Annual Plan 2014-2015

Incorporating the Statement of Intent 2014/15-2017/18

THE CANTERBURY HEALTH SYSTEM

Working together to make it better

Canterbury
District Health Board
Te Poari Hauora ō Waitaha

ANNUAL PLAN & STATEMENT OF INTENT

Produced July 2014
Pursuant to Section 149 of the Crown Entities Act 2004

Canterbury District Health Board
PO Box 1600, Christchurch
www.cdhb.health.nz

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Statement of Responsibility

The Canterbury District Health Board (DHB) is one of 20 DHBs, established under the New Zealand Public Health and Disability Act in 2011. Each DHB is designated as a Crown Agent under the Crown Entities Act 2004 and is responsible to the Minister of Health for a geographically defined population.

This Annual Plan has been prepared to meet the requirements of both governing Acts and the relevant sections of the Public Finance Act. It sets out the DHB's goals and objectives and describes what the DHB intends to achieve in terms of improving the health of its population, ensuring the sustainability of the health system and delivering on the expectations of Government.

Following amendments to the Crown Entities Act, sections of this Annual Plan are now extracted to form two stand-alone documents; the Statement of Intent and the Annual Statement of Performance Expectations, both of which are presented to Parliament.

The Statement of Intent describes the DHB's longer-term strategic direction (focused on the next four years 2014/15 to 2017/18). While the Statement of Performance Expectations describes the intended service delivery in 2014/15. The Statement of Performance Expectations is used at the end of the year to compare the DHB's planned and actual performance and the audited results are the presented in the DHB's Annual Report.

The Plan also contains service and financial forecast information for the current and three subsequent years: 2014/15 to 2017/18.

The Canterbury DHB has made a strong 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 between the Canterbury DHB and its alliance partners to improve the health of the Canterbury community and deliver the expectations of Government. The full work plans of the workstreams under the Canterbury Clinical Network District Alliance can be found on the CCN website: www.ccnweb.org.nz.

The actions the DHB will deliver as part of its commitment to the South Island Regional Alliance are also highlighted throughout this Plan. The full South Island Regional Health Services Plan (of which the Canterbury DHB is a signatory) can be found on the South Island Alliance website: www.sialliance.health.nz.

The Canterbury DHB also has Māori Health and Public Health Action Plans for 2013/14, both of which are companion documents to this Annual Plan. These documents set out further actions and activity to improve population health and reduce inequalities. 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 represents the intentions and commitments of the Canterbury DHB and the wider Canterbury health system for the period 1 July 2014 to 30 June 2015.

Together, we will continue to demonstrate real gains and improvements in the health of the Canterbury population.

Murray Cleverley
Chairman Canterbury DHB

Edie Moke
Board Member Canterbury DHB

Honourable Dr Jonathan Coleman
Minister of Health

Honourable Bill English
Minister of Finance

Date: March 2015

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 8 JUL 2015

Mr Murray Cleverley
Chair
Canterbury District Health Board
PO Box 1600
Christchurch 8140

Dear Mr Cleverley

Canterbury District Health Board 2014/15 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) 2014/15 Annual Plan for one year.

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.

I note that your DHB planned a deficit for 2014/15 and breakeven for the following three years. Please note that I expect your 2015/16 Annual Plan to fully align with the Business Case for the Burwood Hospital Redevelopment and the Christchurch Hospital Acute Services Building.

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.

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

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand. Telephone 64 4 817 6818 Facsimile 64 4 817 6518

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Part I – Overview

A message from the Chairman & Chief Executive

Keeping Cantabrians well and healthy and in their own homes and communities.

The Canterbury DHB is charged by Government with overall responsibility for working within the funding allocated to improve, promote and protect the health and independence of the Canterbury population. 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 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.

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

We collaborate with our health system alliance partners under the Canterbury Clinical Network and work closely with key stakeholders, agencies, provider organisations and our community to 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 work closely with our five colleague District Health Boards and support the work of the South Island Regional Alliance in streamlining patient pathways, and improving the quality and coordination of care. Canterbury's innovative electronic solutions for sharing clinical information and connecting up the system; such as HealthPathways and our electronic shared cared record view and electronic referral management system are now being extended to the whole South Island.

We have a particular focus on connecting Canterbury with the West Coast DHB. Shared executive functions and an integrated clinical workforce, enabled through the development of Transalpine Services, will help to improve the health of the West Coast population and enhance efficiencies across both health systems.

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

Our Reality

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

In Canterbury we are also contending with the consequences of New Zealand's largest natural disaster.

The earthquakes have displaced people from their homes, communities and usual support networks. Our population and our workforce has experienced prolonged levels of stress and anxiety. Poor living arrangements and environments are exacerbating chronic illness and taking a toll on the health of our population.

Three years on demand trends are changing, there are worrying signs in terms of the mental health and wellbeing of young people and families in Christchurch. The long term impacts on our population's health and well-being cannot be accurately predicted because Canterbury's experience is unique, particularly in terms of the extended nature of the crisis we have faced.

What we do know is our health system is operating at full capacity. Resources are stretched, and every day we juggle reduced physical capacity with required repairs, patient need and staff safety. The complexity of this will increase markedly as the development of our new hospital facilities accelerates. Our workforce is tired and showing measureable signs of fatigue in the face of the on-going pressures both at home and at work.

The unique circumstance created by the timing differences between the recognition of insurance proceeds and the eventual spend adds further complexity. The total overall cost of the earthquakes is still an unknown factor and we expect the cost impacts to continue to influence and distort our financial results for the next several years. These costs appear in various types of expenditure, from the securing of external capacity to support our service delivery through to emergency repairs and maintenance.

Our Innovation

Responding to these multiple challenges has required Canterbury to focus on the short term management of the resources and capacity available - whilst maintaining a longer term strategic vision. We have been able to harness an internal capacity to innovate to meet the immediate challenge of ensuring constrained resources are utilised to their maximum effectiveness. This has required a vigilant focus on productivity and the continual improvement of systems and services to ensure the DHB is achieving the highest level of output possible.

Other health systems and government organisations have benefited from Canterbury's innovations. Canterbury's HealthPathways system is now being used in 17 health systems across Australia and New Zealand. Our Design Lab is used by many Canterbury based organisations and government departments as a place to develop new ideas and test solutions that meet the Government's desire for

Better Public Services. Visitors come from all over the world, including the United Kingdom's National Health Service, specifically to experience and learn from the Canterbury Health Systems. We were gratified to be invited to present our approach at the first World Health Organisation Forum (WHO) on Innovation in Ageing in Kobe, Japan late last year.

But while striving for greater productivity, the DHB must also work towards the longer-term goal of reorienting the health system to support our population to stay well, with greater care delivered in community settings closer to people's own homes.

Alongside the hospital redevelopments at Christchurch and Burwood we are working with general practices to facilitate the development of number of integrated family health centres 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 and Ashburton are also looking forward to their new purpose designed facilities that will better support service delivery in their communities.

Overall we expect that a reorientation of service delivery around a single point of continuity, which for most people will be general practice, will enable us to deliver a health system able to withstand future demand.

We can see the impact of our approach in the reduction in numbers of older people requiring hospital and aged residential care. Last year more than 25,000 people received acute care free in the community when they would otherwise have gone to hospital. Analysis shows that Canterbury's acute hospital admissions were 20,000 less than would be expected if we were at the New Zealand average.

The Future

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

With the Government's support the DHB is 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 47,000m^2 of building space being demolished and substantive repairs to be completed, we are also taking the opportunity created by the insurance proceeds to rebuild broken infrastructure in a way that supports our vision. Our partner organisations in health care delivery are equally focused on using this opportunity to build infrastructure that supports an integrated health system focused around the people we all support.

Public health, primary care and community health services provide the context in which hospital and specialist services must operate. Equally, the provision of modern, effective specialist care will support the ongoing journey of transformation in community based health services. We need the whole of the system to be working for the whole of the system to work.

The DHB's 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.

However, even as we focus on rebuilding our damaged infrastructure 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.

Continuing to connect our system to improve the continuity of care, minimise duplication and waste and reduce the time people spend waiting remain key focus areas for the Canterbury health system.

In light of our immediate challenges, we are increasing our emphasis on vulnerable population groups particularly children and young people, our older population, those struggling with mental health issues and our Māori population. We are collaborating with education, social services and justice to wrap care around those with more complex conditions, and lives, who need more support and intervention. We are also working across our system to achieve the expectations of government for better public health services.

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 making sure we are not just delivering more services, but more of the *right services* – delivered in the *right place* at the *right time* by the *right person*.

Murray Cleverley
Chairman Canterbury DHB

David Meates
Chief Executive Canterbury DHB

Date: March 2015

Introducing the Canterbury DHB

The Canterbury DHB is the second largest DHB in the country by both geographical area and population size - serving 482,181 people (11.4% of the New Zealand population) and covering 26,881 square kilometres and six Territorial Local Authorities.

The DHB is the single largest employer in the South Island, employing over 9,000 people across the DHB's hospitals and community bases. A similar number of people are employed in delivering health and disability services in Canterbury – either funded directly or indirectly by the Canterbury DHB.

As a large tertiary DHB, Canterbury also has a significant role to play as regional provider. Each year, close to 4,000 people from outside the region travel to Canterbury for specialist services that other DHBs do not deliver.

1.1 Our role and function

The Canterbury DHB receives funding from Government with which to purchase and provide health and disability services for the Canterbury population. In accordance with legislation, and the objectives of the DHB, we use this funding to:

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

Fund the majority of the health services provided in Canterbury, and through our collaborative partnerships and relationships with service providers, ensure services are responsive, coordinated and focused on what is best for the patient and the system.

Provide 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.

Promote, protect and improve our population's health and wellbeing through health promotion, education and evidence-based public health initiatives.

1.2 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, improves health outcomes and ensures sustainable service provision. The Board also ensures compliance with legal requirements and maintains relationships with the Minister of Health and the Canterbury community.[1]

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 our commitment to shared decision-making, external providers and clinical leaders also regularly present and provide advice to the Board.

While responsibility for the DHB's overall performance rests with the Board, operational and management matters have 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 patient safety and quality.[2]

Since July 2010, Canterbury has formally provided executive and clinical services for the West Coast DHB, with a shared Chief Executive, a growing number of joint appointments and shared corporate divisions including: finance, human resources, information technology, public health and planning and funding.

Planning and funding health services

The DHB's role includes determining how best to use the funding we receive from Government to improve the health, wellbeing and independence of our population. In line with Canterbury's vision, we do not do this in isolation. We work with other providers, agencies, organisations, stakeholders, consumers and our community to understand our population's health need.

Through this collaboration, we ensure that services are people-centred, integrated and sustainable. Our collaborative partnerships also allow us to share resources and reduce duplication, variation and waste across the whole of our health system to achieve the best health outcomes for our community.

Our Planning and Funding Division holds and monitors alliance agreements and service contracts with the organisations and individuals who provide health services to the Canterbury population. This includes an internal service agreement with our Hospital and Specialist Services Division and almost 1,000 service contracts and agreements with community providers, including the three Primary Health Organisations (PHOs), private hospitals, laboratories, mental health service providers, home based support providers and rest homes.

Providing health and disability services

As an 'owner' of hospital and specialist services, the DHB directly provides a significant share of the health and disability services delivered in Canterbury. We provide these services through our Hospital and Specialist

[1] *Refer to Appendix 2 for the legislative objectives of a DHB.*

[2] *Refer to Appendix 4 for the DHB's organisational structure.*

Services Divisions: Medical and Surgical, Mental Health, Rural Health, Women's and Children's, Older Persons' Health and Rehabilitation, and Hospital Support and Laboratory Services.[3]

This is no small responsibility. In 2013/14 there were 94,010 presentations in our Emergency Departments, 116,167 inpatients discharged from our hospitals, 16,961 elective surgeries performed, 5,778 babies delivered, 152,865 consultations with our community based specialist mental health services and 622,837 specialist outpatient appointments.

While most of our secondary and specialist services are provided out of our hospitals, some services are delivered from community bases, through outreach clinics in rural areas and in other DHB facilities. The Canterbury DHB currently own and manage 15 hospitals and more than 18 community bases.

Promoting our population's health and wellbeing

Our Community and Public Health Division provides public and population health services and supports initiatives that focus on keeping people well. This work includes improving nutrition and physical activity levels and reducing tobacco smoking and alcohol consumption through service contracts and collaborative ventures such as 'Healthy Christchurch'.

Community and Public Health also provide health protection services and lead 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.

However, good health is determined by many factors and social determinants that sit outside the direct control of the health system. Our partnerships with other agencies (including local and regional councils, the Canterbury Earthquake Recovery Authority, Housing NZ, the Accident Compensation Corporation and the Ministries of Justice, Education and Social Development) are also vital in supporting the creation of social and physical environments that reduce the risk of ill health.

1.3 Our regional role

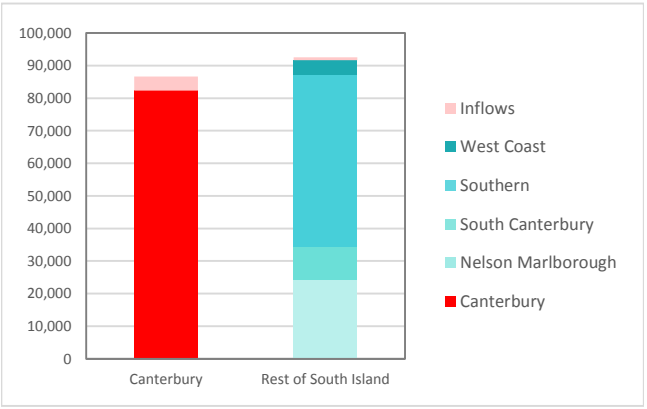
While our responsibility is primarily for our own population, the Canterbury DHB also provides an extensive range of highly specialised and complex services on a regional basis - to people referred from other DHBs where these services are not available.

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

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

[3] *Refer to Appendix 5 for an overview of the services provided.*

Annual hospital discharges by South Island DHB.



In particular, Canterbury provides many services for the population of the West Coast DHB. To formalise this collaborative relationship, we have developed shared service and clinical partnership arrangements that include a number of clinically-led transalpine service pathways.

In total, Canterbury delivers nearly half of all the surgical services provided in the South Island and provides over $100m worth of specialist services to the populations of other DHBs around New Zealand.

1.4 Our accountability to the Minister

As a Crown entity, the DHB must have regard for 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, capital investment or disposing of Crown land. We will also comply with consultation expectations communicated to us.

The Crown Entities Act requires DHBs to report annually to Parliament on their performance, as judged against our Statement of Performance Expectations. We publish this account as our Annual Report, available on our website.

In addition, DHBs have a number of other reporting obligations under the Crown Entities Act and Operational Policy Framework. This includes financial and non-financial service performance reporting provided to the National Health Board including:

- Annual Reports and Audited Financial Statements
- Quarterly non-financial performance reports
- Quarterly health target reports
- Quarterly reports on service delivery against plan
- Bi-annual risk reports
- Monthly financial reports
- Monthly wait time and ESPI compliance reporting.

We also meet requirements with respect to the provision of data for national collections, including: the national health index, national minimum dataset, national booking reporting system, national immunisation register, national non-admitted patient collection and national ethnicity reporting.

Identifying Our Challenges

Analysing the demographics and health profile of our population helps us to predict the demand for services and influences the choices we make when allocating resources across our health system. This information also helps us to understand the factors affecting our performance and to identify areas for focus and improvement.

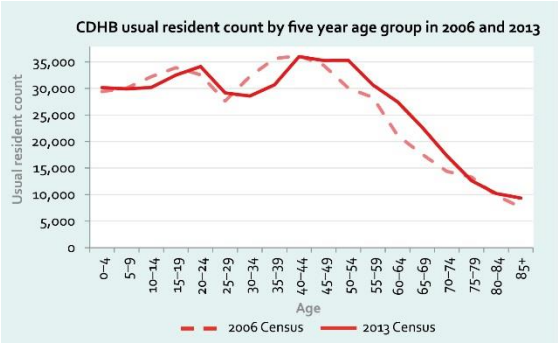
2.1 Population profile

Canterbury remains the second largest DHB in New Zealand by population and was home to a usually resident population of 482,181 people at the 2013 Census. While there was an initial drop in our population after the earthquakes, the census shows that our population has continued to grow. Our population was up from 466,404 in 2006 (an increase of 3.4%).[4]

Our population also continues to age and this is the factor that presents the biggest challenges to our health system. While our younger population decreased slightly between 2006 and 2013, there was significant growth in our older population groups.

In 2013, 15% of our population (72,192 people) were aged over 65 - higher than the national rate (14.3%) and 1.6% higher than in 2006. Of those, 7% (32,190) were over 75.

As we age, we develop more complicated health needs and multiple conditions, meaning we consume more health resources and are more likely to need specialised services. Many long-term conditions become more common with age, including heart disease, stroke, cancer, respiratory disease and dementia. The ageing of our population will put significant pressure on our workforce, infrastructure and finances.



Ethnicity is also a strong indicator of need for health services and our population is becoming more ethnically diverse. In 2013 8.2% of our population identified as Māori, 7.5% as Asian and 2.6% as Pacific.

We must consider the unique health needs of each of our population groups in our planning for the future. Our Māori and Pacific populations, for example, are younger and have a different age structure and growth pattern with 43.7% of our Māori population under 20 years of age, compared to 25.5% of the total population.

2.2 Health profile

Although our population has a higher life expectancy than other parts of New Zealand, the leading causes of death in Canterbury are similar. Cardiovascular diseases, including heart disease and stroke, are the leading cause of death, followed by cancers and respiratory diseases such as Chronic Obstructive Pulmonary Disease (COPD).

Diabetes is the ninth highest cause of death, but also an underlying factor for cardiovascular disease and contributes significantly to avoidable mortality.

In terms of demand for hospital services, there are many conditions for which earlier identification and treatment can prevent hospital admission. Reducing these 'avoidable' admissions provides opportunities to improve our population's health and ease demand.

Canterbury's leading causes of avoidable hospital admission are gastroenteritis/dehydration; angina and chest pain; upper respiratory; and ear, nose and throat infections. Although lower than the national rate, falls are also a major cause of avoidable admission.

Health behaviour and risk factors

The negative health outcomes associated with risk factors such as poor diet, hazardous drinking and tobacco smoking place considerable pressure on our health system. Smoking is also a substantial contributor to socio-economically based health inequalities.

The most recent New Zealand Health Survey found that:

- Over one quarter (27%) of our adult population are classified as obese.
- On average, our population is less likely to drink in a hazardous manner (10% vs. 15% nationally), but this still amounts to one in every 10 adults.
- 15% of our population currently smoke - lower than the national average of 18%. However, smoking rates amongst Māori are significantly higher.

Social and economic factors, such as education, housing and income, are also widely accepted as contributing greatly to a person's health. While deprivation in Canterbury appears to have lowered between the 2006 Census and the 2013 Census, many of the most deprived suburbs were the hardest hit by the earthquakes - displacing people from their usual support networks and reducing housing options and the standard of people's living conditions.

[4] Unless referenced, data is based on Ministry of Health mortality and demographic data and 2013 Census results. The Census results slightly under-count the population, with final adjusted population estimates due in August 2014. A further summary on the Census results is attached as Appendix 3.

Household overcrowding is an area of concern, which can lead to an increased risk of infectious illnesses such as rheumatic fever, meningococcal disease, influenza and ear, nose and throat infections. According to the 2013 Census, 3.2% of our households are overcrowded and over 17% of our Pacific households are overcrowded.

2.3 Operating environment

The Canterbury earthquakes have significantly altered our operating environment. Capacity across our health system has been reduced – not just physically, but also in terms of time wasted as we work around damaged infrastructure. This affects not just the DHB, but almost every health and social service provider in Canterbury.

Our population remains unsettled. Many people are still living in temporary or crowded accommodation and moving about the city while they wait for repairs or look for permanent accommodation. Significant resources are going into maintaining contact with vulnerable population groups, and normal recall systems are not as effective in this transient environment.

There is also uncertainty about the influx of people as the rebuild brings workers into the city. Planning is underway, but there are many questions around how long these people will stay, whether they will bring their families and what their health needs will be.

Demand pressures

Prolonged levels of stress, anxiety and poor living arrangements are exacerbating chronic illness and increasing demand for services. We can estimate future demand based on known factors, but there is a high level of risk in terms of unpredictable demand from a vulnerable population.

Mental health and behavioural disorders are the sixth most common cause of death in Canterbury, and the prolonged stress of the earthquakes and ongoing recovery issues is having a marked psychological impact on our population.

We are beginning to see a significant increase in demand for specialist mental health services, especially for young people. In the last two years there has been: a 20% increase in new presentation to specialist adult mental health services, a 35% increase in new presentations to psychiatric emergency services and a 40% increase in new presentations to Child & Youth Specialist Services.

Cross-sector strategies are being put in place to address this growing need. We are working closely with our primary care partners and the Ministry of Education to provide stress and anxiety support for young people in our schools and increase access to brief intervention counselling and support in the community.

Cross sector work is also focused on reducing alcohol harm with a number of collective workplace initiatives planned, inter-agency collaboration on alcohol harm reduction and additional investment in alcohol intervention counselling.

Accommodation is also a critical factor for patient flow in our services, with an increasing number of patients (particularly mental health clients) 'stuck' in services with no place to go.

Workforce pressures

The prolonged stress of the past two years is also taking its toll on our workforce. When surveyed, 63% of our staff felt they or their families were 'seriously' impacted by the earthquakes, 48% had 'moderate' to 'severe' damage to their home and 37% have had to move.

Recent staff survey results 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, and over 60% are still dealing with EQC and insurance issues.

We are acutely aware that this is not just about our own workforce. While the DHB employs over 9,000 people, we indirectly rely on almost the same number of people in public, private and charitable organisations to deliver services to our population. Workforce pressures are affecting our whole health system.

Facilities pressures

Canterbury has received approval for the Business Case for the redevelopment of Christchurch and Burwood Hospitals. However, it will be 2018 before the redevelopments are complete. Despite converting office space into wards, we are still operating with fewer beds than before, and significant structural repairs are needed across our facilities to maintain service delivery. This is no small undertaking; over 12,000 rooms were damaged.

There will be several years of major disruption as we shift and relocate services to make required repairs and wait for the redevelopment to bring additional capacity online. This will continue to restrict our capacity, increase inter-hospital patient transfers, fragment services and clinical teams and put additional pressure on our workforce.

While the redevelopment process is underway, it is important that we make carefully considered decisions on the repair of current facilities to ensure safety and service continuity – without over-investing in facilities that do not have a future role.

There are also challenges in maintaining viable health services (such as general practices and pharmacies) where the population has dropped near the 'red zone', while in other areas demand is stretching capacity.

Fiscal pressures

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

Numerous factors contribute to fiscal pressures: the increasing demand for services including diagnostics and residential care; rising treatment related 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 public and government expectations, the costs of new technology and demand for a seven-day-a-week service.

The total overall cost of the earthquakes is also an unknown factor. It is apparent that there is a significant level of remedial work needed which will not be covered by the insurance proceeds and we are still unable to accurately determine the final interplay between repair costs, insurance recovery, the impact of new Building Codes, construction inflation and cost escalations.

There are also complexities associated with the timing differences between the recognition of insurance proceeds and the actual spend in regard to repairs.

While fiscal pressures will be an increasing challenge, the Canterbury DHB is committed to operating within our funding allocations with reduced reliance on earthquake funding support from the Ministry of Health.

2.4 Critical success factors

The following areas are where the greatest gains can be made in improving health outcomes for our population and the viability of our health system. They also represent the major factors critical to our success, where failure would significantly threaten the achievement of the strategies and goals outlined in this plan.

Connecting the system

The earthquakes identified a number of gaps and flaws in our infrastructure, particularly the risk associated with disconnected patient information systems.

It is critical that we continue to connect our system electronically as well as organisationally to enable us to identify and target populations with the highest need, ensure continuity of care and the provision of care closer to home to reduce acute events and hospital admissions and reduce duplication and waste across our system.

Reducing acute demand

Acute (urgent or unplanned) admissions are the most significant source of pressure on health resources. Canterbury has already reduced the growth rate of acute medical admissions to well below national rates, avoiding over 20,000 acute admissions into our hospitals. With the loss of bed capacity after the earthquake we would be in real trouble had we not already made in-roads into reducing acute demand; by recognising when people need support earlier and providing appropriate alternatives to a hospital admission, in people's own homes and communities.

Left unchecked, acute demand can quickly 'crowd out' elective (planned) services - increasing waitlists and adversely affecting service quality.

Managing long-term conditions

A substantial portion of acute admissions are due to exacerbation of a long-term condition. The prevalence of long-term conditions (such as heart disease, diabetes and respiratory disease and depression) continues to grow. This is a worldwide pattern associated with an ageing population and lifestyle choices.

It is critical that we continue get ahead of escalating disease prevalence and support people to better manage their conditions and to stay well and healthy – intervening earlier to reduce the need for complex intervention, hospital admission or early entry into residential care.

Without improving the way long-term conditions are managed, we simply will not have the workforce or infrastructure to meet future demand.

Releasing workforce capacity

Our ability to meet immediate and future demand relies heavily on having the right people, with the right skills, working in the right place.

To make better use of our limited resources, it is critical that we continue to engage our workforce in the development of integrated models of care and break down the barriers that prevent health professionals from working to the full extent of their scope.

This includes developing a sustainable 24-7 health service response to reduce delays in diagnosis and treatment and to eliminate barriers to improved patient flow.

We also need to support staff wellbeing. Without a motivated, engaged workforce committed to the future of our health system, we cannot achieve genuine and lasting transformation.

Reducing the cost of service delivery

If an increasing share of our funding is directed into meeting cost growth, our ability to invest in new technology and initiatives that allow us to respond to increasing demand will be severely restricted.

It is vital that we contain the cost of delivering services through improved efficiency and by focusing on mechanisms that have proven successful: 'lean thinking', improved procurement arrangements, the engagement of health professionals in prioritisation and service improvements and the introduction of electronic and technical efficiencies that reduce duplication and waste.

Making the most of rebuild opportunities

With damaged health facilities all across Canterbury, the opportunity exists to make a step-change in our approach to infrastructure and to ensure facilities support, rather than hinder, future models of care.

The DHB now has approval for major redevelopment of our Burwood and Christchurch Hospital sites. We are also supporting primary and community facility rebuilds that will enable the provision of services closer to home – including the development of Community Hubs and Integrated Family Health Centres.

With major shifts in our population, following the earthquakes and significant growth in Waimakariri, Selwyn and Ashburton districts the DHB will also focus on ensuring the provision of sustainable and integrated services in these areas. Construction is about to begin on a new Rangiora Community Hub and Ashburton developments are also underway.

This is an opportunity that will not come again, and it is critical that we step up and align our health facilities to our models of care and the needs of our communities.

Part II – Long-Term Outlook

Our Strategic Direction

What are we trying to achieve?

3.1 Our strategic context

Although they may differ in size, structure and approach, DHBs have a common goal: to improve the health of their populations by delivering high quality, accessible health care. With increasing demand for services, workforce shortages and rising costs, this goal is increasingly challenging and the whole of the New Zealand health system faces an unsustainable future.

In 2010 the National Health Board released *Trends in Service Design and New Models of Care*. This document provided a summary of international responses to the same pressures and challenges facing the New Zealand health sector, to help guide DHB service planning.[5]

International direction emphasises that faced with increasing demand, rising costs and workforce shortages; an aligned, 'whole of system' approach is required to ensure service sustainability, quality and safety while making the best use of limited resources. This entails four major shifts in service delivery:

1. Early intervention, targeted prevention and self-management and a shift to more home-based care.
2. A more connected system and integrated services, with more services provided in community settings.
3. Regional collaboration clusters and clinical networks, with more regional service provision.
4. 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 and accessible care being paramount. However, less-complex care (traditionally provided in hospital settings) is increasingly being provided in the community.

To ensure the sustainability of the New Zealand health system, DHBs need to shift their population's health needs away from the complex end of the continuum of care and support more people to stay well and healthy.

