetes, and associated service utilisation. ▪ Continue to support general practice to deliver appropriate levels of care and support to patients identified with diabetes – in line with the clinical guidelines and minimum standards under the Diabetes Care Improvement Package (DCIP). ▪ Continue to support the Integrated Diabetes Service Development Group (IDSDG) to monitor progress against agreed indicators and population outcomes and participate in service planning.	✓ Six monthly updates of people coded with diabetes in general practice Q2, Q4. ✓ >90% of the population coded with diabetes have had an HbA1c test in the last year. ✓ >75% of the population coded with diabetes have acceptable glycaemic control (HbA1c ≤64mmol/mol).
Increase access to services that support people with diabetes to better manage their condition and to stay well.	▪ Continue to invest in programmes to support and manage newly diagnosed patients in the community and provide tools for improving people's self-management of their diabetes. ▪ Monitor wait times for people with Type 1 or complex Type 2 diabetes to support improved access to specialist support from the Diabetes Centre. ▪ Continue to invest in and develop services for young people with Type 1 diabetes. ▪ Continue to support improved access to community-based diabetes retinal screening for people with diabetes. ▪ Continue to support a best practice podiatry service for diabetes high risk foot patients; including audit and reporting processes.	✓ Increased number of people accessing new diagnosis and starting insulin subsidies in the community – base 799. ✓ No patients wait more than 4 months for a diabetes FSA. ✓ Increased number of people with diabetes accessing retinal screening – base 7,042. ✓ Increased number of people with diabetes referred to podiatry services – base 872.
	▪ Review the diabetes clinical pathways including referral and prescribing protocols to support integration and best practice. ▪ Continue to deliver mentoring and clinical education to health practitioners to improve the care of people with diabetes. ▪ Continue to work closely with Diabetes Consumer Group to identify opportunities for improvement in service delivery. ▪ Build links with organisations such as rest homes and tertiary institutions in order to understand and contribute to clinical education provided outside of the integrated service. ▪ Continue to support quality improvement through monitoring of performance against national guidelines and standards (including the 20 Quality Standards for Diabetes Care).	✓ Clinical pathways reviewed Q2. ✓ Diabetes education sessions delivered as part of the Canterbury clinical education programme Q2, Q4. ✓ Annual review of Diabetes Atlas of Variation data to identify service gaps Q4. ✓ Ongoing review of delivery against the 20 Quality Standards Q2, Q4.

6.6 Cardiovascular Disease

Cardiovascular disease includes coronary heart disease, stroke and other diseases of the heart and circulatory system, and is a leading cause of death and hospitalisation in New Zealand. Like other long-term conditions, improving outcomes for people with cardiovascular disease is reliant on the systematic identification and management of people who are at risk. Increasing the number of Cardiovascular Disease Risk Assessments (CVDRAs) delivered in primary care is a national health target and the DHB is working alongside Canterbury's three Primary Health Care Organisations (PHOs) to increase delivery of CVDRAs to meet the targets.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Maintain visibility of performance against the Primary Care Health Target.	▪ Continue to monitor CVDRA delivery against the primary care health targets at both DHB and PHO level. ▪ Support PHO Clinical Management Teams to monitor the general practice target result and follow-up where performance is low. ▪ Continue to provide practices with information on their CVDRA results, benchmarked against other practices within the PHO to support identification of people at risk.	✓ Quarterly reporting on progress against health target.
Support the use of effective strategies to improve delivery and recording of CVDRA (including structured discussions) and the management of people at risk of cardiovascular disease. [25]	▪ Continue to support identification of champions within general practice to facilitate the delivery of health target activity. ▪ Continue to support development of individual general practice plans that include actions to engage eligible patients in a CVDRA. ▪ Continue to support PHO practice liaison teams to assist general practice with the recall and engagement of patients for CVDRA. ▪ Encourage general practice to engage in the delivery of additional general practice/nurse led CVDRA consultations after hours or in alternative locations to reach people not currently engaged. ▪ Provide general practice with updates on enrolled patients discharged from hospital with a clinical cardiovascular risk of > 20% to allow for appropriate clinical follow-up with patients. ▪ Continue to support clinical governance groups to provide advice and guidance on the delivery of structured discussions with patients on their cardiovascular risk and mitigations strategies. ▪ Collaborate and engage with Māori and Pacific health providers to develop strategies to increase delivery of CVDRAs.	✓ CVDRA activity reported by ethnicity Q1. ✓ Increased number of practices have practice level health target delivery plans Q2. ✓ An increased number of structured CVD discussions delivered – base 9,413. ✓ 90% of the eligible population have had a CVDRA within the last 5 years. ✓ Quarterly increase in Māori CVDRA rates.
	▪ Continue to provide training for administration staff in flagging, recalling and coding of patients to assist in recording CVDRAs. ▪ Link in with the Heart Foundation to access additional training opportunities for general practice staff in CVDRA delivery. ▪ Support the development of a behaviour change programme that will up-skill general practice staff in encouraging patient adherence to health advice, including the adoption of positive lifestyle behaviours.	✓ Monthly practice visits undertaken by Practice Liaison staff. ✓ Heart Foundation training Q2. ✓ Behaviour change education provided Q4.
	▪ Ensure all general practices maintain advanced IT tools to support identification of eligible populations and to prompt and capture activity including Text-2-Remind.	✓ 100% of practices have advanced IT tools in place.

[25] *The actions in this section are in line with those agreed between the PHOs, DHB and Ministry of Health in the Canterbury's Primary Care Health Targets Recovery Plan including use of Budget 2013 funding to support delivery of the More Health & Diabetes Checks target.*

6.7 A whole of system approach to acute demand management

Continued growth in acute (urgent or unplanned) hospital admissions is one of the most significant challenges for DHBs to manage and places intense pressure on our constrained hospital resources. Canterbury's whole-of-system approach to managing this acute demand has enabled us to successfully maintain the lowest age-standardised rate of acute medical admissions of any large DHB in the country.

This work is being driven through the CCN Urgent Care Service Level Alliance, where clinicians, health professionals and managers from across the system provide their collective thinking and experience to developing strategies to reduce the pressures of acute demand. Their focus has been on ensuring an appropriate mix of urgent care services are available in the community, so that only people who need hospital services present at our hospitals. This picture also involves our highly experience Emergency Department (ED) team working with their colleagues across the hospital to make the very best use of ED resources - ensuring people get the care they need quickly and that only those who need hospital services are admitted.

In 2013/14, more than 28,000 episodes of care were managed in the community, through our Acute Demand Management Service, and 95% of the 94,000 people who presented in our EDs were seen within 6 hours.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Develop and refine community-based acute demand services to reduce unnecessary hospital presentations.	▪ Continue to promote calling general practice as first point of contact 24/7 and maintain after-hours phone advice and triage. ▪ Support the roll-out of zero fees for children aged under 13. ▪ Expand the HealthInfo website to provide people with information and tools to better manage their own health and stay well. ▪ Maintain the HealthPathways to provide general practice with best practice advice to support the management of their patients. ▪ Maintain direct GP access to diagnostics including urgent blood tests, X-Rays and ultrasounds to support earlier intervention and appropriate treatment. ▪ Continue to invest in acute demand services that provide primary care with options to support people to access appropriate urgent care in the community rather than in hospital. ▪ Continue to invest in the COPD pathway and heart failure initiatives to reduce avoidable presentations to hospital. ▪ Continue to engage St John Ambulance in the use of alternative Referral Pathways to safely manage patients in the community. ▪ Work with St John Ambulance to implement a Canterbury Solution to the 111 clinical hub model of care being rolled out in 2015.	✓ 100% of children <13 have access to free GP visits afterhours Q1. ✓ Six monthly review and update of Health Pathways. ✓ Quarterly monitoring of diagnostic service referrals. ✓ >28,000 urgent care packages provided in the community Q4. ✓ >400 patients utilise the COPD / Heart Failure Ambulance Referral Pathways Q4. ✓ Rate of acute medical admission maintained at <5,500 per 100,000.
Shorter waits in our Emergency Departments.	▪ Continue to engage in the use of 'real time' data to support patient flow improvements and demand planning and use ED Dashboards to maintain visibility of key drivers and metrics. ▪ Continue to monitor the mandatory and non-mandatory measures under the National Quality Framework (NQF) alongside the local ED metrics to identify areas for improvement. ▪ Actively engage in the collection of data on the rebuild workforce attending ED to identify solutions to this new demand. ▪ Continue to support the redirection policy and frequent attender programme to ensure people are being seen in the right place. ▪ Continue to develop and implement targeted responses to improve the flow of patients and reduce wait times for treatment - particularly with regards to acute referrals, the ERAS initiative, Frail Older Person's Pathway and the ED Quality Framework.	✓ On-screen-queues in use throughout ED Q1. ✓ ED metrics monitored via ED Operational Dashboards Q1. ✓ Monthly review of NQF and ED metrics at Quality meetings Q1. ✓ Real time data on AMAU and rebuild workforce available Q1. ✓ Ongoing improvement against ED NQF measures Q4. ✓ 95% of ED people presenting at ED are admitted, discharge or transferred within 6 hours.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Expand and seek more opportunities to support timely discharge from hospital.	▪ Maintain ADMS and CREST service to support earlier discharge from ED and hospital and reduce the likelihood of readmission. ▪ Support the closer alignment of ADMS liaison nursing with CREST and other services functions to ensure best use of our resources. ▪ Work alongside the Frail Older Persons' Pathway and ERAS project teams to implement targeted responses to improve the flow of patients and support people to return home quicker.	✓ >1,500 people (65+) accessing CREST services Q4. ✓ Reduction in patients aged 75+ with lengths of stay greater than 14 days – base 205.7. ✓ Acute inpatient average length of stay maintained at <2.45 days.
Ensure the effectiveness of the Urgent Care Programme by redefining and evaluating priorities.	▪ Merge primary/secondary datasets to analyse effectiveness of the Acute Demand Management Programme. ▪ Continue to audit safety issues and untoward events through the Urgent Care Clinical Governance to improve the quality of service delivery and revised pathways according. ▪ Participate in national/regional networks focusing on the development of service improvement programmes. ▪ Forge links with similar programmes such as Primary Options for Acute Care (Auckland) and Hospital in the Home (Australia).	✓ 1st combined dataset produced for review by SLA Q3. ✓ Two Clinical Pathways reviewed by the Clinical Governance Group Q4. ✓ Links with similar programmes established nationally and internationally Q4.

Prioritising our vulnerable populations

The Earthquakes have had a considerable impact on Canterbury residents, with many people shifted from their homes and becoming disconnected from their usual community and support networks. It is critical that we respond to the needs of our more vulnerable populations – focusing on people and their families and communities and keeping them at the centre of everything we do.

6.8 Child, youth and maternal health services

The wellbeing of children is critical to the wellbeing of the population as a whole, healthy children are more likely to become healthy adults and positive health outcomes for mothers and babies are an essential part of this. Because disparities in outcomes are associated with many factors integrated service models are key. An integrated, whole-of-system, approach is also particularly critical in Canterbury, in the light of the additional stress on children, young people and their families following the earthquakes.

Our work is primarily driven through the cross-sector Child & Youth Health Alliance Work Stream and the Canterbury/West Coast Maternity Clinical Governance Group. Through these networks we are supporting collaborative, cross-agency initiatives to help bridge gaps between services and to ensure children and young people are expertly assessed and provided with the most appropriate level of intervention and support.

The DHB also has a Māori Health Action Plan which sits alongside the Annual Plan and highlights activity in priorities areas for Māori – including a particular focus on child health.[26]

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Ensure services for pregnant women and babies are of high quality and are nationally consistent.	▪ Maintain the combined (Canterbury and West Coast) Maternity Clinical Governance Group to oversee the continued implementation of the Maternity Quality and Safety Programme. ▪ Review annual performance against the NZ Maternity Clinical Indicators to identify opportunities to improve clinical care and reduce variation in practice. ▪ Maintain service standards and requirements in line with the national guidelines for the screening, diagnosis and management of Gestational Diabetes.	✓ Improved performance and consumer satisfaction as measured by the NZ Maternity Clinical Indicators national and DHB data analysis and surveys Q2, Q4.
Support the seamless handover of mother and child as they move between maternity, general practice and Well Child Tamariki Ora (WCTO) services.	▪ Continue working with the NZ College of Midwives and PHOs to increase awareness of the value of early LMC registration. ▪ Continue to support the web-based information site 'Find a Midwife' to encourage early enrolment with a midwife. ▪ Continue to support continuity of care with education and information programmes and social media campaigns. ▪ Support improved communication and liaison between LMCs, and general practices to support continuity of care. ▪ Maintain processes to support multiple enrolments across maternity, general practice, WCTO and oral health services.	✓ 80% of women registered with an LMC by week 12 of their pregnancy. ✓ 95% of women receive continuity of care during pregnancy. ✓ 98% of new-borns enrolled with general practice within three months of birth.
	▪ Complete the DHB-funded pregnancy and parenting course review and implement key recommendations with a particular emphasis on improving update by first time Māori and Pacific mothers. ▪ Raise awareness of the new pregnancy and parenting courses introduced for young mothers and monitor uptake. [27]	✓ DHB-review actioned Q1. ✓ 30% of first-time Māori, Pacific, and teen pregnant women access pregnancy and parenting education.
	▪ Identify opportunities to increase the profile of peer support breastfeeding counsellors in the primary maternity units to support with normal breastfeeding issues. ▪ Provide additional training to peer support counsellors who have experienced having a baby in NICU to promote the peer to peer service for parents when they go home.	✓ >30 new Peer Support Coordinators in place Q4. ✓ 70% of 6 week old babies exclusively or fully breastfed Q4.

[26] *The DHB's Maori Health Action Plan 2015-2016 is available on its website www.cdhb.health.nz.*

[27] *The DHB has two new parenting and pregnancy courses in place targeting young mothers <23 years 'Bump' and 'YP2B'.*

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Support earlier intervention and continuity of care for children to improve long-term health outcomes.	▪ Continue to support the WCTO Quality Improvement Group to oversee and coordinate improved performance against the WCTO Quality Improvement Framework. ▪ Review progress against the three quality improvement initiatives (QI) undertaken during 2014/15 (QI3, QI19 and QI24) and identify three new improvement initiatives for 2015/16. ▪ Participate in and support the South Island-wide WCTO Quality Improvement Coordination process.	✓ Regional WCTO Quality Improvement Project Manager in place Q1 ✓ 3 new WCTO improvement initiatives identified Q2. ✓ Shared QI project plan, policies and procedures in place across South Island Q4.
	▪ Continue to monitor access and referral patterns for B4 School Checks to identify opportunities to improve delivery and coverage. ▪ Continue to promote and educate parents on the value of B4 School Checks. ▪ Continue to work with public health nurses and ECE providers to identify and engage children who have not had a B4 School Check.	✓ Quarterly reporting on B4 School Check (B4SC) performance. ✓ 90% of children receive a B4SC. ✓ 90% of Māori, Pacific children and children living in high deprivation areas receive a B4SC.
	▪ Explore opportunities for improving the transition to adult care for young people with chronic conditions and/or disability.	✓ 1 new transition pathway identified by Q2.
Work with the regional Child and Youth Health Alliance to develop a regional approach to the management of childhood obesity.	▪ Develop consistent protocols and intervention guidelines for managing the treatment of child obesity. ▪ Support enhanced collaboration with child dental services to support the regional obesity approach. ▪ Share the learnings from the Healthy Families initiative in Heathcote/Spreydon and Invercargill between the regional teams.	✓ Common protocols and guidelines agreed Q3. ✓ Demonstration site in place across Nelson Marlborough and Canterbury DHBs Q4.

6.9 Older people's health services

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

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

There is still scope for reducing demand and improving the quality of people's lives. We will continue to place emphasis on supported discharge and restorative care models as a means of improving outcomes for our older population.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Continue to support the timely and comprehensive assessment of need.	▪ Continue to support the use of the InterRAI Geriatric Assessment tool across community, specialist and ARC services to ensure the provision of effective packages of care. ▪ Continue to monitor and report the number and percentage of older people receiving long-term Home and Community Support Service (HCSS) who have interRAI assessments and care plans. ▪ Instigate regular monitoring of timeframes from referral to completion of assessment for clients receiving HCSS. ▪ Establish means to track percentage of people in ARC who have a second InterRAI LTCF assessment within 230 days of admission. ▪ Continue to monitor utilisation of HCSS/ARC and compare trends.	✓ >98% of long-term HCSS clients have an InterRAI assessment and a completed care plan in place. ✓ >95% of people entering ARC have had an InterRAI assessment. ✓ Baselines established for time from referral to assessment Q4. ✓ Quarterly monitoring of HCSS and in ARC utilisation.
Continue to support the delivery of restorative model of care across community services.	▪ Participate in national working groups to support implementation of negotiated in- between travel settlement. ▪ Work alongside our three home based support providers to implement the allocation of specific funding for in-between travel.	✓ Allocation of funding rolled out in conjunction with MOH expectations.
	▪ Continue to support the Community Rehabilitation Enablement and Support Team (CREST) model to support older people to stay well in their own homes. ▪ Work with the Frail Older Person's Pathway and Enhanced Recovery After Surgery (ERAS) project teams to support roll-out of these key initiatives and further support the care of older people	✓ >1,500 people (65+) accessing CREST services. ✓ Increased number of people accessing Day Activity Programmes - base 455. ✓ Electronic Respite Booking System launched Q2. ✓ Readmission rates for people (65+ and 75) at or below national average.
	▪ Monitor the transition of day care services to restorative Community Activity Programmes as recommended in the 2013 Supporting Carers Project. ▪ Implement an Electronic Early Booking System for Respite Care.	
Continue to improve the Cognitive Impairment Pathway (CIP) to better support people with dementia.	▪ Continue to refine the Cognitive Impairment Pathway (CIP) and build on previous work to further coordinate care. ▪ Support the introduction of regional training for primary care health professionals on "how to break bad news" in the context of dementia, MoCA[28] training and when to use CT Scans to support earlier diagnoses. ▪ Continue to explore service improvements for people recently diagnosed with mild dementia and links to community support. ▪ Expand 'Walking in Another's Shoes' (WIAS) dementia training to other priority groups, including the rural workforce.	✓ Increase number of CIP page views - base 999. ✓ Regional training material developed Q3. ✓ Post training survey indicates increased confidence in diagnosing mild dementia Q4. ✓ 40 new referrals from GPs to Alzheimer's Canterbury Q4. ✓ 52 people trained in WIAS each 8 month training cycle Q4.

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

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Develop and deliver an integrated Fracture Liaison Service.	▪ Support the promotion of preventative care across the system to avoid fragility fractures. ▪ Complete the establishment of a Fracture Liaison Service. ▪ Review Healthpathways to support general practice to manage older people at risk of fragility fracture and falls. ▪ Establish and utilise system-wide process and outcome metrics to monitor improvement in fragility fracture management.	✓ Fracture Service operational Q1. ✓ Pathways reviewed Q2. ✓ Quarterly monitoring of service utilisation and outcome metrics.
Enhance whole of system involvement in preventing falls for older people.	▪ Continue to monitor performance of the falls prevention service and promote 'Zero harm from falls' across our system. ▪ Evaluate the impact of the falls prevention service to identify and implement improvements. ▪ Promote service integration with other key programmes including the Fracture Liaison Service, Frail Older Person's Pathway, Enhanced Recovery after Surgery (ERAS) and alternative ambulance pathways. ▪ Continue to promote and provide a Vitamin D Supplementation Programme in ARC settings.	✓ Falls Dashboard in place Q1. ✓ >1,200 older people (65+) access community-based falls prevention services Q4. ✓ 10% decrease in projected number of people 75+ presenting to ED as a result of a fall Q4. [29] ✓ 75% of ARC residents receive Vitamin D supplements Q4.
Develop and maintain stroke services in Canterbury that meets New Zealand Stroke Guidelines.	▪ Actively participate in the regional stroke network to ensure the Canterbury service meets the New Zealand Stroke Guidelines and support regional DHBs with advice and training including hosting of regional training events. ▪ Identify key clinical leads to support the implement of national and regional stroke plans and improve health system outcomes ▪ Maintain stroke thrombolysis quality assurance procedures, including staff training and audit and continue to participate in the national thrombolysis register. ▪ Ensure equitable access to community stroke rehabilitation services, regardless of people's age. ▪ Complete the reconfiguration of rehabilitation services to establish a single community-based service for rehabilitation after stroke. ▪ Enable the collection of baseline data along the stroke pathway to establish baselines for transfer to community based rehabilitation and assessment within 5 days. ▪ Support ongoing refinement and continuous quality improvement via monthly quality assurance and clinical audit meetings.	✓ Quarterly update on progress towards meeting guidelines. ✓ Regional education event Q2. ✓ Single Community-based Stroke Rehabilitation Service operational Q2. ✓ Community Stroke Rehabilitation Service includes all ages 18+ Q3. ✓ Baseline data for stroke pathway available Q3. ✓ 6% of potentially eligible stroke patient's thrombolysed. ✓ 80% of stroke patient admitted to an organised stroke service with demonstrated stroke pathways.
Continue to support leadership development and the provision of specialist advice to ensure a high standard of care of older people.	▪ Continue to maintain key specialist roles to support the provision of specialist advice to primary care and ARC service providers. [30] ▪ Continue to monitor key programme utilisation and outcome metrics as a means of improving the targeting of services across the system. ▪ Maintain HealthPathways to support the appropriate assessment, referral and management of patients and clients across the Canterbury health system.	✓ Quarterly reporting of OPH metrics. ✓ >2 GNS ARC provider education days provided Q4.