These shifts can only be achieved with the support of connected and integrated clinical networks and multidisciplinary teams and are consistent with the changes being driven across the Canterbury health system to meet the needs of our population.

These shifts are also consistent with the changes being driven across the South Island by the regional alliance of the five South Island DHBs.

3.2 The Canterbury vision

The focus on a whole of system approach and an integrated, connected system is not new in Canterbury. Since 2007, health professionals, providers, consumers and other stakeholders have been coming together to find solutions to the challenges we face. We knew if we didn't actively transform the way we delivered services, by 2020 Canterbury would need 2,000 more aged residential care beds, 20% more GPs and another hospital the size of Christchurch Hospital.

We began reorienting our health system around the needs of the patient. In committing to this direction, we recognised it was not just about our hospitals. At its core, our vision is dependent on achieving a truly integrated, approach where everyone in the health system works together to do the right thing for the patient and the right thing for the system.

Health professionals from across Canterbury are redesigning the way we deliver health services, putting the patient at the centre of everything we do, reducing the time people spend waiting for treatment and improving outcomes for our population.

With a foundation of strong clinical leadership and the establishment of cross-sector alliances to support joint planning (including the large scale Canterbury Clinical Network District Alliance) we have been able to drive considerable transformations across our health system.

Together we are focused on the delivery of a clear direction and vision for our health system that includes:

- 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 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.

[5] *Trends in Service Design and New Models of Care: A Review, 2010, Ministry of Health, www.nationalhealthboard.govt.nz.*

The integrated approach adopted across Canterbury has demonstrated in a relatively short period of time how effective a whole-of-system response can be. The health and system outcomes we are seeing as a result of our commitment have been striking.

More people are healthier and take greater responsibility for their own health.

- More eight-month-olds are receiving their primary course of immunisations - 93% of all eight-month-olds are fully immunised.
- More of our vulnerable populations are receiving influenza vaccinations - 33% of under eighteen-year-olds were vaccinated in 2013, up from 19% in 2012 and 75% of over 65-year-olds were vaccinated.
- More people are receiving advice and support to stop smoking - 95% of all hospitalised smokers. In primary care we are now reaching 65% of all current smokers up from 34% last year.

More people are being supported to stay well in their own homes and communities.

- Our Acute Demand Management Service is easing pressure on our hospitals with 25,374 acute episodes of care managed in the community rather than in our hospitals in the last year.
- Our Community Rehabilitation Enablement and Support Team (CREST) provides a range of home-based rehabilitation packages to support people to leave hospital sooner or avoid admission altogether. In 2012/13, CREST supported close to 2,000 older people in their own homes.
- Our Falls Prevention Service supports older people at risk of falls and takes an integrated approach to reduce harm and hospitalisation. The service responded to 1,613 referrals in 2012/13.
- Our Brief Intervention Counselling Service meant that more than 700 young people and 5,000 adults were able to access mental health support from their general practice in 2012/13.

More people are receiving timely and appropriate care closer to their own home.

- More people are having skin lesions removed in general practice rather than in hospital. Average waits for skin lesion removal have dropped from 196 days in 2007 (when the service began) to under 53. Over 2,000 people accessed the service in 2013/14.
- More people are accessing respiratory services in the community rather than waiting for hospital appointment. Over 1,500 people received a spirometry test and almost 200 people accessed community-based pulmonary rehabilitation.
- Increasing numbers of people are also accessing diabetes services in the community with over 700 people receiving additional diabetes self-management support and almost 6,000 diabetes retinal screens being delivered.

More people are receiving timely hospital care.

- More elective surgery is being delivered in Canterbury than ever before, with 17,066 electives delivered in 2013/14, up from 16,494 in the previous year and 14,974 two years ago.
- Fewer people are being acutely admitted to hospital, with acute demand analysis showing 20,000 fewer events that expected based on the national average.
- People are waiting less for treatment - 95% of patients were admitted, discharged, or transferred from our Emergency Departments within six hours and 100% of patients waited less than four weeks for radiation therapy or chemotherapy treatment.

The system is better connected.

- More than 600 clinically designed patient pathways now provide links across primary and secondary care to streamline referrals and improve outcomes for patients. The HealthPathway system has been so successful it is now being rolled out across 17 other health system in New Zealand and Australia.
- Over 80% of our hospital referrals from general practice are now received electronically through the Electronic Referrals Management System.
- eSCRV now enables all of the health professionals involved in a patients care to access important information to improve clinical decision making and reduce duplication across our system.

While the outcomes to date have been impressive, our challenges are not short-term pressures to which there is a 'quick fix' solution. Our health system is operating at full capacity. Resources are stretched, and every day we juggle reduced physical capacity with required repairs, patient need and staff safety.

While many of our challenges are the same as those that other DHBs face, the difference is the scale on which the Canterbury health system operates (with the second largest population and geographic area of all 20 DHBs) and the fragility of our infrastructure and our population in the wake of the earthquakes.

With capacity tightly restricted, we expect to contract private capacity to deliver some elective surgical services over the short term while we manage repairs to our facilities and complete the redevelopment of our hospitals. It is also likely that the way in which some community services are delivered will be reconsidered to allow for providers' capacity constraints.

In spite of our operating challenges, we will continue to harness innovation and motivate our workforce to improve productivity, systems and services and ensure that we are achieving the highest level of output possible.

We are fortunate that Canterbury has a strong collective vision and system-wide clinical alliances. These collaborative partnerships kept our health system together through one of the worst natural disasters in our country's history and we are confident we can continue to meet our challenges and take the next leap forward in the transformation of our health system

3.3 National direction

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

The ultimate health sector 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 health sector outcomes and Government commitments to provide *'better, sooner, more convenient health services'* by: increasing access to services and reducing waiting times; improving quality, patient safety and performance; and providing better value for money.

Alongside these longer-term national strategies and commitments, the Minister of Health's annual 'Letter of Expectations' also signals annual priorities for the health sector – most specifically with regards to the delivery of better public services and performance against the national health targets. [6]

The Canterbury DHB is committed to making continued progress against national priorities. Activity planned over the coming year to deliver on national expectations is part of the focus of the Canterbury Clinical Network (CCN) District Alliance and prioritised by the Alliance Workstreams and the DHB's Service Divisions.

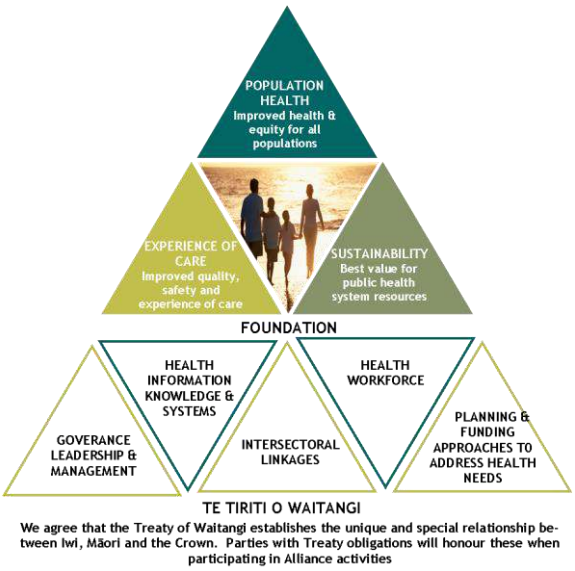
3.4 Regional direction

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

The South Island Alliance was established in 2011 to formalise the partnership between the five South Island DHBs. In 2013, the region's DHBs agreed to further develop this approach with a framework that aligns all regional activity to agreed goals. The '*best for patients, best for system*' framework has become '*Best for People, Best for System',* supporting a focus on the whole population. The shared vision has also been revised to include disability to ensure key population groups are identified within the framework.

A sustainable South Island health and disability 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.

While each DHB is individually responsible for the provision of services to its own population, working regionally enables us to better address our shared challenges and support improved patient care. The South Island DHBs are committed through the Alliance to making the best use of all available resources, strengthening clinical and financial sustainability and ensuring equitable access to services for our populations.



The Canterbury, Nelson Marlborough, West Coast, South Canterbury and Southern DHBs form the South Island Alliance - together providing services for 1,004,380 people (23.7%) of the total NZ population.

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

Closely aligned to the national direction, the shared outcomes goals of the South Island Alliance are:

- Improved health and equity for all populations.
- Improved quality, safety and experience of care.
- Best value for public health system resources.

Regional activity is implemented through service level alliances and workstreams. There are seven priority areas: Cancer, Child Health, Health of Older People, Mental Health, Information Services, Support Services and Quality and Safety.

Regional activity will is also focused on: cardiology, elective surgery, neurosurgery, public health, stroke and major trauma services. Regional asset and workforce planning, through the South Island Regional Training Hub, will contribute to improved delivery in all service areas.

Canterbury DHB is contributing to the achievement of the Regional Plan through membership of all activity streams and clinical leadership of the Mental Health, Health of Older People and Support Services streams.

Canterbury also contributes by leading the delivery of regional activity including the continued rollout of HealthPathways, Heath Connect South, the eReferrals Management Solution, InterRAI assessment tool and the development of regional care protocols.

Our commitment in terms of the regional direction is outlined in the Regional Health Services Plan, available from the South Island Alliance website: www.sialliance.health.nz. Key deliverables are also highlighted throughout this document.

[6] *The Minister's Letter for 2014/15 is attached as Appendix 7.*

Measuring Our Progress

How will we know if we are making a difference?

DHBs are expected to deliver against the national health sector 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 Government commitments to deliver '*better, sooner, more convenient health services*'.

As part of this accountability, DHBs need to demonstrate whether they are succeeding in meeting those commitments and in improving the health and wellbeing of their populations. There is no single measure that can demonstrate the impact of the work DHBs do, so a mix of population health and service performance indicators are used as proxies to demonstrate improvements in the health status of the population and the effectiveness of the health system.

In developing its strategic framework, the South Island DHBs identified three high-level strategic regional goals. To achieve these goals, we have agreed a number of key strategies which will be achieved through the delivery of regional initiatives and the collective activity of all five South Island DHBs. A comprehensive indicator set is currently under development, to sit alongside the regional strategic framework and enable evaluation of regional activity.

While the regional framework is developed, the South Island DHBs have identified four collective outcome goals where individual DHB performance will contribute to regional success - along with a core set of associated outcomes indicators, which will demonstrate whether we are making a positive change in the health of our populations. These are long-term outcome indicators (up to 10 years in the life of the health system) and as such, the aim is for a measurable change in health status over time, rather than a fixed target.

- *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 medical admission rates.

- *Outcome 2: People with complex illnesses have improved health outcomes.*

  A reduction in avoidable mortality rates.

  A reduction in acute readmission rates.

- *Outcome 3: People experience optimal functional independence and quality of life.*

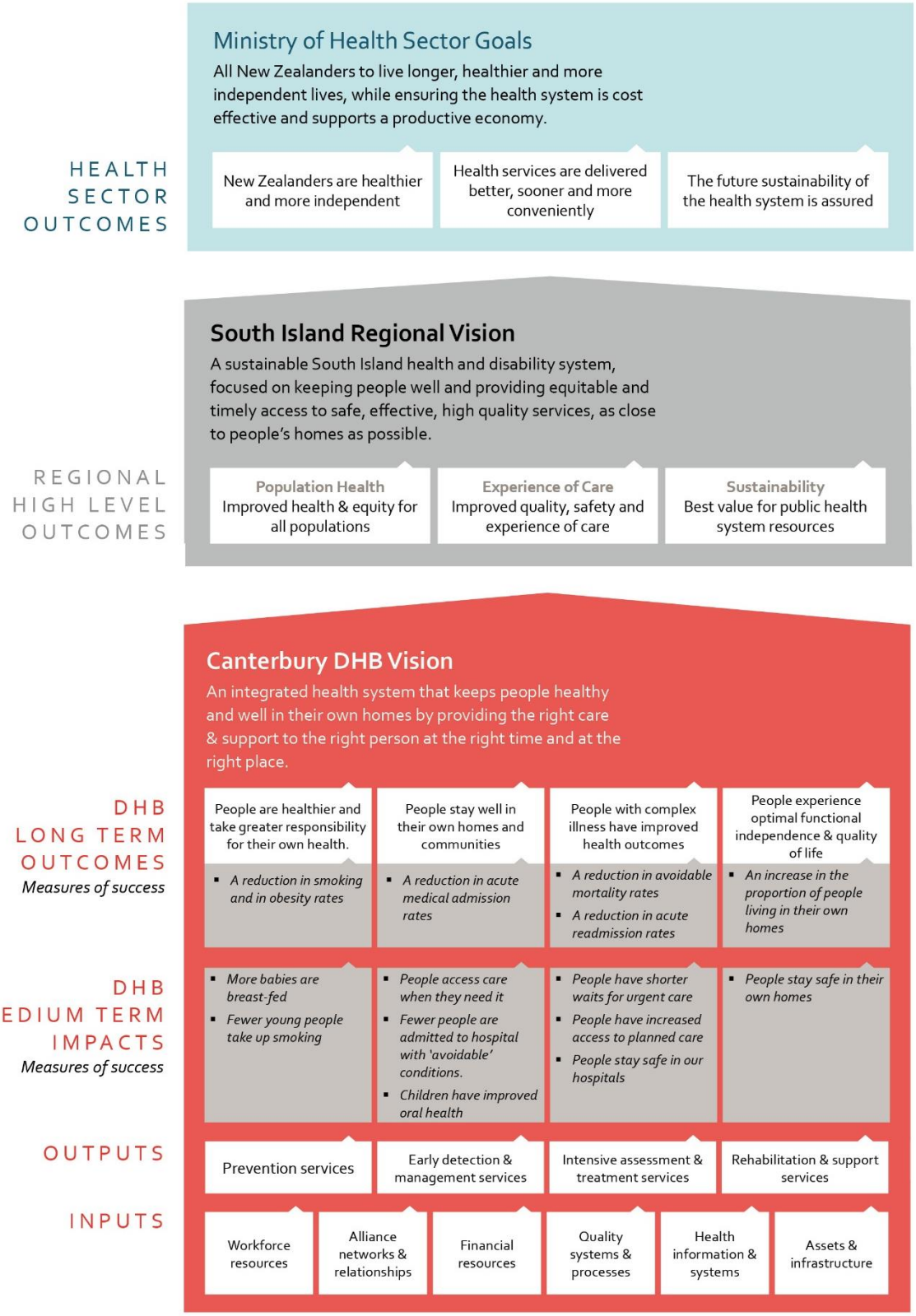
  An increase in the proportion of the population living in their own homes.

Each of the South Island DHBs has also identified a set of associated medium-term indicators of performance. Because change will be evident over a shorter period of time, these impact measures have been identified as the 'headline' or 'main' measures of performance, and each DHB has set local targets in their Annual Plans to evaluate their performance over the next four years. These indicators will sit alongside the 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: 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 the achievement of desired longer-term regional *outcomes* and the expectations and priorities of Government.[7]

[7] *The DHB has a Māori Health Action Plan, which is a companion document to the Annual Plan and sets out key performance measures to support improvements in Māori health and reduce inequalities. The 2013/14 Māori Health Action Plan is available on the DHB's website.*

Overarching intervention logic



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 causes of poor health and account for a significant number of presentations in primary care and hospital and specialist services. We are more likely to develop long-term conditions as we age, and with an ageing population, the burden of long-term conditions will increase. The World Health Organisation (WHO) estimates more than 70% of all health funding is spent on long-term conditions. Long-term 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 and common 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. Supporting people to make healthy choices will enable our population to attain a higher quality of life and to avoid, delay or reduce the impact of long-term conditions.

OUTCOME MEASURES LONG TERM

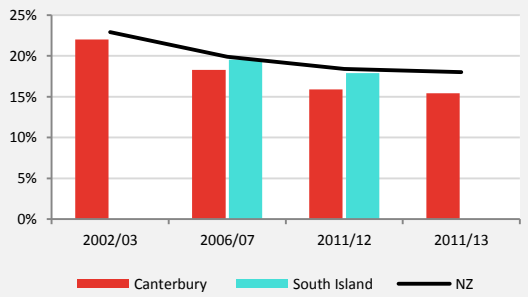
We will know we are succeeding when there is:

A reduction in smoking rates.

- *Tobacco smoking kills an estimated 5,000 people in NZ every year, including deaths due to second-hand smoke exposure. Smoking is also a major contributor to preventable illness and long-term conditions, such as cancer, respiratory disease, heart disease and stroke.*
- *In addition, tobacco and poverty are inextricably linked. In some communities, a sizeable portion of household income is spent on tobacco, meaning less money is available for necessities such as nutrition, education and health. Supporting our population to say 'no' to tobacco smoking is our foremost opportunity to reduce inequalities and target improvements in the health of our population.*

Data sourced from national NZ Health Survey.[8]

Outcome Measure: The percentage of the population (15+) who smoke.

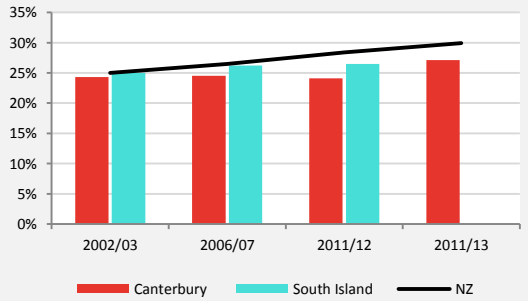


A reduction in obesity rates.

- *There has been a rise in obesity rates in New Zealand in recent decades. The 2011/13 NZ Health Survey found that 30% of adults and 10% of children are now obese. This has significant implications for rates of cardiovascular disease, diabetes, respiratory disease and some cancers (the leading cause of death in Canterbury), as well as poor psychosocial outcomes and reduced life expectancy.*
- *Supporting our population to maintain healthier body weights through improved nutrition and increased 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 sourced from national NZ Health Survey.[9]

Outcome Measure: The percentage of the population (15+) who are obese.



[8] *The NZ Health Survey was completed by the Ministry of Health in 2002/03, 2006/07, 2011/12 and 2012/13. However results by region and DHB are subject to availability. Results for 2011/12 and 2012/13 surveys were combined in order to provide results for smaller DHBs – hence the different time periods presented. Results are unavailable by ethnicity. The 2013 Census results for smoking (while not directly comparable) demonstrate rates for Māori, while improving, are still high, with 30.7% of Canterbury Māori (15+) being regular smokers down from 40.2% in 2006.*

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

IMPACT MEASURES MEDIUM TERM

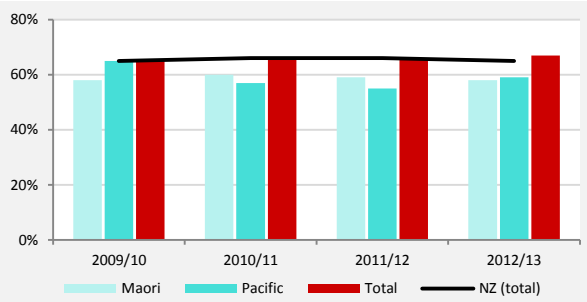
Over the next four years, we seek to make a positive impact on the health and wellbeing of the Canterbury population and contribute to achieving the longer-term outcomes we seek. The following headlines indicators will be used annually to evaluate the effectiveness and quality of the services the prevention services DHB funds and provides.

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 the bonding of mother and baby.*
- *An increase in breastfeeding rates is seen as a proxy measure of successful health promotion and engagement, access to support services and a change in social and environmental factors that influence behaviour and support healthier lifestyles.*

Data sourced from Plunket via the Ministry of Health.[10]

The percentage of babies exclusively or fully breastfed at 6 weeks.	Actual 12/13	Target 14/15	Target 15/16	Target 16/17	Target 17/18
	66%	68%	70%	72%	74%

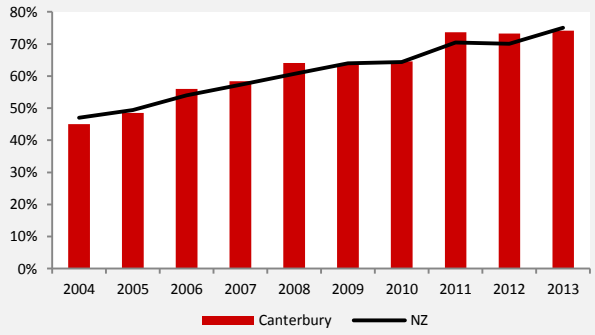


Fewer young people take up tobacco smoking.

- *Most smokers begin smoking by 18 years of age, and the highest prevalence of smoking is amongst younger people. Reducing smoking prevalence across the total population is therefore 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 measure of successful health promotion and engagement and a change in the social and environmental factors that influence risk behaviours and support healthier lifestyles.*

Data sourced from national Year 10 ASH Survey.[11]

The percentage of 'never smokers' amongst Year 10 students.	Actual 2013	Target 2014	Target 2015	Target 2016	Target 2017
	74%	75%	>75%	>75%	>75%



[10] *This data is provide nationally from the Ministry of Health and is Plunket only data. This does not include local WellChild/Tamariki Ora breastfeeding results. The target is based on national Well-Child standards for breastfeeding at 6 weeks.*

[11] *The ASH survey is run by Action on Smoking and Health and provides an annual point prevalence data set: www.ash.org.nz. A national result for 2013 was not available at the time of publication.*

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 for our population, but it reduces the rate of acute hospital admissions 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 for lower cost than countries with systems that focus on specialist level care.

General practice can deliver services sooner and closer to home and prevent disease through education, screening, early detection, diagnosis and timely provision of treatment. The general practice team is also vital as a point of continuity and effective coordination across the continuum of care, particularly in terms of improving the management of care for people with long-term conditions and reducing the exacerbations of those conditions and the complications of injury and illness.

Supporting general practice are a range of other health professionals including midwives, community nurses, social workers, personal health providers and pharmacists. These providers also have prevention and early intervention perspectives that link people with other health and social services and support them to stay well and out of hospital.

OUTCOME MEASURES LONG TERM

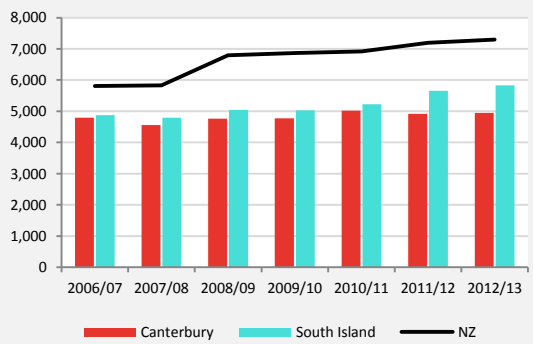
We will know we are succeeding when there is:

A reduction in acute medical admission rates.

- *The impact long-term conditions have on quality of life and demand growth is significant. By improving the management of long-term conditions, people can live more stable, healthier lives and avoid deterioration that leads to acute illness, hospital admission, complications and death.*
- *Acute (urgent) medical admissions can be used as a proxy measure of improved conditions management by indicating that fewer people are experiencing an escalation of their condition leading to an acute or complex intervention. They can also be used to indicate the population's access to appropriate and effective care and treatment in the community.*
- *Reducing acute hospital admissions also has a positive effect on productivity in hospital and specialist services - enabling more efficient use of resources that would otherwise be taken up by a reactive response to demand for urgent care.*

Data sourced from National Minimum Data Set.

Outcome Measure: The rate of acute medical admissions to hospital (age-standardised, per 100,000).



IMPACT MEASURES MEDIUM TERM

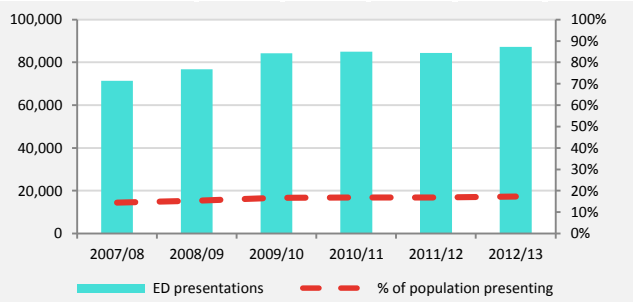
Over the next four years, we seek to make a positive impact on the health and wellbeing of the Canterbury population and contribute to achieving the longer-term outcomes we seek. The following headlines indicators will be used annually to evaluate the effectiveness and quality of the early detection and management services the DHB funds and provides.

People access care when they need it.

- *Supporting people to seek early intervention and providing alternative urgent care pathways will ensure people are able to access the right treatment at the right time, which is not necessarily in hospital Emergency Departments.*
- *Early and appropriate intervention will not only improve health outcomes for our population, but will also reduce unnecessary pressure on our hospitals.*
- *A reduction in the proportion of the population presenting to the Emergency Department (ED) can be seen as a proxy measure of the availability and uptake of alternative care options to more appropriately manage and support people in the community.*

Data sourced from individual DHBs.[12]

The percentage of the population presenting at ED.	Actual 12/13	Target 14/15	Target 15/16	Target 16/17	Target 17/18
	17%	<18%	<18%	<18%	<18%

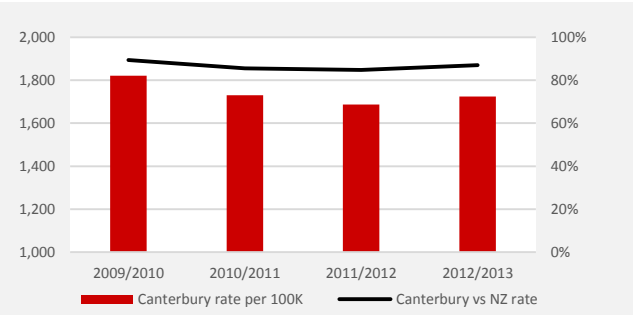


Fewer people are admitted to hospital with conditions considered 'avoidable' or 'preventable'.

- *A number of admissions to hospital are for conditions which are seen as preventable through appropriate early intervention and a reduction in risk factors.*
- *A reduction in these admissions provide an indication of the quality of early detection, intervention and disease management. It also frees up hospital resources for more complex and urgent cases.*
- *The key factors in reducing avoidable admissions are integration between primary/secondary services, access to diagnostics and the management of long-term conditions. Achievement against this measure is therefore seen as a proxy measure of a more unified health system, as well as a measure of the quality of services being provided.*

Data sourced from the Ministry of Health. [13]

The ratio of actual expected avoidable hospital admissions for our population (<75).	Actual 12/13	Target 14/15	Target 15/16	Target 16/17	Target 17/18
	87%	≤95%	<95%	≤95%	≤95%

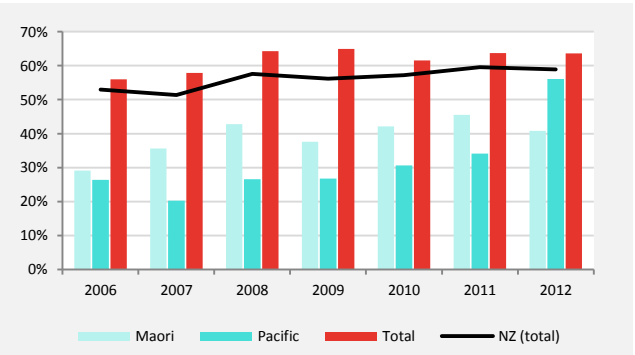


Children have improved oral health.

- *Oral health is an integral component of lifelong health and impacts a person's comfort in eating and ability to maintain good nutrition, self-esteem and quality of life.*
- *Good oral health not only reduces unnecessary complications and hospital admissions, but also signals a reduction in a number of risk factors, such as poor diet, which 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 measure of equity of access and the effectiveness of services in targeting those at risk.*
- *The target for this measure have been set to hold the total population rate steady while placing particular emphasis on bring the rates for Māori and Pacific children up.*

Data sourced from Ministry of Health.

The percentage of children caries-free at age 5 (no holes or fillings).	Actual 2012	Target 2014	Target 2015	Target 2016	Target 2017
	64%	≥63%	65%	>65%	>65%



[12] *The proportion of the population 'presenting' at ED is defined by the Ministry of Health national ED health target.*

[13] *This measure is based on the national 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 the standardised rate per 100,000 population, and the target is set to maintain performance at below 95% of the national rate. There is currently a definition issue with regards to the use of self-identified vs. prioritised ethnicity, while this has little impact on total population results it is having a significant impact on Māori and Pacific results against this measure hence they have not been displayed. The DHB is working with the Ministry to resolve this issue.*

STRATEGIC OUTCOME GOAL 3

4.3 People with complex illness have improved health outcomes

Why is this outcome a priority?

For those people who do need a higher level of intervention, timely access to high quality complex care and treatment is crucial in supporting people to recover or in slowing the progression of illness and improving health outcomes by restoring functionality and improving the quality of life.

As providers of hospital and specialist services, DHBs are operating under increasing demand and workforce pressures. At the same time, Government is concerned that patients wait too long for diagnostic tests, cancer treatment and elective surgery. Shorter waiting lists and wait times are seen as indicative of a well-functioning system that matches capacity with demand by managing the flow of patients through 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 that the South Island has the capacity to provide for the complex needs of its population now and into the future. It also reflects the importance of the quality of treatment. Adverse events, unnecessary waits or ineffective treatment can cause harm, resulting in longer hospital stays, readmissions and unnecessary complications that have a negative impact on the health of our population.

OUTCOME MEASURES LONG TERM

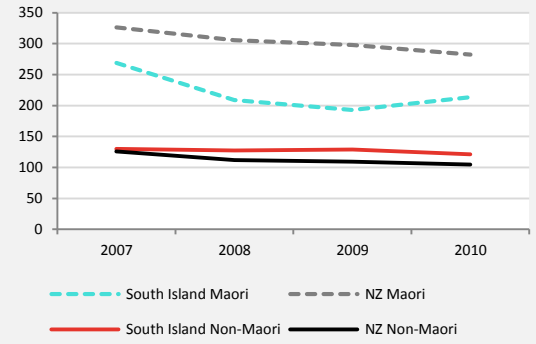
We will know we are succeeding when there is:

A reduction in avoidable mortality rates.

- *Timely and effective diagnosis and treatment are crucial to improving survival rates for complex illnesses such as cancer and cardiovascular disease. Early detection increases the options for treatment and the chances of survival.*
- *Premature mortality (death before age 65) is largely preventable with lifestyle change, earlier intervention and safe and effective treatment. By detecting people at risk and improving the treatment and management of their condition, the more harmful impacts and complications of a number of complex illnesses can be reduced.*
- *A reduction in mortality rates can be used as a proxy measure of responsive specialist care and improved access to treatment for people with complex illness.*

Data sourced from MoH mortality collection 2010 update.[14]

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

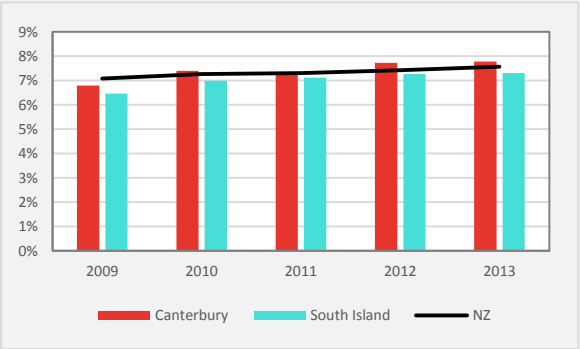


A reduction in acute readmission rates.

- *An unplanned acute hospital readmission may often (though not always) occur as a result of the care provided to the patient by the health system.*
- *Some acute readmissions can be prevented through improved patient safety and quality processes and improved patient flow and service integration - ensuring that people receive more effective treatment, experience fewer adverse events and are better supported on discharge from hospital.*
- *Reducing acute readmissions can therefore be used as a proxy measure of the effectiveness of service provision and the quality of care provided.*
- *Acute readmissions also serve as a counter-measure to balance improvements in productivity and reductions in the length of stay and provide an indication of the integration between services to appropriately support people on discharge.*

Data sourced from Ministry of Health.[15]

Outcome Measure: The rate of acute readmissions to hospital within 28 days of discharge.



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

[15] *This data is provided by the Ministry of Health and the DHB has identified a number of data inconsistencies compared to local calculations particularly with regards to patient transfers between hospitals being coded as readmissions. The DHB is working to resolve this issue.*

IMPACT MEASURES MEDIUM TERM

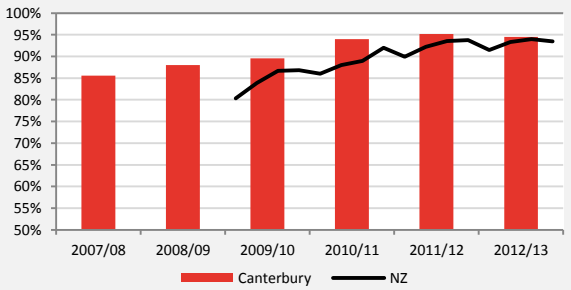
Over the next four years, we seek to make a positive impact on the health and wellbeing of the Canterbury population and contribute to achieving the longer-term outcomes we seek. The following headlines indicators will be used annually to evaluate the effectiveness and quality of the intensive assessment and treatment services the DHB funds and provides.

People have shorter waits for acute (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 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 indicative of how responsive the whole system is to the urgent care needs of the population.*

Data sourced from individual DHBs.[16]

The percentage of people presenting at ED - admitted, discharged or transferred within six hours.	Actual 12/13	Target 14/15	Target 15/16	Target 16/17	Target 17/18
	95%	95%	95%	95%	95%

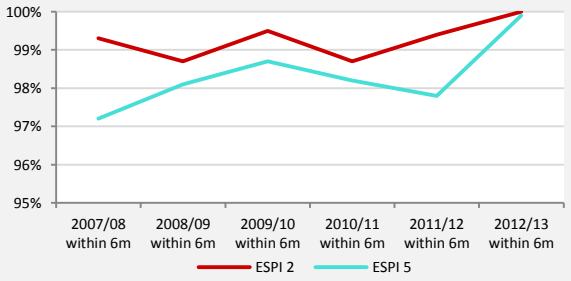


People have increased access to planned care.

- *Elective (planned) services are an important part of the healthcare system: these services improve the patient's quality of life by reducing pain or discomfort and improving independence and wellbeing.*
- *Timely access to services 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 indicative of how responsive the system is to the needs of the population.*

Data sourced from Ministry of Health.[17]

Wait time (months) referral to First Specialist Assessment (ESPI 2).	Actual 12/13	Target 14/15	Target 15/16	Target 16/17	Target 17/18
	<6	<4	<4	<4	<4
Wait time (months) commitment to treatment (ESPI5).	<6	<4	<4	<4	<4

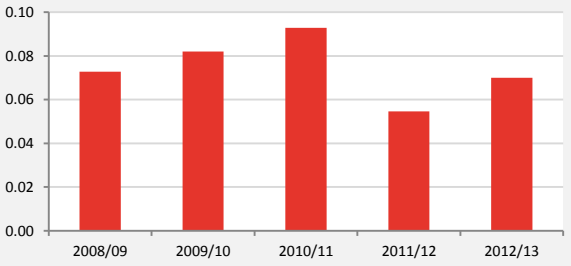


People stay safe in our hospitals.

- *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 sourced from individual DHBs.[18]

The rate of SAC level 1 and 2 falls in Canterbury Hospitals.	Actual 12/13	Target 14/15	Target 15/16	Target 16/17	Target 17/18
	0.07	0.07	0.06	0.06	0.06



[16] This measure is based on the national DHB health target 'Shorter stays in Emergency Departments' introduced in 2009/10.

[17] The Elective Services Patient Flow Indicators (ESPIs) have been established nationally to track system performance and DHBs receive individual performance reports from the Ministry of Health on a monthly basis. National average performance data is not made available. The wait time target for 2014/15 is mixed - being a maximum of 5 months for Q1 and Q2 and a maximum of 4 months from January 2015.

[18] The Severity Assessment Code (SAC) is a numerical score given to an incident, based on the outcome of the incident and the likelihood that it will recur. Level 1 and 2 incidents are those with highest consequence and likelihood. Data reported is per 1,000 inpatient bed days. This measure differs from previous years as quality initiatives are being introduced to prevent falls in all services, not just for those aged 65+.

STRATEGIC OUTCOME GOAL 4

4.4 People experience optimal functional independence and quality of life

Why is this outcome a priority?

As well as providing early intervention and treatment, health services play an important role in supporting people to regain their functionality after illness and to remain healthy and independent. There are also a number of services or interventions that focus on improving quality of life, such as pain management or palliative services.

With an ageing population, the South Island will require a strong base of primary care and community support, including home-based support, respite and residential care. These services support people to recover and rehabilitate in the community, giving them a greater chance of returning to a state of good health or slowing the progression of disease. Even where returning to full health is not possible, access to responsive, needs-based services helps people to maximise function with the least restriction and dependence. This is not only a better health outcome for our population, but it reduces the rate of acute hospital admissions and frees up health resources across the system.

OUTCOME MEASURES LONG TERM

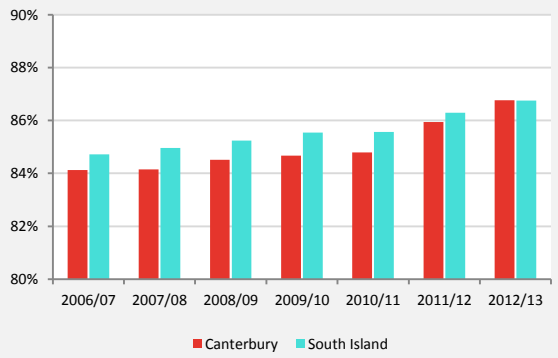
We will know we are succeeding when there is:

An increase in the proportion of the population living in their own home.

- *While living in Aged Residential Care (ARC) is appropriate for a small proportion of our population, evaluation of older people's services 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 facilities 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 people supported in their own homes can be used as a proxy measure of how well the health system is managing age-related long-term conditions and responding to the needs of our older population.*

Data sourced from Client Claims Payments provided by SIAPO.

Outcome Measure: The percentage of the population (75+) living in their own home.



IMPACT MEASURES MEDIUM TERM

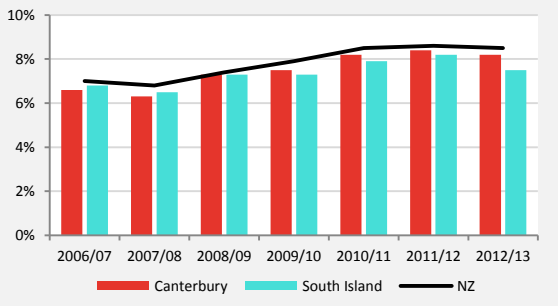
Over the next four years, we seek to make a positive impact on the health and wellbeing of the Canterbury population and contribute to achieving the longer-term outcomes we seek. The following headlines indicators will be used annually to evaluate the effectiveness and quality of the rehabilitation and support services the DHB funds and provides.

People stay safe in their own homes.

- *Around 22,000 New Zealanders (75+) are hospitalised annually as a result of injury due to falls. Compared to people who do not fall, those who do 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.*
- *The solutions to reducing falls address various health issues and associated risk factors including: medications use, lack of physical activity, poor nutrition, osteoporosis, impaired vision and environmental hazards.*
- *A reduction in falls can be seen as a proxy measure for improved health service provision for older people.*

Data sourced from National Minimum Data Set.

The percentage of the population (75+) admitted to hospital as a result of a fall.	Actual 12/13	Target 14/15	Target 15/16	Target 16/17	Target 17/18
	8.2%	7.9%	<7.9%	<7.9%	<7.9%



Our Organisational Capacity and Capability

What do we need to deliver our vision?

Having already identified the challenges we face and set a collective vision for the Canterbury health system, this section highlights the strengths that we have, and will continue to develop, over the next several years to support our transformation and deliver on our goals.

5.1 A patient-centred culture

Our culture is an important element in transforming and integrating our health system. To meet the needs of our population and fully achieve our vision, we need to be able to do things differently. We need a motivated workforce committed to doing the best for the patient and the system. We also need buy-in and support from our community.

Our weekly CEO messages and daily staff updates keep staff and health professionals from across the system 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.

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 prioritises patient's needs. 'Particip8' and 'Collabor8' now sit alongside 'Xcelr8', and all three change leadership programmes are open to anyone in the Canterbury health system, not just DHB employees.

We further engage and empower the Canterbury health workforce through our annual Quality Improvement and Innovation Awards, which recognise excellence in quality improvement across the system.

Investing in a patient-centred culture of participation, innovation, clinical leadership and continuous quality improvement, has helped us to build up considerable momentum and support for transformation. We are committed to maintaining this momentum as we continue the transformation of our system.

5.2 Effective governance & leadership

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 performance.

We are fortunate to have Board members who contribute a wide range of expertise to their governance 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.

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

Clinical 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 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/management model - in place across all service divisions. This model is replicated across the wider health system, with primary/secondary clinical leadership helping to drive transformation through the Canterbury Clinical Network District Alliance.

Clinical governance 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.

The DHB also has a Clinical Board; a multidisciplinary clinical forum that oversees the DHB's clinical activity. The Clinical Board 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.

Consumer participation in decision-making

There are a number of consumer and community reference groups, 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.

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, DHB and the Canterbury Clinical Network.

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 of the DHB.

Decision-making principles

The input and insight of these groups supports good decision-making, but the environment in which we operate still requires the DHB to make some hard decisions about which competing services or interventions to fund with the limited resources available.

The DHB has a prioritisation framework and set of 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 we review existing services or investments and support the reallocation of funding to services that are more effective in improving health outcomes and reducing inequalities.

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 Alliances & partnerships

Canterbury Clinical Network District Alliance

We recognise that 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.

In 2009 we established the Canterbury Clinical Network (CNN) District Alliance, a collective alliance of healthcare leaders, professionals and providers from across the health system. Under the umbrella of the District Alliance the systems key healthcare organisations (including the DHB) come together to improve the delivery of health care in Canterbury and realise opportunities to transform and integrate our health system.[19]

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 Centres and Community Hubs, the development of integrated patient pathways and the strengthening of clinical leadership as a fundamental driver of improved patient care.

Under the CCN, we have established a significant array of local service level alliances and workstreams to deliver these goals. The alliance streams also support the delivery of national expectations such as achievement of the national health targets.

The CNN Work Programme informs the direction of the DHB's annual work plans every year and is reflected in the DHB's Annual Plan (Section 6 and Section 8).

Healthy Christchurch partnership

Healthy Christchurch is a DHB-led, inter-sectoral partnership based on the World Health Organisation Healthy Cities model. The key idea is that all sectors and groups have a role to play in creating a healthy city, whether their specific focus is recreation, employment, youth, environmental enhancement, transport, housing or any other aspect of city life.

There are currently over 200 Healthy Christchurch Charter signatories, ranging from government agencies and business networks to voluntary sector groups and residents' associations.

Much of Healthy Christchurch's current focus is on the recovery of Christchurch. This will involve support and advice to policy and planning processes, community resilience initiatives, and a sustainable and accessible information portal for recovery practice and strategies - all of which contribute to the overall vision of a healthier Canterbury.[20]

[19] *Refer to Appendix 6 for an overview of the CCN structure. For further information, refer to www.ccnweb.org.nz.*

[20] *For further information: www.healthychristchurch.org.nz.*

Health in All Policies partnerships

The concept of 'Health in All Policies' (HiAP) describes an integrated and systematic method of including health in all policy assessment and decision-making. The concept involves working in partnership with other agencies and sectors seeking common outcomes. The premise is that health is greatly influenced by our lifestyles and the environment in which we live, work and play.

The DHB provides leadership for the Canterbury HiAP partnership with the local and regional councils and the Canterbury Earthquake Recovery Authority (CERA). This partnership uses health impact assessment and relevant methodologies to assess policies and initiatives for their potential impact on health outcomes - bringing in a health focus early in the policy-making cycle.

This partnership is ensuring coherent planning for communities, and the DHB is committed to an ongoing partnership role as the recovery gathers momentum.

Canterbury - West Coast transalpine partnership

The Canterbury and West Coast 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, human resources, information support and corporate services teams.

Formalising our collaboration with shared services, joint positions and clinical partnerships has allowed us to actively plan the assistance and services we provide to the West Coast and to build the most appropriate workforce and infrastructure in both locations.

Initial priorities have been to improve the use of video and telemedicine technologies and to develop protocols for the transfer of patients between the two DHBs.

Since 2010, more than 800 telehealth consultations have taken place in a variety of specialties, including oncology, paediatrics, general medicine, plastics, orthopaedics and general surgery – providing access to specialist advice while saving many families the inconvenience of travelling long distances for treatment.

A joint Specialist Recruitment Centre now provides expert advice and resourcing for both DHBs and supports training and secondment opportunities.

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.

In the next few years, the focus will be on transalpine medical and surgical services, services for older people, mental health services and further investment in telemedicine technologies to reduce the need for travel.[21]

National collaboration

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 Child Health 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 all aspect of 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 development and 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 Benefits Limited - for the benefit of our population and the wider health system.

5.4 Subsidiary companies

The Canterbury DHB has two operational subsidiary companies, which as wholly owned subsidiaries have their own Board of Directors (appointed by the DHB). Both subsidiary companies 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. Brackenridge operates a range of houses on its site and in the community, with a third of the clients living on the Brackenridge Estate. As at May 2014 125 clients were being supported. Funding comes from a number of sources with the main funder being the Ministry of Health. The DHB currently owns all shares in the company however, Brackenridge is working through consideration of future ownership, with the view to 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 a range of external 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 company's key output for 2014/15 is the processing (collection, laundering and delivery) of 4.74 million kilos or 13.11 million items of laundry.

[21] *For further detail refer to the West Coast Annual Plan, available at www.westcoastdhb.org.nz.*

Alongside the two operational subsidiary companies:

Canterbury together with Counties Manukau, Waitemata and Auckland DHB is an equal partner in the *New Zealand Health Innovation Hub*. The Hub works to engage with clinicians and industry to develop, validate and commercialise health technologies and services improvement initiatives that will deliver health and economic benefits to the whole of the New Zealand health system. Structured as a limited partnership, with the four foundation DHBs each having 25% shareholding, the Hub produces its own Statement of Intent which can be found at www innovation.health.nz.

Canterbury is also joint shareholder in the *South Island Shared Services Agency Limited*, which is wholly owned by the five South Island DHBs. The company remains in existence; however, following the move to a regional alliance framework, the staff now operate from within the employment and ownership of the Canterbury DHB, as the *South Island Alliance Programme Office*.[22] The Programme Office is jointly funded by the South Island DHBs to provide services such as audit, regional service development and project management with an annual budget of just over $4m.

5.5 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 the 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 and transparent 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 Referral Management System, Health Connect South and eSCRV. In the next few years Canterbury will also replace three hospital based patient administration system (PICs) with one new system in line with the rest of the country.

We will continue to work closely with clinicians and stakeholders across Canterbury to ensure that the right clinical information is provided in the right place, at the right time to the right person. 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.

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 adoption 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 now 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 patients 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.

The Collaborative Care Management System (CCMS) integrates clinical information and shared planning to support clinical teams to better manage individuals with complex needs and long-term conditions. There are already over 8,000 users and 4,500 care plans.

The Electronic Referral 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 carries 12,000 to 14,000 referrals every month. Canterbury is leading the rollout of ERMS across the South Island with the West Coast and South Canterbury DHBs now 'live'.

The Electronic Shared Care Record View (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. The eSCRV enables faster, safer, more informed treatment. Canterbury will lead the rollout of eSCRV across the South Island, beginning with the West Coast and South Canterbury DHBs in 2015, followed by Nelson-Marlborough and Southern DHBs.

The 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 begin to upgrade their old systems and implement the new PICS in 2016/17.

eMedications is a foundation system which promotes patient safety by improving medications management. The system has three components and is being rolled out regionally, with Canterbury to implement ePharmacy in 2014/15 and eMedications Reconciliation in 2015/16.

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 committed to implementing Phase I (collection of referrals to specialists) in 2014/15 and Phase II (non-admitted and associated referral information including diagnostic tests) from 2015/16.

Self-Care Patient Portal – enables patients to be involved in their care and is an essential part of the national vision. Canterbury will work with the PHOs to develop Patient Portals in the coming year.

[22] *Legal transfer of the employees and assets has taken place. The company will be retained as a shell, pending dissolution.*

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 in our health system.

Like all DHBs, our workforce is ageing and we face shortages and difficulties in recruiting to some professional areas. However, Canterbury has the added challenges of attracting staff in the aftermath of the earthquakes and supporting our workforce through a period of extraordinary stress and disruption.

The Canterbury DHB is committed to being a good employer, 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. We will also be reviewing current HR policy and agreeing a phased implementation plan to meet the new Vulnerable Children's Legislation requirements for worker safety checks and three yearly reassessments, as this comes into effect.

However, in Canterbury's current context, it is not sufficient just to be a good employer.

Our 2013 staff engagement survey demonstrated positive levels of engagement. Results showed 70% of our workforce was 'engaged', up from 67% in 2010. Unfortunately, results also showed that the post-earthquake stress that is increasingly evident across our community is also affecting our workforce.

As well as dealing with personal insurance issues, land re-zoning, house repairs and family relocation, our staff must cope with workplace repairs and disruption - all while addressing the increasingly complex health issues experienced by the people in their care.

Over 60% were still dealing with EQC and insurance issues and 20% identified disrupted work environments as having a negative impact on their wellbeing.

Over the next few years we will focus on building resilience through investment in employee wellbeing programmes, workplace support and counselling.

Expanding our workforce capacity

From a recruitment perspective, 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, Facebook and an Alumni and Employee Referral Programme 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 employs over 120 new graduate nurses each year through the national Nursing Entry to Practice programme. The DHB also has a collaborative partnership with Christchurch Polytechnic offering clinical placement for students undertaking Bachelors of Nursing.

CANTERBURY DHB WORKFORCE		
DHB Total Headcount	*Turnover*	*Sick Leave*
9,646	8.7%	3.6%
81% female	8.4% nationally	3.6% nationally
Average Age	*Largest Ethnic Group*	*Diversity*
49 years	NZ European	96 ethnic groups
Largest Workforce	*Oldest Workforce*	*Terms*
Nursing 4,396	Corporate Support	47% part time
47% of workforce	Avg. Age 52 years	80% permanent

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.

Over the next year in conjunction with our primary care partners, we will begin to build an integrated approach to workforce planning that will include improved reporting, analysis and predictive modelling to help understand our whole health systems current and future needs.

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. We have 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.

The Professional Development Recognition Programme and the Regional Allied Health Assistant Training Programme are helping to expand the scope of existing roles and establish new ones. New advanced gerontology nurse specialist and haematology roles also reflect a more connected and capable workforce.

Investment in primary care education enables GPs, practice nurses and pharmacists to attend peer-led, evidence-based education sessions. Aligned to the transformational across Canterbury, these sessions promote the use of clinical best practice and integrated pathways and increase the capability of our system.

The South Island Tertiary Alliance has developed its first leadership and management development curriculum for all health employees in the South Island. Actively supported by Health Workforce NZ, this will support career enhancement and maximise people's potential.

We have also 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 be on Diabetes Nurse Prescribers, Sonographers, GPEP2 training for general practice registrars and implementation of the new 70/20/10 training in medical disciplines. E-learning packages will be progressively roll-out regionally and a full suite of packages will be available on-line 2015/16.

5.7 Investment in quality & safety

Our patient-focused, clinically led culture supports two of our health system's greatest strengths: our commitments 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. A detailed desk audit will be completed in the coming year.

Working with the South Island Quality & Safety Alliance we are implementing a regional Incident and Risk Management system (ICNET) as part of our routine incident management process. This will provide ready access to trends in incidents and risks as well as support the completion of root cause analysis 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 make available vital signs, diabetes charts and fluid balance charts to e-prescribers, enhancing clinical decision-making.

Canterbury is committed to progressing the Health Quality & Safety Commission's (HQSC) national priority areas: reducing hospital-acquired infections, reducing harm from falls, and improving medication and surgical safety. We will continue to report and monitor our performance against the HQSC Quality and Safety Markers and engage in national pilots.

The DHB also 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 key activity and goals across the Canterbury health system, with particular emphasis on priority areas for the Clinical Board. These are refreshed annually.

In line with the national direction, our Clinical Board will champion quality and safety projects focused around:

Improving the patient experience

We recognise that consumers have a unique perspective of health services and are able to provide important information about the experience of care they receive. By working in partnership, we will be able to improve their experience as well as their health and wellbeing. Working closely with our Consumer Council the DHB is facilitating consumer focus groups, gathering consumer stories and identifying effective methods for gathering feedback to help us improve the experience for our consumers.

Preventing healthcare-associated infections

Admission to hospital exposes patients to potential harm through healthcare-associated infection, and we are committed to minimising this risk through three specific projects, in line with the HQSC.

Hand hygiene is an important measure in the fight against healthcare-acquired infections. The 'five moments' of hand hygiene are the key opportunities for staff to dramatically reduce the risk of spreading infection.

Surgical site infections are the second most common healthcare-associated infection. 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.

Another key focus for infection prevention is central-line-associated bacteraemia (CLAB). The use of a central line introduces a potential track for infection, so prevention is a major quality target for critical care. Reducing the number of CLAB infections will lead to safer patients, shorter stays in Intensive Care Units and reduced costs.

Preventing harm from falls

We are committed to achieving a system-wide goal of zero harm from falls with prevention in the community and in our hospitals. Reducing harm from falls is a key component in our strategies for improving the health of older people and reducing acute demand.

We will continue to invest in our community falls champion 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 will continue to pay close attention to the evidence-based essentials of falls prevention and to the specific falls risk for each elderly patient in our care. We will introduce an electronic nursing patient observation system that will record falls risk. This system will revolutionise audit processes, making data visible and real time, assisting with improving adherence to protocol.

Medication and surgical safety

The use of medications always carries the risk of a side effect, allergy or other adverse outcome and we are participating in the national medicine reconciliation and electronic medicines management initiatives being driven through the HQSC. We also maintain an Adverse Drug Event Trigger Tool initiative which provides valuable information about the severity and type of medication events occurring and helps us identify where we need to focus our safety improvement initiatives.

We are also committed to ensuring that the Safe Surgery Checklist is used in our operating theatres. The checklist will assist in improving outcomes by promoting better communication and teamwork in the operating room.

5.8 Research and innovation

A significant body of clinical research is conducted within the Canterbury DHB, with over 400 current projects on our Research Register. 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.

The Research Office is a shared facility funded by the University of Otago (Christchurch) and the DHB and provides open access service for anyone involved in health research working within these organisations. While directing research remains the role of the principal investigator, the Research Office offers functions, such as: providing advice; supporting staff who do not work within a research-based environment; ensuring that clinical groups are adhering to the policy; and maintaining the Research Register. A major focus is also the dissemination of research grant funding information and the provision of advice and assistance to applicants.

Innovation

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 between.

In tandem with this national system, Canterbury has a strong health innovation environment. The Via Innovations brand, launched in late 2012, has strengths in health IT and health service delivery improvement, and represents the CDHB'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.

5.9 Repair and redesign of facilities

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

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 working in inadequate and temporary locations.

The redevelopment of the Burwood and Christchurch Hospitals will be the largest health-related building project in New Zealand's history and will allow us to begin rebuilding part of the health capacity required in Canterbury. However, it is important to realise that this does not address all of our facilities issues.

Our health system will continue to have significant capacity challenges for a number of years. The Burwood Hospital redevelopment will not be completed until 2015, and Christchurch Hospital will not be completed until 2018. In the meantime, we have to continue to maintain service delivery and operate safely with fewer hospital beds and severely damaged infrastructure.

Outside of the redevelopment, we have thousands of damaged rooms, causing continued disruption as we shift and relocate services to repair them. This invasive repair programme will put additional pressure on our workforce and moving services around will increase inter-hospital patient transfers and, despite our best efforts is likely to fragment clinical teams and services.