[29] This measure differs from that used in previous years and is more specifically related to the implementation of the Community-Based Falls Programme – relating to a decreased in the number of projected falls using a baseline of July 2008 to December 2011.

[30] DHB specialist advice and support is provided to primary care and aged residential care providers through psychiatric services for the elderly and a number of dedicated OPHSS roles including: OPHSS geriatricians (4 FTE), gerontology nurse specialist roles (3 FTE) and the CREST Service Team (7 RN Liaison and 6 RN Case Managers.)

6.10 Mental health services

With the unique and ongoing stresses the earthquakes have placed on the Canterbury population significant increases in demand are being experienced across our mental health services – particularly across child and youth services. Over the last three years (to March 2015): there has been a 69% increase in presentations to child and youth community services and a 43% increase in adult community services presentations.

It is critical that our health system is working together to support a cohesive approach to mental health service provision in Canterbury. By improving the integration between health and social services we can provide more responsive and timely responses across our health system and the broader community. We will continue to invest in community-based options that provide services closer to home, supported by expanded consult liaison across our hospital and specialist division. This will provide the benefit of specialist advice without the wait for a specialist appointment or disruption of the primary/community care relationship. It will also help to build much needed capability across our system.

As a result of the increased demand for support, the Canterbury DHB is currently funding mental health services above national ring-fence expectations which is placing strain on other areas and places at risk the DHBs ability to meet its financial performance requirements. The increasing demand for mental health services is also placing strain on our workforce and we will continue to look to support their wellbeing in the coming year. Continued consideration will be given to the arrangement of, and connection between, specialist services to ensure we are making the best use of our limited resources as we respond to increasing demand.

This work will primarily be overseen by our clinically-led, cross-sector Mental Health Alliance Work Stream (which includes primary, secondary and community providers) and our direction is aligned with the priorities identified in the national Mental Health and Addiction Service Plan 'Rising to the Challenge'. [31]

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Continue development of the integrated stepped care model.	▪ Continue to maintain a MH Work Stream under the CCN Alliance to oversee an integrated response to service demand. ▪ Continue to contribute to the psychosocial partnership with CERA to support continued wellbeing of our community. [32] ▪ Strengthen the interface between primary and community services with continuous refinement of the service model. ▪ Expand the number of Mental Health Services covered by HealthPathways to clarify referral and service options. ▪ Continue to support Brief Intervention Counselling (BIC) in primary care and monitor delivery to ensure capacity is aligned. ▪ Continue to closely monitor service utilisation trends to highlight emerging issues and align response strategies.	✓ Quarterly narrative report on work plan activity to the Alliance Leadership Team. ✓ Improved outcomes evident in the 2015 CERA Wellbeing Survey. ✓ 'All Right?' campaign research results available Q2. ✓ Additional mental health HealthPathways developed and available Q2, Q4. ✓ >4,000 people access BIC in primary care Q4.
Embed and strengthen the Adult Mental Health model of care.	▪ Progress the development of extended treatment strategies for people with high and complex mental health needs. ▪ Recruit a Residential Nurse Specialist position to support people with complex needs in community residential settings. ▪ Continue to work with lead agencies on the provision of social housing to reduce consumer distress, unnecessary delays in discharge and negative effects on patient flow. ▪ Review the monitoring framework for the model of care.	✓ Residential Nurse Specialist position in place Q1. ✓ Monitoring framework up Q2. ✓ Access rates for mental health services for adults (20-64) >3.1%. ✓ 80% of adults (20-64) referred for non-urgent mental health services are seen within 3 weeks and 95% within 8 weeks.

[31] The Mental Health Work Stream will identify 14 more priority actions which will be completed by the end of 2015/16 with 6 monthly milestones and 13 more will be completed in 2016/17. This plan will ensure all prioritised actions are completed by the end of 2016/17.

[32] The Psychosocial response, coordinated by CERA, will be jointly supported by key agencies (including health) over the next five years.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Support the implementation of a whole of system suicide prevention and postvention strategy.	▪ Develop a series of evidence-based initiatives and responses in alignment with the National Suicide Prevention Strategy and Canterbury's Suicide Prevention and Postvention Plan. [33] ▪ Implement prevention screening tools and training for staff to better identify and support people at risk. ▪ Deliver a feasibility plan for a 'Perfect Care' approach to the management of depression. ▪ Continue to provide leadership in identifying high-risk situations or clusters and preparing evidence-based responses.	✓ Whole of System Suicide Prevention and Postvention Plan in place Q1. ✓ Prevention Tool developed Q2. ✓ Training underway Q3. ✓ Feasibility plan for Perfect Care developed Q4.
Improve the wellness of and resilience of people with mental illness and Alcohol and Other Drug (AOD) issues.	▪ Undertake a range of health promotion activities targeting people with mental illness. ▪ Improve the physical health of people with mental illness through proactively facilitating connections to primary care. ▪ Continue to support centralised DHB/NGO coordination and allocation processes to reduce duplication and wait times. ▪ Recruit a Clinical Nurse Specialist position to provide support to NGOs with clinical oversight, advice and training.	✓ NGO Clinical Nurse Specialist position in place Q1. ✓ Data match of PHO enrolment rates and people accessing SMHS and NGO services Q2. ✓ 80% of adults (20-64) referred for non-urgent mental health services are seen within 3 weeks and 95% within 8 weeks.
	▪ Explore opportunities with the Ministry of Social Development to support people using SMHS services into employment. ▪ Seek to monitor the employment status of all long-term clients through Project for the Integration of Mental Health Data (PRIMHD) as functionality becomes available.	✓ Quarterly narrative report on progress.
	▪ Continue to support primary mental health services to increase capacity to deliver AOD Brief Intervention Counselling. ▪ Roll out alcohol brief intervention training and engagement around the rebuild; working with managers and frontline staff to reduce harm in the construction sector. ▪ Continue to work with Corrections and Courts to increase access to AOD assessment and treatment, including clinicians in Courts. ▪ Work with the National Health Promotion Agency to support national health promotion activity around alcohol consumption, particularly during pregnancy.	✓ >300 people access alcohol BIC. ✓ ACC evaluation on the impact of workplace targeting demonstrate positive impacts Q2.
	▪ Work with the Ministry of Health to implement the Children of Parents with Mental Illness of Addictions (COPMIA) Guidelines as they are released.	✓ National Guidelines anticipated release June 2015.
Work within the Regional Mental Health Alliance to support specialist service delivery.	▪ Explore current treatment options for binge eating disorders and utilisation of technologies to increase family/whānau involvement in inpatient care. ▪ Collaborate regionally on seclusion and restraint processes with a specific focus on improving outcomes for Māori. ▪ Embed Hub and Spoke service delivery model for youth forensic services to increase capacity and responsiveness.	✓ Review key metrics for eating disorder service utilisation Q1. ✓ Review seclusion rates Q1. ✓ Review the youth Hub and Spoke model Q4. ✓ Support implementation of change processes identified and agreed regionally Q1-Q4.

[33] *Canterbury's Suicide Prevention & Postvention Plan will be agreed and submitted to the Ministry of Health by July 2015.*

Delivering better public services

6.11 Increasing immunisation rates

Improved immunisation coverage leads to reduced rates of vaccine preventable disease and better health and independence for children, who will be enrolled with primary care and visiting their primary care provider on a regular basis. Canterbury has a clinically-led cross-sector Immunisation Service Level Alliance whose members provide collective oversight of service delivery and identify opportunities to improve immunisation rates.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Increase immunisation rates to reduce vaccine preventable diseases and improve health and wellbeing.	▪ Continue to support LMCs to promote and educate pregnant women on the value of immunisation. ▪ Maintain systems for multi-enrolment and seamless handover between maternity (LMCs), general practice and Well Child Tamariki Ora (WCTO) services. ▪ Continue to support the National Immunisation Register (NIR) Team to deliver timely reporting to follow up children with no nominated provider.	✓ Quarterly immunisation performance reporting. ✓ 95% of all new-born babies are enrolled on the National Immunisation Register at birth. ✓ 98% of new-borns are enrolled with general practice by 3 months of age. ✓ 85% of six week olds are fully vaccinated. ✓ 95% of eight month olds are fully vaccinated. ✓ 95% of two year olds are fully immunised. ✓ 90% of four year olds are fully vaccinated Q4.
	▪ Continue to monitor and evaluate immunisation coverage at DHB, PHO and general practice level to identify service gaps. ▪ Provide practice-level coverage reports to PHOs to identify unvaccinated children and support improved service coverage. ▪ Continue to review declines and engage with and support general practices with a high number of declines to have immunisation conversations with parents and care givers. ▪ Maintain a Missed Event and Outreach Immunisation Service to locate and vaccinate missing children. ▪ Continue to support wards clerks to identify the immunisation status of children presenting in child health wards and refer them to Outreach if immunisation are not up to date.	
	▪ Continue to provide the 11 year old event and HPV to all eligible young people, in a general practice setting at age 11. ▪ Enhance the Secondary School HPV Programme to further support delivery of the HPV vaccination. ▪ Work to implement and promote new national online learning tools to support the HPV programme as they are developed.	✓ 65% of eligible girls have received dose 3 of the HVP immunisation.
	▪ Promote the seasonal influenza vaccine, especially those with chronic health conditions, those aged 65+ and pregnant women. ▪ Support LMCs to promote and provide free pertussis (whooping cough) vaccinations to pregnant women.	✓ Seasonal flu plan in place Q2. ✓ 75% of people aged 65+ have a seasonal flu vaccination Q3.
Encourage the whole health system to promote, courage and engage in immunisation.	▪ Maintain an Immunisation Service Level Alliance and Providers Group to provide oversight of immunisation service delivery and coverage and identify opportunities to increase rates. ▪ Maintain an 'Immunisation Toolkit' to support General Practice to discuss and deliver immunisations with annual updates. ▪ Implement a DHB wide Immunisation Week Plan to raise awareness of the value of vaccinations. ▪ Use the Māori Keke and other key tools to support improved Immunisation coverage amongst Māori women and girls. ▪ Continue to explore linkages with other social service agencies to raise awareness of the importance of vaccination.	✓ Canterbury DHB is represented at regional and national forums. ✓ Annual update of Immunisation Toolkit provided to practices Q3. ✓ Narrative report on interagency activities to promote Immunisation Week Q4.

6.12 Reducing the incidence of Rheumatic Fever

Rheumatic fever is a serious but preventable illness that mainly affects Māori and Pacific children, and young people. While the symptoms of rheumatic fever may disappear on their own, the inflammation can cause rheumatic heart disease, where there is scarring of the heart valves, it can also be life threatening. The South Island has adopted a regional approach to reducing rheumatic fever and meeting national expectations.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Maintain an integrated response to meet the needs of people at risk of rheumatic fever. Contribute to reducing the incidence of rheumatic fever by two thirds by June 2017.	▪ Continue to support the implementation of the Regional Rheumatic Fever Prevention Plan and align activity with the agreed approach. ▪ Continue to provide care packages for patients with rheumatic fever including: free provision of prophylactic benzathine penicillin injections, GP visits and dental care. ▪ Undertake a root-cause analysis on any new rheumatic fever case in Canterbury and report on lessons learn and actions taken.	✓ Maintain low South Island rheumatic fever rates (< 0.2 per 100,000 – 2 cases).

6.13 The Children's Action Plan

Far too many children suffer from assaults which can seriously diminish their life chances and, in the worst cases, result in death. Maltreatment in childhood can also have significant enduring effects on a child's development, and health and wellbeing in later life. By working together with community providers, primary care partners and other government agencies the implementation of the Children's Action Plan creates a real opportunity to make a difference to a vulnerable child's life.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Implement a collaborative and integrated response to better meet the needs of vulnerable and at risk children. Contribute to a 5% reduction in the number of children experiencing physical abuse nationally by 2017.	▪ Continue to support the establishment of multi-disciplinary Children's Teams in conjunction with providers from across the health system and other government agencies across Canterbury. ▪ Continued participation in the Local Governance and Children's Team Advisory Groups to provide oversight of implementation. ▪ Adopt and apply shared referral pathways between Children's Teams to support early response, assessment and treatment. ▪ Work within the DHB and PHOs to enable health professionals to attend necessary training to support and/or participate in the Christchurch Children's Team.	✓ Quarterly narrative report on progress. ✓ All staff working within or alongside Children's Teams appropriately screened and trained Q1. ✓ Multi-disciplinary Children's Teams in place Q3. ✓ Referral pathways in place Q3.
	▪ Maintain delivery of Gateway Assessments for children referred by CYFS services and monitor access and referral patterns to improve service response. ▪ Continue to invest in the Early Start Programme to provide additional support for pregnant women with complex needs. ▪ Work with the Ministry of Health to implement the Children of Parents with Mental Illness of Addictions (COPMIA) Guidelines as they are released.	✓ 100% of children referred by CYFS received Gateway assessments. ✓ Reporting against Early Start Programme metrics aligned with WCTO metrics Q1. ✓ National Guidelines anticipated release June 2015.
	▪ Continue to maintain and evaluate the Canterbury DHB VIP Programme ensuring high audit scores for each of the child and partner abuse components. ▪ Maintain the National Child Protection Alert System and continue to train staff in the identification of harm and neglect. ▪ Continue the progressive implementation of policy changes in line with the requirements of the Vulnerable Children's Legislation.	✓ National Child Protection Alert System functioning and aligned with other child protection information systems Q1. ✓ Audit scores of 80/100 maintained Q4.

6.14 The Prime Minister's Youth Mental Health Project

The expansion of access to primary mental health services alleviates the distress and suffering of young people and reduces the risk of long-term adult mental health and addiction problems. In line with the expectations of DHBs under the Prime Minister's Youth Mental Health Project, we will prioritise children and young people with the highest need and focus on strengthening relationships across the sector and between agencies to make a positive impact on the mental health and wellbeing of young people.

This work will be driven under the clinically-led, cross-sector Child & Youth Health Work Stream and the Mental Health Work Stream under our Canterbury Clinical Network Alliance.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Continue to support School Based Health Services (SBHS).	▪ Continue to deliver SBHS in all decile one to three secondary schools, teen parent units and alternative education facilities. ▪ Work with the SBHS provider to implement Youth Health Care in Secondary Schools: A framework for continuous quality improvement across all Canterbury SBHS schools ▪ Implement an annual PDSA cycle to reflect, on identified need, by school and align the skill-mix of staff to best meet these needs. ▪ Aligned to the principle of "Youth Participation" develop a process to seek feedback from young people across all SBHS schools.	✓ Youth Health Care Framework in place across all SBHS schools Q2. ✓ Plan, do, study act (PDSA) reflection cycle in place Q3. ✓ Youth Participation process in place across all SBHS schools Q4. ✓ 95% of Year 9 students receive a HEEADSSS assessment Q4.
Improve the responsiveness of primary care to the needs of young people.	▪ Implement targeted actions identified in the 2014/15 stocktake analysis under the C&Y Workstream Youth Health Education Group. ▪ Continue to develop and enhance child health 'navigator links' on HealthInfo and HealthPathways sites. ▪ Agree Youth Health Pathways content using stakeholders' expertise and youth consultation links. ▪ Work with community support providers to develop their function as child and youth 'health navigators'.	✓ Annual review of C&Y Alliance membership and work plans Q3. ✓ Quarterly report on work plan activity to the Alliance Team. ✓ Evidence of improved access to youth health information for young people and their whānau/families Q4.
Improve and strengthen the mental health service response for young people.	▪ Continue to deliver the School Based Mental Health Service (SBMHS) to support earlier intervention for young people. ▪ Build on the link between the Child Adolescent & Family (CAF) service and the SBMHS to improve the system response for young people with a higher level of need. ▪ Implement the BRAVE Programme for Youth and promote the use of SPARX for young people with depression. ▪ Continue to support the cross sector Youth Network 'YAMHA' to bridge the gap for young people no longer in school. [34] ▪ Maintain access to primary care based Brief Intervention Counselling (BIC) for youth 12-19 years. ▪ Monitor activity and demand across the Stepped Care Model to highlight areas that need additional focus.	✓ >70 schools have tailored SBMHS in place Q2. ✓ BRAVE Programme in place Q2. ✓ >500 BIC sessions delivered for young people (12-19) in primary care setting. ✓ Access rates for mental health services for youth (0-19) are maintained >3.1%.
	▪ Continue to implement the Choice and Partnership Approach to improve access to Child and Adolescent Mental Health Services (CAMHS) and Youth AOD specialist services and reduce wait times. ▪ Monitor demand and wait times performance for CAMHS and Youth AOD to ensure targets are being met.	✓ 80% of youth (0-19) referred for non-urgent mental health or addiction services are seen within 3 weeks and 95% within 8 weeks. ✓ 95% of CAMHS and Youth AOD clients have follow-up advice set out in discharged letters.
	▪ Implement the National Transition Guidelines and monitor delivery to ensure planning and follow-up for young people discharged from CAMHS and Youth AOD services.	✓ 95% of all long-term young (0-19) clients have current relapse prevention plans in place.

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

6.15 Whānau ora

We have made some positive gains for Māori in Canterbury, with substantial improvements in immunisation and B4 School Check rates and reductions in avoidable hospital admissions over the last several years — nonetheless, inequalities still exist. With a collective approach from across the health system, we are determined to make further progress. There are two Whānau Ora Provider Collectives implementing Programmes of Action in Canterbury. The Te Waipounamu collective led by He Oranga Pounamu and the Pacific Trust Canterbury collective led by Pacific Trust Canterbury. The DHB will continue to support the national Whānau Ora programme by working closely with the lead agencies for the Whānau Ora Collectives to support them to grow their capacity and capability.

Because Whānau Ora is a key cross-government work programme inter-agency relationships will continue to be built and nurtured with Te Puni Kōkiri, the Ministry of Health, the Ministry of Social Development and Te Pūtahitanga (South Island Commissioning Agency) to ensure that Whānau Ora remains on everyone's agenda.

In the coming year the DHB will socialise the Whānau Ora framework and in line with the framework, and the goals of the Canterbury health system, will continue to influence the transformation of the Canterbury health system towards Whānau – centred practice and delivery of services. The DHB will also work with the two Collectives to better target service delivery and facilitate outcomes based contracting to support the development of collective strategies to build healthy and vibrant communities.

The DHB has a Māori Health Action Plan which provides more detail on areas of focus for the coming year.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Strengthen the relationship with South Island Whānau Ora Commissioning Agency, Te Pūtahitanga.	▪ Initiate regular engagement with Te Pūtahitanga through South Island Māori GM network, Te Herenga Hauora. ▪ Work towards formalising collaboration between South Island DHBs and Te Pūtahitanga. ▪ Continue to participate in national processes to obtain a broader sector view on Whānau Ora implementation.	✓ Regular engagement with Te Pūtahitanga Q1. ✓ Strategic Alliance Agreement in place with Te Pūtahitanga Q4.
Strengthen the relationship between the DHB, Te Waipounamu and the Pacific Trust Canterbury Whānau Ora Provider Collectives to deliver improved outcomes for Māori.	▪ Continue to meet regularly and collaborate with He Oranga Pounamu and Pacific Trust Canterbury to support the implementation of the Whānau Ora Programme in Canterbury. ▪ Support Pacific Trust Canterbury to lead the development of the Healthy Families initiative in the Spreydon-Heathcote ward, Christchurch and participate in the initiative. ▪ Work with the Collectives to understand and articulate the desired outcomes for Whānau and better align provider contracts and service specifications to achieve those outcomes. ▪ Support Pacific Trust Canterbury to trial the Whānau Ora Information System. ▪ Develop and distribute a Māori Health Outcomes Dashboard to monitor performance against key metrics and better target collective effort to make improvement in Māori health.	✓ Quality reporting against Māori Health Outcomes Dashboard Q1. ✓ Signed relationship agreements in place with collectives Q4. ✓ Service specification changes made to contracts in line the development of Whānau Ora programmes Q4.
Support strategies and initiatives to expand capacity and capability of Māori and Pacific providers across Canterbury.	▪ Continue to support the Māori appointment process (led by He Oranga Pounamu) to enhance the capability of working groups to support Whānau Ora at a strategic and system level. ▪ Work with the HealthPathways team to increase the number of Māori and Pacific health service options listed. ▪ Support the development of the Māori Relationship Manager role within the DHB's Public Health Division to ensure Māori health needs are addressed in line with Te Pae Mahutonga. ▪ Continue to work with Kia Ora Hauora to increase the number of Māori on health career pathways and support the health scholarship programme to enhance provider capacity.	✓ CPH Māori Relationship Manager role in place Q1. ✓ Six-monthly report against the Māori Health Action Plan Q2, Q4. ✓ Māori and Pacific Health Scholarships funding distributed through He Oranga Pounamu. ✓ Increased number of Canterbury participants on Kia Ora Hauora programme Q4.