The timing of the rebuild projects is critical. As we begin repairs, we must make careful decisions about short-term capital investments in the context of the longer-term direction, or health dollars will be wasted. This risk is heightened by changes in building codes, which increase the extent and cost of repairs - not all of which is covered by insurance.

In order to avoid costly and wasteful investment, close alignment of redevelopment and repair programmes is essential, and the DHB is working closely with Ministry of Health through the nationally appointed Hospital Redevelopment Partnership Group to ensure that the most is made of every opportunity.

The DHB is also working closely with primary and community health and social services providers 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.

The business case for the redevelopment of the Kaikoura Hospital site as an Integrated Family Health Centre received Cabinet and Capital Investment Committee approval in April 2013. Detailed design plans have been completed and the DHB expects to commence construction in mid-late 2014.

The DHB will progress development of the Community Hub in Rangiora in the coming year. Detailed design plans have been completed and the first phase of construction is set to being mid-late 2014.

In Ashburton demolition is already underway in preparation for development of a new theatre block, acute admitting unit and ward refurbishment. Construction will be completed in 2015.

The development of the Christchurch Health Precinct is another major anchor project under the Christchurch City Rebuild. The DHB is working in a partnership with the Christchurch Central Development Unit, Universities of Canterbury and Otago and the Christchurch Institute of Technology on this project. Our outpatient, teaching and parking facilities are being considered in this master plan.

The DHB will also carefully consider the future of all of its rural hospitals, many of them significantly damaged by the earthquakes. A Rural Strategy will consider the role of facilities, alongside strategies for the future sustainability of health services in rural communities.

Part III – Annual Outlook

Delivering Our Service Priorities

Connecting our health system

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 managing patient flow and reducing demand becomes critical. The answer to improving the health of our population, meeting the demands on our system and rebuilding our lost capacity 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.

Our approach has been to bring health professionals from the community, general practice and hospital specialties together under the banner of the Canterbury Clinical Network (CCN) District Alliance. By working alongside one another to design new models of care we are streamlining the interface between services and improving outcomes for our population by making the best use of all our health system's resources. Under the Alliance, newly evolving radiology, laboratory and pharmacy models are focusing on freeing up specialists to play a bigger role in patient care as part of multidisciplinary teams. Backed by integrated information systems this approach is improving both service quality and clinical outcomes.

6.1 Service integration

To deliver truly seamless care for our population, the whole Canterbury health system must be engaged in the vision, connected through system-wide pathways and shared information systems, and supported by infrastructure that complements and enables responsive service delivery models.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY [23]**
Continue to 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. Develop a leadership succession plan for CCN to ensure the sustainability of the District Alliance. Broaden the range of partners within the District Alliance. Support implementation of the Integrated Performance and Incentive Framework (IPIF) once developed nationally.	More signatories to the district alliance agreement – base 8. Increased visibility of CCN activity and system improvements. Mechanism for implementation of IPIF established in line with national timeframes.
Invest in the development of a Rural Health Strategy to create a clear vision and tailored rural health solutions.	Support the Rural Health Workstream to deliver a fit for purpose vision of sustainable health services for rural areas. Support the Rural Funding Service Level Alliance to determine the distribution of rural subsidies for the Canterbury region. Consolidate, fund and implement models for sustainable after-hours services in rural areas. Support strategies and initiatives to improve mental health and wellbeing and improve the resilience of the rural population.	Agreed rural solutions documented and recommended to ALT Q4. Rural Funding allocations reviewed and distribution plan agreed Q4. Rural Funding distribution plan implemented Q1 2015/16.
	Facilitate the increased use of video conferencing technology for education, peer support, supervision, and clinical sessions to reduce to need for patient travel.	Video conferencing technology embedded in remote rural practices Q4.
	Bring a rural voice to the Canterbury-wide recruitment strategy to ensure retention and recruitment initiatives support a full staffing complement in rural areas. Monitor and provide input to the development of a Canterbury Locum Coordination Service	Canterbury Locum Coordination Service operational Q4.
Implement new models for community pharmacy services to promote the role of the pharmacist in the multi-disciplinary team.	Support the Pharmacy Service Level Alliance (SLA) to oversee the Demonstration Pharmacy Programme and foster patient-centred clinical relationships across the system. Facilitate the implementation of 'Lean' principle and practices in demonstration sites to free up pharmacists for patient care. Enable access to eSCRV and CCMS in Demonstration Sites as part of the integrated approach to care planning. Support effective use of Pharmacy Long-term Condition (LTC) Assessments and funding (under the national contract). Continue to support the Medication Management Service (MMS) give people greater understanding of their medications and reduce the risk of harm from medications use.	Demonstration site evaluation completed Q2. Lean resources toolkit available to demonstration sites and wider community pharmacy Q2. More patients enrolled in the Pharmacy LTC programme – base 11,901. 2,000 people referred to MMS.

[23] *The Q references refer to quarters of the financial year Q1: July-September, Q2: October-December, Q3: January-March and Q4: April-June.*

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Develop a responsive radiology service to improve access to diagnostics and support appropriate clinical intervention and treatment.	Support the Radiology Service Level Alliance to develop a seamless radiology service that provides radiology images and reports to clinicians in both public and private practice. Implement service development initiative to improve imaging quality and reporting at Kaikoura Hospital. Support continuous process improvement through service audits on wait times and service quality of contracted providers. Align radiology referral and triage criteria (across and between primary and secondary care) to improve equity of access to radiology services and appropriately target acute services.	GP access to Ultrasounds, X-ray and CT scans maintained. 90% of accepted referrals for CT scans receive their scan within six weeks. 80% of accepted referrals for MRI scans receive their scan within six weeks.
Implement a seamless and patient-centric model of laboratory services to support appropriate clinical intervention and treatment.	Support the Laboratory Service Level Alliance (SLA) to complete the review of sample collection sites and roll-out the new collection centre plan to improve access to laboratory services. Undertake laboratory patient satisfaction surveys on all aspects of laboratory service and identify areas for improvement. Work with practices to encourage timely communication of test results and identify strategies to support patients to better access and understand their laboratory test results.	Consultation with collection centre users completed Q1. First Centres relocated Q4. Increased proportion of patients test results are explained Q4. Advice and education provided to referrers via HealthPathways.
Support the closer alignment of clinical information, processes, systems and technology to support the transformation of the system.	Continue to maintain direct GP access to elective surgical procedures lists and specialist advice with ongoing GP-2-GP referral, procedure training and specialist oversight. Maintain current clinical HealthPathways to support the delivery of the right care, in the right place, at the right time. Support the expansion of 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 25,451.
	Continue to support the use of eSCRV to provide secure access to a patient's key health information in any health setting. Continue to support the use of ERMS to streamline referrals and improve triaging capabilities within the system. Further enhance the capability of the Collaborative Care Management Solution (CCMS) to better coordinate care for individuals with long-term conditions/complex health needs.	95% of general practices and pharmacies have access to eSCRV. ≥80% of all GP referrals to CHCH Hospital are e-Referrals via ERMS. Increase number of CCMS records – base to be established Q1.
Support the closer alignment of physical infrastructure to the model of care.	Enable the IFHS Governance Group to support general practice to develop and implement Integrated Family Health Services (IFHCs) and encourage projects in targeted areas of Christchurch city where high demand and limited capacity are evident. Support implementation of the Collaborative Care Programme and CCMS in newly developed IFHSs. Develop an IFHS Training Programme to support Canterbury general practices and PHOs in developing IFHCs.	IFHS Process training package developed Q1. 6 IFHS groups in progress phase. 10 IFHS groups engaged in implementation phase.
	Support the Kaikoura Service Level Alliance to deliver the IFHC facility and strengthen the integration of rural health services. Enable information transfer between Kaikoura service providers with support of a common Patient Management System. Continue to support the Akaroa community to develop a community owned and operated Akaroa IFHC. Continue to explore the feasibility of a private development of an IFHC on Ashburton Hospital grounds.	Construction of the Kaikoura IFHC underway Q1. Shared patient record in use in Kaikoura Q3. Decision on Akaroa IFHC developments Q1. Decision on Ashburton IFHC development Q1.
	Complete the development of the Rangiora Community Health Hub to provide a range of outpatient and community specialist activity alongside extended primary care in Rangiora.	Construction of the Rangiora Community Hub underway Q1. Maternity and Flexi-Beds open Q3.

6.2 Disease prevention

The World Health Organisation estimates that more than 70% of healthcare funds are spent on long-term conditions. Many long-term conditions share common risk factors, such as smoking, inactivity, poor nutrition and obesity. By promoting healthy lifestyles and supporting people to identify and reduce their risk factors, many long-term conditions are preventable.

International literature on disaster recovery indicates an increase in risk behaviours is typical in response to stressful events, and those vulnerable prior to the disaster have an increased risk of poor health. The earthquakes have had a considerable impact on Canterbury residents, with many people shifting from their homes and becoming disconnected from their usual community and support networks. The impact on people's health and wellbeing is not always immediate and may develop and progress for several years after the event.

As we rebuild our communities, it is crucial that we continue to provide population and community-based prevention, education and support services that promote wellbeing and healthy lifestyles. Without a deliberate focus, unhealthy lifestyle behaviours and the impact on people's wellbeing may become ingrained for the longer-term.

Canterbury has a detailed Public Health Action Plan for 2014/15, which can be found at www.cdhb.govt.nz.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Ensure health and wellbeing are considerations in earthquake recovery to positively influence the key determinants of health.	Lead the inter-sectorial work of Healthy Christchurch. Work alongside the Mental Health Foundation to lead the 'All Right?' social marketing wellbeing campaign. Update issues papers for the City Health and Wellbeing Profile to inform cross-sector recovery work and promote the use of Health and Social Impact Assessments. Engage with CERA and CCC rebuild and recovery planning, including participation in the Community Wellbeing Planners Group (CWPG), Interagency Psychosocial Committee, CERA Wellbeing Survey (CWS) Working Group, and Canterbury Wellbeing Index Project (CWI). Partner with ECAN to ensure health and drinking water quality are key considerations in the Canterbury Water Management Strategy.	A regular programme of Healthy Christchurch hui and lunchtime seminars is developed, with 2 hui and 8 seminars held. 'All Right?' campaign evaluation initial results available Q2. 1-2 medium-scale Health Impact Assessments completed Q4.
Contribute to programmes and initiatives that improve housing quality.	Work alongside Community Energy Action encouraging referral of vulnerable people to the 'Warm Families' programme. Contribute to the work of the CERA-initiated Sustainable Homes Working Party to further enable sustainable home improvements. Continue to contribute to cross-sector initiatives to resolve housing issues, particularly for unwell and at-risk families and support health organisations to identify housing issues and locate help.	Increased referrals to Warm Families Q4. CDHB contribution is evident in relevant group/project outputs.
Implement programmes that reduce the harm caused by alcohol.	Build on DHB Alcohol Position Statement and facilitate development of DHB Alcohol Harm Reduction Strategies (AHRS), with associated outcomes frameworks and indicators. Develop new communication tools to engage and inform patients and professionals around alcohol misuse and improve the overall response of the health sector in addressing alcohol-related harm. 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. Participate in national Health Promotion Agency activity aimed at preventing Fetal Alcohol Spectrum Disorder.	AHRS Outcomes framework developed Q2. 30 host training sessions delivered Q4. All licence applications responded to within 15 working days. 12 CPOs and 12 night-time visits completed 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 (such as 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.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Through the DHB Advisory Group and Smokefree Canterbury work to ensure an integrated approach towards Smokefree Aotearoa 2025.	Update the Canterbury's DHB 2012-15 Tobacco Control Plan. Refine the Smokefree Canterbury's website to match the uptake of cessation services, policy templates and toolkits. Continue work with local councils to extend smokefree public spaces and provide advice on implementing smokefree social housing. Continue to support social service organisations, schools and workplaces to establish smokefree policies and environments to reduce smoking and support increase quit attempts. Establish the Health Precinct as a 'role model' smoke free space.	Updated Plan in place Q2. >73% of year 10 students have 'never smoked'. ≥7,000 Canterbury residents seek cessation support from Quitline. <5% of the population will be current smokers by 2025.
Build on gains made in the delivery of the ABC programme within primary care with a continued focus on successful strategies to achieve the health target.[24]	Support the development of individual practice smokefree policies and identification of clinical leads to champion the ABC programme and ensure the health target is 'owned'. Continue DHB, PHO and Practice-level performance tracking and review to enable targeting of practices where performance is low. Expand use of advanced IT tools to prompt and capture ABC activity including Text-2-Remind and appointment scanners and support practice-level coaching to improve the recording of interventions. Supplement the positive inquiry and education by PHO practice liaison and support teams with additional targeted support from the ABC Smokefree team to improve performance and systems. Share primary and secondary ABC data to ensure follow-up of patients as clinically indicated and matching of activity. Continue to support regular health target meetings between DHB and PHO leads to review performance and targets.	Monthly monitoring of performance against the health target. Advanced IT tools in place in all practices Q1. 50 ABC training sessions delivered in primary care by the ABC team Q4. Quarterly progress towards 90% of enrolled patients seen in general practice being provided with advice and help to quit.
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 where 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. Review and revise the process for the distribution of Quit packs to make this easier for staff and reduce time spent making packs. Progressively introduce 'ABC data fields' to all new electronic documentation.	Monthly monitoring of performance against the health target. Quit Pack process streamlined Q2. >250 staff members receive ABC training Q4. 95% of all hospitalised smokers are provided with advice and support to quit.
Support the provision of advice and support to pregnant women who smoke.	Support the DHB's LMC Liaison to engage LMCs in delivering ABC and provide a feedback loop on performance against the targets. Offer Smokefree and ABC training to LMCs, including spaces on DHB lunchtime training sessions. Work alongside LMCs, Smokechange, Aukati Kaipipa and Pacific Quit Coaches to provide cessation support to pregnant women. Through the Well Child Tamariki Ora Quality Improvement Plan identify opportunities to increase the proportion of mothers smoke free at two weeks postnatal with a particular focus on Māori.	Training sessions offered to LMCs Q1. Cessation data review Q2. 90% of pregnant smokers are offered advice and support to quit. 86% of mothers smoke free at two weeks post natal.
Provide targeted community-based ABC and cessation support to high risk population groups.	Continue to provide ABC training to pharmacy staff to increase the number of ABC interventions provided. Continue to provide targeted cessation support through Pacific Trust Canterbury and the Aukati Kaipaipa cessation programme. Maintain the electronic referral pathway to specialist cessation providers to streamline and increase cessation referrals.	≥1,000 Quit Cards provided by Pharmacy Q4. ≥100 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.*

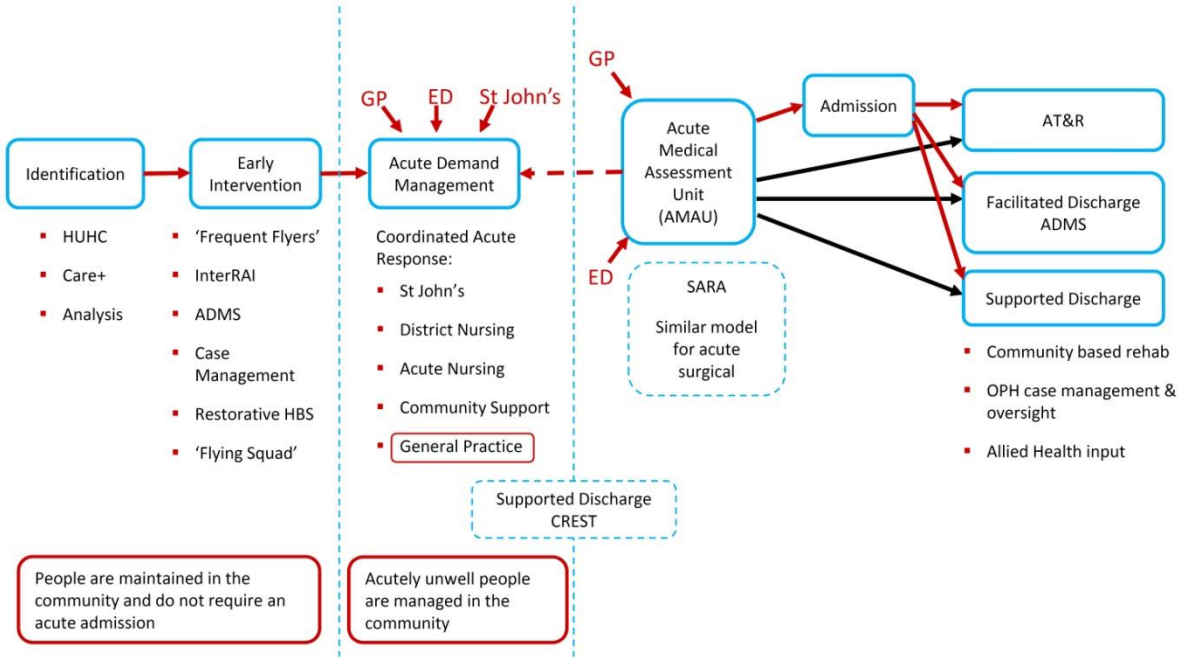
6.3 Acute demand management

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 constrained hospital resources. Canterbury's whole-of-system approach to managing acute demand has enabled us to successfully maintain the lowest age-standardised rate of acute medical admissions of any large DHB in the country (and the second lowest rate of overnight admissions).

This work is being driven under the CCN through the Urgent Care Service Level Alliance, whose members are clinicians, health professionals and managers from across the system providing their collective thinking and experience to developing strategies and initiatives to reduce the pressures of acute demand. Their focus has been on ensuring an appropriate mix of urgent care services are available, so that only people who need hospital services present at emergency departments (ED), and that people leaving our hospitals are appropriately supported on discharge - reducing both the time spent in hospital and the likelihood of readmission. This picture also involves making the very best use of our ED resources enabling clinical teams to ensure people get the care they need quickly and that only those who need hospital services are admitted.

In 2012/13, Canterbury's Acute Demand Management Service (ADMS) managed 25,374 episodes of urgent care in the community rather than in hospital. Many acute admissions result from exacerbations of long-term conditions, so acute demand services have close links with programmes that optimise the management of long-term conditions both in terms of prevention and rehabilitation.

FIGURE 1: CANTERBURY'S IMPROVED ACUTE CARE MODEL



OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Continue to develop and refine community-based acute demand response to ensure only people who need hospital services present at ED.	Promote calling general practice as first point of (phone) contact 24/7. Maintain zero fees after hours for children under six and free afterhours nurse phone advice and triage service. Engage in strategies to increase enrolment with general practice amongst people new to Christchurch (particularly the rebuild population). 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 hospitals. Maintain direct GP access to diagnostics including urgent blood tests, X-Rays and Ultrasounds. Engage St John Ambulance crews to use the Ambulance Referral Pathway and ADMS to safely manage patients in the community (with a key focus on COPD and Heart Failure patients). Enable proactive management of vulnerable patients in the community through investment in community observation capacity.	>25,000 urgent care packages provided in the community. >400 patients utilise the Ambulance Pathway. Rate of acute medical admissions maintained at <5,000 per 100,000. Proportion of the population presenting to ED maintained at ≤18%.
Deliver shorter stays in emergency departments.	Develop cross-hospital agreements to maximise patient flow from arrival (including GP referral) to exit from ED which are robust enough to manage winter peaks and capacity/bed constraints due to invasive repairs. Progressively implement the national ED Quality Framework and associated ED Quality Measures in line with national expectations. Use the ED Quality Framework to review key ED performance metrics and improve patient flow via visible ED dashboards. Further develop and refine the acute patient journey in AMAU to eliminate wasted time and ensure patients are admitted or supported for early discharge in the community. Continue to proactively address key contributors to ED overcrowding including: unenrolled population demand (i.e. rebuild workforce), primary care capacity for same day/early evening appointments, length of stay, wait times for inpatient services and frequent attendees patterns.	Reporting against ED Quality Measures Q1. ED Quality Framework introduced in line with national expectations Q3. 95% of people presenting at ED are admitted, discharged or transferred within 6 hours.
Improve facilitated discharge services to reduce the time spent in hospital and the likelihood of readmission.	Complete the implementation of the Restorative District Nursing and Community Support Services model to better support people on discharge and reduce the likelihood of readmission. Apply acute demand resources to support transition to the community from ED and timely discharge for patients where appropriate. Work alongside COPD, Heart Failure and Frail Older Person's Pathway development teams to implement targeted responses that improve the flow of patients to the most appropriate services. Ensure older people (65+) discharged after fall events are referred to the Falls Prevention Programme to reduce the risk of further falls. Expand CREST services (and ADMS) to maximum capacity to support earlier discharge from hospital and reduce the likelihood of admission or readmission.	>1,200 people (65+) referred to community-based falls prevention services. >2,200 people accessing CREST Services. Reduction in beds occupied by patients aged 75+ for more than 14+ days – baseline 197. Acute inpatient average length of hospital stay maintained at ≤3.86 days.
Ensure the effectiveness of the Urgent Care Programme by evaluating and redefining priorities.	Review acute demand (and supported discharge) services to ensure they are targeted at patients with the greatest capacity to benefit and support people with the highest level of need. Participate in national and 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).	Monthly data reporting Q1. Primary/Secondary dataset produced Q3. Links established with similar programmes nationally and internationally Q4.

6.4 Long-term conditions management

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

Our approach in addressing long-term conditions is to support good systematic practice at every point of the care continuum while aligning service models and funding to facilitate earlier intervention and treatment. This work is driven by clinically led service groups who review patient pathways across our health system and identify opportunities to improve patient care. Closely aligned to our acute demand strategy, our approach to long-term conditions management is already reducing acute and avoidable admissions into our hospitals and minimising the impact long-term conditions have on people's lives.

The clinically led Integrated Respiratory Service was one of the first focus areas where health professionals from across the system came together to design and implement more integrated models of care 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, including sleep assessments and mobile spirometry testing. The development of alternative ambulance pathways with people with Chronic Obstructive Pulmonary Disease (COPD), a major cause of prevented hospital admission, has also been a major shift with over 40% of winter COPD call-outs now being safety treated in the community rather than in hospital emergency departments.

A deliberate focus, through our Collaborative Care Programme (CCP), on improving the identification of people at-risk, proactive self-management and integrated care planning for those with long-term and complex conditions will further improve outcomes for our population. The CCP is a coordinated and multi-disciplinary Programme that places the patient at the centre (by involving them in the development of their care plan) and facilitates the sharing of that care plan across all the clinical teams involved with the patient. The Programme is clinically led and supported by dedicated primary care liaisons and care coordinators who facilitate the development of the care plans and the management of patients.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Improve the coordination of care and support for all patients identified with long term and complex health conditions.	Encourage identification and enrolment of patients with long-term and complex conditions into the Collaborative Care Programme. Support clinical teams to develop and refine shared-care-plans for complex patients with access to, and training in, the Collaborative Care Management Solution (CCMS) software. Facilitate monthly Model of Collaborative Care Advancement meetings to support care coordinators to deliver a more collaborative approach across general practice. Engage with St John and the 24 Hour Surgery around high users and promote the use of CCMS and Acute Care Plans to improve support for patients at risk of hospital admission.	Increased number of patient records in the CCMS – base to be established Q1. Increased number of CCMS users – base established Q1. CCMS available to St John and the 24 Hour surgery Q4. Patients report improved self-management and quality of life through EQ3D and PIH tools.
Improve the identification of people at risk of respiratory disease.	Continue to consolidate and refine the early identification of people with COPD through active case finding in primary care. Continue to maintain direct access to diagnostics in community settings rather than in hospital to support diagnosis of COPD.	>1,000 people referred to community-based spirometry testing.
Increase access to services that support people with respiratory disease to stay well and better manage their condition.	Promote programmes that encompass warmer homes and smoking cessation to support people at risk of respiratory disease. Establish a Continuous Positive Airway Pressure (CPAP) model that supports annual patient reviews in the community. Establish a model of community-based care for cystic fibrosis and bronchiectasis patients (with ambulatory suppurative lung disease). Develop strategies to reduce sleep assessment waiting times. Continue to support clinical education in managing respiratory disease and provide general practice managing COPD patients with specialist support from community respiratory nurses.	>800 people access community-based sleep assessments. CPAP HealthPathway live Q3. Community-based lung disease model established Q4. Reduction in COPD admissions rates Q4.[25]
	Continue to support access to pulmonary rehabilitation programmes and promote programmes amongst general practice to increase referrals and improve people's management of their condition. Continue to support the COPD admission avoidance project.	>150 people access pulmonary rehabilitation. Reduction in COPD readmission rates – base 23.7%.

[25] *The baseline rate for COPD admissions is from the 2011/12 year – admissions were 1,403 and the readmission rate for COPD was 23.7%.*

Improving the identification and management of people with Diabetes

Building on the success of our Integrated Respiratory Service, we have established an Integrated Diabetes Service Development Group (IDSDG) to design and implement a more integrated and coordinated approach to diabetes care and to improve outcomes for people with diabetes. Under the leadership of the IDSDG, we have already begun to provide more enhanced services for people with diabetes with an agreed baseline standard of care for all patients, the development of clinical pathways to improve referral to community-based support services and increased investment in those support services. The integrated model is facilitated by a community-based dietician and team of Clinical Diabetes Nurse Specialists who support general practices to ensure the systematic identification and improved management of people with diabetes.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Improve the identification and management of people with diabetes.	Support general practice to identify their population with diabetes, including the identification of high-risk patients. Continue to support general practice to deliver appropriate levels of care and support to patients identified with diabetes, in line with clinical guidelines established under the Diabetes Care Improvement Package (DCIP). Monitor service delivery against agreed quality indicators. Continue to refine the DCIP and review the model against the national Quality Standards for Diabetes (*in draft)*. Review the clinical pathways for diabetes and update referral protocols and service links to support the improved management of patients. Continue to support the IDSDG to review and monitor diabetes outcome indicators for the population.[26]	Six monthly service reporting on patients with diabetes coded in general practice systems Q2, Q4. Review of Diabetes Clinical HealthPathways Q2. Annual review of diabetes outcomes indictors Q4. ≥90% of the population identified with diabetes have had an HbA1c test within last year. ≥75% of the population identified with diabetes have acceptable glycaemic control (HbA1c ≤64mmol/mol).
	Review existing protocols for diagnosing and managing women with gestational diabetes to ensure they reflect evidence based guidance and align to new national guidance on gestational diabetes (*yet to be released*).	Review of Diabetes Screening HealthPathway Q2.
Increase access to services that support people with diabetes to modify their lifestyles, stay well and better manage their condition.	Maintain diabetes lifestyle information on the HealthInfo site to support people to reduce diabetes risk-factors and improve self-management of their condition. Encourage increased referrals to lifestyle programmes that help reduce diabetes risk factors including: Green Prescription, Appetite For Life and Senior Chef programmes Continue to invest in community based support for those newly diagnosed with diabetes or starting insulin to provide them with the tools to better manage their condition. Support actions and processes to increase referrals and access to community-based diabetes retinal screening. Implement a best-practice podiatry service for high-risk diabetes patients; including audit and reporting processes. Continue to support the community dietician and diabetes nurse specialists to deliver mentoring and clinical education to general practice teams.	Podiatry service operational Q2. Diabetes education sessions delivery as part of Canterbury education programme Q3. 3,000 people access Green Prescriptions for additional physical activity support. Increased number of people newly diagnosed with Type 2 diabetes access support in the community – base 432. [27] Increased number of people with Type 2 diabetes and starting insulin, access support in the community – base 307.[27] Increased number of people identified with diabetes access retinal screening – base 5,805.
	Support 'transfer of care' processes between service providers to improve the coordination of care. Monitor wait times for people with Type 1 or complex Type 2 diabetes accessing support from the Diabetes Centre.	No patient waits more than 4 months for a FSA Q4.

[26] The review of diabetes outcomes indicators will include reference to the Health Quality and Safety Commission's Atlas of Healthcare Variation for Diabetes and consideration of the quality improvements required to improve outcomes for people with diabetes.

[27] Total of subsidies claimed by general practice to assist people newly diagnosed with Type 2 diabetes and to assist people in starting insulin in the 2012/13 year as at February 2014 (includes late claims for the period).