Improving Patient Flow

As a result of taking a hard look at current practices, we are identifying how we can change the way we work to make our systems and processes leaner, and even more patient-focused. Improving the flow of patient across our hospitals and between departments is essential to ensure we stay ahead of the demand curve and play our part in supporting people to stay safe and well and remain in their own homes and communities.

Last year we identified five key themes for additional focus and results are already being demonstrated in terms of reduced waiting times, lengths of stay and readmissions. We will continue to focus effort in these key areas over the coming year. We will also focus on areas of collaboration with our DHB colleagues to improve patient flow across the South Island and between specialist level services across New Zealand. [35]

6.16 Spinal cord impairment action plan

Spinal cord impairment is rare but complex. Every year in New Zealand approximately 80 to 130 people are diagnosed with spinal cord impairment through injury or medical/congenital causes. This affects their lives and those of many others, especially their families and whānau and can occur at any age. Due to medical advancements most people living with SCI now have a near normal life expectancy, but this brings with it progressive complexity for people and their lifelong self-management. In New Zealand, the current model of care for medical interventions and lifelong supports is seen as fragmented and in need of better coordination.

Canterbury DHB is working alongside Counties Manakau DHB, the Ministry of Health, ACC and the St John Ambulance Service to implement the national Spinal Cord Impairment Action Plan. The approach aims to improve the coordination of services that support people with spinal cord impairment, enhance health outcomes and maximise the quality of people lives.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Improve acute clinical outcomes for adults requiring acute spinal cord impairment care.	▪ Collaborate with Counties Manakau DHB to implement the agreed acute referral and destination pathway for spinal cord impairment including development of a communication plan. ▪ Develop a standardised plan for identifying and decanting patients when required between units to ensure appropriate access to specialist care. ▪ Work alongside St John and the Emergency Care Coordination Team (ECCT) to implement the spinal cord impairment pre-hospital destination and referral pathway locally. ▪ Collaborate with the South Island DHBs through the South Island Alliance to highlight the pathway and ensure regional alignment. ▪ Link with the regional Major Trauma Workstream to align with work around the development of Destination and Inter-Hospital Transfer policies and protocols.	✓ Commitment to pathway reflected in Annual Plan of South Island DHBs Q1. ✓ Links with Major Trauma Work Stream established Q1. ✓ Consistent communication plan developed Q3. ✓ Guidelines disseminated to all DHB's Q4.
Improve information sharing.	▪ Implement a pilot to test if the capture and reporting of spinal cord impairment data in NZ will optimise quality and consistency of care delivered, both acutely and in rehabilitation services.	✓ Evaluation of pilot and recommendations for a national register/s Q2.
Provide nationally consistent and high quality rehabilitation services.	▪ Explore a quality framework that could be used across Counties Manakau and Canterbury DHB spinal services. ▪ Commencing with the development of a standardised patient experience questionnaire.	✓ Patient experience questions developed Q3. ✓ Process and mode for collection established Q4.
	▪ Work alongside the Ministry of Health and ACC to improve access to modified housing and specialised equipment to maximise community reintegration.	✓ Regular meetings with the Ministry of Health and ACC to agree processes.

[35] *Refer to Appendix 6 for an over view of the Canterbury DHB's five key themes: The Frail Older Person's Pathway; Theatre Utilisation; Enhanced Recovery After Surgery; Faster Cancer Treatment; and 100 Days Programme.*

6.17 Shorter waits for diagnostic services

Diagnostic services such as radiology tests are a key enabler of a more integrated health system. Timely access to diagnostics and specialist advice can better inform a treatment plan – not only saving people's time, but also minimising the harm and complications that can arise from a delay in intervention.

This work will be driven by the DHB's Radiology Department and the Community Referred Radiology Service with oversight from the clinically-led Radiology Service Level Alliance sitting under the CCN Alliance.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Improve the matching of capacity to demand across radiology services to facilitate timely and appropriate diagnosis and treatment.	▪ Maintain the Radiology Service Level Alliance to provide cross-system input into the development of demand management strategies and to provide oversight of service response.	✓ Radiology Service Level Alliance meets regularly.
	▪ Continue to maintain direct GP access to a full suite of diagnostics to reduce waiting time for diagnosis and treatment. ▪ Maintain HealthPathways to support appropriate referrals. [36] ▪ Install InteleConnect software to enable full access to imaging and reports by referring clinicians.	✓ >600 HealthPathways in place. ✓ InteleConnect software installation complete Q1.
	▪ Continue to implement demand management strategies and align radiology capacity with demand to increase access, reduce waiting times and better support clinical decision making. ▪ Undertake demand reviews where data analysis identifies service gaps, or new requirements are introduced nationally and continue to screen for inappropriate demand. ▪ Develop a value proposition for a single point of entry for radiology referrals to improve equity of access system-wide. ▪ Complete ongoing review and alignment of community referred radiology and acute radiology pathways. ▪ Implement ongoing workforce planning (recruitment, retention, training) strategies to enable the radiology service to manage the transition to Burwood Hospital and meet ongoing demand.	✓ Monthly reports on referral activity circulated to clinical departments. ✓ Implement single point of entry if appropriate Q4. ✓ 95% of people receive their CT scan within six weeks of referral Q4. ✓ 85% of people receive MRI scan within six weeks of referral Q4.
	▪ Continue to participate in the National Radiology Service Improvement programme and contribute to the development of improvement programmes in other DHBs. ▪ Continue to participate in the National Patient Flow programme with reconfiguration of systems to capture diagnostic tests.	✓ CDHB production planner seconded to National Programme Q1. ✓ Implementation of Phase II of the NPF Project completed Q2
Improve matching of capacity to demand to facilitate timely access to diagnostic services to support earlier treatment and minimise the impact of Cancer.	▪ Promote HealthPathways to ensure timely GP referral to diagnostics for patients with suspicion of cancer. ▪ Progressively implement actions identified through the national Endoscopy Quality Improvement (EQI) programme to support improvements in colonoscopy services. ▪ Continue to reduce wait times for the 2 week category to support faster cancer treatment targets without compromising other diagnostic groups. ▪ Identify opportunities and strategies to further reduce waiting times for colonoscopy such as: expanding the service delivery model to include out-placed clinics, use of the Mobile Surgical Services Bus or additional weekend clinics. ▪ Implement national referral criteria for direct outpatient colonoscopy and review thresholds and pathways to ensure people are referred for CT Colonography when appropriate.	✓ 75% of people accepted for an urgent diagnostic colonoscopy wait no longer than two weeks, Q4 ✓ 65% of people accepted for non-urgent diagnostic colonoscopy wait no longer than six weeks Q4 ✓ 65% of people scheduled for a surveillance/follow-up colonoscopy wait no longer than 12 weeks beyond plan Q4

[36] *Canterbury's HealthPathways have been aligned with the National Access Criteria for Community Referred Diagnostics.*

6.18 Shorter waits for elective services

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

With the loss of hospital beds after the earthquakes and a long and disruptive repair schedule ahead of us, this is going to be a significant challenge. To respond to our capacity constraints, we have adopted a whole-of-system production planning approach and will focus on the five key themes to improve the flow of patients through our hospitals and into the community.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Appropriately allocate electives funding to support increased delivery of elective surgery.	▪ Continue to monitor intervention rates to ensure compliance with national surgery targets and to assess equity of access. ▪ Continue to use national Clinical Priority Access Criteria tools and support treatment of patients in order of priority. ▪ Promote the use of live data to assist teams to monitor delivery and performance, predict trends and address issues. ▪ Participate in the implementation of the National Patient Flow Project, include regular data submission. ▪ Utilise private providers to maintain delivery and reduce waiting times until internal capacity comes online with new facilities. ▪ Utilise other DHBs' facilities and staff resources to deliver care to Canterbury residents where possible and appropriate.	✓ Implementation of Phase II of the National Patient Flow Project completed Q2. ✓ 20,474 elective surgical discharges delivered Q4.[37] ✓ Standardised intervention rates maintained (per 10,000): ▪ Major joints: 21 ▪ Cataracts: 27
Identify and implement productivity and efficiency gains to enhance patient flow, reduce wait times and improve health outcomes for patients.	▪ Continue to implement the Electives Redesign '100-days' Project to ensure sustainable service delivery and certainty for patients. ▪ Progressively introduce see-and-treat and advice-only flows to provide more direct advice to primary care, reduce the reliance on secondary care and make the best use of resources. ▪ Implement standardised processes for triage, notification and forecasting to streamline patient flow. ▪ Through the Theatre Utilisation Project continue to identify opportunities to improve the flow of patients and use of resources across specialities.	✓ Monthly and quarterly monitoring of elective waiting times. ✓ Elective theatre utilisation maintained at >85%. ✓ 100% of patients wait no more than 4 months for their First Specialist Assessment or treatment.
	▪ Maintain the Electronic Request Management System (ERMS) to streamline and improve referral processes. ▪ Maintain direct GP access to: elective surgical procedures; GP-2-GP referral; procedure training; and access to specialist advice to reduce waiting times and demand on hospital services. [38] ▪ Continued to implement the national Enhanced Recovery after Surgery (ERAS) pathways to help prepare patients for surgery, reduce the impact and help them to recovery quicker. [39] ▪ Continue to implement the Frail Older Person's Pathway to streamline patient flow within the hospital and reduce the harm and de-conditioning associated with long hospital stays.	✓ Elective inpatient average length of hospital stay <1.59 days. ✓ Reduction in patients aged 75+ with lengths of stay greater than 14 days – base 205.7.
Participate in the Regional Services Alliance to support specialist services delivery across the South Island.	▪ Roll-out the agreed model for regional fertility services. ▪ Continue with implementation of a Major Trauma Register and support regional timeframes to ensure the South Island DHBs contribute to the Major Trauma Minimum Dataset. ▪ Contribute to the development of regional destination policies and inter-hospital transfer protocols to support a regional major trauma response.	✓ SI Tertiary Infertility Service implemented Q2. ✓ Regional transport and transfer policies agreed Q2. ✓ CDHB contributing data to NZMTMD Q1.

[37] *These are electives as defined under the national health target and do not count all elective surgeries delivered by the Canterbury DHB.*

[38] *Current procedures include: skin lesion excisions, Mirena insertions, Pipelle biopsy and musculoskeletal injections.*

[39] *ERAS is initially focused on acute neck of femur fracture surgery (NOF) and elective total hip (THR) or knee (TKR) arthroplasty patients.*

6.19 Shorter waits for cardiac services

Cardiovascular disease is the leading cause of death in New Zealand. Improving access to cardiac services across the continuum will help our population to live longer, healthier and more independent lives. The provision of timely cardiac services is closely intertwined with the delivery of the transalpine services to the West Coast DHB and activity through the Regional Cardiac Services Alliance.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Identify and support productivity and efficiency gains to enhance patient flow, reduce wait times and improve health outcomes for patients.	▪ Continue to provide direct GP access to Echocardiography and Exercise ECGs to improve referral quality and patient flow. ▪ Continue to invest in the Canterbury 'Heart Failure Initiative' to assist patients, general practice and ambulance staff to safely manage heart conditions in the community and reduce avoidable acute admissions and readmissions.[40]	✓ Health Failure HealthPathway maintained. ✓ 342 cardiac surgery discharges delivered Q4. ✓ Standardised intervention rates maintained (per 10,000): ✓ Percutaneous Revascularisation: 12.5 ✓ Coronary Angiography: 34.7 ✓ 100% of patient wait no more than 4 months for their First Specialist Assessment or treatment. ✓ Waiting list for cardiac surgery remains between 5 and 7.5% of annual cardiac throughput.
Maintain production capability for the delivery of cardiac surgery for Canterbury and South Island populations.	▪ Maintain capacity to deliver cardiac surgery at 6.5 per 10,000, even if numbers of patients needing this type of surgery are below the rate. ▪ Continue to monitor ESPI waiting time and intervention rates to ensure equity of access and continued compliance with nationally agreed urgency timeframes. ▪ Continue to use national Clinical Priority Access Criteria tools and support treatment of patients in order of priority. ▪ Continue to implement the 100 Days, Theatre Utilisation, ERAS, and Frail Elderly projects to improve patient flow and free-up capacity to deliver additional elective services.	
Identify and implement quality improvement initiatives to improve outcomes for ACS patients.	▪ Continue to implement regionally agreed protocols and pathways for patients with Acute Coronary Syndrome (ACS) to ensure prompt risk stratification, stabilisation and transfer. ▪ Continue to participate in the collection and provision of data for the national Cardiac (ANZACS QI) and Cath/PCI Registers to enable monitoring of intervention rates and quality of service. ▪ Continue to support delivery of additional weekend lists, as needed, to reduce waiting times and meet ACS targets. ▪ Continue to engage and support the ANZAC QI Coordinator to help train staff on rotation to ensure an understanding of protocols and the important of recording of patient data.	✓ Monthly reporting to ANZACS QI Register. ✓ Regional PCI HealthPathway in place Q3. ✓ Transport guidelines reviewed and updated Q4. ✓ 95% of people receive their elective coronary angiograms within 90 days. ✓ 70% of high-risk patients receive an angiogram within 3 days of admission. ✓ 95% of patients presenting with ACS who undergo angiography have completion of registry data collection within 30 days.
Participate in the South Island Alliance Cardiac Workstream to align cardiac activity across the South Island.	▪ Continue to work with referring DHBs to ensure waiting time targets are met for ACS patients from other DHB regions. ▪ Support the development of a common Percutaneous Coronary Intervention (PCI) HealthPathway for ACS patients. ▪ Participate in a review of the regional guidelines for the arranged transportation of cardiac patients agreed in 2013.	
	▪ Continue to support the regional implementation of the Accelerated Chest Pain Pathway in Emergency Departments to reduce unnecessary hospital admissions.	✓ Common Accelerated Chest Pain Pathway in place regionally Q4.

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

6.20 Shorter waits for cancer treatment

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

Canterbury is participating in the national initiative 'Faster Cancer Treatment' and improving the timeliness of the patient journey from referral to treatment. This work requires a collaborative approach and commitment from a number of clinical specialties across the DHB and is closely aligned to the '100 Days' Project where we are improving patient flow and reducing the time people spend waiting for assessment and treatment.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Identify and support productivity and efficiency gains to enhance the flow of patients from referral to treatment to reduce waiting times.	▪ Continue to monitor waiting times, demand and service delivery in order to maintain access to radiotherapy and chemotherapy within current wait time expectations. ▪ Continue existing outsourcing arrangement to ensure capacity is available to meet demand at peak times. ▪ Work alongside the '100 Days' project teams to improve the flow of patients and reduce wait times across the hospital.	✓ Monthly submission of FCT data to national systems. ✓ Quarterly health target performance reporting. ✓ 100% of patients ready for treatment wait less than 4 weeks for radiotherapy or chemotherapy Q1. ✓ Application submitted for second round service improvement funding. ✓ 85% of patients (referred with a high suspicion of cancer and a need to be seen within two weeks) receive their first treatment within 62 days of referral Q4.
	▪ Continue to implement the agreed model for identifying people with a high suspicion of cancer and enable tracking of patients from referral to treatment across all specialties. ▪ Continue to support data collection activity and use best endeavours to implement improvements within available resources. ▪ Develop and submit an application for additional funding in the second round of service improvement fund initiatives. ▪ Apply the principles of 'Equity of Health Care for Māori' to best deliver high quality, equitable health care that meets the needs and aspirations of Māori.	
Identify actions to improve the quality of the cancer patient pathway from the time patients are referred into the DHB through treatment to follow-up/palliative care.	▪ Continue to work with Central Cancer Network, Southern Cancer Network and Orion on the Proof of Concept for enhancement of electronic referral processes for multidisciplinary meetings (MDMs). ▪ Continue to utilise the MDM coordination roles to improve the coverage and functionality of Multidisciplinary Meetings. ▪ Implement process improvements to ensure that timely referrals are made for patients who might benefit from chemotherapy.	✓ Quarterly performance reporting (PP24). ✓ 100% of MDMs have MDM coordinator support Q1. ✓ Proof of Concept process complete Q2. ✓ Electronic Referral Process in place Q4.
	▪ Identify and progress actions to support implementation of the national Cancer Health Information Strategy (anticipated release June 2015). ▪ Identify actions to disseminate and implement the national Prostate Cancer Guidelines (anticipated release July 2015).	✓ Feedback provided on Prostate Cancer Guidelines Q1. ✓ Guidelines implemented Q4.
Participate in the Southern Cancer Network to align cancer activity across the South Island.	▪ Support the agreed regional approach to reviewing services against at least two national tumour standards including the provision of data and steps to improve data collection. ▪ Implement recommendations from the regional tumour stream audits as released. ▪ Support the development of the regional plan to deliver Supportive Care Services for cancer patients with oversight from the Southern Cancer Network.	✓ Acceptable level of tumour data quality agreed Q1. ✓ Data quality recommendations implemented Q2. ✓ Regional Support Care Services Plan endorsed and agreed Q1. ✓ Support Care Service in place in Canterbury Q2.

Making the most effective use of our resources

6.21 Improving quality and patient safety

The Canterbury DHB is committed to a number of initiatives that encourage quality improvement and innovation to enhance services and patients outcomes – including a commitment to the NZ Business Excellence in Health Care Programme and the priority areas of the national Health Quality and Safety Commission (HQSC). In the coming year will we continue to embrace this momentum, support clinical leadership across the system and engage our workforce in these initiatives.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Increase the focus on continuous improvement processes.	▪ Support the use of the rapid cycle Plan-Do-Study-Act (PDSA) for service improvement. ▪ Complete the Health Excellence Criteria Desk Audit and take action to strengthen prioritised processes. ▪ Refine the DHB's Quality Accounts based on the HQSC evaluation and continue to monitor system-wide performance annually.	✓ Annual publication of DHB Quality Accounts. ✓ Regular education series in place Q1. ✓ Desk Audit complete Q4.
Improve the patient experience.	▪ Support reporting on the '4 Questions' (what is happening today - when am I going home?) at the bedside in medical services to increase patient involvement in decision making about their care. ▪ Support Consumer Council involvement in patient care improvement teams and in the design of the new facilities. ▪ Continue to use patient experience and stories to inform the design of service process improvements and to celebrate success. ▪ Promote the patient experience survey through discharge materials to increase response levels.	✓ 90% completion of answers to 4 Questions in medical wards. ✓ Two consumer representatives on each improvement team. ✓ Patient Experience response levels increased to over 33%.
Support projects that make a difference to improving the quality of care and reducing patient harm and contribute to the national patient safety campaign 'Open for Better Care'.	▪ Implement reporting from the Safety 1st E-incident management and feedback system (RL6) to enable shared clinical outcome reviews. ▪ Implement the electronic patient vital-signs early-warning system and risk assessments nursing observation application. ▪ Improve on performance against the national Quality Safety Markers (QSM) with integration into appropriate improvement programmes.	✓ RL6 live in all areas Q2. ✓ Observation application implemented in 10 wards Q4. ✓ Quarterly monitoring of progress against Quality Markers.
	▪ Promote prevention of healthcare associated infection through Open Campaign activities. ▪ Continue to monitor Central-Line-Associated Bacteraemia (CLAB) free days and engage staff in the target. ▪ Support the review of key process information collected for hip and knee data using the new electronic scope form.	✓ 95% of hip & knee replacement patients receive cefazolin ≥ 2g as surgical prophylaxis. ✓ 100% of hip and knee replacement patients have appropriate skin preparation. ✓ 100% of patients receive antibiotic 0-60 minutes before 'knife to skin". ✓ Observation application implemented in 10 wards Q4. ✓ 90% of older patients are given a falls risk assessment. ✓ 98% of patients assessed at risk of falling have an individualised care plan in place. ✓ 85% compliance with good hand hygiene practice. ✓ All 3 parts of the surgical safety checklist used 90% of the time. ✓ MedChart roll out completed Q4. ✓ 80% of prioritised patients have medicines reconciliation completed <24 hrs of admission.
	▪ Continue to promote Zero Harm from Falls by rolling out the new electronic nursing patient observation system to record and make visible patients falls risk. ▪ Continue to support referrals to community-based Falls Prevention Programmes to reduce re-admissions for people at risk of falls. ▪ Complete the roll out of the visual cues project across medical and surgical services.	
	▪ Continue to support adherence to the '5 Moments in Hand Hygiene', and promote frontline leadership to improve practice and maintain the appropriate number of trained hand hygiene auditors. ▪ Continue to work with Auckland DHB and the HQSC to support the national Surgical Site Infection Surveillance Programme. ▪ Participate in Phase 3 roll out Brief and Debrief and reinforce use of the Surgical Safety Checklist to support adherence to policy. ▪ Complete the roll out of e-prescribing and e-administration and implement eMR in inpatient services to improve medication safety.	

6.22 Connecting information systems

The Canterbury DHB is taking a lead in transforming information technology systems to enable a more integrated health system and more integrated service delivery models – both across the Canterbury health system and across DHB boundaries throughout the South Island.

In particular, Canterbury is leading the development and roll-out of a number of electronic solutions that reduce duplication, save clinical time and improve patient safety. Major systems implementations includes the Electronic Request Management System (ERMS) which enables GPs to refer patients to anywhere in the health system directly from their desktop, HealthPathways which provides current local assessment, management and referral information online and HealthOne (formally eSCRV) which integrates core clinical information from multiple systems and makes it available to health professionals at the point of care. Continued development of these systems will enable faster, more accurate referrals and safer, more efficient sharing of clinical information between South Island health professionals.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Deploy new systems to empower the Patient.	▪ Continue to work with the 3 Canterbury PHOs to design and implement a Patient Portal to provide patients with access to their core health information.	✓ Quarterly update on progress in implementing the portal.
Enhance current information systems to support integrated models of care and service delivery.	▪ Maintain current clinical HealthPathways to support the delivery of the right care, in the right place, at the right time.	✓ >600 HealthPathways available across the Canterbury system.
	▪ Complete implementation of eReferrals Stage 2 (via HCS). ▪ Implement eReferrals Stage 3, providing triage and internal referrals functionality across all services. ▪ Complete the roll out clinical workstation under a Virtual Desktop Infrastructure (VDI) environment to allow more efficient capture of clinical notes in different locations.	✓ 90% of all services using eReferrals Stage 2 Q1. ✓ 60% of services using eReferrals triage functionality Q3. ✓ Installation of VDI at Christchurch Hospital complete Q4.
Deploy new clinical information systems to improve patient safety.	▪ Support electronic medicines reconciliation to reduce transcription errors and improve care communication with deployment of e-Discharge Summary MedCharts. ▪ Introduce the electronic nursing observation application to improve patient assessment screening and escalation of care. ▪ Replace the current Maternity System to streamline systems and provide a complete set of maternity information. ▪ Implement RL6 software for reporting and managing incidents and enabling shared clinical outcome reviews.	✓ eMed reconciliation deployed Q2. ✓ Nursing Observation application implemented in trial ward Q2. ✓ Replacement of Maternity System (Caresys) Q3. ✓ RL6 live in all areas Q4.
Develop information infrastructure alongside facilities development.	▪ Establish a clear mobile device, application, and data strategy. ▪ Develop functional design for digital hospitals incorporating the Christchurch Hospital requirements.	✓ Mobile device strategy Q2. ✓ Christchurch digital design concepts complete Q3.
Enable seamless and transparent access to clinical information across the South Island.	▪ Continue to lead the rollout of HCS across the South Island, providing upgrades and support. ▪ Continue the deployment of the HealthOne (formally eSCRV) to the rest of the South Island. ▪ Implement the South Island Patient Information Care System (SI PICS) to further integrate systems regionally. ▪ Upgrade Canterbury's electrocardiogram (ECG) and Holter management systems for regional access. ▪ Deploy the Maximo EAM asset management system CDHB-wide and extend to West Coast and South Canterbury DHBs.	✓ NMDHB using the regional HCS portal Q3 and SDHB Q4. ✓ eSCRV deployed to and South Canterbury DHBs Q2. ✓ SI PICS prepared for use in Burwood Hospital services Q2. ✓ All captured ECGs and Holter reports available in HCS Q3. ✓ Maximo EAM deployed Q4.

6.23 Supporting our health workforce

Fostering innovation and engaging the Canterbury health workforce in the transformation and change needed to meet our future challenges is a critical factor in ensuring a sustainable future for our health system. Our clinical workforce is already well engaged in the development of alternative models of care and whole of system patient pathways designed to ensure we can continue to provide quality services into the future.

Recent staff survey results suggest that our workforce is generally engaged in work and wants to be here, however staff resilience and support programmes will remain a priority over the coming year. Our workforce transition programmes acknowledge the added challenge and stress ongoing repairs and new facilities development work creates for staff and collectively aim to smooth staff transitions into new facilities.

We will maintain a focus on expanding and integrating training and professional development programmes, supporting the piloting of new roles and developing core leadership/management curricula to increase capability and ready our staff for the move to our new facilities.

In addition the South Island Training Hub provides further opportunities for greater collaboration across the South Island and clinical networks are well established across nursing, allied health, midwifery and medicine. Critical role identification, piloting of new roles, clinical training placements and career planning will all be driven by educational providers in consultation with each DHB and the South Island Regional Training Hub.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Promote and support the desired culture of the Canterbury DHB and improve employee engagement levels.	▪ Continue to promote a health excellence culture throughout the organisation. ▪ Invest in programmes and initiatives that reiterate the desired behaviours and culture, including 'XcelR8', 'Particip8', 'Elev8' and 'Releasing Time to Care' and Releasing Time to Lead. ▪ Continue to align goal-setting, performance reporting, and communications to reinforce cultural messages. ▪ Strengthen patient safety and Just Culture across the organisation under the leadership of the Clinical Board. ▪ Improve usage rates and reporting on attachment and exit surveys to identify further opportunities for improvement.	✓ Ongoing staff participation in XcelR8, Particip8 and 'Elev8' programmes. ✓ 3 Releasing Time to Care modules completed Q3. ✓ 500 people completed the Patient Safety on-line learning module by Q4. ✓ >80% of staff surveyed on exit would consider returning.
Continue actively promoting an organisational culture which values all staff and supports their wellbeing.	▪ Continue to embed a more overt focus on staff wellbeing across organisational business practices. ▪ Continue to implement the Staff Wellbeing Strategy building on the current programme of initiatives. ▪ Complete a 2016 Staff and Family Wellbeing Survey.	✓ High levels of attendance at Staff Wellbeing Programme initiatives ✓ Improved outcomes against key staff wellbeing metrics Q4.
Expand workforce capacity through improved workforce planning, recruitment and retention.	▪ Continue to seek opportunities to maximise clinical placement for undergraduate and graduate entry nursing trainees and NETP/NESP positions to meet future workforce needs. ▪ Maintain a programme of Medical Physicist development. ▪ Continue to participate in sector wide and regional employment negotiations and maintain a robust and transparent approach to salary setting. ▪ Continue to lead the regional delivery of the Kia Ora Hauora Māori Workforce Development Service. ▪ Provide access to the HWNZ Hauora Māori funding pool to allow Māori staff in our health system study and upskill. ▪ Support non-Māori staff with regular Tikanga and Treaty workshops to improve their cultural competence when dealing with Māori patients and clients.	✓ >180 nurse positions within the NETP and NESP programmes Q4. ✓ >12 people enrolled on the SMHS Allied Health New Entry programme Q4. ✓ Post Graduate Diploma offered and sonographer training position created Q4. ✓ 5 Pacific primary care scholarships awarded Q4. ✓ 10 Māori primary care scholarships awarded Q4. ✓ 4 Tikanga and Treaty workshops run Q4

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Expand workforce capability through improved training, education, learning and career development.	▪ Enhance talent management and succession planning through the use of shared recruitment and retention technology. ▪ Continue to provide training in performance management and introduce online technology to allow more time for quality conversations on performance expectations.	✓ Talent Identification and leadership development seminars run Q2. ✓ 70% of DHB employees using the online performance system Q4.
	▪ Support allied health role development for: allied health assistants; pharmacy technicians; and advanced roles. Actively participate in the regional implementation of a delegation model for AHAs (Calderdale framework). ▪ Maintain the Health Care Assistant Development Programme. ▪ Support relevant expanded nursing roles or services to participate in the credentialing process ensuring the nursing workforce are working at the top of expanded scope. ▪ Embed Crisis Resolution Model within Community focussed SMHS clinical practice through targeted training. ▪ Establish a "Talking Therapies" training programme for all front line SMHS clinical staff using a tiered approach. ▪ Introduce a Clinical Risk Training Programme targeting prevention of suicide and violence implemented ▪ Continue to invest in extending primary care education programme coverage and expand education channels.	✓ Allied Health Calderdae framework implemented Q4. ✓ New Health Care Assistant intake established by Q2. ✓ Regional nursing framework in place Q4. ✓ RN Diabetes Nurse prescribing supported Q4. ✓ 25% of SMHS font line staff have completed Talking Therapies training by Q4. ✓ Suicide Prevention Training underway Q3. ✓ >85% GPs and Practice Nurses have access to primary care education programme Q4.
Comply with statutory regulations in line with the Vulnerable Children's Act.	▪ Support the development and implementation of plans and procedures to ensure the safety vetting of new core workers. ▪ Review the Recruitment Policy and HR Handbook for managers and update supporting documentation. ▪ Provide appropriate training to HR staff and line managers. ▪ Review contracts to ensure contracted service providers also have a Child Protection Policy in place.	✓ Review of documentation completed and policy on DHB website by Q1. ✓ Training completed Q1. ✓ All new core workers vetted in accordance with regulations Q1.
Support regional planning programmes to identify future workforce requirements and agree a common set of planning tools to identify workforce gaps and opportunities.	▪ Participate in regional working groups addressing priority workforce areas including Sonography, expanded role of nurse specialists and nurse practitioners, increasing nurse specialists, palliative care and support roles and the role of nurses in performing colonoscopies. ▪ Align with Medical Council of NZ requirements for community based rotations through hosting regional pilot of PGY2s into General Practice. ▪ Participate in regional workforce development groups including development of University of Otago post graduate diploma in imagining. ▪ Support the development of regional education sessions, forums, peer support and mentoring using innovative approaches including e-learning and video conferencing. ▪ Ensure systems are in place to provide all trainees with access to career guidance and a career plan.	✓ Increase in SI sonogrophy trainees from 4 to 6. ✓ 8 House Officers complete 3 month rotations by Q4. ✓ 100% of HWNZ-funded staff have career plans in place Q4.

6.24 Living within our means

With current and projected constraints on Government funds, we must focus on maximising value from our limited resources and reducing unnecessary cost and waste. If an increasing proportion of our funding has to be directed into meeting cost growth, it will severely restrict our ability to invest in technology and services to better meet the needs of our population. It will also put continued healthcare service delivery at risk.

Rather than achieving savings through service reductions or cuts, we seek to deliver services in more effective and efficient ways, reduce waste and duplication and make the best use of our resources.

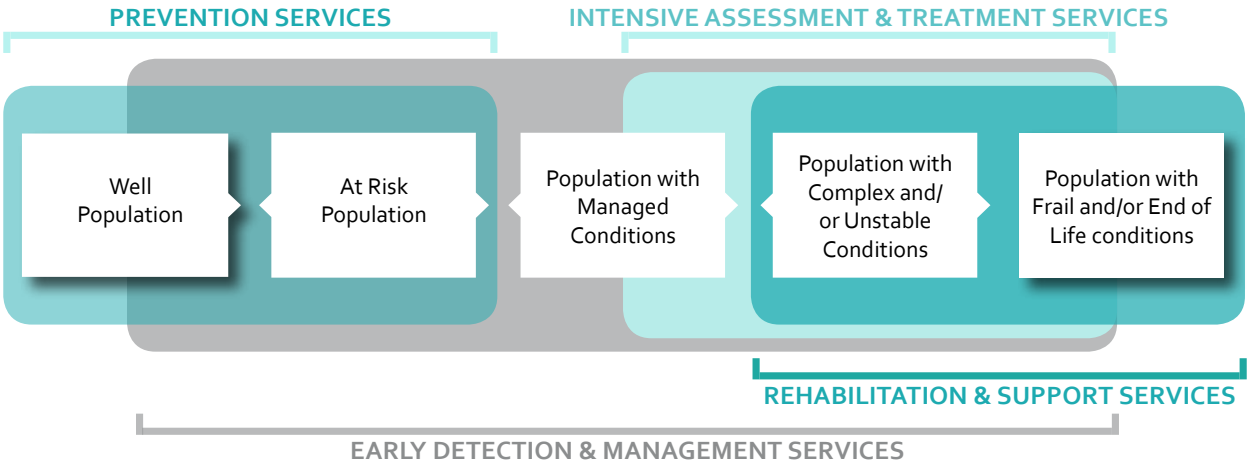
We are committed to our vision of an integrated system that supports people to stay well and provides the right service, in the right place at the right time. When people are supported to stay well, they need fewer hospital-level interventions and spend less time in hospital. This not only results in better health outcomes but also reduces demand and frees up health resources. Last year alone almost 30,000 people who would have been admitted to hospital with acute medical conditions received their treatment and care in their own homes.

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
Better connect the system to support technical and clinical efficiencies to reduce waste and duplication.	▪ Continue to review clinical pathways to support the delivery of the right care, in the right place, at the right time. ▪ Continue to support the use of the ERMS to streamline referrals and improve triaging capabilities within the system. ▪ Continue to support development of HealthOne to provide secure access to key health information in any health setting. ▪ Support the Laboratory SLA to implement an integrated, patient centre model that reduced waste and duplication.	✓ >600 HealthPathways available across the Canterbury system. ✓ HealthPathways in the hospital underway Q1. ✓ 90% of DHB services using ERMS. ✓ 95% of general practices and pharmacies access HealthOne. ✓ E-ordering of Lab Tests live Q4.
Support people to stay well and reduce unplanned or acute demand for health services.	▪ Continue to invest in the CCN Alliance and IFHS model to support improved service delivery and support people to stay well. ▪ Maintain direct GP access to diagnostic services to support earlier intervention without the need for specialist referral. ▪ Continued to invest in the delivery of community-based acute demand services and packages of care to support people in the community rather than in our hospitals. ▪ Maintain direct GP access to CREST services to support people at risk of a hospital admission to stay well in their own home. ▪ Continued to invest in the community-based Falls Prevention Service to reduce hospital admissions for falls. ▪ Continue to implementation a stepped care model for mental health to support people to stay well in the community.	✓ >28,000 urgent care packages provided in the community Q4. ✓ >1,500 people (65+) accessing CREST services. ✓ >4,000 people access brief intervention counselling in the community. ✓ 10% decrease in the number of people 75+ presenting to ED as a result of a fall. ✓ Rate of acute medical admissions maintained at <5,500 per 100,000.
Maintain a focus on efficient and effective use of resources to reduce the cost of service delivery.	▪ Review and refine acute theatre models to reduce the impact of acute demand variation of the delivery of elective surgery. ▪ Implement HQSC medication, infection control and surgical site infection initiatives to support safer and shorter patient stays. ▪ Continue to implement the 100 days and faster cancer treatment projects to reduce the wait times for treatment. ▪ Continue to implement the national Enhanced Recovery After Surgery (ERAS) initiative to better prepare people for surgery to reduce lengths of stay and enhance recovery. ▪ Continue to invest in the Frail Older Person's Pathway to reduce the deconditioning and negative outcomes associated with long lengths of stay for older people and release hospital capacity.	✓ Information on rebuild and overseas demand informs response strategies. ✓ Elective theatre utilisation maintained at >85%. ✓ Improved performance against the HQSC national quality markers. ✓ Elective inpatient average length of hospital stay <1.59 days. ✓ Reduction in patients

OUR PERFORMANCE STORY 2015/16		
OBJECTIVE	ACTIONS TO DELIVER IMPROVED PERFORMANCE	EVIDENCED BY
	▪ Apply scrutiny to contractual arrangements and ensure payment for Inter-district flows, insurance and ACC services. ▪ Maintain tight controls around repairs and maintenance to ensure investment is not wasted on short-term fixes. ▪ Actively engage in strategies to better identify and respond to the service demand created by unenrolled/overseas patients	aged 75+ with lengths of stay greater than 14 days – base 205.7. ✓ Readmission rates for people (65+ and 75) at or below national average.15
Participate in regional and national initiatives focused on the efficient and effective use of resources to achieve financial sustainability.	▪ Continue to support the Regional Support Services Alliance to achieve regional Procurement and Supply Chain savings. ▪ Continue to support the regional rollout of ERMS, HealthONE and Health Connect South to better connect the system and reduce duplication and delay in treatment. ▪ Expand the use of telemedicine and video technology to reduce patient and clinician travel to and from the West Coast.	✓ Regional Capital Plan in place Q1. ✓ Procurement and Supply Chain achieves savings as agreed Q4. ✓ SCDHB using HealthONE Q2. ✓ NMDHB and SDHB using regional Health Connect South Q4.
	▪ Participate in the implementation of agreed Shared Services initiatives aligned to the Health Partnership work programme and commit resource where required to progress the Finance, Procurement & Supply Chain, Food Services, Linen & Laundry Services and National Infrastructure Platform Business Cases. ▪ Work collaboratively with the National Health Committee (NHC) to solve sector issues including engaging with and providing advice to the NHC on: prioritisation and assessment and approaches to new and emerging technologies and those driving expenditure. ▪ Support the implementation of national PHARMAC initiatives including national contracting for the procurement of hospital medical devices, management of hospital pharmaceuticals and product standardisation.	✓ Implementation of national shared services business cases are agreed. ✓ Regional Strategic Planning & Integration Team engage with the NHC to support consistent approaches to sector issues. ✓ Implementation of national PHARMAC initiatives.

Statement of Performance Expectations

How will we demonstrate success?



EVALUATING OUR PERFORMANCE

We aim to make positive changes in the health status of our population. As the major funder and provider of health and disability services in Canterbury, the decisions we make about which services will be delivered will have a significant impact on people's health and wellbeing.

Understanding the dynamics of our population and the drivers of demand are fundamental when determining which services to fund and at what level. Just as fundamental is our ability to evaluate whether the services we are purchasing and providing are making a measureable difference.

Over the longer term we evaluate the effectiveness of the decisions we make by tracking performance against a set of desired population outcomes which are outlined in the strategic direction section of this document and highlighted in the overarching intervention logic diagram on page 23.

On an annual basis, we evaluate our performance by providing a forecast of the services we plan to deliver in the coming year and the standards we expect to meet. We then report actual performance against this forecast in our end-of-year Annual Report. [41]

When evaluating our performance, many service indicators could have been included. We have chosen those that we believe are important to our patients, community and stakeholders and that provide a measure of how well the DHB is meeting the challenges confronting our Health System.

The DHB has a separate Māori Health Action Plan and where the performance indicators align they have been included in the forecast to highlight the areas of particular priority in terms of improving health outcomes for Māori in Canterbury. [42]

Because our aim is to give a fair and accurate insight into how our health system is performing, we cannot simply measure 'volumes' of services delivered. The number of people who receive a service is often less important than whether 'the right person' or 'enough' of the right people received the service, and whether the service was delivered 'at the right time'. We have therefore chosen to present a mix of indicators that address four key aspects of our performance: Volume (V); Timeliness (T); Coverage (C); and Quality (Q).

Wherever possible, past year's baseline 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. Services have also been grouped into four 'output classes' that are a logical fit with the continuum care and are applicable to all DHBs. Those are: prevention services; early detection & management services; intensive assessment & treatment services; and rehabilitation & support services.

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 tend to reflect the objective of increasing the coverage

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

[42] *Specific actions to improve Māori health are outlined in our Māori Health Action Plan, also available on our website.*

of prevention programmes, reducing acute or avoidable demand 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 a certain level of need for service. These services include: diagnostic tests and assessments, emergency care, maternity services, rehabilitation and respite services, aged residential care and palliative care. Estimated service volumes have been provided against these services, not as targets to be achieved, but to give context in terms of the use of resources across our health system.

With a growing Māori population and persistent inequalities amongst our population achieving equity of outcomes is an overarching priority for our health system. All of our targets are universal (the same for all) 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 are also contending with the consequences of New Zealand's largest natural disaster and difficulties of predicting the ongoing impact on the health needs of our population. The impact is being felt most markedly in an increased demand for mental health and emergency services. It is also felt in terms of reduced capacity within our hospitals - with the loss of beds, rooms and buildings and the constant disruption repairs and construction are having on normal business for our departments.

A number of the standards set are based on national expectations and will be particularly difficult for the DHB to meet, whilst experiencing unprecedented increases in demand. However it is important that we monitor these indicators in order to understand the impact of the earthquakes and make appropriate funding decisions as we move forward. [43]

WHERE DOES THE MONEY GO?