Improving the identification of people at risk of 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 priority.

The DHB is working alongside Canterbury's three Primary Health Care Organisations (PHOs) to support the improved identification of people at risk of cardiovascular disease and increased delivery of CVDRAs in line with national expectations.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Maintain visibility of progress in delivery of the Primary Care Health Target.	Monitor CVDRA delivery with dashboard reporting on Canterbury's progress against the primary care health targets by DHB and PHO. Continue to meet with the PHOs to review delivery and set progress targets to maintain momentum and share success strategies.	Monthly dashboard reporting on progress against target. More Heart & Diabetes Checks Action Plan in place Q1.
	Identify clinical leads in general practice to facilitate the delivery of health target activity and provide clinical guidance.	Identified clinical leads across general practice Q2.
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. [28]	Complete a 'gap analyses of the eligible population not recorded as having received a CVDRA by age, gender and ethnicity to inform improved coding and delivery of risk assessments.	Gap analysis completed Q2.
	Supporting PHO practice liaison teams to assist general practice to support a programme of automatic recall and contact with patients eligible for CVDRA. Encourage the development of individual practice plans for delivery of CVDRA to ensure the health target is 'owned'. 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. 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. Support clinical governance groups to provide advice and guidance on the delivery of structured discussions with patients on their cardiovascular risk and mitigations strategies. Maintain direct GP access to exercise tolerance testing to support CVDRA and improved cardiovascular disease management. Collaborate and engage with Māori and Pacific health providers to develop strategies to increase delivery of CVDRAs. Review successful outreach programmes in other DHBs and identify opportunities to implement this activity in Canterbury.	An increased number of practices have individual CVDRA plans in place Q1. Monthly reporting on activity and progress against target. Delivery of CVDRA after-hours clinics or community events Q2, Q4. An increased number of structured CVD discussions delivered – base 358. Quarterly progress towards 90% of the eligible population having had a CVDRA within the last 5 years. Quarterly increase in Māori CVDRA rates
	Continued to provide training for administration staff in flagging, recalling and coding of patients to assist in the recording of activity. Continue to provide nurse training in CVDRA through induction programmes and routine practice visits. Continue to support PHO practice liaison teams to provide advice / education to general practice to improve performance and systems. Link in with the Heart Foundation to access additional training opportunities for general practice staff in CVDRA delivery.	Education round post-topic CVDRAs bulletin circulated Q1. Monthly practice visits undertaken. Heart Foundation training provided Q2, Q4.
	Ensure all general practices have advanced IT tools in place to support identification of eligible populations and to prompt and capture activity including Text-2-Remind and appointment scanners. Provide training for general practice teams in the use of the patient dashboard, Dr. Info and other advanced tools.	100% of practices have advanced IT tools in place. Increased number of practices actively using the Patient Dashboard – base 86.

[28] *The action in this section are in line with those agreed between the PHOs, DHB and Ministry of Health in the Canterbury Action Plan "Support for Primary Care Health Targets" including provision of Budget 2013 funding to support delivery of the More Health & Diabetes Checks target.*

Reducing the time people spend waiting

Timely access to services is a key factor in minimising the progression of illness, helping people to stay well, supporting their functional independence and improving the quality of their lives. Health professionals across Canterbury are working to deliver a health system where the key measure of success, at every point, is reducing the time people waste waiting.

6.5 Short waits for diagnostic services

Diagnostic services such as laboratory and 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.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Continue to improve patient pathway mapping and access to diagnostics to facilitate timely and appropriate referral and treatment.	Continue to maintain direct GP access to a full suite of diagnostics to reduce waiting times for treatment. Ensure internal data collection systems are in place to facilitate accurate reporting and monitor diagnostic waiting times to identify issues and barriers to access. Facilitate access to referral samples and 'live' data tools to support peer review of radiology utilisation in readiness for introduction of electronic ordering.	Report on analysis of demand trends completed Q1. Monthly reports on referral activity disrupted to clinical departments. Complete implementation of Phase II of the National Patient Flow Project Q4.
	Work to recover CT and maintain MRI wait time compliance through improved demand management strategies and matching of capacity to constraint.[29] Assess identified barriers to diagnostic radiology and prepare mitigation solutions in an action-based plan. Continue to participate in national and regional clinical networks focused on the development of diagnostic radiology service improvement programmes. Implement a service development initiative to improve imaging quality and reporting at Kaikoura Hospital. Implement a continuous process improvement through service audits on wait times and service quality of DHB contracted radiology providers. Reforecast annual demand expectations and seek to match radiology staff accordingly.	Issues-based Action Plan completed Q2. Quarterly service audits completed for DHB-contracted providers. 90% of accepted referrals for CT scans receive their scan within six weeks. 80% of accepted referrals for MRI scans receive their scan within six weeks. 90% of accepted referrals for elective coronary angiography receive the procedure within 3 months.
Improve 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. Achieve a 50% reduction in waiting times for the current 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 by expanding the service delivery model to include out-placed clinics, use of the Mobile Surgical Services Bus and 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.	Measurements for the EQI programme documented Q2. 50% reduction in wait times for the 2 week category achieved Q2. 75% of people accepted for an urgent diagnostic colonoscopy wait no longer than two weeks. 60% of people accepted for non-urgent diagnostic colonoscopy wait no longer than six weeks. 60% of people scheduled for a surveillance/follow-up colonoscopy wait no longer than 12 weeks beyond plan.

[29] *The DHB will use best endeavours to achieve and sustain performance against the national targets for CT and MRI however radiology support needed to achieve priorities around reducing ESPI and cancer treatment waiting times will put additional pressure on the service - the CCN Radiology Service Level Alliance will closely monitor system pressures and waiting times.*

6.6 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 independent 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. As the major provider of hospital and specialist services in Canterbury and regionally, it is crucial that we continue to reduce waiting times and improve access services to meet the needs of not only our own population but also the wider population across the South Island.

With the loss of hospital beds after the earthquakes and an invasive 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 significantly increase outsourcing to the private sector while repairs and the redevelopment of our facilities are completed. We will redesign our electives planning to increase capacity and improve turnaround time for surgical patients and patient flow across our hospitals. These are a key part of our 'lean' production planning processes.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Appropriately allocate electives funding to support increased delivery of elective surgery and ensure equitable access for Canterbury and South Island populations.	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 identify improvement. Participate in the development and implementation of the new National Patient Flow (NPF) system, including amending data submission for FSA referrals as required. Utilise private providers to maintain capacity and reduce waiting times while building internal capacity and workforce in line with the 2018 new facilities timeframes. Utilise other DHBs' facilities and staff resources to deliver care to Canterbury residents where possible and appropriate.	≥17,484 elective surgical discharges delivered Q4. Patient-level data for referrals and FSA reporting into new NPF system Q1. Implementation of Phase II of the National Patient Flow Project completed Q4. Standardised intervention rates maintained (per 10,000): Major joints: 21 Cataracts: 27
Implement the Electives Redesign Project to ensure sustainable service delivery with certainty for patients and referrers.	Progressively introduce see-and-treat and advice-only flows to provide more direct advice to primary care and reduce the reliance on secondary care. Implement standardised processes for triage, notification and forecasting to streamline patient flow and maximise capacity.	Elective theatre utilisation maintained at ≥85%. 100% of patient wait no more than 5 months for FSA or treatment Q1-Q2 and no more than 4 months from Q3-Q4.
Continually identify and support productivity and efficiency gains to improve patient flow and outcomes for patients.	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 both waiting times and demand on hospital services.[30] Implement the national Enhanced Recovery after Surgery (ERAS) pathways to help prepare patients for, and reduce the total impact of, surgery and help them to recovery more quickly.[31] Progressively implement the Frail Older Person's Pathway to streamline patient flow within the hospital and reduce de-conditioning and the harm associated with it.[32]	ERAS pathway in place Q2. Frail Older Person's Pathway embedded Q3. Elective inpatient average length of hospital stay ≤3.18 days. Reduction in beds occupied by patients aged 75+ for more than 14+ days – baseline 197.
Participate in the Regional Elective Services Alliance to support elective services delivery across the South Island.	Support the rollout of regional clinical pathways for bariatric surgery and the development of one new regional service. Support establishment of regional Major Trauma Workstream and development of a three year action plan including implementation of a Major Trauma Register.	Regional Bariatric Surgery Pathway implemented Q1. Designated Major Trauma clinical lead identified Q2. New regional service identified and under development Q3. Major Trauma Registry Q4.

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

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

[32] *The Frail Older Person's Pathway is currently being piloted in Christchurch and Princess Margaret Hospitals and will be rolled out to Burwood Hospital in the coming year.*

6.7 Shorter waits for cardiac services

Cardiovascular disease is the leading cause of death in New Zealand. Improving access to cardiac services across the continuum (screening, early intervention, surgery and rehabilitation) 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 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Continually identify and support productivity and efficiency gains to improve patient flow and outcomes for patients.	Continue to provide direct GP access to Echocardiography and Exercise ECGs to improve referral quality and patient flow. Embed the 'Heart Failure Initiative' to assist patients, general practice and ambulance staff to safely manage heart conditions in the community where appropriate and reduce unnecessary acute admissions and readmissions.[33] Update HealthPathways to reflect the Heart Failure Pathway model and to guide care management and referral to specialist services where appropriate.	Heart Failure HeathPathway updated Q2. Increased number of patients with Heart Failure Red Cards Q3. 100% of patients wait no more than 5 months for First Specialist Assessment (FSA) or treatment Q1-Q2. 100% of patients wait no more than 4 months for FSA or treatment Q3-Q4.
Maintain production capability for the delivery of cardiac surgery and ensure equitable access 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.	Wait list for cardiac surgery no more than 10% of annual throughput Q4. ≥336 cardiac surgery discharges delivered Q4. Standardised intervention rates maintained (per 10,000) Q4: ▪ Percutaneous Revascularisation: 12.5 ▪ Coronary Angiography: 34.7
Participate in the South Island Alliance Cardiac Workstream to align cardiac activity across the South Island.	Continue to implement regionally agreed protocols and pathways for patients with Acute Coronary Syndrome (ACS) to ensure prompt risk stratification, stabilisation and appropriate transfer of ACS patients. Continue to work with referring DHBs to ensure waiting time targets are met for ACS patients from other DHB regions. 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 delivery.	Reporting to ANZACS QI Register Q1. 90% of people receive their elective coronary angiograms within 90 days. 70% of high-risk patients will receive an angiogram within 3 days of admission (where day of admission is day 0). 95% of patients presenting with ACS who undergo angiography have completion of registry data collection within 30 days.
	Support development of a regional approach to cardiology nurse training through the Regional Training Hub. Support development and implementation of a regional Percutaneous Coronary Intervention Pathway. Support the regional implementation of the Accelerated Chest Pain Pathway in Emergency Departments to reduce unnecessary hospital admissions. Support a regional approach to the storage/sharing of ECGs.	Participation in regional nurse educator subgroup Q1. PCI patient flow agreed Q2. Common Accelerated Chest Pain Pathway in place regionally Q4. ECG records stored in Concerto Q4.

[33] *In implementing the Heart Failure Initiative Canterbury is implementing a best practice model of care across primary and secondary services (including emergency, general medicine, acute demand and older persons' health), following the example of the COPD Initiative. A red card has been developed to guide patients with self-management, and when to access additional medical support. Ambulance staff are being supported to identify people that can be safely managed in primary care and/or help them access a clinically appropriate level of care.*

6.8 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. At least one third of cancers are preventable, and the impact and death rate of cancer can be significantly reduced through early diagnosis and treatment.

Over the coming year Canterbury is participating in the national initiative around delivering Faster Cancer Treatment and improving the collection of data tracking the patient journey from referral to treatment. This work is wider than Oncology Services and requires a collaborative approach and commitment from a number of clinical specialties across the DHB. Canterbury also supports the South Cancer Network (regional cancer services workstream) with a focus on improving linkages between the South Island DHBs, improving the coordination and quality of services and implementing the South Island Clinical Cancer Information System.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Identify and implement actions to provide faster cancer treatment to reduce the impact of Cancer and improve patient outcomes.[34]	Continue to implement 'lean thinking' processes to remove bottlenecks, improve patient flow and reduce waiting times. Maintain flexible arrangements with external providers to ensure maximum four-week wait times for radiation treatment. Monitor waiting lists to proactively identify capacity issues and provide the South Island DHBs with regular performance data. Support Cancer Nurse Coordinators to attend national/regional training and mentoring forums to build capability and supports. Support more interactive recruitment strategies for key oncology roles including: branding, facebook, alumni.	Monthly and quarterly monitoring of wait times for Cancer services. 100% of patients ready for treatment wait less than 4 weeks for radiotherapy or chemotherapy. FCT data provided to national collection systems from Q1. Progress towards meeting Faster Cancer Treatment indicators Q4: ▪ Patients with a confirmed diagnosis of cancer receive first cancer treatment within 31 days; and ▪ 85% Patients referred urgently with high suspicion of cancer receive first cancer treatment within 62 days by July 2016.
	Implement the agreed model for identifying people with a high suspicion of cancer to enable the system-wide tracking of patients from referral to treatment across all specialities. Introduce a high suspicion of cancer triage code to enable the tracking of referrals across all data points. Increase the use of ERMS to streamline referral and triage. Integrate the data from MOSAIQ Oncology Information System with other clinical information systems to streamline the workflow from first diagnosis/staging to treatment/follow-up. Support the implementation of the South Island Clinical Cancer System as a regional clinical data repository.	
	Continue to utilise the new MDM coordination roles to improve the coverage and functionality of Multidisciplinary Meetings. Standardise information and electronic processes to better support MDMs including electronic referrals and data sharing. Continue to support clinical decision-making and governance processes around MDMs to implement the new model. Expand use of videoconferencing to extend coverage of MDMs.	All tumour streams utilising MDMs. Increased number of cases discussed at MDMs Q4.
Participate in the Southern Cancer Network to align strategic activity across the South Island.	Support the regional review of three more tumour stream standards including provision of relevant data. Support the development of a cervical screening initiative to improve rates of Maori women accessing cervical screening. Review the Southern Cancer Network modelling, Regional Linear Accelerator Investment Plan and the National Radiation Oncology Plan to ensure Canterbury has appropriate radiation treatment capacity to meet future demand.	Regional audit against three tumour standards complete Q3. Regional cervical screening initiative identified Q4.

[34] *Refer to page 36 for actions around shorter waits for Cancer Diagnostics.*

Supporting 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.

6.9 Child, youth and maternal health services

A focus on child and youth health is an investment in the future of our population. Poor health in childhood can lead to poorer health outcomes into adulthood and risk behaviours and social patterns established in childhood and adolescence have a significant impact on our long-term health and wellbeing.

Integrated service models for child, youth and maternity services streamline the coordination of similar services and help to reduce duplication and fragmentation and better identify vulnerable children and target service delivery. An integrated, whole-of-system approach is particularly critical in light of the quake-related capacity pressures we face and the additional stress on children and young people and their families. As part of this approach, the DHB will support collaborative, cross-agency initiatives to help bridge the gap between primary brief intervention and specialist services so that children and young people can be expertly assessed and provided with the most appropriate level of intervention and support.

This work will primarily be driven through the Child & Youth Health Workstream. However a positive journey starts with maternity services that by supporting expectant mothers provide children with the best possible start in life. Canterbury and West Coast DHB's now have a combined Maternity Clinical Governance Group overseeing implementation of the Maternity Quality and Safety Programme which will enable greater services integration and quality improvements.

Implement a collective and integrated approach to the delivery of maternal and child health services

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Work collaboratively to improve consistency and quality of services for mothers and their babies.	Continue to implement the Maternity Quality & Safety Programme and support the combined (Canterbury/West Coast) Maternity Clinical Governance Group to oversee the Programme. Review performance against the NZ Maternity Clinical Indicators to identify opportunities to improve care and reduce variation. Identify and implement local quality improvement priorities and those identified by the National Maternity Monitoring Group.	Third MQSP Annual Report completed and circulated Q4. Improved maternity outcomes evident as measured by national and DHB data analysis and surveys.
	Support improved communication and liaison between LMCs, Well Child Tamariki Ora (WCTO) providers and general practices. Enhance current systems and processes that support multiple enrolments across maternity, immunisation, WCTO, general practice and school and community dental services.	≥ 95% of newborns enrolled on the NIR at birth. 98% of newborns enrolled with general practice within three months of birth.
Implement strategies to increase the number of pregnant women registering with an LMC.	Work with the NZ College of Midwives to identify barriers to registration within the first trimester. Work with consumer groups to increase awareness of the value of LMC registration through education and information programmes, social media campaigns and web-based info sites.	80% of pregnant women register with an LMC by week 12 of their pregnancy.
Enhance pregnancy, and parenting programmes to meet the needs of new mothers.	Review DHB-funded pregnancy/parenting courses to better meet the needs of a wider range of women – particularly Māori and Pacific women and younger mothers.[35]	30% of new mothers access DHB-funded pregnancy and parenting education courses.
	Promote supportive environments and expand the variety and locations of breastfeeding courses to better engage with women. Invest in supplementary services including Mum-4-Mum support and lactation services to support high-needs and at-risk women. Collaborate with Māori and Pacific health providers to identify strategies to improve breastfeeding rates for Māori and Pacific women.	75% of mothers have established breastfeeding on hospital discharge. 67% of babies exclusively or fully breastfed at 6 weeks. 28% of babies exclusively, fully or partially breastfed at 6 months.

[35] *The Ministry of Health is reviewing service specifications for pregnancy and parenting education; the DHB will align service delivery with national requirements once this review is complete.*

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Implement a collaborative and integrated approach to the delivery of child and youth services.	Establish a WCTO Quality Improvement Group to develop and implement a WCTO Quality Improvement Plan focused on achievement of the following three indicators: ▪ QI3 - Increase the proportion of infants who receive all WCTO core contacts due in their first year. ▪ QI19 - Increase the proportion of mothers who are smoke free at two weeks postnatal with a particular focus on Māori. ▪ QI24 - Increase the proportion of children with a 'Lift the Lip' score of 2-6 who are referred to specialist dental services.	WCTO QI Group in place Q1. Progress towards targets Q4: 86% of infants receive all WCTO core contacts in their first year. 86% of mothers are smokefree at two weeks post natal. 86% of children referred to specialist oral health services.
	Continue to monitor access and referral patterns for B4 School Checks to identify opportunities to improve delivery and coverage. Explore opportunities to promote the value of B4 School Checks. Monitor timeliness of access to referred services following assessment and implement actions to expedite service delivery. Work with public health nurses and ECE providers to identify and engage children who have not had a B4 School Check.	90% of children receive a B4 School Check. 90% of Māori and Pacific children and children living in high deprivation areas receive a B4 School Check.
	Maintain delivery of Gateway Assessments and monitor access and referral patterns to further develop the service. Work with MSD to review Gateway referral processes.	100% of children referred by CYF receive Gateway Assessments.
Implement a collaborative and integrated response to better meet the needs of vulnerable children and young people in line with the national Children's Action Plan.	Contribute towards the establishment of a Canterbury Children's Team governance and leadership group. Support the establishment of multi-disciplinary Children's Teams in conjunction with health providers from across the sector and other government agencies across Canterbury. Develop appropriate referral pathways to/from Children's Teams and between primary and secondary health services. Work within DHB and within PHOs to enable health professionals to attend necessary training to support Children's Teams.	Cross-sector Children's Team Leadership Group in place Q3. Multi-disciplinary Children's Teams established Q4. First referral pathway Q4. 5% reduction in the number of children experiencing physical abuse nationally by 2017.
	Continue to maintain, monitor and audit the Canterbury DHB VIP programme for each of the child and partner abuse components. Review Canterbury's current Child Protection Policy and Procedures in line with the new Vulnerable Children's Legislation. Make revised Policy and Procedures available online to all staff. Continue to provide training for health professionals on the impact of family violence and identification of abuse and harm. Complete implementation of the National Child Protection Alert System alongside Canterbury's eProsfae system.	Child Protection Policy and Procedures updated Q1. Report on implementation of the Policy Q4. National Child Protection Alert System fully operational Q4. Combined audit score of child and partner abuse components of the VIP >170/200.
Improve coordination across oral health services to improve access rates and the quality of oral health service provision.	Maintain the clinically led Oral Health Steering Group to oversee implementation of the whole-of-DHB Oral Health Promotion Plan. Implement strategies to ensure all newborn babies are enrolled. Continue to work alongside WCTO providers and general practice to identify and support children most at risk of tooth decay. Continue to implement alternative oral health service models for adolescents to engage more young people, particularly those in low decile schools and Māori and Pacific adolescents. Investigate sedation levels across Canterbury to identify any patterns of increased anxiety and strategies to alleviate this.	75% of children (0-4) are enrolled with DHB oral health services. 90% of children are examined according to planned recall. DMFT rate for Year 8 children (11-12 years) $\leq$ 1.0. 85% of adolescents (<18) access DHB-funded oral health services.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Increase immunisation rates and coverage to reduce vaccine-preventable diseases and improve health and wellbeing.[36]	Support and maintain systems for seamless communication and handover between maternity, general practice and WCTO services and support the multiple enrolments of newborns including: ▪ Supporting LMC early hand-over to GP and WCTO providers; ▪ Early enrolment with GP teams, and use of B code; ▪ Timely NIR reporting to follow up unenrolled children. Continue to work alongside CYF, MSD, Justice and other social service agencies to raise awareness of the importance of immunisation and to improve the timely delivery of vaccinations.	≥95% of newborns enrolled on the National Immunisation Register at birth.
	Continue to use the NIR to monitor immunisation coverage at DHB, PHO and general practice level, circulating performance reports to maintain coverage and identify unvaccinated children. Continue to support the Outreach Immunisation Services to locate missing children and provide advice and immunisation. Continue to support the Child Health Division to identify the immunisation status of children presenting and provide missing or overdue immunisations or link families with Outreach Services.	Quarterly performance reports. 85% of 6 week vaccinations are completed. 95% of all eight-month-olds are fully vaccinated. 95% of all two-year-olds are fully immunised.
	Implement the DHB Immunisation Promotional Plan 'Immunise for Life' to increase rates and profile the importance of immunisation. Maintain a systems resource 'Immunisation Toolkit' to support general practice to discuss and deliver immunisations. Support Immunisation week and increased interagency activity.	Action Plan developed for Immunisation Week Q3. Narrative report on interagency activities to promote Immunisation Week Q4.
	Maintain a HPV Programme in a school setting and promote HPV vaccinations for eligible young women. Continue to link 11-year-old and HPV immunisation events.	60% of girls have received HPV dose 3.
	Promote and provide free seasonal flu vaccinations for young people under 18 as well as people aged over 65, pregnant women and people with chronic health conditions. Support LMCs to provide free pertussis (whopping cough) vaccinations for pregnant women.	Seasonal flu plan developed Q2 40% of people aged <18 have a seasonal flu vaccination Q4.
Work with the Regional Child & Youth Alliance to support specialist service delivery.	Support the implementation of the Regional Rheumatic Fever Prevention Plan and align activity with the agreed approach. Undertake a root-cause analysis on any new rheumatic fever case in Canterbury and report on lessons learn and actions taken. Participate in the development of regional protocols and guidelines for treatment of childhood obesity. Explore opportunities for improving the transition to adult care for young people with chronic conditions and/or disability. Support the regional review and proposal for the delivery of Fertility Services to align service delivery across the South Island.	Maintain low South Island rheumatic fever rates (< 0.3 per 100,000). Protocols and guidelines for childhood obesity agreed Q4. Transition pathway identified Q2. Request for Proposal completed for Fertility Services Q2.

[36] Canterbury's Immunisation Service Level Alliance was established in 2010, and has developed an integrated service model for immunisation. This model identifies the actions required to improve service delivery for all immunisation events, including childhood, HPV and seasonal influenza programmes.

Delivering the Prime Minister's Youth Mental Health Project

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 both the Child & Youth Health and the Mental Health workstreams under the CCN District Alliance.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Support an integrated and responsive service approach for young people with mild to moderate mental health issues.	Develop a Youth Stream under the Child & Youth Health Alliance to provide leadership with regards to youth specific services.	Youth Stream in place Q1.
	Maintain current coverage of School-Based Health Services (SBHS) and provision of HEEADSSS assessments to Year 9 students. Expand HEEADSSS assessment training opportunities to increase the number of competent providers to increase assessment capacity. Continue to work with primary care to improve coordination of referrals resulting from HEEADSSS assessments.	An increased number of HEEADSSS assessment providers trained Q2. 100% of Year 9 students in SBHS receive HEEADSSS assessments Q4.
	Expand delivery of the new School-Based Mental Health Service (SBMHS) into additional schools to respond to increased service need as a result of the earthquakes.[37] Provide training and support to school guidance counsellors and teachers to better respond to increased needs of young people. Establish links between Child Adolescent & Family (CAF) services and the SBMHS to improve the system response for young people with a higher level of need. Maintain access to primary care based Brief Intervention Counselling (BIC) for youth 12-19 years. Continue to support the cross sector Youth Network 'Yamaha' to bridge the gap for young people no longer in school.[38] Continue to invest in the collaborative Community Youth Mental Health Service (CYMHS) to bridge the gap between primary and secondary services.[39]	>20 Canterbury schools have tailored SBMHS in place Q2. Increased number of counsellors and teachers trained Q3. >500 BIC sessions delivered to young people 12-19 in primary care settings. Access rates for mental health services for youth (0-19) are maintained >3.1%.
	Continue to implement the Choice and Partnership Approach to improve access and achieve phased waiting time targets by 2015. Monitor demand and waiting times for referrals to CAF and Youth AOD services to ensure waiting time 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.
	Review processes to ensure appropriate planning and follow-up for young people discharged from CAF and Youth AOD services.	95% of CAF and Youth AOD clients discharged with follow-up plans Q4.

[37] This Service is part of a joint response between Ministries of Education and Health, to address increased stress and anxiety amongst young people after the earthquakes. Delivered in schools the Service involves training for teachers, education for parents and individual intervention from specialist mental health services. It is captured as 'Initiative 26' of the Prime Minister's Youth Mental Health Service.

[38] Yamaha is a Youth Services Provider Network who meet regularly to streamline access, standardise referrals and up skill community services and agencies to better respond to the needs of young people. This Network includes Kaupapa Maori Service providers and Canterbury's Pacific Service Provider who provide cultural advice and leadership to the Network and help to ensure service responses are appropriate and responsive to the needs of Maori and Pacific youth.

[39] The Community Youth Mental Health Service is a cross-agency initiative involving Odyssey House, Stepping Stone Trust, Purapura Whetu and specialist Child and Family Services. The team is mobile and provides short-term intervention, assessment, treatment and support in a range of youth venues in community and school settings. The service is free for young people and the team also work closely with general practice and specialist services and coordinates referrals to long-term treatment and other professional services if required.

6.10 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 than other population groups, and the majority of health spending for an individual generally occurs in the last two years of life. The ageing of our population comes with an increase in the risk of illness and the demand for health services including aged residential care (ARC) services. We estimate that approximately half our health resources are used to provide care for people aged over 65.