The table below presents a summary of the budgeted financial expectations for 2015/16, by output class. Over time, we anticipate it will be possible to use this framework to demonstrate changes in the allocation of resources and funding from one end of the continuum of care to the other.

2015/16

REVENUE	TOTAL $'000
Prevention	30,372
Early detection and management	322,196
Intensive assessment & treatment	1,029,779
Primary health & community	442
Rehabilitation & support	233,985
Total Revenue	1,616,774

EXPENDITURE	TOTAL $'000
Prevention	30,379
Early detection and management	322,408
Intensive assessment & treatment	1,029,389
Primary health & community	443
Rehabilitation & support	234,155
Total Expenditure	1,616,774

Surplus/(Deficit) - $'000	-

NOTE:

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

E Some service are demand driven and it is not appropriate to set targets, instead estimated volumes are provided to give context as to the use of resource across our system.

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

† Performance data for some programmes relates to the calendar rather than 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 West Coast's Māori Health Action Plan for 2015-16.

[43] The performance results referenced in this section refer only to the Canterbury population. Baselines which include the population of the Chatham Islands will be confirmed over the coming year. Targets set throughout this section will apply to both populations.

OUTPUT CLASS

7.1 Prevention services

Preventative health services promote and protect the health of the population and address individual behaviours by targeting changes to physical and social environments that engage, influence and support people to make healthier choices. These services include: 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; and individual health protection services such as immunisation and screening that support early intervention that support people to modify lifestyles and maintain good health.

WHY IS THIS OUTPUT CLASS SIGNIFICANT FOR THE DHB?

By supporting people to make healthier choices we can reduce the risk factors that contribute to long-term conditions and prevent or minimise the impact of these conditions. Services are often designed to disseminate consistent messages to large numbers of people and can be cost-effective. At-risk and 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-needs populations and to reduce inequalities in health status and health outcomes.

SERVICE PERFORMANCE INDICATORS (2015/16)

Health Promotion and Education Services These services inform people about risks and support them to be healthy. Success begins with awareness and engagement, reinforced by programmes and legislation that support people to maintain wellness and make healthier choices.	Notes	2013/14 Result	2015/16 Target	2013/14 National Average
% of babies exclusively breastfeeding on hospital discharge	Q [44]	76%	≥75%	-
Lactation support and specialist advice consults provided in community settings	V	1,031	>600	-
% of babies exclusive/fully breastfed at LMC discharge	Q [45]	70%	75%	74%
% of Māori babies exclusive/fully breastfed at LMC discharge	Q ◆	67%	75%	69%
% of priority schools supported by the Health Promoting Schools framework	C [46]	80%	>70%	-
'Appetite for Life' nutrition courses provided in the community	V	56	>50	-
People accessing Green Prescriptions for additional physical activity support	V [47]	2,879	3,000	-
% of Green Prescription participants more active 6-8 months after referral	Q [48]	57%	>50%	62%
% of smokers enrolled with a PHO receiving advice and help to quit (ABC)	C ◇ [49]	75%	90%	86%
% of smokers identified in hospital receiving advice and help to quit (ABC)	C ◇	95%	95%	96%
Enrolments in the Aukati Kaipaipa smoking cessation programme	V	408	>240	-
% of women smokefree at two weeks postnatal	Q [50]	89%	95%	87%
% of Māori women smokefree at two weeks postnatal	Q ◆	66%	95%	65%

[44] *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.*

[45] *Standards and baselines are aligned to the national WellChild Quality Framework targets and national WCTO performance reports.*

[46] *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.*

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

[48] *Results taken from national patient survey completed by Research NZ on behalf of the Ministry of Health.*

[49] *This is the national health target measure. For 2015/16 the time period of the measure has changed from 'offered ABC within the last 12 months' to 'offered ABC within the last 15 months'. Baseline results are against the previous target.*

[50] *Standards and baselines are aligned to the national WellChild Quality Framework targets and national WCTO performance reports.*

Population-Based Screening Services These services help to identify people at risk of illness and pick up conditions earlier. The DHB's role is to encourage uptake, as indicated by high coverage rates.	Notes	2013/14 Result	2015/16 Target	2013/14 National Average
% of four-year-olds provided with a B4 School Check (B4SC)	C [51]	90%	>90%	91%
% of 'high needs' four-year-olds provided with a B4 School Check (B4SC)	C ◆ [52]	92%	>90%	90%
% of Year 9 students in decile 1-3 schools provided with a HEEADSSS assessment	C † [53]	100%	>95%	-
% of women aged 25-69 having a cervical cancer screen in the last 3 years	C [54]	76%	80%	77%
% of Māori women aged 25-69 having a cervical cancer screen in the last 3 years	C ◆	56%	80%	63%
% of women aged 50-69 having a breast cancer screen in the last 2 years	C [54]	80%	>70%	73%
% of Māori women aged 50-69 having a breast cancer screen in the last 2 years	C ◆	80%	>70%	65%

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	2013/14 Result	2015/16 Target	2013/14 National Average
% of newborns enrolled on the National Immunisation Register at birth	C	99%	>95%	-
% of children fully immunised at eight months of age	C ◇	93%	95%	92%
% of Māori children fully immunised at eight months of age	C ◆	88%	95%	88%
% of eight-month-olds 'reached' by immunisation services	Q [55]	95%	95%	-
% of eligible girls completing HPV vaccinations (receiving Dose 3)	C † [56]	39%	65%	60%
% of eligible Māori girls completing HPV vaccinations (receiving Dose 3)	C ◆	28%	65%	64%
% of older people (65+) receiving a free influenza ('flu') vaccination	C †	75%	75%	-
% of older Māori (65+) receiving a free influenza ('flu') vaccination	C ◆	70%	75%	-

[51] 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.

[52] The high needs grouping includes Maori, Pacific and children living in High Depreciation areas.

[53] 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.

[54] These are national screening programmes and standards are based on national screening unit targets. The breast screening target criteria was revised in 2014/15 from women 45-69 to women 50-69 – previous year's result are for the wider age band.

[55] '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.

[56] The baseline is the percentage of girls born in 2001 receiving Dose 3 and the target for 2015/16 is girls born in 2003. This measure differs the previous year as the age-bands have been realigned to match the national HPV programme target definition. However as Canterbury's HPV programme differs to that provided in other regions the results are not directly comparable to the national figures. Canterbury's programme is primarily General Practice rather than primarily Schools based.

OUTPUT CLASS

7.2 Early detection and management services

Early detection and management services are services, which help to maintain, improve and restore people's health by ensuring that those at risk, or with disease onset, are recognised 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 FOR THE DHB?

New Zealand is experiencing an increasing prevalence of long-term conditions, so called because once diagnosed people usually have them for the rest of their lives. Some population groups suffer from these conditions more than others 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. Providing flexible and responsive services in the community, without the need for a hospital appointment, better supports people to stay well and stabilise or manage their condition—reducing complications, acute illness or crises and therefore acute and avoidable hospital admissions. Reducing avoidable demand will have a major impact in freeing up hospital and specialist services to allow for more complex and planned interventions.

SERVICE PERFORMANCE INDICATORS (2015/16)

Primary Health Care (GP) Services These services are offered in local community settings by general practice teams and other primary healthcare professionals, aimed at improving, maintaining or restoring people's health. High levels of enrolment or uptake of services are indicative of engagement, accessibility and responsiveness of primary care services.	Notes	2013/14 Result	2015/16 Target	2013/14 National Average
% of the population enrolled with a Primary Health Organisation	C	96%	>95%	-
% of the Māori population enrolled with a Primary Health Organisation	C ◆	83%	95%	-
Avoidable hospital admission rate for children aged 0-4	Q [57]	TBC	TBC	TBC
Avoidable hospital admission rate for Māori children aged 0-4	Q ◆	TBC	TBC	TBC
Young people (0-19) accessing Brief Intervention Counselling	V Δ[58]	786	>500	-
Adults (20+) accessing Brief Intervention Counselling	V Δ	5,712	>3,500	-
Skin lesions (growths, including cancer) removed in primary care	V Δ	2,432	>2,000	-
Number of clinical HealthPathways in place across the health system	V [59]	762	>600	-

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	2013/14 Result	2015/16 Target	2013/14 National Average
% of pre-school children (0-4) enrolled in DHB-funded oral health services	C †	71%	85%	73%
% of pre-schools Māori children (0-4) enrolled in DHB-funded oral health services	C ◆	31%	90%	59%
% of enrolled children (0-12) examined according to planned recall	T †	94%	>90%	90%
% of adolescents (13-17) accessing DHB-funded oral health services	C †	64%	85%	70%

[57] *Some admissions to hospital are seen as preventable through appropriate early intervention and therefore provide an indication of access to and effectiveness of primary care the interface between primary and secondary services. The measure is a national DHB performance indicator (SI1), and is defined as the standardised rate per 100,000. The definition for this measure is being revised nationally and was not available at the time of printing – targets will be confirmed once the definition is set.*

[58] *The Brief Intervention Coordination Service provides people with mild to moderate mental health concerns free 'early' intervention from their general practice teams for mild to moderate mental health issues including depression and anxiety. Results include face-2-face and phone consultations but may undercount people accessing BIC where dates of birth have not been provided.*

[59] *The HealthPathways website helps general practice navigate clinically designed pathways that guide patient-centred models of care.*

Long-term Conditions Programmes These services are targeted at people with high health need due to having a long-term condition and aim to reduce deterioration, crises and complications through good management (and control) of that condition. Success is demonstrated through early intervention, monitoring and management strategies which reduce negative impacts and the need for hospital admission.	Notes	2013/14 Result	2015/16 Target	2013/14 National Average
Spirometry tests provided in community rather than hospital settings	V Δ [60]	1,533	>1,000	-
% of the eligible population having a CVD Risk Assessment in the last 5 years	C ◇ [61]	66%	90%	84%
% of the eligible Māori population having a CVD Risk Assessment in the last 5 years	C ◆	60%	90%	80%
% of the population identified with diabetes having an HbA1c test in the last year.	C [62]	94%	>90%	-
% of the population identified with diabetes with acceptable glycaemic control.	Q	77%	>75%	-
People receiving subsidised diabetes self-management support from their general practice team when newly diagnosed with Type 2 diabetes or starting insulin	V Δ	799	>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	2013/14 Result	2015/16 Target	2013/14 National Average
Subsidised pharmaceutical items dispensed in the community	V Δ [63]	6.2m	E.<8m	-
Laboratory tests completed for the Canterbury population	V Δ	2.4m	E. <2.6m	-
People on multiple medications receiving a Medication Management Review	V Δ [64]	1,703	1,500	-
GP requested Community Referred Radiology tests completed	V Δ	43,094	E. >30k	-
% of people receiving urgent diagnostic colonoscopy within 2 weeks	T [65]	85%	95%	55%
% of people receiving Computed Tomography (CT) scans within 6 weeks	T [62]	92%	95%	80%
% of people receiving Magnetic Resonance Imaging (MRI) within 6 weeks	T [62]	88%	>85%	61%
% of people receiving elective coronary angiography within 3 months	T [62]	99%	>95%	95%

[60] 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. Volumes include those delivered by both GPs and mobile community respiratory providers.

[61] This refers to CVD risk assessments undertaken in primary care in line with the national 'More heart and diabetes checks' health target.

[62] An annual HbA1c test of patient's blood glucose levels is seen as a good means of assessing the management of their condition - HbA1c ≤64mmol/mol reflects an acceptable blood glucose level.

[63] This measure covers all items dispensed in the community and not in hospital, however it may include some non-Canterbury residents who had prescriptions filled while in Canterbury.

[64] There has been a shift in focus with the introduction of a new higher level service offering more intense medication therapy services for more complex patients who need additional support. This new service was launched in May 2015. This may result in the delivery of fewer Medical Management Reviews and hence the target has been revised for this service.

[65] All diagnostic result baselines are the June 2014 result as published by the Ministry of Health.

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 and are usually provided in hospital settings, which enable the co-location of clinical expertise and specialist equipment. A proportion of these services are in response to an acute event 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 FOR THE DHB?

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

SERVICE PERFORMANCE INDICATORS (2015/16)

Quality and Patient Safety Measures These quality and patient safety measures apply across all hospital services and are newly introduced national quality and safety markers championed and monitored by the Health Quality & Safety Commission. High compliance levels indicate robust quality processes and strong clinical engagement.	Notes	2013/14 Result	2015/16 Target	2013/14 National Average
Rate of compliance with good hand hygiene practice	Q ◇[66]	67%	80%	75%
% of hip and knee replacement patients receiving cefazolin >2g	Q ◇[67]	96%	>95%	85%
% of hip and knee replacement patients who have appropriate skin preparation	Q ◇	99%	100%	97%
% of time all three parts of the surgical safety checklist are used	Q ◇[68]	88%	90%	94%
% of inpatients (aged 75+) who received a falls assessment	Q ◇[69]	93%	>90%	89%

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	2013/14 Result	2015/16 Target	2013/14 National Average
% of women registered with an LMC by 12 weeks of pregnancy	C †	75%	80%	59%
Maternity deliveries in Canterbury DHB facilities	V	5,654	E. 6,000	-
% of total deliveries made in Primary Birthing Units	V [70]	9%	13%	-

[66] This measure is based on ward audits of the Medical and Surgical wards conducted according to Hand Hygiene NZ standards. Baseline results differ due to alignment with national results and financial years. The 2013/14 result relates to the June 2014 audit period.

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

[68] The surgical safety checklist, developed by the World Health Organisation, helps ensure the correct procedures are carried out on the correct patient. Previously published results differ due to alignment with national results and financial years.

[69] 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.

[70] 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, in order to make better use of resources and to ensure 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 & emergency responses, short-stay acute assessment and observation, acute care packages, acute medical and surgical services and intensive care services.	Notes	2013/14 Result	2015/16 Target	2013/14 National Average
% of children under thirteen with access to free primary care after hours	C [71]	*New*	100%	-
% of general practices providing telephone triage outside business hours	C	89%	95%	-
Acute demand packages of care provided in community settings	V [72]	28,378	>28,000	-
Attendances at Canterbury Emergency Departments	V [73]	94,010	E. <96k	-
% of people waiting less than 4 weeks for radiotherapy or chemotherapy	T ◇[74]	100%	100%	100%
% of patients (referred with a high suspicion of cancer and a need to be seen within two weeks) receive their first treatment within 62 days of referral.	T ◇[75]	*New*	85%	*New*
Acute inpatient average length of hospital stay (standardised)	Q [76]	2.45	<2.45	2.64

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	2013/14 Result	2015/16 Target	2013/14 National Average
First Specialist Assessments provided (medical and surgical)	V [77]	67,122	E.>60k	-
% of First Specialist Assessments that were non-contact (virtual)	Q [78]	13.5%	>10%	-
Elective surgical discharges delivered (surgeries provided)	V ◇[79]	16,961	20,474	-
% of elective/arranged surgeries provided as day cases	Q [80]	57%	57%	-
% of people who receive their surgery on the day of admission	Q [80]	91%	90%	-
Elective inpatient average length of hospital stay (standardised)	Q [76]	1.59	<1.59	1.67
Outpatient attendances	V	640,678	E.>600k	-
Outpatient 'Did not Attend' rates	Q [81]	4.4%	<5%	-
Outpatient 'Did not Attend' rates (Māori)	Q ◆	7.2%	<5%	-

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

[72] Acute demand packages of care allow people who would otherwise require a hospital admission to be treated in their own homes or community and are provided through Canterbury's Acute Demand Management Service (ADMS).

[73] This measure is the national ED health target measure and counts both Christchurch and Ashburton Hospital Emergency Departments.

[74] 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.

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

[76] 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.

[77] This measure counts both medical and surgical assessments but counts only the first assessments (where the specialist determines treatment) and not the follow-up assessments or consultations after treatment has occurred.

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

[79] This measure is a national performance measures (the electives health target). The measure was redefined in 2015/16 and now includes inpatient surgical discharges, regardless of whether the discharge is from a surgical or non-surgical speciality and both 'elective' and 'arranged' admissions. Previous year's baselines were provided by the Ministry of Health.

[80] 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 and it frees up hospital resources.

[81] The DNA rate is calculated as the proportion of all outpatient appointments where the patient was expected to attend but did not.

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 responsiveness to need.	Notes	2013/14 Result	2015/16 Target	2013/14 National Average
% of young people (0-19) accessing specialist mental health services	C Δ[82]	3.2%	>3.1%	3.4%
% 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 [83]	70%	80%	79%
% of people referred for non-urgent MH and AOD services seen within 8 weeks	T	86%	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 rate of people discharged home with support, rather than to residential care or hospital environments (where appropriate) reflects the responsiveness of services.	Notes	2013/14 Result	2015/16 Target	2013/14 National Average
Admissions into all inpatient AT&R services	V Δ	3,313	E.>3,000	-
% of admissions into OPH AT&R made by direct community referral	Q [84]	19%	20%	-
% of OPH AT&R inpatients discharged to their own home rather than into ARC	Q Δ [85]	87%	>80%	-

[82] This measure is a national performance measure (PP26) and targets 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 undercounts service provision with a number of local providers not currently set up to report to the national system.

[83] This measure is a national performance measure (PP8). Results are provided three months in arrears to March 2014.

[84] 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).

[85] 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 'needs' assessment and include: domestic support, personal care, community nursing, respite and residential care. Services are mostly for older people, mental health clients and people with complex conditions.

WHY IS THIS OUTPUT CLASS SIGNIFICANT FOR THE DHB?

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 people 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 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.

SERVICE PERFORMANCE INDICATORS (2015/16)

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	2013/14 Result	2015/16 Target	2013/14 National Average
% of people referred to an organised stroke service (with demonstrated stroke pathway) after an acute event	C	74%	80%	-
% of people accessing cardiac rehabilitation services after an acute event	C [86]	20%	30%	-
People accessing pulmonary rehabilitation courses	V [87]	230	>200	-
People (65+) accessing community-based falls prevention programmes	V	1,505	>1,200	-

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 measured against delayed entry into residential or hospital services with more people supported to live longer in their own homes.	Notes	2013/14 Result	2015/16 Target	2013/14 National Average
% of older people (65+) receiving long-term home and community support services who have had a clinical assessment using InterRAI	Q Δ [88]	91%	95%	-
People accessing CREST services on hospital discharge or GP referral	V Δ [89]	1,992	>1,500	-
People supported by long-term home-based support services	V Δ	8,796	E.<8,000	-
People supported by district nursing services	V Δ	7,645	E.>6,000	-

[86] This measure counts those enrolled in Phase 2 (outpatient) cardiac rehabilitation on discharge.

[87] This measure includes people attending all pulmonary rehabilitation (Ashburton, Christchurch, Community-based).

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

[89] 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 2013/14 baseline differs to that previous published following a review of definitions and methodology – the results measure the number of clients having received unique packages of care rather than referrals.

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	2013/14 Result	2015/16 Target	2013/14 National Average
People supported by day services	V Δ	672	E.>550	-
People accessing mental health planned and crisis respite	V Δ	819	E.>750	-
Occupancy rate of mental health planned and crisis respite beds	C Δ[90]	84%	85%	-
People supported with aged care respite services	V Δ	1,262	E.>1,000	-

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	2013/14 Result	2015/16 Target	2013/14 National Average
People supported by hospice or home-based palliative services	V Δ	3,815	E.>2,500	-

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 care is seen as indicative of more people being successfully supported to continue living in their own homes and is balanced against the level of home and community-based support.	Notes	2013/14 Result	2015/16 Target	2013/14 National Average
% of people entering ARC having had a clinical assessment using interRAI	Q Δ[88]	96%	95%	-
% of ARC residents receiving vitamin D supplements	C [91]	68%	75%	-
Subsidised ARC rest home beds provided (days)	V Δ	569,643	E.<676k	-
Subsidised ARC hospital beds provided (days)	V Δ	487,687	E.<507k	-
Subsidised ARC dementia beds provided (days)	V Δ	244,581	E.>212k	-
Subsidised ARC psycho-geriatric beds provided (days)	V Δ	72,450	E.>62k	-

[90] 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.

[91] Note that the data collection methodology for this programme is being reviewed. The DHB anticipates that the review will demonstrate an undercounting of Vitamin D supplementation and that performance is better than reported.

Meeting Our Financial Challenges

While health continues to receive a large share of national funding, clear signals have been given that Government is looking to the health sector to rethink how we will meet the needs of our populations 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 and to ensure services and service delivery models are financially sustainable.

8.1 Canterbury's financial outlook

Funding from Government, via the Ministry of Health, is the main source of DHB funding; supplemented by revenue agreements from ACC and patient co-payments.

The Canterbury DHB, like the rest of the health sector, faces significant financial pressure from rising treatment costs, wage expectations and heightened public expectations. However, unlike health providers in other regions, we are also managing the ongoing impacts of the earthquakes, increased service demand and the costs and operational challenges of a significant repair programme.