There is scope for reducing this demand and improving the quality of people's lives. Under the leadership of the Health of Older People's Workstream and the Collaborative Care Service Level Alliance (under the CCN) a number of wrap-around strategies were introduced to help address capacity pressures across our system after the earthquakes. We are now seeing improved outcomes from these programmes with reduced acute hospital admissions and readmissions for people aged over 65. We will continue in the coming year to place emphasis on implementation of the supported discharge and restorative care models that have proved so successful to further support people to live safe and well in their own homes for longer.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Ensure older people receive timely and comprehensive assessments of their needs to support the development of effective packages of care.	Continue to support Community Support Services (CSS) providers and the DHB's Older Persons' Health Specialist Services (OPHSS) to assess clients using InterRAI. Support ARC providers to undertake clinical assessments using the InterRAI Long-Term Care Facility (LTCF) module – with training and advice from the DHB's InterRAI trainers and Gerontology Nurse Specialists. Quarterly monitoring of InterRAI use.	≥95% of long-term CSS clients have an InterRAI assessment and a current care plan in place. ≥95% of people entering ARC have had an InterRAI assessment. 100% of ARC facilities using the InterRAI LTCF assessment tool.
Consolidate and refine wrap-around services for older people to support people to stay well in their own homes and communities.	Allocate additional budget 2013 funding to increase the input and support level available for a further 60 complex clients. Review and refine the restorative home support services model and further develop service processes to define interaction with CREST, OPHSS and general practice. Test and confirm the district nursing casemix (needs-based) model and ensure appropriate alignment of funding. Identify any constraints within restorative services and outline key actions to further refine the model including training. Review the current response to service users with complex or urgent needs and roll out a standardised referral process for acute events.	Increased support level available to complex clients Q1. Increased support level accessed by 60 clients Q4.[40] Quarterly review of case mix levels and service utilisation. Quarterly review of readmission rates for people (65+ and 75+). Standardised referral process for acute events in place Q4.
Continue to support a (goals-based) rapid response and supported discharge service to support people to stay well.	Roll out the recommendations from the Community Rehabilitation Enablement and Support Team (CREST) review to refine the rapid response and supported discharge model. Work alongside the Acute Demand Management Services to expand CREST services into rural areas. Maintain relationships between CREST, general practice and OPHSS teams to support increased GP referrals into CREST and the provision of specialist advice to general practice. Monitor CREST service utilisation by ethnicity to identify opportunities to improve engagement with services. Support implementation of the Frail Older Person's Pathway to streamline patient flow within the hospital and reduce de-conditioning and the harm associated with it.	>2,200 people access CREST services including referrals direct from GPs. Reduction in beds occupied by patients aged 75+ for more than 14+ days – baseline 197. Quarterly review of readmission rates for people (65+ and 75+). Acute inpatient average length of hospital stay maintained at ≤3.86 days.

[40] *The number of clients accessing increased support will be measured through case-mix criteria changes.*

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Invest in the development of targeted, specialised services and pathways to support older people with more complex needs and reduce harm, hospitalisation or early entry into residential care.	Continue to implement clinically led falls prevention strategies that promote 'zero harm from falls'. Review the effectiveness of falls prevention programmes to further refine services and take action on findings. Establish links with 24-hour Surgery and St John Ambulance and seek options to enhance access in rural areas. Monitor falls programme utilisation by ethnicity to identify opportunities to improve engagement with services. Promote 'Zero harm from falls' in ARC settings by providing an ARC-based Vitamin D supplementation programme.	Action findings from the Falls Programme Review Q3. >1,200 people (65+) access community-based falls prevention. 75% of ARC residents receive Vitamin D. 5% reduction in the proportion of the population (75+) presenting at ED as a result of a fall.[41]
	Engage clinical leads and multidisciplinary stakeholders in delivering the integrated Fracture Liaison Service.[42] Review current HealthPathway to best align preventative care to prevent fragility fractures. Agree and capture key metrics to identify those at risk of fragility fractures, monitoring ED attendance, hospital admissions and utilisation of the FLS HealthPathway.	Clinical Lead attendance at South Island FLS workshops Q1. Pathways reviewed Q3. Quarterly key metrics dashboard reporting running Q4.
	Maintain the Medication Management Service (MMS) to reduce the risk of harm from medications. Work alongside the Pharmacy Service Level Alliance to refine and enhance MMS services and promote interdisciplinary review for adults aged 85+ on 9+ medications. Review the effectiveness of MMS for CREST clients and alignment of MMS with the Pharmacy LTC Programme.	>2,000 people referred to MMS. Effectiveness review complete and findings implemented Q4.
	Continue to refine the Cognitive Impairment Pathway to improve care for people with dementia across the system. Implement a new service pathway for older adults recently diagnosed with mild dementia. Expand access to 'Walking in Another's Shoes' (WIAS) dementia training to other priority professional groups.	CI Pathway reviewed Q3. New Dementia Service in place Q4. Increased number of carers completing the WIAS training – base 64.[43]
Engage community providers in quality improvement work and leadership development to ensure older people receive consistent and high quality health services.	Promote strategies, advice and training to reduce the incidence and severity of pressure injuries and falls in ARC. Implement reporting dashboard to monitor service delivery using national core quality measures (*once released*).	Quarterly review of readmission rates for people (65+ and 75+). Quarterly dashboard monitoring of pressure injury and CSS core quality measures.[44]
	Continue to maintain key specialist roles to support the provision of specialist advice to primary care and ARC. [45] Continue to support the Gerontology Acceleration Postgraduate nursing programme and rotations in setting across the system to promote leadership in the ARC sector.	>10 nurses complete postgraduate nursing leadership programme Q4.

[41] The baseline rate for falls presentations is from the 2013/14 year – the presentation rate was 24% with 2043 presentations due to falls..

[42] Supported by the Minimum Data Set for hip fracture developed by the Australia NZ Hip Fracture Registry Working Group.

[43] This is a calendar year result with the base being the number of carers undertaking WIAS training in 2013.

[44] This timeline is dependent on the MoH and HIQ establishing these measures.

[45] Specialist advice and support is provided by DHB services 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) and gerontology nurse specialist roles (3 FTE) and the CREST Service Team (7 RN Liaison and 6 RN Case Managers).

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Engage clinical leads in the integration of Stroke Services and referral pathways to support a single Canterbury stroke service that meets NZ Stroke Guidelines.	Provide an organised stroke service with standardised referral process for people requiring support and rehabilitation after an acute event. Continue to provide dedicated areas for the management of people with stroke in accordance with NZ Clinical Guidelines. Develop stroke thrombolysis quality assurance procedures, including processes for staff training and audit. Continue to participate in the regional Stroke Workstream and national clinical stroke networks to align pathways and improve outcomes for people after stroke.	Current pathways reviewed against integrated model Q2. Thrombolysis quality procedures implemented Q4. 6% of potentially eligible stroke patient's thrombolysed. 80% of stroke patients admitted to an organised stroke service with demonstrated stroke pathway.
Work with the Regional Health of Aged Care Workstream to align specialist service delivery across the South Island.	Attend regional Dementia Workshops to align the local review of Cognitive Impairment Pathway (CIP) with regional work. WIAS Master Class model developed and implemented. Attend regional Fracture Service Workshops to align direction. Participate in regional activity to improve health outcomes for older Māori including service data collection and review. Participate in the Regional Thrombolysis audit. Support staff to attend regional Advance Care Plan training.	Regionally consistent CIP Q4. Review of InterRAI and stroke data by ethnicity Q2. Thrombolysis Audit Q3.

6.11 Mental health services

It is estimated that at any one time, 20% of the population have a mental illness or addiction and 3% are severely affected by mental illness. With the ongoing stresses on our population and the pressure on mental health services as a result of the earthquakes, it is even more critical that our health system is working together to improve the mental health and wellbeing of our population at all levels of the continuum.

Our response is based on a recovery approach and a commitment to integrated services, which is evident in the willingness of all parties to work closely together to wrap care around the individual particularly across child and youth services. We will continue to develop community-based options that provide services closer to home, supported by expanded consult liaison across a range of services within our hospital and specialist division. This will provide the benefit of timely specialist advice without the need for a specialist appointment or disruption of the primary/community care relationship and build capability across our system. The DHB funds its mental health services in accordance with the national ring-fence funding expectations and will continue to apply the ring-fence criteria and guidelines to ensure it meets mental health expenditure commitments.

This work will primarily be driven by the Mental Health Workstream under the CCN Alliance and is aligned with the priority areas of '*Rising to the Challenge*' the national Mental Health and Addiction Service Development Plan for 2012-2017.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Continue implementation of the integrated Stepped Care Model to improve the integration and responsiveness of mental health services.	Contribute to the psychosocial partnership with CERA to support continued wellbeing strategies for youth.[46] Strengthen the interface between primary and community services by reviewing and refining the current service model. Expand the number of Mental Health Services covered by HealthPathways to clarify referral and service options. Continue to invest in Brief Intervention Counselling (BIC) in primary care and monitor delivery to ensure capacity is aligned. Expand the range of services under the Community Access Pathway (CAP) to support people with more complex needs.[47] Monitor service utilisation trends to highlight emerging issues and align strengthen or strategies in response.	Improved outcomes evident in the 2015 CERA Wellbeing Survey. 'All Right?' campaign evaluation initial results available Q2. Additional mental health HealthPathways developed and available Q2. Increased range of support services available through referral to CAP Q2. >4,000 people access BIC in primary care Q4.
Continue the implementation of the Adult Mental Health Services Direction of Change to improve access to mental health services.	Maintain direct telephone access to specialist support for general practice and consult liaison service 24/7. Complete integration of the four Multidisciplinary Locality Teams across inpatient and community services with extended hours and operation from shared treatment plans. Complete development of a Crisis Resolution Service. Identify and develop extended treatment strategies for people with high and complex mental health needs. Investigate development of a Residential Nurse Specialist role to support people with complex needs in community residential settings. Continue to work with lead agencies on the provision of social housing to reduce unnecessary delays in discharge and negative effects on patient flow across the system.	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. 95% of adults (20-64) referred for non-urgent mental health services are seen within 8 weeks.
Support the development of suicide prevention and postvention strategies to improve the system response and build on gains in resilience and recovery.	Establish a clinically led Suicide Prevention Oversight Group. Develop a series of evidence-based initiatives and responses in alignment with the National Suicide Prevention Strategy. Identify and 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 developed for Canterbury Q2. Training in place Q3. Feasibility plan for Perfect Care developed Q3.

[46] The Psychosocial response, coordinated by CERA, will be jointly supported by key agencies (including health) over the next five years.
[47] The Community Access Pathway (CAP) is the referral point for mental health community support services and is an alliance of NGO providers. CAP was established post-earthquake as a way of streamlining access (including direct access for GPs), eliminating the need to refer to multiple organisations, and establishing a system wide view of capacity across multiple providers.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Implement national policy and action plans to improve the coordination between public health services and the continuum of care for vulnerable population groups.	Increase the number of mental health and addiction clients enrolled in the Knowing the People (KPP) planning project into full or part time employment. Seek to monitor the employment status of all long-term clients through PRIMHD as functionality becomes available.	Increased number of people enrolled in KPP – base 244. Increased number of people in KPP in full or part time employment – base 17.[48]
	Develop training and support resources for target organisations and workplaces to reduce alcohol harm. Continue to support School-Based Health Services (SBHS) to deliver HEEADSSS Assessments to Year 9 students. Support primary mental health services to increase capacity to deliver Alcohol and Drug Brief Intervention Counselling. Continue to work with Corrections and courts to increase access to AOD additional assessment and treatment.	>3 workplaces engaged Q3. 100% of Year 9 students receive HEEADSSS assessments Q4.
Work within the Regional Mental Health Alliance to support specialist service delivery.	Lead discussion on alternative treatment options for eating disorders patients and utilisation of technologies to increase family/whānau involvement in inpatient care. Establish a Hub and Spoke service delivery model for youth forensic services to increase capacity and responsiveness. Participate in the regional review of Perinatal and Maternal Mental Health Services consult liaison mechanisms. Participate in the review of service responsiveness to Māori.	Research findings shared Q2. Forensic Hub embedded Q2. COPMIA pathway in place Q4. Regional Māori service review completed Q4.

[48] *Recording of employment status is currently only through the Knowing the People Planning (KPP) Project. The DHB anticipates being able to measure performance across a wider base of clients once this is enabled nationally through PRIMHED.*

6.12 Whānau ora Services

The Canterbury population generally has better access to health services and better health status than the average New Zealander. This is true for all ethnicities living in Canterbury nonetheless, inequalities still exist. We will not achieve our vision while Māori and Pacific health outcomes lag behind the general population. Reducing inequalities pervades everything we do but in the aftermath of the earthquakes, and considering the young make-up of our Māori and Pacific populations, we are placing specific emphasis on child and youth population groups.

We have already made some positive gains for Māori and Pacific people, with substantial improvements in immunisation rates and reductions in avoidable hospital admissions over the last several years. With a collective approach from across the health system, we are determined to make further progress. In line with the activity and initiatives planned for the coming year the DHB has refreshed its Māori Health Action Plan - available on the DHB website: www.cdhb.health.nz.

The DHB is also committed to working with Manawhenua Ki Waitaha, the two Whānau Ora collectives (Te Waipounamu & Pacific Trust Canterbury) and local stakeholder & provider networks in the development of strategies to build healthy, vibrant communities and support new ways of working to improve health outcomes for both Māori and Pacific populations.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Work collaboratively to support the implementation of the national Te Puni Kokiri-led Whānau Ora initiative.	Enhance the capacity and capability of provider collectives through activity of the CDHB-funded Māori Development Organisation: He Oranga Pounamu and Pacific Trust Canterbury. Continue to support the agreed Māori appointment process (led by He Oranga Pounamu) to enhance the capability of advisory boards and working groups. Work with the newly established South Island Whānau Ora Commissioning Agency to identify where Canterbury DHB can support the vision and implementation of the new model.	Appointment process being used by Advisory Boards. Whānau Ora Government Agency Network Terms of Reference agreed by Q1. Relationship between CDHB and Whānau Ora Commissioning Agency agreed Q3.
Continue to support implementation of Memorandum of Agreement between He Oranga Pounamu, Pacific Trust Canterbury and the Canterbury District Health Board.	Assist Whānau Ora collectives with: ▪ Service planning, the provision of information and trend data for analysis and analysis of 2013 Census. ▪ Development of organisational infrastructure. ▪ Research and professional development within collectives. ▪ Advice around outcomes-based monitoring and evaluation frameworks that have proved successful. ▪ Provision of information on Māori and Pacific service planning and reviews that may affect providers within Whānau Ora collectives. ▪ Engagement with the Māori and Pacific Health Provider Forum to enhance relationships with local providers. ▪ Identification of opportunities for integrated cross government contracts to support Whānau Ora models. ▪ Support for GP providers in Whānau Ora collectives to use patient management systems to report whānau outcomes.	2013 Census data summaries distributed to Whānau Ora collectives Q2. Hauora Waitaha I Māori Health Profile updated with 2013 Census Results Q4.
Continue to support strategies and initiatives to expand capacity and capability of Māori and Pacific providers across Canterbury.	Support the implementation of the Ethnicity Data AuditToolkit (EDAT) across the three PHO's in Canterbury. Continue to work with Kia Ora Hauora to improve the number of Māori on health career pathways and support the Māori and Pacific health scholarship programme. Work with Māori Health Providers to review patient management systems to better support alignment to Whānau Ora and HealthPathways implementation. Work with HealthPathways to increase the number of Māori and Pacific health service options listed. Continue to promote and advance the Canterbury Māori Health Framework across the whole of health system. Work through the CCN Alliance to implement the actions and activity agreed in the 2014/15 Māori Health Action Plan.	Assessment of HealthPathways stock-take completed Q2. EDAT Audit process complete Q3. Māori and Pacific Health Scholarships funding distributed through He Oranga Pounamu Q4. Increased number of Canterbury participants on Kia Ora Hauora programme Q4. At least four Māori Health Framework sector presentations completed Q4.

Delivering clinically and financially viable health services

6.13 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 Referral 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 the Electronic Shared Care Record View (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 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Deploy new systems to empower the Patient.	Design and implement a Patient Portal (integrated with Health Connect South (HCS)), to provide patients with access to their core health information.	Patient Portal designed Q1. Patient Portal in place Q2.
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.	MedChart deployed Q2. Nursing Observation application implemented in trial ward Q2. Replacement of Maternity System (Caresys) Q3. RL6 live in all areas Q4.
Enhance current information systems to support integrated models of care and service delivery.	Complete implementation of ERMS Phase 1 so all services can use the functionality. Implement ERMS Phase 2 to provide triage and internal referrals functionality across all services. 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 ERMS Phase 1 Q1. 60% of services using ERMS triage functionality Q3. Complete installation of 2,000 VDI at Christchurch Hospital Q1.
	Maintain current clinical HealthPathways to support the delivery of the right care, in the right place, at the right time. Further enhance the capability of the Collaborative Care Management Solution (CCMS) to better coordinate care for individuals with long-term conditions/complex health needs.	>600 HealthPathways available across the Canterbury system.
Develop information infrastructure alongside facilities development.	Establish a clear mobile device, application, and data strategy. Develop functional design for digital hospitals incorporating the Burwood Hospital requirements.	Mobile device strategy Q2. Burwood 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. Commence the deployment of the Electronic Shared Care Record View (eSCRV) to the rest of the South Island. Prepare to 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 West Coast and South Canterbury DHBs Q3. SI PICS prepared for use in Burwood Hospital services Q4. All captured ECGs and Holter reports available in HCS Q3. Maximo EAM deployed Q4.

6.14 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 2014/15		
OBJECTIVE	**ACTIONS TO DELIVER IMPROVED PERFORMANCE**	**EVIDENCED BY**
Increase the focus on continuous improvement processes across the Canterbury health system.	Support the use of service level data in the implementation of the Plan-Do-Study-Act (PDSA) cycle for service improvement. Complete a Clinical Governance Stocktake and implement any recommendations from the Clinical Board. 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.	Quality Activities Database in place Q2. Governance Stocktake complete Q3. Desk Audit complete Q4. Annual publication of DHB Quality Accounts.
Improve the patient experience.	Implement 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. Integrate the patient experience survey results collected as part of the national collection system into service datasets. Support Consumer Council involvement in patient care improvement teams and in the design of the new facilities. Continue to use patient stories to inform the design of service process improvements and to celebrate success.	Quarterly reporting on patient experience survey data. 90% completion of answers to 4 Questions in medical wards. Two consumer representatives on each improvement team.
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 the electronic 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. Develop an electronic audit process for falls risk and pressure ulcer risk assessment. Integrate the national Quality Safety Markers into appropriate improvement programmes.	RL6 live in all areas Q4. Observation application implemented in 10 wards Q4. Updated electronic audit reporting system in place Q4.
	Promote prevention of healthcare associated infection through Open Campaign activities. Implement national Central-Line-Associated Bacteraemia (CLAB) processes in the Neonatal Unit. Continue to monitor CLAB-free days and engage staff in the target. Support the collection of key process information required for hip and knee data using the new electronic scope form. Support Clinical Nurse Mangers to regularly audit skin preparation to ensure appropriate action is taken in all cases.	CLAB processes implemented in Neonatal Unit Q3. 95% of hip & knee replacement patients receive cefazolin ≥ 2g as surgical prophylaxis. 100% of hip and knee replacement patients have appropriate skin preparation.
	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.	Mobility Plans in use at the bedside Q4. 90% of older patients (65+) have a falls risk assessments completed.
	Continue to support adherence to the '5 Moments in Hand Hygiene' with promotion of expectations to staff. Continue to work with Auckland DHB and the HQSC to support the national Surgical Site Infection Surveillance Programme. Reinforce and monitor Brief and Debrief and completion of the Surgical Safety Checklist to support adherence to policy. Roll-out e-prescribing and administration across the organisation to improve medication safety.	MedChart deployed Q2. 80% compliance with good hand hygiene practice. All three parts of the surgical safety checklist used 90% of the time.

6.15 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 whole of system patient pathway to ensure we can continue to provide quality services into the future. We are also expanding our capacity by supporting service delivery and innovative roles that enable health professionals to work to the upper end of their scope and to spend more quality time with patients.

Recent staff survey results provide indications that our workforce feel supported and want to be here, but staff reliance and support programmes will continue over the coming year. We will also 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, we will build on the collaborative models of care we have already begun to develop with the West Coast using technology such as telemedicine and joint positions through which staff in Canterbury support the delivery of care on the Coast. 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 from the Regional Training Hub.

OUR PERFORMANCE STORY 2014/15		
OBJECTIVE	**ACTION**	**EVIDENCE**
Implement change leadership and development programmes.	Continue to drive change and improved outcomes through the development of clinically led patient pathways. Pilot a consistent way of assessing, planning and implementing change management with two organisational projects. Introduce talent identification programmes and a core curriculum that supports leadership development.	>600 HealthPathways Q4. Two change management projects evaluated Q4. CDHB/WCDHB core curriculum in place by Q4.
Promote and support the desired culture of the CDHB and improve employee engagement.	Promote health excellence culture throughout the organisation. Invest in programmes and initiatives that reiterate the desired behaviours and culture, including 'XcelR8', 'Particip8' and 'Releasing Time to Care', and conclude Releasing Time to Lead pilot. Introduce a diagnostic tool to assess current and ideal culture values and identify opportunities for change. Align systems for goal-setting, performance reporting, and communications to reinforce cultural messages. Strengthen patient safety and Just Culture across the organisation Act on opportunities identified in the 2013 Staff Engagement Survey to improve engagement levels across the organisation. Improve usage rates and reporting on attachment and exit surveys to identify further opportunities for improvement.	Desk audit against the health excellence criteria completed Q2. Ongoing staff participation in XcelR8 and Particip8 programmes Q4. 3 Releasing Time to Care modules completed Q3. 500 people completed the Just Culture on-line learning module by Q4. ≥80% of staff leaving would consider returning.
Expand workforce capacity through improved workforce planning, recruitment and retention.	Support regional planning programmes to identify future workforce requirements and agree a common set of planning tools to identify workforce gaps and opportunities. Continue to participate in sector wide and regional employment negotiations and maintain a robust and transparent approach to salary setting. Maximise clinical placements for undergraduate and graduate entry nursing trainees and NETP/NESP positions across the Canterbury Health System to meet future ageing workforce needs. Increase NETP community and primary positions to further ensure health care delivery and access to services closer to home. Develop an Allied Health, Technical & Scientific recruitment website. Introduce a Canterbury Alumni and Employee Referral Programme. Lead the regional delivery of the Kia Ora Hauora Māori Workforce Development Service and support local scholarships. Implement an Employee Resiliency Strategy to support our current workforce in stressful environments including workforce support, counselling programmes and wellness days.	>160 nurse positions within the NETP and NESP programmes Q4. Five new Dedicated Education Units established Q4. 5 Pacific primary care scholarships awarded Q4. 10 Māori primary care scholarships awarded Q4. Staff turnover rates maintained <8.7%.

Expand workforce capability through improved training, education, learning and career development.	Enhanced talent management and progression planning through shared resources, recruitment and retention technology (Phoenix). Digitise all Human Resources (HR) administration processes to streamline process and further integrate Canterbury and West Coast HR systems. 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.
	Expand the Gerontology Acceleration Programme to address the challenges of an ageing population and gerontology workforce. Pilot E-portfolio for NETP/NESP nurses established in conjunction with Ngā Manukura o Āpōpō. Support allied health role development for: allied health assistants; pharmacy technicians; and advanced roles. Support nurses to further engage in the credentialing process to enable more of the nursing workforce to work at the top of scope. Seek support for a pilot Nurse Practitioner Training Programme. Invest in extending primary care education programme coverage and expand the variety of education channels. Establish a seamless shared services model for the Health Precinct to facilitate integration and access for staff and students to health services and to research, education and training.	60 NETP/NESP nurses complete e-portfolio Q3. >85% GPs and Practice Nurses have access to primary care education programme Q4. Regional nursing framework in place Q4. RN Diabetes Nurse prescribing supported Q4.
Participate in the South Island Regional Training Hub to expand workforce capacity and capability through improved workforce planning, sourcing and training.	Support the development of regional education sessions, forums, peer support and mentoring using innovative approaches including e-learning and video conferencing. Review and standardise the career pathways and training opportunities for all HWNZ funded trainees.	E-learning platforms established Q4. 100% of HWNZ-funded staff have career plans in place Q4.
	Support the identification of vulnerable workforces and the development of plans established to mitigate these. Support a regional approach to workforce training for vulnerable workforce areas and the coordination of clinical placements to specialist training programmes. Support the development of workforce capability to match future workforce models and the shift to community care. Support the roll out of GPEP 2 in South Island. Continue to support targeted workforce initiatives across regional workstreams including training and role development.	PGY2 & PGY3 pilot Q4. GPEP2 rollout Q4. Allied Health Assistant training & development framework in place Q4. Regional training of sonography coordinated across South Island Q4. Compliance with 70/20/10 funding criteria Q4.
	Support the development of a regional HR Platform and an integrated workforce plan for the South Island. Lead the development of a common set of workforce planning tools, core HR policies, HR metrics and learning & development tools. Adopt consistent application of common terms and conditions of employment for regional health services.	Common and consistent HR policies in place Q2. Regional health workforce plan developed by Q4. Regional Recruitment and Retention Strategy Q4.

6.16 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 firstly to deliver services in more effective and efficient ways. This will be a challenge, but in achieving this, we will demonstrate to our community and Government that we can operate sustainably.

OUR PERFORMANCE STORY 2014/15		
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 and roll-out clinical pathways to support the delivery of the right care, in the right place, at the right time. Maintain eSCRV, HCS and ERMS to provide a core set of patient information at the point of care, support more informed treatment and improve the management of referrals. Maintain GP access to diagnostics and specialist nursing support to reduce unnecessary hospital and specialist referrals.	>600 HealthPathways available across the Canterbury system. 90% of all DHB services using ERMS. Regional implementation of HCS Q4.
Support people to stay well and reduce unplanned or acute demand for health services.	Continue to invest in acute demand services to provide people with access to urgent care in the community rather than in hospital. Invest in the Collaborative Care Programme and CCMS to support people to better manage their long-term conditions. Maintain CREST and Falls Prevention Services to support earlier discharge from hospital and reduce the likelihood of readmission. Continue to implementation a stepped care model for mental health to support people to stay well in the community.	>25,000 urgent care packages provided. Rate of acute medical admissions maintained at <5,000 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 medication and infection control initiatives to support safer and shorter patient stays. Implement the Frail Older Person's Pathway to reduce the length of stay for older people and improve patient flow in our hospitals. Implement the national Enhanced Recovery After Surgery (ERAS) pathway to reduce the total impact of surgery. Apply scrutiny to contractual arrangements and ensure that payment is sought for Inter-district flows, insurance and ACC costs. Maintain tight controls around repairs and maintenance to ensure investment is not wasted on short-term repairs.	Elective theatre utilisation maintained at ≥85%. Elective inpatient length of hospital stay ≤3.18 days. Reduction in beds occupied by patients aged 75+ for more than 14+ days – baseline 197. Reduced deficit by half – from $25m (2013/14) to $12.5m year end 2014/15.
Participate in regional and national initiatives focused on the efficient and effective use of resources to achieve financial sustainability.	Actively participate in the Regional Support Services Alliance to achieve regional Procurement and Supply Chain savings. Maintain clinical and HBL representation on the Support Services Alliance to ensure endorsement and alignment. Identify opportunities for cost savings from national Health Benefits Limited (HBL) initiatives and apply these locally. Actively participate in the development of national Food, Linen & Laundry, Infrastructure Platform, HR Information Systems, Banking & Insurance and Finance, Procurement and Supply Chain business cases - as approved by the DHB Board. Provide expert advice and support to the National Health Committee in review of the burden of disease and the assessment and prioritisation of technologies driving fast growing spend. Provide clinical support to the Health Innovation Partnership. Support national PHARMAC initiatives focused the procurement of medical devices, and the management of hospital pharmaceuticals. Regional Strategic Planning & Integration Team take on role as Regional Prioritisation Network.	Regional Capital Plan in place Q1. Regional Procurement and Supply Chain achieves savings as agreed Q4. Opportunities for joint ventures explored Q4. Annual review of regional patient transport undertaken Q3. Burden of disease documents reviewed as received. Regional Prioritisation Network liaise with NHC as required.

Service configuration

As we move ahead with the transformation of our health system and respond to the after-effects of the Canterbury earthquakes, it is critical that we are able to refocus and flex the limited resources we have available to enable us to do more for our population

Canterbury's recovery is underway, but our population remains stressed and vulnerable. Our health system's capacity is still reduced and will continue to be stretched until additional capacity comes online with the completion of the hospital redevelopment.

Flexibility in our approach enabled us to deliver core health services despite significant disruption and constraint in the wake of the earthquakes. We plan to continue to be as flexible as possible in the way we fund and contract health services in order to enable our recovery and support service providers to respond to the changing needs of their populations.