Over the past four years Canterbury has absorbed $69 million in revenue and cost impacts related to the quake, over and above the deficit funding from the Government of $84 million. This has largely been achieved by significantly reducing our dependence on aged residential care, reorganising how laboratory services are funded and provided, maintaining lower rates of acute demand, and a continued focus on removing waste and variation from our system.

However, several unknown factors relating to the impact of the earthquakes continue to create an ongoing level of financial volatility with regards to our financial outlook.

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. An accurate total overall cost is still difficult to pre-determine.

A significant level of remedial 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 are over $518 million. Our recovery programme requires ruthless prioritisation in order for it to remain affordable as we navigate the uncertainties of escalating repair costs.

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 earthquake related depreciation and as equity to offset capitalised repair costs. But equity drawdowns incur a capital charge, in addition to the operational impact of depreciation, adding additional pressure to our already tight fiscal environment.

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

The population based funding formula was never designed to deal with the dynamic population changes we are experiencing. From Canterbury's perspective, the funding formula is not proving to be flexible enough mechanism in a post-quake environment.

In line with other international recovery profiles, the post-disaster impacts on the health and well-being of our population are still being acutely felt. This is particularly evidenced by increased demand for mental health services across our health system.

Our integrated systems approach, with increased service delivery in community settings, has helped to reduce hospital demand growth and enabled Canterbury to respond to population need following the earthquake. However, normal measures of demand and service utilisation are largely hospital rather than community-based. Because demand measures are not yet comprehensive enough to reflect these changes in the model of care, they are effectively masking over-all demand from the central agencies.

While the Canterbury DHB has achieved considerable efficiencies in past years (and will continue to strive to further improve productivity), our population and health demand continues to grow.

The new Burwood Hospital (planned pre earthquake) has been delayed. We won't see the planned savings from the consolidation of services in this financial year as anticipated in the Detailed Business Case.

International disaster evidence would suggest we should expect disruption, population and subsequent financial impacts for up to a decade.

Increased costs will appear in various types of expenditure: treatment costs to meet additional demand; securing of external capacity to support service delivery through emergency repairs; and the more obvious costs of our recovery and repair work.

8.2 Achieving financial sustainability

There is no 'quick-fix' solution. To ensure our health system is both financially and clinically sustainable, we will continue to deliver our vision of an integrated system and focus on making decisions that balance what is best for the patient and for the system.

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

Doing the basics well is critical to our success:

Prioritising resources to meet demand and deliver maximum health benefits.

Integrating systems, services and process 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.

The Canterbury DHB is actively supporting the South Island Support Services Alliance to implement tighter cost controls and make purchasing and productivity improvements to limit the rate of cost growth and is taking a lead in the Procurement and Supply Chain Workstream to deliver savings for the region.

We are also committed to supporting national entity initiatives locally to achieve mutual benefits and cost savings across the sector. Our level of inclusion in 2015/16 financial projections is provided in the table at the end of this financial section.

Significant challenges to service planning continue to be experienced and the DHB will work with the Ministry of Health to address these going forward:

- More work needs to be done to support populations facing the long-term impacts of disasters, in particular children and young people.
- Standard methodologies are unable to take into account the impacts of the incoming rebuild population and results of internal and external migration.
- Measures of deprivation are proving to be insensitive and were never designed for such a dynamic environment, with no way to account for the impacts of forced migration, housing shortages and secondary stressors.
- Delays in rebuilds and new builds are creating additional financial pressures.
- Positive economic indicators such as employment and traditional measures of demand mask the development of a more vulnerable population.

8.3 Planned results

The Canterbury DHB's 2015/16 plan is based on a 1.5% increase in population based funding. Whilst this equates to an $18.8 million increase in funding, this is lower than previously anticipated and reflects the minimum percentage funding increase available to DHBs in this funding year.

In addition to this increase the DHB will be separately funded for the provision of services to the population of the Chatham Islands (which is being transferred from Hawke's Bay DHB) at an estimated cost of $4 million per annum.

Canterbury's planning was based on receiving a conservative sector average increase of around 2.5% or approximately $35 million for 2015/16 (including Chatham Islands funding). In addition to funding being lower than expected, Canterbury is also facing additional costs in meeting earthquake related service demand and interest and depreciation costs associated with the new Burwood facility and our earthquake programme of works.

Given these fiscal challenges, and initial funding advice, the Canterbury DHB was planning a $16.4 million deficit for the 2015/16 financial year. This included agreement with the Ministry of Health that the DHB would receive an additional $4 million funding for Chatham Island services, thereby making assumption of responsibility for this population fiscally neutral.

Subsequent to this planning, the Canterbury DHB was advised that it would receive an additional one-off payment of $16 million in revenue. This funding was provided in consideration of the exceptional issues faced by Canterbury and will enable the DHB to submit a break-even financial plan for the 2015/16 year, as reflected in this document.

OUT-YEARS SCENARIO

The current reality in Canterbury continues to create a high level of uncertainty and variability with regards to both revenue and expenditure in out-years. Our outlook depends on a number of assumptions and interrelated factors including: revenue volatility based on population shifts; changing health demands post-earthquake; earthquake repair cost risks; unforeseen delays in facilities redevelopment; meeting the costs of services to a rebuild population; and revenue and expenditure in assuming responsibility for the Chatham Islands.

Interest, depreciation and capital charge costs arising from the earthquake programme of works and the new Burwood and Christchurch Hospital facilities will have significant impact on our out-year financial projections. These costs will increase by approximately $34 million over the next 4 years (from $80 million per annum in 2014/15 to approximately $114 million in 2018/19).

The DHB has provided out-year results based on these assumptions and variables to provide a sense of our anticipated financial results. However, changes in the complex mix of any contributory factors will drive results that are likely to differ from those shown in our forecasts.

8.4 Assumptions

We are aware that the costs around building and infrastructure repairs and the additional costs of compliance with new building codes will be significant. However, like the wider population impacts from the earthquakes, these costs are still uncertain and difficult to ascertain.

Revenue and expenditure have been budgeted on current government policy settings and known health service initiatives and in preparing our forecasts, we have made the following assumptions:

- Population-based funding in 2015/16 will remain at the level indicated by the Ministry of Health in December 2014.
- Out-years funding is assumed at the sector average of 2.5% increase per annum.
- The DHB will retain early payment arrangements.
- 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 (during the term of this Plan). This includes assumption of responsibility for the population of the Chatham Islands.
- The balance of Canterbury's $290 million earthquake settlement proceeds (transferred to the Crown to minimise capital charge expenses and not yet fully drawn down) will be available to be drawn down as required by the DHB to fund its earthquake repair 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 respective earthquake capital and operating repair spend for the particular year.
- There will be fluctuations between budget and actual results depending on both the costs and applicable accounting treatment of repairs to buildings, infrastructure and equipment not covered by insurance recoveries. Due to the recognition of insurance proceeds in 2012/13 (as required under current NZ accounting standards) future costs are not able to be offset with the corresponding inflow of insurance proceeds, therefore creating a timing mismatch. This will continue to influence reported financial results for a number of years.
- Earthquake related repairs, as funded by insurance proceeds and internally sourced funding, will continue over several years.
- Estimates of the corresponding capital repairs and maintenance expenditure expected to take place during the term of this Plan, together with an estimate of earthquake draw-downs, have been included.
- Revaluations of land and buildings will continue and will impact on land, building and infrastructure values. In addition to regular periodic revaluations, further impairment in relation to earthquakes may be necessary. The impact of these is not yet known, and no adjustment has been made in our forecasts.
- Work will continue on the redevelopment of Canterbury DHB's facilities in accordance with the business case agreed with the Ministry of Health. Capital expenditure associated with the redevelopment that will take place during the term of this Plan has been included.
- 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.
- Transformation and earthquake recovery strategies will not be delayed due to sector or legislative changes and investment to meet increased earthquake related demand will be prioritised and approved in line with our Board's strategy.
- National and regional initiatives savings and benefits will be achieved as planned.
- 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.

8.5 Asset planning and investment

NATIONAL BUSINESS CASES

The business case for the redevelopment of Burwood and Christchurch Hospital was approved by Cabinet and the Capital Investment Committee in March 2013. Delivery against the timeframes set for design and construction is crucial in order to avoid substantial and unnecessary costs associated with short-term repair of facilities already seen as unfit for future service needs. The timelines for completion of the redevelopment of the Burwood Health Campus is now 2016 and the Acute Services Building at Christchurch Hospital is 2018.

The business case for the redevelopment of the Kaikoura Hospital site as an Integrated Family Health Centre received approval in April 2013. We expect to complete construction in February 2016.

The regional business case and Canterbury's detailed implementation business case for the replacement of the current legacy patient administration systems with the one South Island Patient Information Care System (PICS) has been approved by Cabinet. We are currently progressing with the staged implementation with Burwood hospital being the first go-live site, aligning with its new facility timeframe.

CAPITAL EXPENDITURE

Any lengthy building delays, changes in building codes or price increases for any of our major projects could have a significant impact on expenditure over the full programme of works. Subject to the appropriate approvals, Canterbury's capital expenditure budget totals $322 million for the 2015/16 year, comprised of:

- $215m new Burwood facility (cost of asset to be transferred from the Crown).
- $65m strategic earthquake programme of works (capital expenditure portion).
- $5m Kaikoura facility (balance of spend to completion).
- $9m Patient Information Care System (including $4m carried forward from 2014/15).
- $3m Electronic Medication Management.
- $25m other new/replacement assets.

ANTICIPATED ACTIVITY FOR 2015-2019 INCLUDES:

- Completion of the facilities redevelopment on the Burwood and Christchurch Hospital sites in line with the nationally approved business case.
- Completion of the Kaikoura, Rangiora and Akaroa site redevelopments in line with approvals.
- Replacement of our oldest Linear Accelerator.
- Strategic IT developments, including continued upgrade of our Patient Administration System, roll-out of the e-Medicines, HealthONE, patient portal, and the ICT Strategy moving towards digital hospital.
- Continuation of repair and re-instatement strategies under our 10 year earthquake recovery programme of work including the interim expansion of the Christchurch Hospital Intensive Care Unit, replacement of the car parking buildings, energy centre, and outpatients department.

8.6 Debt and equity

The Canterbury DHB currently has a $146.401 million total loan facility with the National Health Board, which is fully drawn down other than $0.416 million.

The DHB's total term debt is expected to rise from $145.985 million to $274.985 million as at June 2016; the increase being the estimated new loan for the new Burwood facility (assuming a 60% debt and 40% equity split for the $215 million facility cost, as indicated in the approved detailed business case).

By June 2019, the debt level is expected to be $563.585 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 assets transfer dates.

Canterbury DHB repaid equity to the Crown of $60 million in 2013/14 and another $120 million in 2014/15 as part of our $180 million contribution towards the Burwood and Christchurch Hospital site redevelopments.

Canterbury DHB also paid $290 million of our earthquake settlement proceeds in 2013/14 to the Crown as an equity repayment. As agreed with the Ministry of Health, the $290 million will be progressively drawn down to fund future earthquake repair works. $20 million was drawn down in 2013/2014 and a further $13.15 million was drawn down in 2014/15.

The extent of insured damage to Canterbury DHBs assets is well in excess of $518 million. Despite a successful negotiation, which eliminated discount factors and restrictions on use, the nature of the collective sector insurance that was in place at the time of the earthquake meant a total maximum loss capacity of $320 million.

While the entire $320 million was able to be attained by Canterbury DHB, the total cost of the earthquake programme of works will need to be met from within our existing funds. The inherent shortfall between insurance proceeds and cost of repairs and reinstatement means the Crown contribution for the Burwood and Christchurch Hospital redevelopment programme will need to remain as set out in the detailed business case and the DHB will need to access the $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. While the development of the Central Business District Plan and CERA Recovery Strategy may have an impact on decisions that can be taken in regard to land and facilities, our normal policy is that we will not dispose of any estate or interest in any land without having first obtained the consent of the responsible Minister and completed the required public consultation.

ANTICIPATED ACTIVITY FOR 2015-2019 INCLUDES:

- Sale of a residential house property in Amuri Avenue, Hamner Springs. This property was approved for disposal by the former Minister of Health but not purchased by the Crown as part of a larger holding.
- Sale of a 40m strip of land at Ellesmere Hospital Site to the Selwyn District Council for flood planning.
- Sale of the former Akaroa Hospital site to enable the development of the Akaroa Integrated Family Health Centre.

The DHB is considering the future of the former Women's Hospital site and Princess Margaret Hospital (following the completion of the Acute Services Building) and is likely to declare intent with regards to these sites in the next year.

The DHB is also in discussions with CERA and the Christchurch City Council regarding a number of sites in the area of the Metro Sports Facility and the Health Hub Anchor site.

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

ACCOUNTING POLICIES

The accounting policies adopted are consistent with those in the prior year. For a full statement of accounting policies, refer to Appendix 10.9 (need to check this reference is correct).

COMMITMENT TO NATIONAL INITIATIVES

2014/15 (in $'000s)	CAPITAL COSTS	OPERATING COSTS		OPERATING BENEFITS	NET OPERATING
		ONE-OFF	ONGOING		
NHITB - eMedicines Reconciliation (eMR) with eDischarge Summary	-	-	(70)	-	(70)
NHITB - Regional Clinical Workstation (CWS) and Clinical Data Repository (CDR)	-	-	-	-	-
NHITB - Replacement of legacy Patient Administration Systems	(5,257)	(1,091)	(432)	212	(1,311)
NHITB - National Patient Flow	-	(195)	-	-	-
NHITB - MoH contribution to National Patient Flow	-	(195)	-	-	(195)
NHITB - Provider & Patient Portal	-	-	-	-	-
Warehouse	-	-	(27)	-	(27)
HQSC - SSIP DHB Infections Management systems (ICNet NG system)	-	-	-	-	-
HQSC - Patient experience indicators	-	-	(4)	-	(4)
HBL (Health Benefits Ltd)					
Core Funding	-	-	(667)	-	(667)
FPSC Integrator	-	-	(41)	-	(41)
NIP Integrator	-	-	(115)	-	(115)
FPSC (existing oracle licenses)	-	-	(22)	-	(222)
FPSC (gap funding)	-	-	(344)	-	(344)
FPSC (technology)	-	-	-	-	-
FPSC (investment)	-	-	(105)	-	(105)
FPSC (hA costs)	-	-	(1,187)	-	(1,187)
FPSC (benefits)	-	-	-	3,346	3,346
Food	-	-	(63)	-	(63)
Linen & Laundry	-	-	(87)	-	(87)
National Infrastructure Platform	-	-	-	-	-
IT Procurement	-	-	-	-	-
Human Resource Management Information System	-	-	-	-	-
Banking and insurance	-	-	(16)	-	(16)
Human Resource Management Information System	-	-	(16)	-	(16)
TOTAL	(5,257)	(1,481)	(3,397)	3558	(1,319)

Statement of Financial Expectations

Where will our funding go?

9.1 Group statement of comprehensive revenue and expense

FOR THE YEARS ENDING 2013/14 - 2018/19 *in thousands of New Zealand dollars*	2013/14 **Actual**	2014/15 **Forecast**	2015/16 Plan	2016/17 Plan	2017/18 Plan	2018/19 Plan
REVENUE						
Patient care revenue	1,465,170	1,511,274	1,540,961	1,579,948	1,619,912	1,660,873
Other revenue	32,349	31,552	35,637	34,812	36,461	38,439
Earthquake repair revenue redrawn	-	13,100	21,000	18,000	15,000	14,000
Interest revenue	15,795	5,263	2,800	3,116	3,744	4,615
Total revenue	1,513,314	1,561,189	1,600,398	1,635,876	1,675,117	1,717,927
EXPENSE						
Employee benefit costs	637,283	660,528	678,558	694,754	713,412	731,703
Treatment related costs	133,379	144,870	148,361	150,402	153,389	157,179
External service providers	584,312	585,093	597,400	603,973	611,223	618,558
Other expenses	98,385	95,647	95,986	93,718	93,431	93,674
Earthquake building repair costs	-	13,100	21,000	18,000	15,000	14,000
Depreciation and amortisation	58,423	61,199	61,224	69,679	71,883	76,299
Finance costs	5,454	5,886	6,612	10,642	11,412	15,540
Capital charge expense	18,990	12,845	7,633	18,375	20,788	21,833
Total operating expenses	1,536,226	1,579,168	1,616,774	1,659,543	1,690,538	1,728,786
Surplus/(Deficit) before deficit funding	-	(17,979)	-	(23,667)	(15,421)	(10,859)
Deficit funding revenue	22,912	-	16,376	-	-	-
Surplus/(Deficit) after deficit funding	-	(17,979)	-	(23,667)	(15,421)	(10,859)
Other comprehensive income	(383)	-	-	-	-	-
Total comprehensive revenue and expense	**(383)**	**(17,979)**	**-**	**(23,667)**	**(15,421)**	**(10,859)**

9.2 Group statement of financial position

FOR THE YEARS ENDING 2013/14 - 2018/19 *in thousands of New Zealand dollars*	30/06/14 **Actual**	30/06/15 **Forecast**	30/06/16 Plan	30/06/17 Plan	30/06/18 Plan	30/06/19 Plan
CROWN EQUITY						
Contributed capital	(204,429)	(313,790)	(167,651)	(110,845)	(82,285)	129,113
Revaluation reserve	199,158	199,158	199,158	199,158	199,158	199,158
Accumulated surpluses	209,644	191,665	191,665	167,998	152,577	141,718
Total equity	204,373	77,033	223,172	256,311	269,450	469,989
REPRESENTED BY:						
CURRENT ASSETS						
Cash & cash equivalents	90,044	3,038	23,133	9,786	35,010	84,307
Trade & other receivables	75,171	75,185	62,685	86,352	78,106	73,544
Inventories	9,128	8,593	8,593	8,593	8,593	8,593
Restricted assets	10,674	13,228	13,228	13,228	13,228	13,228
Investments	3,064	788	788	788	788	788
Total current assets	188,081	100,832	108,427	118,747	135,725	180,460
CURRENT LIABILITIES						
HBL sweep bank account	-	9,278	-	-	-	-
Trade & other payables	113,017	101,346	104,346	104,346	104,346	104,346
Employee benefits	158,012	161,782	161,782	161,782	161,782	161,782
Restricted funds	13,760	14,008	14,008	14,008	14,008	14,008
Borrowings	15,000	-	-	-	-	-
Total current liabilities	299,789	286,414	280,136	280,136	280,136	280,136
Net working capital	(111,708)	(185,582)	(171,709)	(161,389)	(144,411)	(99,676)
NON-CURRENT ASSETS						
Investments	34,650	-	-	-	-	-
Property, plant, & equipment	406,667	402,649	650,618	665,493	658,887	1,103,442
Intangible assets	9,784	12,283	25,580	33,524	36,291	36,140
Restricted assets	3,086	780	780	780	780	780
Total non-current assets	454,187	415,712	676,978	699,797	695,958	1,140,362
NON-CURRENT LIABILITIES						
Employee benefits	7,121	7,112	7,112	7,112	7,112	7,112
Borrowings	130,985	145,985	274,985	274,985	274,985	563,585
Total non-current liabilities	138,106	153,097	282,097	282,097	282,097	570,697
Net assets	**204,373**	**77,033**	**223,172**	**256,311**	**269,450**	**469,989**

9.3 Group statement of movements in equity

FOR THE YEARS ENDING 2013/14 - 2018/19 *in thousands of New Zealand dollars*	2013/14 **Actual**	2014/15 **Forecast**	2015/16 Plan	2016/17 Plan	2017/18 Plan	2018/19 Plan
Total equity at beginning of the year	536,617	204,373	77,033	223,172	256,311	269,450
Total comprehensive revenue and expense for the year	(383)	(17,979)	-	(23,667)	(15,421)	(10,859)
OTHER MOVEMENTS:						
Equity repayments						
Earthquake insurance remitted to the Crown	(290,000)	-	-	-	-	-
Contribution towards new facilities redevelopment	(60,000)	(120,000)	-	-	-	-
Annual depreciation funding repayment	(1,861)	(1,861)	(1,861)	(1,861)	(1,861)	(1,861)
Equity injections						
Earthquake repair capital redrawn	20,000	-	62,000	35,000	15,000	10,000
Operating deficit support	-	12,500	-	23,667	15,421	10,859
New facilities redevelopment assets transferred from the Crown (equity value)	-	-	86,000	-	-	192,400
Total equity at end of the period	**204,373**	**77,033**	**223,172**	**256,311**	**269,450**	**469,989**

9.4 Group statement of cash flow

FOR THE YEARS ENDING 2013/14 - 2018/19 *in thousands of New Zealand dollars*	2013/14 **Actual**	2014/15 **Forecast**	2015/16 Plan	2016/17 Plan	2017/18 Plan	2018/19 Plan
CASH FLOW FROM **OPERATING** ACTIVITIES						
CASH WAS PROVIDED FROM:						
Receipts from Ministry of Health	1,447,684	1,469,518	1,510,421	1,531,394	1,569,678	1,608,918
Earthquake repair revenue redrawn	-	13,100	21,000	18,000	15,000	14,000
Other receipts	75,268	106,457	82,553	83,366	86,695	90,394
Interest received	15,795	5,263	2,800	3,116	3,744	4,615
	1,538,747	1,594,338	1,616,774	1,635,876	1,675,117	1,717,927
CASH APPLIED TO:						
Payments to employees	643,409	656,758	678,558	694,754	713,412	731,703
Payments to suppliers	821,550	863,658	859,747	866,093	873,043	883,411
Interest paid	5,439	5,886	6,612	10,642	11,412	15,540
Capital charge	18,990	12,845	7,633	18,375	20,788	21,833
GST - net	4,059	5,138	-	-	-	-
Net cash flow from operating activities	**45,300**	**50,053**	**64,224**	**46,012**	**56,462**	**65,440**
CASH FLOW FROM **INVESTING** ACTIVITIES						
CASH PROVIDED FROM:						
Sale of property, plant, & equipment	55	10	-	-	-	-
Earthquake insurance proceeds	295,250	-	-	-	-	-
Receipt from investments and restricted assets	24,104	35,018	-	-	-	-
	319,409	35,028	-	-	-	-
CASH APPLIED TO:						
Purchase of investments & restricted assets	4,484	-	-	-	-	-
Purchase of property, plant, & equipment	41,694	59,504	322,490	92,498	68,044	520,703
	46,178	59,504	322,490	92,498	68,044	520,703
Net cash flow from investing activities	**273,231**	**(24,476)**	**(322,490)**	**(92,498)**	**(68,044)**	**(520,703)**
CASH FLOW FROM **FINANCING** ACTIVITIES						
CASH PROVIDED FROM:						
Loans raised	16,335	-	129,000	-	-	288,600
Equity injections						
Earthquake repair capital redrawn	20,000	-	62,000	35,000	15,000	10,000
Operating deficit support	-	-	12,500	-	23,667	15,421
New facilities redevelopment assets transferred from the Crown(equity value)	-	-	86,000	-	-	192,400
	36,335	-	289,500	35,000	38,667	506,421
CASH APPLIED TO:						
Repayments of capital to the crown						
Earthquake insurance remitted to the Crown	290,000	-	-	-	-	-
Contribution to new facilities redevelopment	60,000	120,000	-	-	-	-
Annual depreciation funding repayment	1,861	1,861	1,861	1,861	1,861	1,861
	351,861	121,861	1,861	1,861	1,861	1,861
Net cash flow from financing activities	(315,526)	(121,861)	287,639	33,139	36,806	504,560
Net increase/(decrease) in cash and cash equivalents	3,005	(96,284)	29,373	(13,347)	25,224	49,297
Cash and cash equivalents at beginning of year	87,039	90,044	(6,240)	23,133	9,786	35,010
Cash and cash equivalents at end of year	**90,044**	**(6,240)**	**23,133**	**9,786**	**35,010**	**84,307**

9.5 Summary of revenue and expenses by arm

FOR THE YEARS ENDING 2013/14 - 2018/19 *in thousands of New Zealand dollars*	2013/14 **Actual**	2014/15 **Forecast**	2015/16 Plan	2016/17 Plan	2017/18 Plan	2018/19 Plan
FUNDING ARM						
REVENUE						
Patient care revenue	1,373,687	1,412,175	1,439,797	1,475,790	1,512,684	1,550,500
Other revenue	-	250	-	-	-	-
Total Revenue	1,373,687	1,412,425	1,439,797	1,475,790	1,512,684	1,550,500
EXPENSES						
Personal Health	980,975	1,020,351	1,048,741	1,076,842	1,106,198	1,132,782
Mental Health	142,536	144,415	145,040	149,063	153,257	157,044
Disability Support	237,808	242,490	242,814	246,758	250,986	255,023
Public Health	2,318	2,484	3,212	3,247	3,285	3,323
Māori Health	1,910	2,041	1,936	1,959	1,983	2,007
Total expenditure	1,365,547	1,411,781	1,441,743	1,477,869	1,515,709	1,550,179
Surplus/(Deficit) before deficit funding	8,140	644	(1,946)	(2,079)	(3,025)	321
Deficit funding revenue	22,912	-	16,376	-	-	-
Surplus/(Deficit) after deficit funding	31,052	644	14,430	(2,079)	(3,025)	321
Other comprehensive revenue and expense	-	-	-	-	-	-
Total comprehensive revenue & expense	**31,052**	**644**	**14,430**	**(2,079)**	**(3,025)**	**321**
GOVERNANCE & FUNDER ADMIN						
REVENUE						
Patient care revenue	1,682	2,033	2,412	2,472	2,534	2,597
Other revenue	191	312	216	221	227	233
Total Revenue	1,873	2,345	2,628	2,693	2,761	2,830
EXPENSE						
Employee benefit costs	7,315	7,136	7,243	7,388	7,532	7,678
Treatment related costs	748	211	120	122	124	126
Other expenses	(6,211)	(5,034)	(4,772)	(4,854)	(4,932)	(5,011)
Depreciation and amortisation	21	32	37	37	37	37
Interest expenses on loans	-	-	-	-	-	-
Capital charge expense	-	-	-	-	-	-
Total Operating Expenses	1,873	2,345	2,628	2,693	2,761	2,830
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

FOR THE YEARS ENDING 2013/14 - 2018/19 *in thousands of New Zealand dollars*	2013/14 **Actual**	2014/15 **Forecast**	2015/16 Plan	2016/17 Plan	2017/18 Plan	2018/19 Plan
PROVIDER ARM						
REVENUE						
Patient care revenue	871,036	923,754	943,095	975,582	1,009,180	1,039,397
Other revenue	32,158	30,990	35,421	34,591	36,234	38,206
Earthquake repair revenue redrawn	-	13,100	21,000	18,000	15,000	14,000
Interest revenue	15,795	5,263	2,800	3,116	3,744	4,615
Total Revenue	918,989	973,107	1,002,316	1,031,289	1,064,158	1,096,218
EXPENSE						
Employee benefit costs	629,968	653,392	671,315	687,366	705,880	724,025
Treatment related costs	132,631	144,659	148,241	150,280	153,265	157,053
Earthquake building repair costs	-	13,100	21,000	18,000	15,000	14,000
Other expenses	104,596	100,681	100,758	98,572	98,363	98,685
Depreciation and amortisation	58,402	61,167	61,187	69,642	71,846	76,262
Interest expenses on loans	5,454	5,886	6,612	10,642	11,412	15,540
Capital charge expense	18,990	12,845	7,633	18,375	20,788	21,833
Total Operating Expenses	950,041	991,730	1,016,746	1,052,877	1,076,554	1,107,398
Surplus/(Deficit) before deficit funding	(31,052)	(18,623)	(14,430)	(21,588)	(12,396)	(11,180)
Deficit funding revenue	-	-	-	-	-	-
Surplus/(Deficit) after deficit funding	(31,052)	(18,623)	(14,430)	(21,588)	(12,396)	(11,180)
Other comprehensive revenue and expense	(383)	-	-	-	-	-
Total comprehensive revenue & expense	(31,435)	(18,623)	(14,430)	(21,588)	(12,396)	(11,180)
IN-HOUSE ELIMINATION						
REVENUE						
Patient care revenue	(781,235)	(826,688)	(844,343)	(873,896)	(904,486)	(931,621)
Total Revenue	(781,235)	(826,688)	(844,343)	(873,896)	(904,486)	(931,621)
EXPENSE						
Other expenses	(781,235)	(826,688)	(844,343)	(873,896)	(904,486)	(931,621)
Total Operating Expenses	(781,235)	(826,688)	(844,343)	(873,896)	(904,486)	(931,621)
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

FOR THE YEARS ENDING 2013/14 - 2018/19 *in thousands of New Zealand dollars*	2013/14 **Actual**	2014/15 **Forecast**	2015/16 Plan	2016/17 Plan	2017/18 Plan	2018/19 Plan
CONSOLIDATED						
INCOME						
Patient care revenue	1,465,170	1,511,274	1,540,961	1,579,948	1,619,912	1,660,873
Other revenue	32,349	31,552	35,637	34,812	36,461	38,439
Earthquake repair revenue redrawn	-	13,100	21,000	18,000	15,000	14,000
Interest revenue	15,795	5,263	2,800	3,116	3,744	4,615
Total Revenue	1,513,314	1,561,189	1,600,398	1,635,876	1,675,117	1,717,927
EXPENSE						
Employee benefit costs	637,283	660,528	678,558	694,754	713,412	731,703
Treatment related costs	133,379	144,870	148,361	150,402	153,389	157,179
External service providers	584,312	585,093	597,400	603,973	611,223	618,558
Other expenses	-	13,100	21,000	18,000	15,000	14,000
Earthquake building repair costs	98,385	95,647	95,986	93,718	93,431	93,674
Depreciation and amortisation	58,423	61,199	61,224	69,679	71,883	76,299
Finance costs	5,454	5,886	6,612	10,642	11,412	15,540
Capital charge expense	18,990	12,845	7,633	18,375	20,788	21,833
Total operating expenses	1,536,226	1,579,168	1,616,774	1,659,543	1,690,538	1,728,786
Surplus/(Deficit) before deficit funding	(22,912)	(17,979)	(16,376)	(23,667)	(15,421)	(10,859)
Deficit funding revenue	22,912	-	16,376	-	-	-
Surplus/(Deficit) after deficit funding	-	(17,979)	-	(23,667)	(15,421)	(10,859)
Other comprehensive revenue and expense	(383)	-	-	-	-	-
Total comprehensive revenue & expense	(383)	(17,979)	-	(23,667)	(15,421)	(10,859)

Part IV

Further Information for the Reader

Appendices

Appendix 10.1	Glossary of Terms
Appendix 10.2	Objectives of a DHB: New Zealand Public Health and Disability Act (2000)
Appendix 10.3	Organisational Chart and System Governance Structure
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Appendix 10.5	Canterbury Clinical Network Alliance Structure
Appendix 10.6	Minister's Letter of Expectations
Appendix 10.7	Canterbury's Commitment to National Health Targets
Appendix 10.8	DHB Performance Monitoring Framework
Appendix 10.9	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 Ministry of Health or National Health Board documents referenced in this document are available either on the Ministry's website (www.health.govt.nz) or the National Health Board's website (www.nationalhealthboard.govt.nz).

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

Appendix 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 Agent	A Crown entity that must give effect to government policy when directed by the responsible Minister.
	Crown Entity	A generic term for a diverse range of entities referred to in the Crown Entities Act 2004. Crown Entities are legally separate from the Crown and operate at arm's length from the responsible or shareholding Minister, but are included in the annual financial statements of the Government.
CFA	Crown Funding Agreement	An agreement by the Crown to provide funding in return for the provision of, or arranging the provision of, specified services.
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.
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 and 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	An action or activity intended to enhance outcomes or otherwise benefit an agency or group.
	Intervention logic model	A framework for describing the relationships between resources, activities and results, which provides a common approach for planning, implementation and evaluation. Intervention logic focuses on being accountable for what matters: impacts and outcomes.
IPIF	Integrated Performance and Incentive Framework	IPIF has been established to support the health system to address equity, safety, quality, access and cost of services. It is a quality and performance improvement programme that will reward good performance and will be developed and implemented over several years.
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. A person's NHI number is stored on the NHI along with their demographic details. The NHI is used to help with the planning, coordination and provision of health and disability services across NZ.
NGO	Non-Government Organisations	In the context of the relationship between Health and Disability NGOs and the Canterbury DHB, NGOs include independent community and iwi/Māori organisations operating on a not-for-profit basis, which bring a value to society that is distinct from both government and the market.
OPF	Operational Policy Framework	An annual document endorsed by the Minister of Health that sets out the operational-level accountabilities 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.

Appendix 10.2

Objectives of a DHB: New Zealand Public Health and Disability Act (2000)

PART 3: SECTION 22:

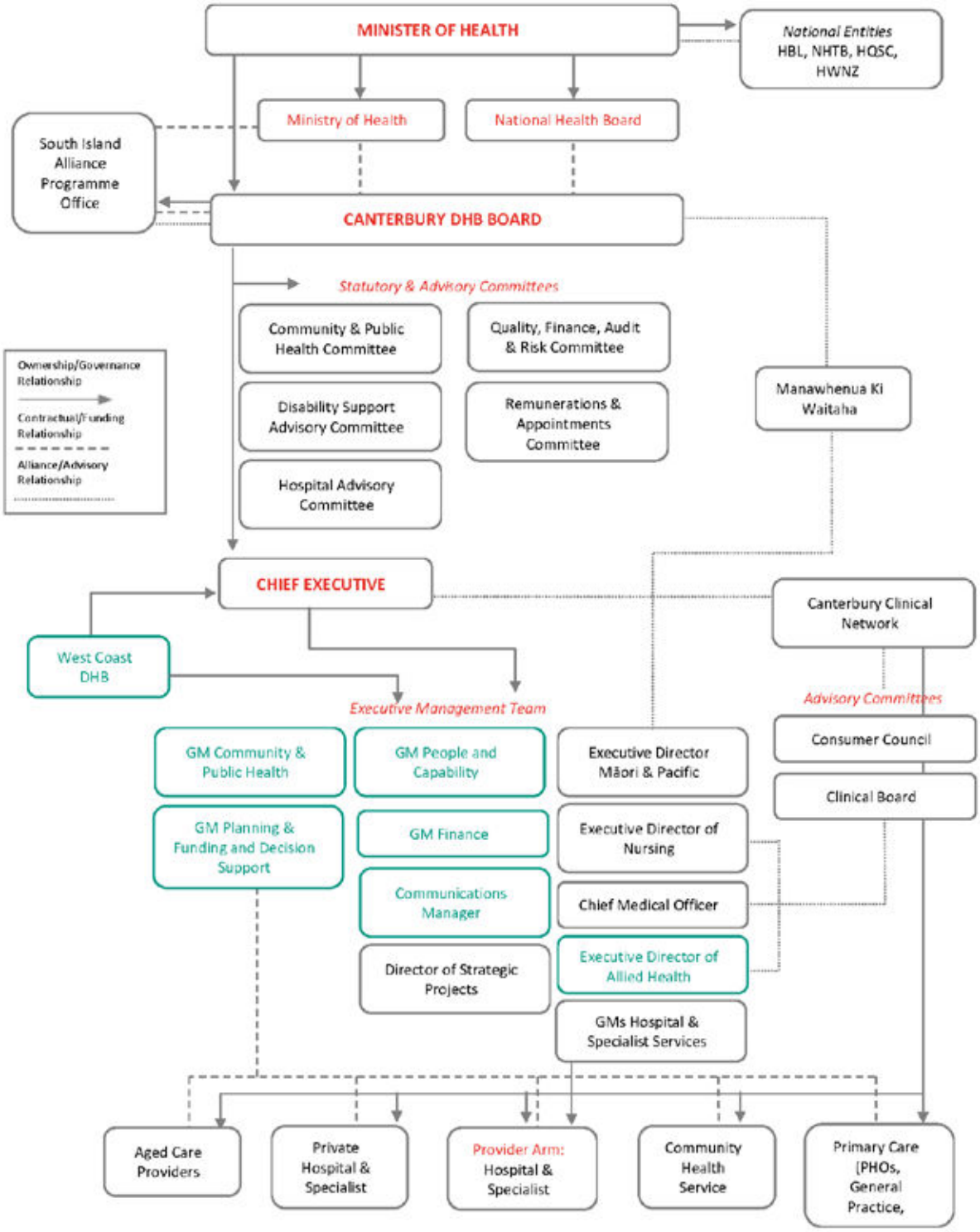
The New Zealand Public Health and Disability Act outlines the following objectives for DHBs:

To reduce health disparities by improving health outcomes for Māori and other population groups;

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

Appendix 10.3

Organisational Chart and System Governance Structure



Appendix 10.4

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

Cover a wide range of services provided in rural areas, generally based out of Ashburton Hospital, but also covering services provided by the smaller rural hospitals of Akaroa, Darfield, Ellesmere, Kaikoura, Oxford and Waikari. Services include: general medicine and surgery; palliative care; maternity services; gynaecology services; assessment, treatment and rehabilitation services for the elderly; and long-term care for the elderly, including specialised dementia care, diagnostic services and meals on wheels. Also offered in Ashburton are rural community services: day care, district nursing, home support and clinical nurse specialist outreach services, including respiratory, cardiac, diabetes, wound care, urology, continence and stoma therapy. Within Ashburton, the division also operates Tuarangi Home, which provides hospital-level care for the elderly in Ashburton and 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.

Appendix 10.5

Canterbury Clinical Network Alliance Structure

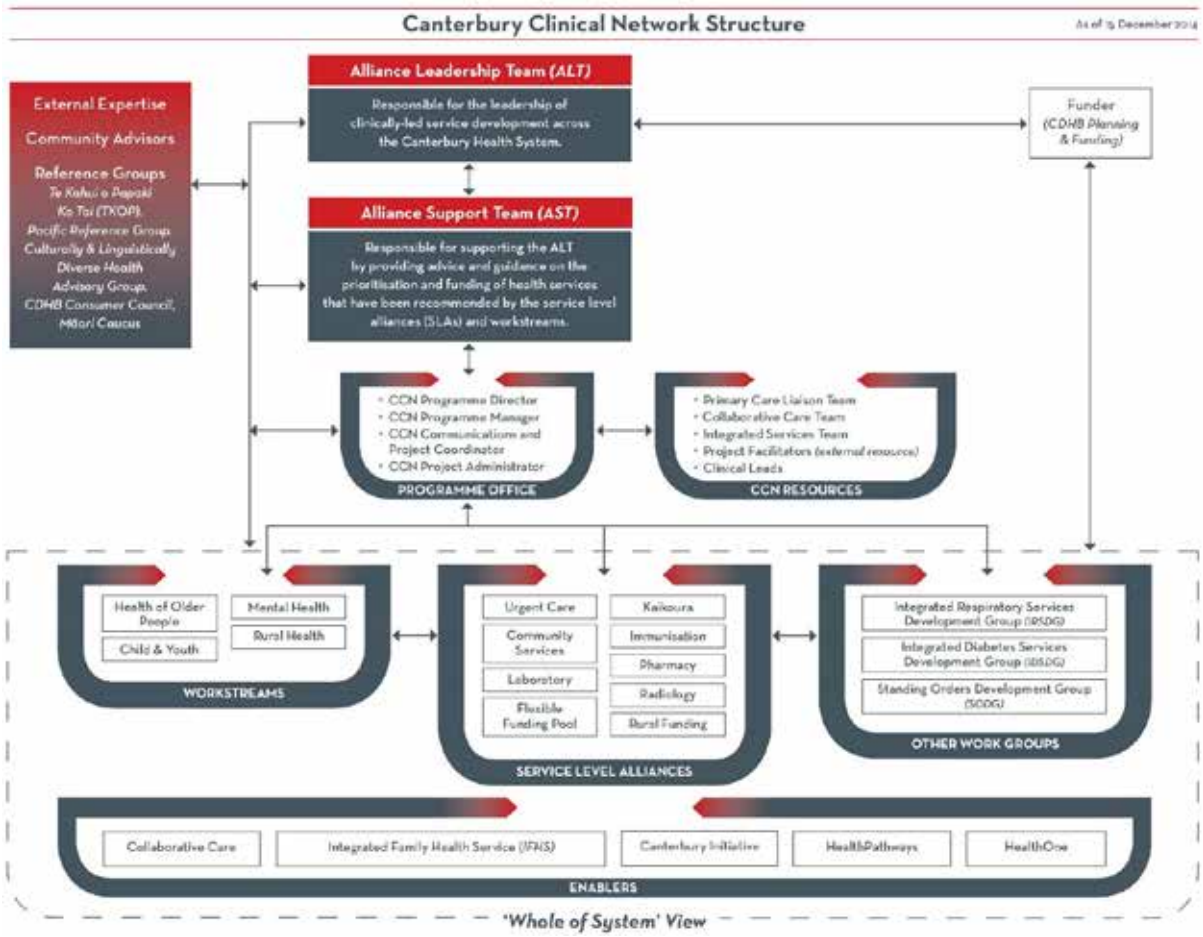
The Canterbury Clinical Network (CCN) is a collective alliance of healthcare leaders, professionals and providers from across the Canterbury health system (including the DHB and eight other partner organisations). The Alliance is the vehicle through which we provide leadership and oversight to deliver the transformation of the Canterbury health system in collaboration with system partners and on behalf of the Canterbury population.