Service coverage

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

The Canterbury DHB seeks to identify service coverage gaps through analysis of performance indicators, risk reporting, formal audits and complaints mechanism and the ongoing review of patient pathways. We will continue to manage and resolve any service coverage issues in a timely manner.

In our current exceptional circumstances, it is likely that the way in which some services are delivered will have to be adjusted to allow for short-term capacity constraints and the movement of services as we undertake extensive and invasive facility repairs.

However, we anticipate that these services will be contracted through private providers or other DHBs and as such are not seeking any formal exemptions to the Service Coverage Schedule for 2014/15.

Service redesign and reconfiguration

The DHB recognises its obligations (under the Operational Policy Framework) to notify the Minister of Health with respect to plans for 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 in partnership with the people delivering the service. Therefore, while we anticipate that new models of care and service delivery will continue to emerge as we respond to the changing needs of our population; we cannot always pre-determine the extent or detail of any service change.

In all areas, the DHB will ensure service redesign is consistent with previously approved plans and national direction towards stepped care models, integrated service delivery and improved service quality. The service redesign and reconfiguration anticipated in the coming year is either clinically-led or nationally driven including:

Internal service shifts or reconfiguration to support the repair of infrastructure or the provision of services with reduced capacity while facilities are redeveloped.

The redesign of service models to improve patient safety, system capacity and patient outcomes including: elective services redesign and implementation of the Frail Older Person's Pathway, ERAS model, Faster Cancer Treatment track, and the Electronic Incident Management System.

System-wide redesign of service models to build capacity to meet immediate needs and future demand and to improve health outcomes including: implementation of the Heart Failure Pathway and extended treatment strategies for people with mental health needs.

Regional service change or service reconfiguration to support regional consistency and equity of access and ensure the sustainability of vulnerable services including a regional review and proposal for Fertility Services in line with the South Island Regional Health Services Plan.

National service redesign or changes to align processes with national policy, implement Government strategies and the expectations of our Minister including: implementation of the Children's Action Plan, Whānau Ora initiative and national entity priorities.

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 also be carefully considered so as not to destabilise or negatively affect our neighbouring DHBs.

Risks and opportunity

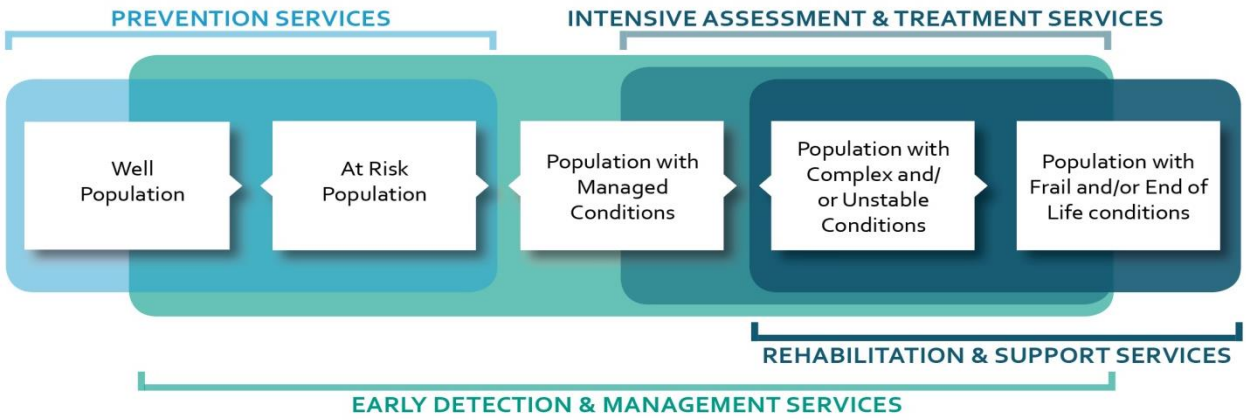
In our current circumstances our greatest service risk going into the next 12 months continues to be simply dealing with the unknown. We are already seeing increased vulnerability and health need amongst our population, consistent with international research on disaster recovery. The unpredictable influx of workers for the rebuild adds a further degree of uncertainty with regards to future demand.

We will continue our open dialogue with the Ministry in regards to our recovery and any service coverage issues or risks that become apparent.

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.

Statement of Performance Expectations

What will we deliver in the coming year?



Evaluating our Performance

As both the major funder and provider of health and disability services in Canterbury, we are strongly motivated to ensure our population gets the most efficient and effective services possible.

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 are making a measureable difference in the health and wellbeing of our population.

One of the functions of this document is to demonstrate how we will evaluate the effectiveness of the decisions we make. Over the longer term, we do this by measuring our performance against a set of desired population outcomes (Section 4).

In the more immediate term, we evaluate our performance by providing a forecast of the services we will fund and provide in the coming year in order to achieve those outcomes and the standards we expect to meet. We then report actual performance against this forecast in our end-of-year Annual Report.[49]

Achieving equity of outcomes is an overarching priority for the Canterbury health system and reflects our commitment to ensuring that our population should enjoy the best possible health status.

With a growing Māori population and persistent inequalities amongst our population, this goal pervades everything we do. All of the Canterbury targets and standards are therefore set the same for all population groups with the aim of bringing performance up for all.

Specific actions with respect to improving Māori health are outlined in our Māori Health Action Plan along with performance against key indicators by ethnicity.

Choosing performance measures

In order to present a fair picture of performance, the services we deliver have been grouped into four '*output classes*' that are a logical fit with the stages of the continuum care and are applicable to all DHBs:

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

Identifying a set of appropriate measures for each output class is difficult. We cannot simply measure '*volumes*'. 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 chose to present a mix of measures demonstrating: Timeliness (T), Coverage (C), Volume (V) and Quality (Q) - all of which help us to evaluate different aspects of our performance. Against each we have set targets to demonstrate the standard expected.

The measures chosen cover those activities we believe have the potential to make the greatest contribution to the wellbeing of our population. Others are relevant in that they represent areas where we are developing new services or expect to see a change in activity levels or settings in the coming year.

[49] *DHB Annual Reports can be found at www.cdhb.health.nz.*

Setting standards

Wherever possible, we have included past year's baseline and national results to give context in terms of what we are trying to achieve and to support evaluation of our performance. However, measures that relate to new services have no baselines and some measures relate to Canterbury-specific services for which there is no national comparison available.

In setting performance standards, we have considered the changing demographics of our population, increasing demand and the assumption that funding growth will be limited. Targets tend to reflect the objective of maintaining service access while reducing waiting times and delays in treatment to demonstrate increased productivity and capacity.

To ensure the quality of services provided, the DHB invests in programmes that are evidence-based or evidence-informed, where research shows definite gains and positive outcomes. In these cases, the DHB will measure the number of people 'trained' or the development of a particular evidence-based programme or method, to give further assurance of quality provision and of the capacity of the system to deliver these services.

This provides greater assurance that these are quality services, allowing the DHB to focus on monitoring implementation and timely and appropriate access.

It is important to note that a significant proportion of the services funded by the DHB are demand driven – such as laboratories tests, emergency care, maternity services, mental health services, aged residential care and palliative care. Estimated service volumes have been provided, not as targets to be achieved, but to give the reader context in terms of the use of resource across the Canterbury health system.

Notation

Some data is provided to the DHB by external parties and can be affected by a delay in invoicing. Rather than footnote every instance, symbols are used to indicate where this is the case: Δ indicates data that could be affected by invoicing delay and is subject to change (data for these measures was pulled on or before 10 August 2014.

A † symbol indicates where data relates to the calendar year rather than financial year.

There are also a number of national health targets where performance is tracked and reported nationally on a quarterly basis rather than annually. A ◇ symbol indicates that the baseline, national average and target refer to the fourth quarter result of that year.

Where does the money go?

The table below presents a summary of the 2014/15 budgeted financial expectations by output class.

Over time, we anticipate it will be possible to use this output class framework to demonstrate changes in allocation of resources and activity from one end of the continuum of care to the other.[50]

REVENUE	TOTAL $'000
Prevention	30,658
Early detection and management	334,222
Intensive assessment & treatment	1,004,477
Support & rehabilitation	232,543
Grand Total	**1,601,900**

EXPENDITURE	TOTAL $'000
Prevention	30,841
Early detection and management	336,016
Intensive assessment & treatment	1,013,904
Support & rehabilitation	233,689
Grand Total	**1,614,450**
Surplus/(Deficit)	**(12,550)**

[50] *Note: The budgeted expenditure includes expected earthquake settlement proceeds and repair costs. These earthquake related amounts have been pro-rated across the four output classes. It should be noted that as the earthquake proceeds and costs could fluctuate significantly between years this may affect comparison of the output class information over the next several years.*

OUTPUT CLASS

8.1 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 and services to 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 programmes) that support early intervention to modify lifestyles and maintain good health.

Why is this output class significant for the DHB?

By improving environments and raising awareness, these services support people to make healthier choices – reducing major risk factors that contribute to long-term conditions and delaying or reducing 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 and to 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.

OUTPUTS SHORT-TERM PERFORMANCE MEASURES (2013/14)

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	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of babies exclusively breastfeeding on hospital discharge	Q [51]	76%	≥75%	-
Lactation support and specialist advice consults provided in community settings	V	858	>580	-
'Appetite for Life' nutrition courses provided in the community	VΔ	52	≥50	-
People accessing Green Prescriptions for additional physical activity support	V [52]	1,936	3,000	-
% of Green Prescription participants more active 6-8 months after referral	Q [53]	50%	≥50%	63%
% of smokers identified in primary care receiving advice and help to quit (ABC)	C◇	35%	90%	57%
% of smokers identified in hospital receiving advice and help to quit (ABC)	C◇	93%	95%	96%
Enrolments in the Aukati Kaipaipa smoking cessation programme	V	345	≥240	-
% of priority schools supported by the Health Promoting Schools framework	C [54]	74%	≥70%	-

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	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of four-year-olds provided with a B4 School Check (B4SC)	C [55]	86%	90%	80%
% of Year 9 students in decile 1-3 schools provided with a HEEADSSS assessment	C†[56]	99.6%	100%	-
% of women aged 25-69 having a cervical cancer screen in the last 3 years	C [57]	75%	80%	77%
% of women aged 45-69 having a breast cancer screen in the last 2 years	C [57]	82%	≥70%	72%

[51] The percentage of babies' breastfed demonstrates the effectiveness of consistent health promotion messages delivered during the antenatal, birthing and early postnatal period. Standards are based on national targets.
[52] A Green Prescription is a health professional's written advice to a patient to be physically active, as part of their health management.
[53] Results taken from national patient survey completed by Research NZ on behalf of the Ministry of Health.
[54] 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.
[55] 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.
[56] A HEADSSS assessment is provided to Year 9 students it is free and covers: Home, Education/Employment/Eating/Exercise, Activities; Drugs, Sexuality; Suicide, Safety; and Spirituality. The assessment allows health concerns to be identified and addressed early.
[57] These are national screening programmes and standards are based on national screening unit targets.

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	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of newborns enrolled on the National Immunisation Register at birth	C	98%	≥95%	-
% of children fully immunised at eight months of age	C◇	92%	95%	90%
% of eight-month-olds 'reached' by immunisation services	Q [58]	97%	95%	95%
% of eligible girls completing HPV vaccinations (i.e. receiving Dose 3)	C†[59]	43%	60%	54%
% of older people (65+) receive a free influenza ('flu') vaccination	C†	71%	75%	65%

[58] *'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.*

[59] *The baseline is the percentage of girls born in 1996 receiving Dose 3 by the end of 2012, and the target for 2014 is girls born in 1998. Canterbury's programme is slightly different to that delivered elsewhere as it is primarily general practice rather than school based. This measure differs slightly to previous years as the age-bands have been lifted to better align with the school-based programme.*

OUTPUT CLASS

8.2 Early detection and management services

Early detection and management services maintain, improve and restore people's health by ensuring that people at risk or with disease onset are recognised early, their need is identified, long-term conditions are managed more effectively and services are coordinated - particularly where people have multiple conditions requiring ongoing interventions or 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, and prevalence also increases with age. By promoting regular engagement with health services, we support people to maintain good health through earlier diagnosis and treatment, which provides an opportunity to intervene in less invasive and more cost-effective ways associated with better long-term outcomes. These services also support people to better manage their long-term conditions and avoid complications, acute illness and crises.

Our current move to better integrate services presents a unique opportunity. Providing flexible and responsive services in the community, without the need for a hospital appointment, will support people to stay well and reduce the overall rate of admissions, particularly acute and avoidable hospital admissions. Reducing avoidable demand will have a major impact in freeing up hospital and specialist services for more complex and planned interventions.

OUTPUTS SHORT-TERM PERFORMANCE MEASURES

Primary Health Care (GP) Services *These services are offered in local community settings by teams of general practitioners (GPs), registered nurses, nurse practitioners 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	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of the total DHB population enrolled with a Primary Health Organisation	C	96%	≥95%	96%
Avoidable hospital admission rate for children aged 0-4	Q [60]	114%	<111%	100%
Young people (0-19) accessing Brief Intervention Counselling	VΔ[61]	758	≥500	-
Adults (20+) accessing Brief Intervention Counselling	VΔ	5,023	≥3500	-
Skin lesions (skin growths, including cancer) removed in primary care	VΔ	2,358	≥2,000	-
Number of clinical HealthPathways in place across the Canterbury health system	V [62]	667	>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	2012 DHB Result	2014 Target	2012 National Average
% of pre-schools children (0-4) enrolled in DHB-funded oral health services	C†	71%	75%	70%
% of enrolled children (0-12) examined according to planned recall	T†	90%	≥90%	90%
% of adolescents (13-17) accessing DHB-funded oral health services	C†	65%	85%	73%

[60] Some admissions to hospital are seen as preventable through appropriate early intervention. These admissions provide an indication of the access and effectiveness of primary care and an improved interface between primary and secondary services. The measure is based on the national DHB performance indicator SI1, which has been redefined as the standardised rate per 100,000. The baseline differs slightly from previously published figures (112%) due to an update of national data.

[61] 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. Previous years have presented total population provided with BIC but this has been split into age groups to heighten the emphasis on young people accessing support. Results include face-2-face and phone consultations and may undercount people accessing BIC where dates of birth have not been provided.

[62] 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 the negative impact and the need for hospital admission.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
Spirometry tests provided in community rather than hospital settings	VΔ[63]	1,503	≥1,000	-
% of the eligible population having a CVD Risk Assessment in the last 5 years	C◇[64]	33%	90%	67%
% of the population identified with diabetes having an HbA1c test in the last year.	C [65]	86.5%	≥90%	-
% of the population identified with diabetes with acceptable glycaemic control.	Q [66]	75.6%	≥75%	-
People receiving subsidised diabetes self-management support from their general practice team when newly diagnosed with Type 2 diabetes or starting insulin	VΔ[67]	739	≥739	-

Pharmacy and Referred Services *These are services which a health professional may prescribe or refer a person 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 pharmaceuticals are largely demand driven to improve performance, we will target primary care access to diagnostics and shorter wait times to aid decision-making and improve referral processes.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
Subsidised pharmaceutical items dispensed in the community	VΔ[68]	6.7m	est. <8m	-
Laboratory tests completed for the Canterbury population	VΔ	2.0m	est. <2.6m	-
People on multiple medications receiving a Medication Management Review	VΔ[69]	1,771	2,000	-
GP requested Community Referred Radiology tests completed	VΔ	45,555	est.>30,000	-
% of people receiving their urgent diagnostic colonoscopy within 2 weeks	T [70]	30%	75%	56%
% of people receiving their Computed Tomography (CT) scan within 6 weeks	T	89%	90%	79%
% of people receiving their Magnetic Resonance Imaging (MRI) within 6 weeks	T [71]	83%	≥80%	52%
% of people receiving their elective coronary angiography within 3 months	T	82%	90%	88%

[63] 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. Community spirometry volumes include those delivered by both GPs and mobile community respiratory providers.

[64] This refers to CVD risk assessments undertaken in primary care in line with the national 'More heart and diabetes checks' health target. The baseline differs slightly against previously published data (33%) due to timing issues.

[65] Part of good diabetes management includes an annual test of patient's blood glucose levels (via an HBA1c test) to consider and improve the management of their condition.

[66] HbA1c ≤64mmol/mol reflects an acceptable blood glucose level.

[67] Number of subsidised procedures claimed for the 2012/13 year as at February 2014 (includes late claims for the period).

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

[69] The 2012/13 number differs slightly from the previously published number (1,694) due to late invoices

[70] All diagnostic result baselines are the June 2013 result published by the Ministry of Health. Targets are set to national standards.

[71] The DHB will use best endeavours to achieve and sustain performance against the national targets for CT and MRI however radiology support needed to achieve priorities around reducing ESPI and cancer treatment waiting times are putting additional pressure on the service - the CCN Radiology Service Level Alliance will closely monitor system pressures and waiting times.

OUTPUT CLASS

8.3 Intensive assessment and treatment services

Intensive assessment and treatment services are usually complex services provided by specialists and other healthcare professionals working closely together. These services are therefore usually (but not always) provided in hospital settings, which enable the co-location of clinical expertise and specialist equipment. These services include ambulatory services, inpatient and outpatient services and emergency or urgent care services. A proportion of these services are driven by demand which the DHB must meet, such as acute and maternity services and others are planned where provision and access are determined by capacity, clinical triage, national service coverage agreements and treatment thresholds.

Why is this output class significant for the DHB?

Equitable, timely access to intensive assessment and treatment can significantly improve people's quality of life either through early intervention or through corrective action. Responsive services and timely treatment support improvements across the whole system and give people confidence that complex intervention is available when needed. People are then able to establish more stable lives, resulting in improved public confidence in the health system. As an owner of these services, the DHB is also committed to providing high quality services. Quality improvement in service delivery, systems and processes will improve patient safety, reduce the number of events causing injury or harm and improve health outcomes. Adverse events and delays in treatment, as well as causing harm to patients, drive unnecessary costs and redirect resources away from other services. Appropriate and quality service provision will reduce readmission rates and better support people to recover from complex illness and/or maximise their quality of life.

OUTPUTS SHORT-TERM PERFORMANCE MEASURES

Quality and Patient Safety Measures *These quality and patient safety measures apply across all services provided in West Coast DHB hospitals and are newly introduced national quality and safety markers championed and monitored by the Health Quality & Safety Commission.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
Rate of compliance with good hand hygiene practice	Q [72]	67%	80%	71%
% of hip and knee replacement patients receiving cefazolin ≥2g	Q [73]	new	95%	-
% of hip and knee replacement patients who have appropriate skin preparation	Q	new	100%	-
% of time all three parts of the surgical safety checklist are used	Q [74]	40%	90%	71%
% of inpatients (aged 75+) who received a falls assessment	Q [75]	97%	≥90%	77%

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 in home, community and hospital settings by a range of health professionals, including lead maternity carers, GPs and obstetricians. Utilisation is monitored to ensure service levels are maintained and to demonstrate responsiveness to need.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of women registered with an LMC by 12 weeks of pregnancy	C	73.3%	80%	63%
Maternity deliveries in Canterbury DHB facilities	V	5,778	est. 6,000	-
% of total deliveries made in Primary Birthing Units	V [76]	9%	13%	-
Baby friendly hospital accreditation of Canterbury DHB facilities maintained	Q [77]	yes	yes	-

[72] This measure is based on ward audits of the Medical and Surgical wards conducted according to Hand Hygiene NZ standards. The baseline result is taken from national Health Quality & Safety Commission (HQSC) reporting for Quarter 4 2012/13.

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

[74] The surgical safety checklist, developed by the World Health Organisation, is a common sense approach to ensuring the correct surgical procedures are carried out on the correct patient. The baseline result is taken from HQSC reporting for Quarter 3 2012/13.

[75] 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. The baseline result is taken from HQSC reporting for Quarter 3 2012/13.

[76] 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 needed, 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.

[77] The Baby Friendly Initiative is a worldwide programme of the World Health Organization and UNICEF to encourage maternity hospitals to deliver a high standard of care and implement best practice. An assessment/accreditation process recognises achievement of the standard.

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	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of children under six with access to free primary care after hours	C	100%	100%	-
% of general practices providing telephone triage outside business hours	C[78]	86%	95%	-
Acute demand packages of care provided in community settings	V [79]	25,374	>25,000	-
Attendances at Canterbury Emergency Departments (ED)	V [80]	87,221	≤93,000	-
% of people waiting less than 4 weeks for radiotherapy or chemotherapy	T◇[81]	99.5%	100%	100%
Acute inpatient average length of hospital stay (standardised)	Q [82]	3.86	≤3.86	3.99

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	2012/13 DHB Result	2014/15 Target	2012/13 National Average
First Specialist Assessments provided (medical and surgical)	V [83]	60,819	est. >60,000	-
% of First Specialist Assessments that were non-contact	Q [84]	12.1%	>10%	-
Elective surgical discharges delivered (surgeries provided)	V [85]	17,066	≥17,484	-
% of elective/arranged surgeries provided as day cases.	Q [86]	57%	≥57%	-
% of people who receive their surgery on the day of admission	Q [86]	91%	≥90%	-
Elective inpatient average length of hospital stay (standardised)	Q [82]	3.19	≤3.18	3.36
Outpatient attendances	V	622,837	est. >600k	-
Outpatient 'Did not Attend' rates	Q [87]	4.4%	≤5%	-
Outpatient 'Did not Attend' rates (Māori)	Q [88]	8.6%	≤5%	-

[78] *Results for 2012/13 differ from those previously stated due to a recalculation of practices which had closed and merged over the year.*

[79] *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).*

[80] *This measure is a national performance measure (the ED Health Target). As such, it counts Christchurch and Ashburton Emergency Departments. The number differs slightly to previously published number (by 20 people) due to refreshed coding.*

[81] *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. The result differ to that previously published (100%) due to an error discovered after the Plan was published.*

[82] *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.*

[83] *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.*

[84] *Non-contact FSAs are those where specialist advice and assessment is provided without the need for a hospital appointment.*

[85] *This measure is a national performance measures (the electives health target) and excludes 'arranged' cardiology and dental volumes.*

[86] *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. These rates are balanced against readmissions rates to ensure service quality is appropriate. These were previously national performance measures (OS6 & OS7) discontinued at the end of 2012/13 the internal data now referenced differs slightly due to timing and standardisation issues and national averages are no longer available.*

[87] *This 2012/13 result differs slightly from previously published result (4.6%) due to inclusion of those people who presented but did not wait.*

[88] *The DNA rate presented differs slightly to that previously published (4.6%) and is now calculated as the proportion of all outpatient appointments where the patient was expected to attend but did not present themselves at the department.*

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	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of young people (0-19) accessing specialist mental health services	CΔ[89]	2.6%	≥3.1%	2.8%
% of adults (20-64) accessing to specialist mental health services	CΔ	3.4%	≥3.1%	3.4%
% of people referred for non-urgent MH and AOD services seen within 3 weeks	T [90]	72%	80%	76%
% of people referred for non-urgent MH and AOD services seen within 8 weeks	T	87%	95%	91%

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	2012/13 DHB Result	2014/15 Target	2012/13 National Average
Admissions into inpatient AT&R services	V	3,101	est. >3,000	-
% of admissions into AT&R (PMH) made by direct community referral	Q	18%	20%	-
% of AT&R inpatients discharged to their own home rather than ARC	QΔ[91]	85%	>80%	-

[89] *This measure is based on the national performance measure (PP26) and expectations that 3% of the population will need access to specialist level mental health services.*

[90] *This measure is a national performance measure (PP8). Results are provided three months in arrears, the results stated are to March 2013.*

[91] *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'. These results differs from that previously published as they did not exclude patients who were ARC residents prior to AT&R admission.*

OUTPUT CLASS

8.4 Rehabilitation and support services

Rehabilitation and support services provide people with the assistance they need to maintain or regain maximum functional independence, either temporarily while they recover from illness or disability, or over the rest of their lives. These services are delivered after a clinical 'needs assessment' process and include: domestic support, personal care, community nursing, services provided in people's own homes and places of residence, day care, respite care and residential care. Services are mostly for older people, mental health clients and personal health clients with complex conditions. 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.

Why is this output class significant for the DHB?

Services that support people to manage their needs and live well, 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 responsive support services enables people to maximise function and independence. In preventing deterioration and acute illness or crisis, these services have a major impact on the sustainability of hospital and specialist services and on the wider health system in general by reducing acute demand, unnecessary ED presentation and the need for more complex intervention. These services also support the flow of patients and improved recovery after an acute illness or hospital admission – helping to reduce readmission rates and supporting people to recover from complex illness and/or maximise their quality of life.

OUTPUTS SHORT-TERM PERFORMANCE MEASURES (2013/14)

Rehabilitation Services *These services restore or maximise people's health or functional ability following a health-related event. They include mental health community support, physical or occupation therapy, treatment of pain or inflammation and retraining to compensate for specific lost functions. Success is measured through increased referral of the right people to these services.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of people referred to an organised stroke service with demonstrated stroke pathway after an acute event	C	74%	80%	-
% of people enrolled in cardiac rehabilitation services after an acute event	C [92]	25%	30%	-
People accessing pulmonary rehabilitation courses	V [93]	206	>150	-
People (65+) accessing community-based falls prevention programmes	V [94]	1,613	>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. They may be short or longer-term in nature. An increase in the number of people being supported is indicative of increased capacity in the system, and success is measured against decreased or delayed entry into residential or hospital services.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of older people (65+) receiving long-term home and community support services who have had a comprehensive clinical assessment using InterRAI	QΔ[95]	90%	95%	-
People accessing CREST services on hospital discharge or GP referral	VΔ[96]	1,850	2,200	-
People supported by long-term home-based support services	VΔ	8,860	est.>8,000	-
People supported by district nursing services	VΔ	7,911	est.>6,000	-

[92] *This measure counts those enrolled in Phase 2 (outpatient) Cardiac Rehabilitation on discharge.*
[93] *This measure now includes all people attending pulmonary rehabilitation (Ashburton, Christchurch, Community-based).*
[94] *This measure refers to Canterbury's Integrated Falls Prevention Service which launched in February 2012.*
[95] *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. This number differs from previous years after alignment to the national measure.*
[96] *The CREST service began in April 2011 and provides a range of home-based rehabilitation services to facilitate early discharge from hospital or avoid admission entirely (via pro-active GP referral).*

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. They may also include support and respite for families, caregivers and others affected. Services are expected to increase over time, as more people are supported to remain in their own homes.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
People supported by day services	VΔ	654	est. >550	-
People accessing mental health planned and crisis respite	VΔ[97]	829	est. >750	-
Occupancy rate of mental health planned and crisis respite beds	CΔ[98]	81%	85%	-
People supported with aged care respite services	VΔ	1,192	est. >1,000	-

Palliative Care Services *These are services that improve the quality of life of patients and their families facing life-threatening illness, through the prevention and relief of suffering by means of early intervention, assessment, treatment of pain and other supports.*	Notes	2012/13 DHB Result	2014/15 Target	2012/13 National Average
People supported by hospice or home-based palliative services	VΔ	3,295	est. >2,000	-
ARC facilities trained to provide the Liverpool Care Pathway option to residents	C [99]	42	≥45	-
People in ARC services supported by the Liverpool Care Pathway	V	134	>150	-

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	2012/13 DHB Result	2014/15 Target	2012/13 National Average
% of people entering ARC having had a clinical assessment of need using interRAI	QΔ[95]	91%	95%	-
% of ARC residents receiving vitamin D supplements	C [100]	73%	75%	-
Subsidised ARC rest home beds provided (days)	VΔ[101]	573,866	est. <676,000	-
Subsidised ARC hospital beds provided (days)	VΔ	453,716	est. <507,000	-
Subsidised ARC dementia beds provided (days)	VΔ	222,445	est. >212,000	-
Subsidised ARC psycho-geriatric beds provided (days)	VΔ	69,468	est. >62,000	-

[97] This measure includes the new mental health mobile respite service, launched in 2013.