Our collective aims under the Alliance are to improve health outcomes for our populations through:

- Transforming healthcare services by supporting clinical decision making and the shifting of activities closer to patients
- Providing leadership within the health community
- Assessing the needs of our populations
- Planning health services in our district to make the best use of health resources
- Balancing a focus on the highest priority needs areas in our communities, while ensuring appropriate care across all of our populations.

Our CCN is the broadest health alliance in New Zealand with nine partner organisations and, since being established in 2009, has pioneered the health alliancing approach in New Zealand. With all alliance partners making a commitment to a whole of system approach numerous innovation and advances have been made possible —particularly at the interface between community, primary and secondary sectors. Clinical leadership is an integral part of our alliance model. It is recognised that clinicians are in the best position to make decisions about service redesign and system improvements and clinical leads play an important leadership role across all of the CCN Workstreams, Service Level Alliances and Working Groups helping to ensure sustainable and meaningful change across our system.

Because the CCN is an alliance of organisations from across the Canterbury health system, the CCN has only a few 'employees', drawing instead from resources and expertise across the health system.



Appendix 10.6

Minister's Letter of Expectations

Office of Hon Dr Jonathan Coleman

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

17 DEC 2014

CORPORATE OFFICE
22 DEC 2014

Mr Murray Cleverley
Chair
Canterbury DHB
PO Box 1600
CHRISTCHURCH 8140

Dear Chair Murray

Letter of expectations for DHBs and subsidiary entities 2015/16

Thank you for the continued contribution you and your staff are making to a better public health service. It is important that we drive a team approach across the system.

While recognising these are tight economic times, the Government is committed to improving the health of New Zealanders and will continue to invest in key health services. Investment in our public health services has risen from a budget of $11.8 billion in 2008/09 to $15.6 billion in 2014/15. Health is the only portfolio with this sort of increase, which demonstrates the Government's on-going commitment to protecting and growing our public health services.

Fiscal Discipline/Management of the Health Portfolio

As I have discussed with you previously, DHBs need to budget and operate within allocated funding and must have detailed plans to improve year-on-year financial performance. This includes seeking efficiency gains and improvements in purchasing, productivity and quality aspects of DHBs' operation and service delivery. You and your Board must monitor and hold your Chief Executive accountable against these expectations as keeping to budget allows investment into new and more health initiatives.

Improvements through national, regional and sub-regional initiatives must continue to be a key focus for all DHBs. I recognise that DHBs want to have a greater role in the process of making back office savings to reinvest into frontline services, and want greater control of the implementation phase of the four health shared service business cases. It is essential that these business cases are implemented swiftly and savings achieved. The current transition process in place to shift responsibility for implementation of the business cases takes these considerations on board.

Leadership

Strong clinical leadership and engagement should be embedded in DHBs and utilised in all aspects of DHBs' core business eg budgeting and service design. Clinically driven service changes are encouraged where these make sense for patients and encourage positive

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system changes. DHBs are expected to include clear detail in their annual plans for 2015/16 that shows how they will foster clinical leadership.

DHB governance, senior management and clinical leaders need to work together in order to ensure we are heading in the same direction. As agents of the Crown you and your Board must assure yourselves that you have in place the appropriate clinical and executive leadership to deliver on the Government's objectives. I expect you to spend time talking with clinical leaders and fostering, encouraging and supporting clinically-led decision making.

Integration between Primary and Secondary Care

Integrating primary care with other parts of the health service is vital for better management of long-term conditions, mental health, an aging population and patients in general. The pathways to achieve better co-ordinated health and social services need to be developed and supported by clinical leaders in both community and hospital settings. I expect DHBs to move services closer to home in 2015/16, and DHBs need to have clear evidence of how they plan to do this. The key to better health, as well as financial sustainability, is earlier intervention and population-based initiatives delivered in the community.

National Health Targets

The national health targets are very important for driving overall hospital performance, and have resulted in major improvements in the health outcomes of New Zealanders. Health target performance continues to improve, but DHBs must remain focussed on achieving and improving performance against the targets, particularly the primary care targets, which are still some way from being achieved. I expect DHBs to work directly with primary health organisations and individual practices to drive performance against the primary care targets, and to provide clear and specific plans for achieving all national health targets in their annual plans.

As you are aware, from quarter two of 2014/15, the 62 day Faster Cancer Treatment indicator has become the cancer health target with a target achievement level of 85 percent by July 2016 and then increasing to 90 percent by July 2017. The addition of this indicator ensures continued focus on improving cancer services.

Targets will continue to evolve over time, reflecting a range of dynamic factors. Any changes to current targets for 2015/16 are expected to be known early next year, and may entail adjustments to the electives, more heart and diabetes checks and better help for smokers to quit targets.

I also expect to see elective surgery access further boosted by [$50 million of] new funding to target more orthopaedic and general surgery, and the development of community-based intervention teams to treat musculoskeletal pain non-surgically.

Clinicians should focus on implementation of the agreed clinical prioritisation tools to support appropriate access for patients.

Tackling Key Drivers of Morbidity

As Minister of Sport and Recreation as well as Minister of Health, I am looking to strengthen the link between physical activity and keeping New Zealanders healthy. Obesity is a major risk factor for diabetes and other chronic conditions, which are key drivers of morbidity. We are currently doing a stocktake of 'what works' to reduce obesity, but in the meantime I expect all DHBs to be considering what they can do to help reduce the incidence of obesity in New Zealand.

A key Government priority is reducing the number of children living in material hardship. DHBs are already working closely with other social sector organisations to achieve sector goals in relation to the Government's Better Public Services initiatives and other cross-agency initiatives, such as Whānau Ora, Social Sector Trials, Children's Action Plan and Youth Mental Health. I expect district health boards to support cross-agency work that delivers outcomes for children across a range of dimensions – health, education, social and justice.

Refreshed New Zealand Health Strategy

At my request, the Ministry of Health is planning to update and refresh the New Zealand Health Strategy. Once this process is completed, the Strategy will provide DHBs and the wider sector with a clear strategic direction and road map for delivery of health services to New Zealanders into the future. I expect DHBs to take an active part in the consultation for the refresh of the Strategy.

Additionally, a renewed focus on strategic direction should be evident in DHB annual plans for 2015/16. Therefore, all DHBs must refresh their statements of intent in 2015/16 and build these in to their annual plans. I also encourage you to take a strong interest in the Ministry of Health's four-year plan when it is available, as it will provide further clarity on how the sector is expected to manage its resources and prioritise activities over the next four years.

Finally, please keep in mind that the Budget 2015 process will clarify these and other Government priorities, and more information will be provided when available. Please share this letter with your clinical leaders and local primary care networks.

I thank you for the considerable effort you and your team are making, and I look forward to working with you in the future.

Yours sincerely

Hon Dr Jonathan Coleman
Minister of Health

Appendix 10.7

Canterbury's Commitment to the National Health Targets

SHORTER STAYS IN EMERGENCY DEPARTMENTS

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

Target: 95% of people presenting at ED will be admitted, discharged or transferred within six hours.

Canterbury contribution – see section 6.7

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 4000 per year.

Target: 20,474 elective surgical discharges will be delivered in 2015/16

Canterbury contribution – see section 6.18

FASTER CANCER TREATMENT

Expectation: 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 July 2016

Target: 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.

Canterbury contribution – see section 6.20

INCREASED IMMUNISATION

Expectation: 95% of all eight-month-olds are fully vaccinated against vaccine preventable diseases.

Target: 95% of all eight-month-olds will be fully vaccinated.

Canterbury contribution – see section 6.11

BETTER HELP FOR SMOKERS TO QUIT

Expectation: 90% of smokers seen in primary care, 95% of hospitalised smokers and 90% of women at confirmation of pregnancy with general practice or a Lead Maternity Carer (LMC) are offered brief advice and support to quit smoking.

Target: 90% of smokers seen in primary care, 95% hospitalised smokers , and 90% of pregnant smokers are offered advice and help to quit smoking.

Canterbury contribution – see section 6.4

MORE HEART AND DIABETES CHECKS

Expectation: 90% of the eligible population have their cardiovascular risk assessed once every five years.

Target: 90% of the eligible population will have had CVD risk assessment within the past five years.

Canterbury contribution – see section 6.5

Appendix 10.8

DHB Performance Monitoring Framework

PERFORMANCE MEASURE	PERFORMANCE EXPECTATION		CANTERBURY TARGET	NATIONAL TARGET	REPORTING FREQUENCY
PP6 Improving the health status of people with severe mental illness through improved access.	% of the population accessing specialist mental health services.	Age 0-19	>3.1%	3%	Quarterly
		Age 20-64	>3.1%		
		Age 65+	>3.0%		
PP7 Improving mental health services using transition (discharge) planning and employment.	% of clients discharged with a transition (discharge) plan.	Child & Youth	95%	95%	Quarterly
	Employment status of clients.	Long term Client 20+	Report as specified		
PP8 Shorter waits for non-urgent mental health and addiction services for 0-19 year olds.	% of young people (0-19) referred for non-urgent mental health services seen within 3 weeks and within 8 weeks.	3wks	80%	80%	Quarterly
		8wks	95%	95%	
	% of young people (0-19) referred for non-urgent addictions services seen within 3 weeks and within 8 weeks.	3wks	80%	80%	Quarterly
		8wks	95%	95%	
PP10 Oral Health DMFT Score at Year 8.	DMFT score at Year 8.	2015	0.82	82%	Annual
		2016	0.82	80%	
PP11 Children caries-free at age 5 years.	% caries-free at age 5.	2015	65%	65%	Annual
		2016	65%	66%	
PP12 Utilisation of DHB-funded dental services by adolescents.	School Year 9 up to and including age 17 years.	2015	85%	85%	Annual
		2016	85%	85%	
PP13 Improving the number of children enrolled in DHB-funded dental services.	% of children (age 0-4) enrolled.	2015	85%	85%	Annual
		2016	95%	95%	
	% of children (0-12) not examined according to planned recall.	2015	<10%	<10%	
		2016	<10%		
PP20 Improved management of LTC					
Focus area 1: Long term conditions.	Report on delivery of the actions and milestone in the Annual Plan, six monthly teleconference and quarter four report against HQS Atlas diabetes measures.				Quarterly
Focus area 2: Diabetes Care Improvement Packages and Diabetes Management (HbA1c).	% of enrolled people aged 15-74 with acceptable glycaemic control (HbA1c ≤64mmol/mol).		Improve or, where high, maintain percentages.		
	Narrative quarterly report on DHB progress towards meeting its deliverables for Diabetes Care Improvement Packages (DCIP) identified in the 2015/16 annual plans				
Focus area 3: Acute Coronary Syndrome.	% of high-risk patients receiving an angiogram within 3 days of admission (where the day of admission is day 0).		70%	70%	
	% of patients presenting with ACS who undergo angiography and have completion of registry data collection within 30 days.		≥95%	≥95%	
	% of patients undergoing cardiac surgery at the five regional cardiac surgery centres will have completion of Cardiac Surgery registry data collection with 30 days of discharge.		>95%	>95%	
	Report on delivery of the actions and milestones identified in the Annual Plan, including actions and progress in quality improvement initiatives to support the improvement of ACS indicators as reported in ANZACS-QI.				

PERFORMANCE MEASURE	PERFORMANCE EXPECTATION		CANTERBURY TARGET	NATIONAL TARGET	REPORTING FREQUENCY
Focus area 4: Stroke services.	% of potentially eligible stroke patients thrombolysed.		6%	6%	Quarterly
	% of stroke patients admitted to a stroke unit or organised stroke service with a demonstrated stroke pathway.		80%	80%	
	Report on delivery of the actions and milestones identified in the Annual Plan.				
PP21 Immunisation coverage.—IPIF HealthStart	% of two-year-olds fully immunised.		95%		Quarterly
	% of five-year-olds fully immunised.		90% by end 2015/16 95% by end 2016/17		
	% of eligible girls fully immunised with dose three of HPV vaccine		65% for dose 3		
PP22 Improving system integration.	Report on delivery of the actions and milestones identified in the Annual Plan. Quarter four report to include PHO financials statements and forecasts.				Quarterly
PP23 Improving wrap-around services – health of older people.	Report on delivery of the actions and milestones identified in the Annual Plan.				Quarterly
	% of older people receiving long-term home support who have a comprehensive clinical assessment and an individual care plan		Provision of data that demonstrates an improvement on current performance		
PP24 Improving waiting times – cancer multidisciplinary meetings.	Report on delivery of the actions and milestones identified in the Annual Plan.				Quarterly
PP25 Prime Minister's youth mental health project.	Report on delivery of the actions and milestones identified in the Annual Plan.				Quarterly
PP26 The Mental Health & Addiction Service Development Plan.	Report on status for a minimum of 8 actions to be completed in 2015/16 and for any actions which are in progress/going into 2016/17.				Quarterly
PP27: Delivery of Children's Action Plan.	Report on delivery of the actions and milestones identified in the Annual Plan.				Quarterly
PP28: Reducing rheumatic fever.	Provide a progress report against the region's rheumatic fever prevention plan.				Quarterly
	Undertake a root cause analysis on any new rheumatic fever cases and provide a report to the Ministry on lessons learned and actions taken.				
	Acute rheumatic fever rate of hospitalisation per 100,000.	South Island rate	< 0.2 per 100,000		
PP29: Improved waiting times for diagnostic services.	% of accepted referrals for elective coronary angiography will receive procedure within 3 months (90 days).		95%	95%	Monthly
	% of accepted referrals for CT and MRI scans will receive scans within 6 weeks (42 days).	CT Scan	95%	95%	
		MRI Scan	85%	85%	
	% of people accepted for an urgent diagnostic colonoscopy receive their procedure within 2 weeks (14 days).		75%	75%	
	% of people accepted for a diagnostic colonoscopy receive their procedure within 6 weeks (42 days).		65%	65%	
	% of people waiting for a surveillance colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date.		65%	65%	
PP30: Faster cancer treatment	(<10% of records submitted by the DHB are declined)		<10%	<10%	Quarterly
	% of people ready for treatment wait less than four weeks for radiotherapy or chemotherapy		100%	100%	
SI1 Ambulatory sensitive (avoidable) hospital admissions.	DHB rate vs. national rate	Age 0-4	TBC	NA	Six-monthly
		Age 45-64	TBC		

PERFORMANCE MEASURE	PERFORMANCE EXPECTATION		CANTERBURY TARGET	NATIONAL TARGET	REPORTING FREQUENCY
		Age 0-74	TBC		
SI2 Delivery of regional service plan.	A single progress report on behalf of the region, agreed by all regional DHBs.				Quarterly
SI3 Ensuring delivery of service coverage.	Report progress achieved during the quarter towards resolution of exceptions to service coverage identified in the Annual Plan, and not approved as long-term exceptions, and any other gaps in service coverage.				Six-monthly
SI4 Elective services standardised intervention rates.	Major joint replacement procedures (per 10,000).		21	21	Annual
	Cataract Procedures (per 10,000).		27	27	
	Cardiac surgery (per 10,000).		6.5	6.5	Quarterly
	Percutaneous revascularisation (per 10,000).		12.5	12.5	
	Coronary angiography services (per 10,000).		34.7	34.7	
SI5 Delivery of Whānau Ora.	Report progress on planned activities with providers to improve service delivery and develop mature providers.				Annual
SI6 IPIF Healthy Adult – Cervical Screening	% of eligible women have received cervical screening services within the last 3 years		80%	80%	Six-monthly
OS3 Inpatient length of stay (LOS).	Average Elective LOS.		≤1.59	1.59	Quarterly
	Average Acute LOS.		≤2.45	≤2014 base	
OS8 Acute readmissions to hospital.	% total population.		Improvement on baseline performance		Quarterly
	% population aged 75+.				
OS10 Improving the quality of identity data within the national health index and data submitted to national collections.					
Focus area 1: Improving quality of identification data.	New NHI registrations in error (Group A).		>2% - ≤ 4%	>2% - ≤ 4%	Quarterly
	Recording on non-specific ethnicity (set to 'Not stated' or 'Response Unidentifiable').		>0.5% - ≤2%	>0.5% - ≤2%	
	Updating of specific ethnicity value in existing NHI record with a non-specific value.		>0.5% - ≤2%	>0.5% - ≤2%	
	Invalid NHI data updates .		TBC	TBC	
Focus are 2: Improving the quality of data submitted to National Collections.	NBRS links to NNPAC and NMDS.		≥97%-<99.5%	≥97% - <99.5%	Quarterly
	National collections file load success.		≥98% - <99.5%	≥98% - <99.5%	
	Standard vs. edited descriptors.		≥75% - <90%	≥75% - <90%	
	NNPAC timeliness.		≥95% - <98%	≥95% - <98%	
Focus area 3: Improving the quality of the programme for integration of mental health data (PRIMHD).	PRIMHD data quality.		Routine audits undertaken with appropriate action where required.		Quarterly
OP1 Mental health output delivery against plan.	Volume delivery for specialist Mental Health and Addiction services is within: a) five percent variance (+/-) of planned volumes for services measured by FTE, b) five percent variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day, and c) actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan.		Within 5% of plan	Within 5% of plan	Quarterly
DV4: Improving patient experience	Provide patient experience data and establish baselines for future targets.				Quarterly

Appendix 10.9

Statement of Accounting Policies

The prospective financial statements in this Annual Plan for the year ended 30 June 2016 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 Annual Plan:

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

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

(iii) Assumptions
The main assumptions underlying the forecast are noted in Section 8 of the Annual Plan.

REPORTING ENTITY AND STATUTORY BASE

Canterbury DHB ("Canterbury DHB") is a Health Board established by the New Zealand Public Health and Disability Act 2000. Canterbury DHB is a Crown entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand.

Canterbury DHB has designated itself and its subsidiaries, as public benefit entities (PBEs) for financial reporting purposes.

Canterbury DHB's primary objective is to deliver health and disability services and mental health services in a variety of ways to the Canterbury community. Canterbury DHB does not operate to make a financial return.

The consolidated financial statements of Canterbury DHB consist of Canterbury 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.

These financial statements comply with PBE accounting standards.

These financial statements are the first financial statements presented in accordance with the new PBE accounting standards. There are no material adjustments arising on transition to the new 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: derivative financial instruments (foreign exchange and interest rate swap contracts), financial instruments classified as available-for-sale, and land and buildings.

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

Functional and presentation currency
The financial statements are presented in New Zealand dollars (NZD), rounded to the nearest thousand 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.

Standards, issued but not yet effective and not early adopted.
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 will apply these updated standards in preparing its 30 June 2016 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 fit out
- 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.

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.

Donated Assets

Where a physical asset is gifted to or acquired for nil consideration or at a subsidised cost, the asset is recognised at fair value and the difference between the consideration provided and fair value of the asset is recognised as revenue.

Depreciation

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

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

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

The residual value of assets is reassessed annually.

Work in progress is not depreciated. The total cost of a project is transferred to the appropriate class of asset on its completion and then depreciate d.

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.

Equity Investments

Financial assets held for trading are classified as current assets and are stated at fair value, with any resultant gain or loss recognised in other comprehensive income.

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

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

Trade and other receivables

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

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 isrecognised 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.

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.

Restricted assets and liabilities

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.

Borrowings

Borrowings are recognised initially at fair value. Subsequent to initial recognition, borrowings are stated at amortised cost using the effective interest method.

Employee entitlements

Defined contribution plans

Obligations for contributions to defined contribution plans are recognised as an expense in the surplus or deficit as incurred.

Defined benefit plans

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

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

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

Canterbury DHB's net obligation in respect of long service leave, sabbatical leave and retirement gratuities is the amount of future benefit that employees have earned in

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

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

Presentation of employee entitlements
Non vested long service leave and retirement gratuities are classified as non-current liabilities, all other employee entitlements are classified as current liabilities.

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

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

The liability for the ACC Partnership Programme is measured using actuarial techniques at the present value of expected future payments to be made in respect of the employee injuries and claims up to the reporting date. Consideration is given to anticipated future wage and salary levels and experience of employee claims and injuries. Expected future payments are discounted using market yields on government bonds at balance date with terms to maturity that match, as closely to possible, the estimated future cash outflows.

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

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

Derivative financial instruments are recognised initially at fair value. Subsequent to initial recognition, derivative financial instruments are re-measured to fair value at each balance date. The gain or loss on a re-measurement to fair value is recognised immediately in the surplus or deficit.

The full fair value of a forward foreign exchange derivative is classified as current if the contract is due for settlement within 12 months of balance date. Otherwise, foreign exchange derivatives are classified as non-current.

Income tax
Canterbury DHB is a crown entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under section CW38 of the Income Tax Act 2007.

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

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

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

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

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

Operating lease payments
Payments made under operating leases are recognised in the surplus or deficit on a straight-line basis over the term of the lease. Lease incentives received are recognised in the 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; and,
- 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 of land and buildings as further described in note 16. 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.

ANNUAL PLAN AND STATEMENT OF INTENT

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