[98] Occupancy rates provide an indication of a service's 'capacity'. The aim is to maintain enough beds to meet demand requirements (with some space to flex) but not too many to imply that resources are underutilised and could be better directed to other areas. The result for 2012/13 differs to that previous published (85%) due to an error found in start and finish dates.

[99] The Liverpool Care Pathway is an international palliative care programme adopted nationally and reflects best-practice care.

[100] ARC Vitamin D supplementation results are provided quarterly by MoH. The 'actual' provided is for the three months to June 2012.

[101] Results for 2012/13 differ for all ARC beds provided due to late invoices.

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 whole of the health sector to rethink how we will meet the needs of our populations with a more moderate growth platform. The Minister of Health expects DHBs to operate within existing resources and approved budgets and to work collaboratively to ensure service delivery is clinically and financially sustainable.

9.1 Canterbury's financial outlook

The Canterbury DHB, like the rest of the health sector, faces significant financial pressures from increasing service demand, rising treatment costs, wage expectations and increased public expectations – all of which must be managed within allocated funding.

Despite these pressures, Canterbury was on track to deliver a break-even financial performance. However, the earthquakes have resulted in unplanned net expenditure and costs of over $60m to date.

As a direct result of the earthquakes, Canterbury's planned financial result in 2012/13 was initially estimated at a $40m deficit, the major contributors being earthquake-related costs and the revenue impacts of short-term population changes. Through a variety of initiatives and measures, Canterbury DHB was forecasting a net deficit of $35m for 2012/13. This was reduced to a breakeven position with the addition of planned earthquake funding support from the Ministry of Health.

Post year-end the insurance claims for the Canterbury earthquake were settled at the policy maximum $320m. This was subsequently recognised in the 2012/13 year creating a net surplus of $287m. Timing differences between the recognition of insurance proceeds and the prolonged spend in regard to repairs (both operating repairs and maintenance and capital re-instatement) will be evident for a number of financial years.

The total overall cost of the earthquakes is still an unknown factor and we expect the cost impacts to also continue to influence and distort our financial results for the next several years. They appear in various types of expenditure: from the securing of external capacity to support our service delivery through to emergency repairs and maintenance.

We are still unable to accurately determine the final interplay between repair costs and insurance recovery and the impact of new Building Codes, construction inflation and cost escalation on repair costs. However, it is apparent that there is a significant level of remedial work needed which is not able to be covered by the insurance proceeds in a like for like manner.

The DHB has devised a 10 year programme of earthquake repair work in which the long-term delivery of services can be sustained and remain affordable in the context of the $320m insurance proceeds available.

This programme will require ruthless prioritisation in order for it to remain affordable as we navigate the uncertainties of repair costs and maintain safe and effective service provision for staff and patients.

We are also unable to precisely predict the likely increase in demand for services from a vulnerable population that has been under stress for more than three years. We are already experiencing significant uplift in a number of areas, such as mental health services, and are fully expecting this demand to be sustained for a prolonged period. This creates a level of financial volatility in regards to the long-term outlook; further exacerbated by revenue volatility driven by population fluctuations.

There is no 'quick-fix' solution. To ensure our health system is clinically and financially sustainable, we have focused on making decisions that are 'best for patient and best for system'. Constraining future cost growth is critical to our success. If an increasing share of our funding is directed into meeting the cost of providing services, our ability to maintain current levels of service will be at risk. We will also be severely restricted in terms of our ability to invest in new equipment, technology and initiatives that will allow us to meet future demand.

It is also critical that we continue to reorient and rebalance our health system. By integrating services and improving the quality of the care we provide, we can reduce rework and duplication, avoid unnecessary expenditure and do more (and see more people) within our current resources.

9.2 Achieving financial sustainability

Canterbury's future is not about doing more of the same, but doing more with the same.

Revenue from the Government (via Ministry of Health) is the main source of DHB funding. This is supplemented by additional funding from side agreements with organisations such as ACC and payments from other DHBs for services provided to their populations.

We are forecasting that Canterbury's base funding for 2014/15 will increase by approximately $28.6m.

This funding, whilst at '*normal*' funding increase levels, has not corrected the downward adjustment made in the year following the earthquakes (based on an estimated reduction in population which did not eventuate). The 2013 Census data, which has yet to be factored into funding calculations, points to a population which is largely in line with the pre earthquake trajectory.

Living within our means

In order to meet the needs of our population and the expectations of the Minister of Health, the Canterbury DHB will continue to focus on strategies to constrain cost growth and rebalance our health system.

Savings will be made not in dollars terms, but in terms of costs avoided through more effective utilisation of the resources available and reduced demand for services.

Strategies reflected throughout this document include:

- Reducing variation, duplication and waste.
- Doing the basics well and understanding our core business – best for patient, best for system.
- Investing in clinical leadership and clinical input into operational processes and decision-making.
- Integrating systems to share resources.
- Enabling clinical decision-making at the point of care to reduce delays and improve the quality of care.
- Developing workforce capacity and supporting integrated, less traditional workforce models.
- Realigning service expenditure to better manage the demand growth with reduced bed capacity.

The Canterbury DHB also actively supports the South Island Support Services Alliance to implement tighter cost controls and make purchasing and productivity improvements to limit the rate of cost pressure growth. In particular, Canterbury is taking a lead in the Procurement and Supply Chain Workstream.

In line with our decision-making principles the Support Services Workstream has a clinical lead alongside the CEO sponsor and involves clinicians in the rationalisation and standardisation of products and services to reduce clinical risk and increase engagement in the programme.

The regional Workstreams focused on Food, Laundry, Maintenance & Engineering and Clinical Engineering Services are being re-engaged in the coming year and regional work plans being identified.

Through the Regional Alliance, the DHB will also maintain and strengthen the relationship with Health Benefits Limited (HBL) to assist them in implementing an operational model (in partnership with DHBs) to achieve mutual benefits and cost savings. The key actions to align Support Services activity with HBL work programmes are identified in the South Island Regional Health Services Plan, available at www.sialliance.health.nz.

Canterbury DHB is an active participant on a number of HBL workstreams to provide assistance and support to external providers of solutions, particularly in regard to food, linen & laundry and supply chain services priorities.

We are also committed to supporting national entity initiatives locally to achieve mutual benefits and cost savings across the sector; the table below indicates the level of inclusion in the 2014/15 financial projections.

Out-years scenario

The current reality in Canterbury creates a high level of uncertainty and variability related 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 and population deprivation post-earthquake; earthquake repair cost volatility; and timing around facilities plans and costs of building repairs not covered by insurance in addition to affordability.

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

CANTERBURY COMMITMENT TO NATIONAL INITIATIVES

2014/15	CAPITAL COSTS	OPERATING COSTS		OPERATING BENEFITS	NET OPERATING
		ONE-OFF	ONGOING		
	$'000s	$'000s	$'000s	$'000s	$'000s
Health Benefits Limited					
Finance, Procurement & Supply Chain	(1,283)	(223)	-	(671)	(894)
Human Resource Management Information Systems	-	(167)	-	-	(167)
National Health IT Board					
eMedicines Reconciliation with eDischarge	(327)	-	-	-	-
Replacement of legacy Patient Administration Systems	(6,403)	(346)	-	-	(346)
National Patient Flow	-	(195)	-	-	(195)
Self-Care Portal	-	(533)	-	-	(533)
Health Quality & Safety Commission					
Patient experience indicators			(15)		(15)
Total	**(8,013)**	**(1,464)**	**(15)**	**(671)**	**(2,150)**

9.3 Assumptions

We have made the assumption that Canterbury will run a reduced deficit for the 2014/15 financial year as a continued result of covering the cost of the earthquakes. This is entirely consistent with the financial assessments considered under the detailed facilities business case approved by Cabinet.

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 wider system impacts from the earthquakes, these costs are still uncertain and have not been assumed in our forecasts.

We are also aware that there will be increased demand from a population that has been under stress for more than three years. However, there are few comparative situations we can use as a base for making assumptions about the level of this demand. We have made conservative predictions as a precautionary measure.

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 2014/15 will remain at the level indicated in December 2013.
- Fair prices will be received for services provided on behalf of other DHBs and the Crown, including paediatric oncology services.
- 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).
- The Ministry of Health will continue to fairly fund Canterbury for additional operational expenditure in relation to the earthquakes.
- Canterbury DHB's $290m earthquake settlement proceeds (transferred to the Crown to minimise capital charge expenses) 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 actual results and budget depending on both the costs and applicable accounting treatment of repairs to buildings, infrastructure and equipment not covered by insurance recoveries. Due to the previous year's recognition of insurance proceeds (as required under current NZ accounting standards) these 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 stated fiscal results for a number of years.
- Earthquake related repair programmes, as funded by insurance proceeds and internally sourced funding, will continue. Estimates of the corresponding capital, repairs and maintenance expenditure expected to take place during the term of this plan, together with an estimated of the earthquake proceeds draw-down, have been included. Due to the fluidity and timing of repair works, some fluctuations in estimates and actual spend are expected to occur.
- Revaluations of land and buildings will continue and as a result there will be further impacts on land, building and infrastructure values. The quantum of the earthquake impairment, coupled with the regular period valuation, is not yet known and no adjustment have been made for this in our forecasts.
- Work will continue on the Facilities Redevelopment Plan. Capital expenditure associated with the redevelopment that will take place during the term of this Plan have therefore been included.
- Borrowings required to fund the Facilities Redevelopment Plan will be available from an external source.
- 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 be made within available funding levels.
- Transformation and earthquake recovery strategies will not be delayed due to sector or legislative changes, and investment to meet increased demand will be prioritised and approved in line with our Board's strategy.
- There will be no disruptions associated with natural disasters or pandemics. Revenue and expenditure have been budgeted on current and expected operations with no further disaster assumptions.

9.4 Asset planning and investment

National business cases

In 2010, the DHB submitted a business case seeking approval for the redevelopment of Christchurch Hospital and Older Persons' Health Specialist Services. This process culminated in approval of the Business Case redevelopment by Cabinet and the national Capital Investment Committee in March 2013.

Timeframes for the fast-tracked design and execution of this redevelopment are particularly critical to avoid the substantial and unnecessary costs of short-term structural upgrades that will not improve the clinical suitability of facilities already unfit for service needs. The timelines for completion of the redevelopment are: Burwood (Older Persons' Health Services) hospital redevelopment by 2015 and Christchurch by 2018.

A business case for the redevelopment of the Kaikoura Hospital site as an Integrated Family Health Centre received Cabinet and Capital Investment Committee approval in April 2013. Detailed design plans have been completed and the DHB expects to commence construction in mid-late 2014.

The Regional Programme business case for the South Island Patient Information Care System (PICS) has been approved by Cabinet. The system will replace its current legacy Patient Administration System. The DHB is currently progressing with a detailed implementation business case and this is expected to be submitted to the National Health IT Board and Capital Investment Committee in October/November 2014.

Capital expenditure

The Canterbury DHB's capital expenditure budget totals $303m for the 2014/15 year, subject to appropriate approvals. In addition to normal clinical and operational capital requirements, this includes the following significant capital projects:

- Children's Haematology Oncology Centre (deferred from 2011/12 due to earthquake disruption).
- Ashburton Hospital rebuild, including procedure rooms and wards.
- Phase 1 of the Facilities Redevelopment Programme, focusing on the Burwood Hospital site.
- Strategic IT developments, including the upgrade of our Patient Administration System and the roll-out of the next stages of the national e-Medicines Programme, eSCRV and the Collaborative Care Management System.
- Continuation of reinstatement and alternative accommodation strategies under our 10 year earthquake recovery programme of work.

Capital expenditure associated with projects required as a result of earthquake damage to our infrastructure and that of providers we fund has been included within our capital plans. The overall impact of lengthy building delays in any of these projects, given the current construction micro-climate in Canterbury, could be a significant increase in expenditure over these projects.

9.5 Debt and equity

The Canterbury DHB currently has a $145,985m total loan facility with the Ministry of Health (formerly the Crown Health Funding Agency), which is fully drawn down. The DHB's total term debt is expected to remain at $145,895 as at June 2015.

The DHB debt level is planned to rise in out years - reflecting new loans required for the new Burwood and Christchurch facilities. The respective loans will be raised when the assets are transferred to the DHB (i.e. 2015/16 for the Burwood facility and 2018/19 for Christchurch).

The Ministry-funded term loans are secured by a negative pledge. Without the Ministry of Health's prior written consent, the DHB cannot:

- Create any security over its assets, except in certain circumstances.
- Lend money to another person or entity (except in the ordinary course of business and then only on commercial terms) or give a guarantee.
- Make a substantial change in the nature or scope of its business as presently conducted, or undertake any business or activity unrelated to health.
- Dispose of any of its assets except disposals at full value in the ordinary course of business.

The DHB is repaying $1.861m of equity annually as part of the agreed FRS-3 funding. In addition the DHB is also:

- Repaying $60m in 2013/14 and $120m in 2014/15 as equity repayment as part of the DHB's contribution towards the Burwood and Christchurch hospital redevelopments.
- Repaying $290m of the DHB's earthquake settlement proceeds in 2013/14 as an equity repayment. As agreed with the Ministry of Health, the $290m will progressively be drawn down to fund future earthquake recovery works. $20m of the $290m will be drawn down by June 2014, leaving a balance of $270m for out years.

The extent of insured damage as identified to support the insurance claim was well in excess of $518m. Despite successful negotiation which eliminated discount factors and restrictions on use, the nature of the insurance that was in place at the time of the earthquake meant a total loss capacity of $320m.

The entire $320m was able to be attained by Canterbury DHB but the total earthquake programme of works will need to be afforded from within existing the DHB's funds. The inherent shortfall between insurance proceeds and cost of reinstatement means the total Crown contribution for the Facilities Redevelopment Programme will need to remain as set out in the detailed business case.

9.6 Additional information

Disposal of land

As part of the preparation required for the Christchurch Hospital redevelopment, a land exchange has been agreed between the Christchurch City Council and the Canterbury DHB. This was part of a significant public consultation in 2010, which received Christchurch City Council and widespread community support. The nationally appointed Hospital Redevelopment Partnership Group are pursuing the land transfer.

Disposal of surplus assets over the next three years may include a house property in Amuri Avenue, Hamner Springs. This property was previously approved for disposal by the former Minister of Health but not purchased by the Crown as part of a larger holding.

Due process will be undertaken with regard to any sale of DHB land. Our 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 required public consultation.

The development of the Central Business District Plan and the CERA Recovery Strategy may have an impact on decisions that can be taken in regard to land and facilities.

Activities for which compensation is sought

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

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.

Statement of Financial Expectations

Where will our funding go?

10.1 Group statement of comprehensive income [102]

	2012/13 Actual $'000	2013/14 Forecast $'000	2014/15 Plan $'000	2015/16 Plan $'000	2016/17 Plan $'000	2017/18 Plan $'000
Income						
Ministry of Health revenue	1,416,121	1,424,439	1,461,345	1,494,743	1,528,249	1,561,868
Patient related revenue	50,460	50,400	51,297	54,048	55,233	56,443
Other operating income	315,876	25,188	81,638	57,566	87,784	65,392
Interest income	9,417	15,122	7,620	5,370	3,950	3,890
Total Income	1,791,874	1,515,149	1,601,900	1,611,727	1,675,216	1,687,593
Operating Expenses						
Employee benefit costs	614,301	639,565	656,865	671,488	686,878	701,261
Treatment related costs	128,949	132,673	142,068	143,489	145,712	149,349
External service providers	581,265	586,046	590,499	596,741	608,805	620,313
Depreciation & amortisation	48,191	57,650	58,330	61,234	66,585	67,345
Interest expenses on loans	5,716	5,446	5,772	6,210	7,557	7,592
Other expenses	113,556	99,458	147,208	125,244	137,621	119,423
Total Operating Expenses	1,491,978	1,520,838	1,600,742	1,604,406	1,653,158	1,665,283
Operating surplus before capital charge	299,896	(5,689)	1,158	7,321	22,058	22,310
Capital charge expense	13,019	19,309	13,708	7,319	22,049	22,299
Surplus / (Deficit)	286,877	(24,998)	(12,550)	2	9	11
Other comprehensive income	(68,137)	-	-	-	-	-
Total Comprehensive Income	**355,014**	**(24,998)**	**(12,550)**	**2**	**9**	**11**

[102] *Other operating income includes planned earthquake proceeds drawn down as revenue.*

10.2 Group statement of financial position

	30/06/13 Actual $'000	30/06/14 Forecast $'000	30/06/15 Plan $'000	30/06/16 Plan $'000	30/06/17 Plan $'000	30/06/18 Plan $'000
CROWN EQUITY						
General funds	127,432	(179,431)	(276,742)	(92,603)	(89,464)	(87,325)
Revaluation reserve	199,541	199,541	199,541	199,541	199,541	199,541
Retained earnings / (losses)	209,644	184,646	172,096	172,098	172,107	172,118
TOTAL EQUITY	**536,617**	**204,756**	**94,895**	**279,036**	**282,184**	**284,334**
REPRESENTED BY:						
CURRENT ASSETS						
Cash & cash equivalents	87,039	102,974	42,808	40,783	57,516	88,011
Trade & other receivables	374,000	42,204	42,204	42,204	42,204	42,204
Inventories	7,983	8,536	8,536	8,536	8,536	8,536
Investments	2,491	1,221	1,221	1,221	1,221	1,221
TOTAL CURRENT ASSETS	471,513	154,935	94,769	92,744	109,477	139,972
CURRENT LIABILITIES						
Trade & other payables	121,389	98,704	98,704	98,704	98,704	98,704
Capital charge payable	-	-	-	-	-	-
Employee benefits	163,506	155,047	155,047	155,047	155,047	155,047
Borrowings	-	15,000	-	-	-	-
TOTAL CURRENT LIABILITIES	284,895	268,751	253,751	253,751	253,751	253,751
NET WORKING CAPITAL	186,618	(113,816)	(158,982)	(161,007)	(144,274)	(113,779)
NON CURRENT ASSETS						
Investments	54,882	35,456	2,090	2,090	2,090	2,090
Property, plant, & equipment	427,483	416,044	401,020	623,487	611,203	584,159
Intangible assets	5,038	5,811	4,506	3,205	1,904	603
Restricted assets	14,766	9,937	9,937	9,937	9,937	9,937
TOTAL NON CURRENT ASSETS	502,169	467,248	417,553	638,719	625,134	596,789
NON CURRENT LIABILITIES						
Employee benefits	7,754	7,754	7,754	7,754	7,754	7,754
Restricted funds	14,766	9,937	9,937	9,937	9,937	9,937
Borrowings	129,650	130,985	145,985	180,985	180,985	180,985
TOTAL NON CURRENT LIABILITIES	152,170	148,676	163,676	198,676	198,676	198,676
NET ASSETS	**536,617**	**204,756**	**94,895**	**279,036**	**282,184**	**284,334**

10.3 Group statement of movements in equity [103] [104]

	2012/13 Actual $'000	2013/14 Forecast $'000	2014/15 Plan $'000	2015/16 Plan $'000	2016/17 Plan $'000	2017/18 Plan $'000
Total Equity at Beginning of the Period	185,325	536,617	204,756	94,895	279,036	282,184
Total Comprehensive Income	355,014	(24,998)	(12,550)	2	9	11
Other Movements						
Contribution back to Crown - FRS3	(3,722)	(1,861)	(1,861)	(1,861)	(1,861)	(1,861)
Contribution back to/from Crown - Earthquake settlement proceeds*	-	(270,000)	12,000	6,000	5,000	4,000
Contribution back to/from Crown - Facility Redevelopment**	-	(60,000)	(120,000)	180,000	-	-
Contribution from Crown - Operating Deficit Support	-	24,998	12,550	-	-	-
Total Equity at End of the Period	**536,617**	**204,756**	**94,895**	**279,036**	**282,184**	**284,334**

[103] **Earthquake proceeds drawn down as revenue are reflected in the Comprehensive Income Statement.*

[104] ***The negative amounts relate to the DHB's contribution to the facility redevelopment while the positive amount reflects the equity portion of the new Burwood facility asset to be transferred from the Crown to the DHB. The remaining funding of the Burwood facility asset is reflected as new loan. Transfer of the new Christchurch facility is expected in 2018/19 and hence not reflected in the financial statements.*

10.4 Group statement of cashflow

	2012/13 Actual $'000	2013/14 Forecast $'000	2014/15 Plan $'000	2015/16 Plan $'000	2016/17 Plan $'000	2017/18 Plan $'000
CASH FLOW FROM OPERATING ACTIVITIES						
Cash provided from:						
Receipts from Ministry of Health	1,286,449	1,335,045	1,357,132	1,388,133	1,419,187	1,450,298
Other receipts	187,793	497,552	237,148	218,224	252,079	233,405
Interest received	9,417	15,122	7,620	5,370	3,950	3,890
	1,483,659	1,847,719	1,601,900	1,611,727	1,675,216	1,687,593
Cash was applied to:						
Payments to employees	602,382	648,024	656,865	671,488	686,878	701,261
Payments to suppliers	831,501	852,886	879,775	865,474	892,138	889,085
Interest paid	5,638	5,446	5,772	6,210	7,557	7,592
Capital charge	13,503	19,309	13,708	7,319	22,049	22,299
GST - net	1,363	1,532	-	-	-	-
	1,454,387	1,527,197	1,556,120	1,550,491	1,608,622	1,620,237
Net Cashflow from Operating Activities	**29,272**	**320,522**	**45,780**	**61,236**	**66,594**	**67,356**
CASH FLOW FROM INVESTING ACTIVITIES						
Cash was provided from:						
Sale of property, plant, & equipment	-	-	-	-	-	-
Receipt from sale of investments	71,132	20,696	33,366	-	-	-
	71,132	20,696	33,366	-	-	-
Cash was applied to:						
Purchase of investments & restricted assets	-	-	-	-	-	-
Purchase of property, plant, & equipment	61,936	34,755	42,001	282,400	53,000	39,000
	61,936	34,755	42,001	282,400	53,000	39,000
Net Cashflow from Investing Activities	**9,196**	**(14,059)**	**(8,635)**	**(282,400)**	**(53,000)**	**(39,000)**
CASH FLOW FROM FINANCING ACTIVITIES						
Cash provide from:						
Equity Injection	-	44,998	24,550	186,000	5,000	4,000
Loans Raised	-	16,335	-	35,000	-	-
	-	61,333	24,550	221,000	5,000	4,000
Cash applied to:						
Loan Repayment	-	-	-	-	-	-
Equity Repayment	3,722	351,861	121,861	1,861	1,861	1,861
	3,722	351,861	121,861	1,861	1,861	1,861
Net Cashflow from Financing Activities	**(3,722)**	**(290,528)**	**(97,311)**	**219,139**	**3,139**	**2,139**
Overall Increase/(Decrease) in Cash Held	34,746	15,935	(60,166)	(2,025)	16,733	30,495
Add Opening Cash Balance	52,293	87,039	102,974	42,808	40,783	57,516
Closing Cash Balance	**87,039**	**102,974**	**42,808**	**40,783**	**57,516**	**88,011**

10.5 Summary of revenue and expenses by arm

	2012/13 Actual $'000	2013/14 Forecast $'000	2014/15 Plan $'000	2015/16 Plan $'000	2016/17 Plan $'000	2017/18 Plan $'000
Funding Arm						
Revenue						
MoH Revenue	1,370,375	1,377,064	1,407,217	1,439,424	1,471,714	1,504,089
Total Revenue	1,370,375	1,377,064	1,407,217	1,439,424	1,471,714	1,504,089
Expenditure						
Personal Health	958,042	984,706	1,026,338	1,044,722	1,068,180	1,091,530
Mental Health	137,096	141,382	143,796	146,563	149,934	153,382
Disability Support	234,635	235,352	238,806	243,581	248,942	254,419
Public Health	2,127	2,294	2,431	2,479	2,533	2,589
Maori Health	1,916	1,919	2,038	2,079	2,125	2,172
Governance & Admin	-	552	-	-	-	-
Total Expenditure	1,333,816	1,366,205	1,413,409	1,439,424	1,471,714	1,504,092
Net Surplus/(Deficit)	**36,559**	**10,859**	**(6,192)**	**-**	**-**	**(3)**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**36,559**	**10,859**	**(6,192)**	**-**	**-**	**(3)**
Governance & Funder Admin						
Revenue						
Other	4,077	5,004	2,256	2,301	2,347	2,394
Total Revenue	4,077	5,004	2,256	2,301	2,347	2,394
Expenditure						
Personnel	6,751	7,213	7,296	7,442	7,590	7,741
Depreciation	17	-	-	-	-	-
Other	(2,691)	(2,209)	(5,040)	(5,141)	(5,243)	(5,347)
Total Expenditure	4,077	5,004	2,256	2,301	2,347	2,394
Net Surplus/(Deficit)	**-**	**-**	**-**	**-**	**-**	**-**
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	**-**	**-**	**-**	**-**	**-**	**-**

	2012/13 Actual $'000	2013/14 Forecast $'000	2014/15 Plan $'000	2015/16 Plan $'000	2016/17 Plan $'000	2017/18 Plan $'000
Provider Arm						
Revenue						
MoH Revenue	798,297	826,982	877,038	898,002	919,444	941,558
Patient Related Revenue	46,840	46,048	49,197	51,906	53,048	54,214
Other	324,836	40,210	89,102	62,777	91,572	69,117
Total Revenue	1,169,973	913,240	1,015,337	1,012,685	1,064,064	1,064,889
Expenditure						
Personnel	607,550	632,352	649,569	664,046	679,288	693,520
Depreciation	48,174	57,650	58,330	61,234	66,585	67,345
Interest & Capital Charge	18,735	24,755	19,480	13,529	29,606	29,891
Other	245,196	234,340	294,316	273,874	288,576	274,119
Total Expenditure	919,655	949,097	1,021,695	1,012,683	1,064,055	1,064,875
Net Surplus/(Deficit)	**250,318**	**(35,857)**	**(6,358)**	**2**	**9**	**14**
Other Comprehensive Income	68,137	-	-	-	-	-
Total Comprehensive Income	**318,455**	**(35,857)**	**(6,358)**	**2**	**9**	**14**
In House Elimination						
Revenue						
MoH Revenue	(752,551)	(780,159)	(822,910)	(842,683)	(862,909)	(883,779)
Total Revenue	(752,551)	(780,159)	(822,910)	(842,683)	(862,909)	(883,779)
Expenditure						
Other	(752,551)	(780,159)	(822,910)	(842,683)	(862,909)	(883,779)
Total Expenditure	(752,551)	(780,159)	(822,910)	(842,683)	(862,909)	(883,779)
Net Surplus/(Deficit)	-	-	-	-	-	-
Other Comprehensive Income	-	-	-	-	-	-
Total Comprehensive Income	-	-	-	-	-	-
CONSOLIDATED						
Revenue						
MoH Revenue	1,416,121	1,423,887	1,461,345	1,494,743	1,528,249	1,561,868
Patient Related Revenue	46,840	46,048	49,197	51,906	53,048	54,214
Other	328,913	45,214	91,358	65,078	93,919	71,511
Total Revenue	1,791,874	1,515,149	1,601,900	1,611,727	1,675,216	1,687,593
Expenditure						
Personnel	614,301	639,565	656,865	671,488	686,878	701,261
Depreciation	48,191	57,650	58,330	61,234	66,585	67,345
Interest & Capital Charge	18,735	24,755	19,480	13,529	29,606	29,891
Other	823,770	818,177	879,775	865,474	892,138	889,085
Total Expenditure	1,504,997	1,540,147	1,614,450	1,611,725	1,675,207	1,687,582
Net Surplus/(Deficit)	**286,877**	**(24,998)**	**(12,550)**	**2**	**9**	**11**
Other Comprehensive Income	68,137	-	-	-	-	-
Total Comprehensive Income	**355,014**	**(24,998)**	**(12,550)**	**2**	**9**	**11**

Part IV – Appendices

Further information for the reader

Appendix 1	Glossary of terms
Appendix 2	Objectives of a DHB
Appendix 3	2013 Census summary for Canterbury
Appendix 4	Organisational chart and system governance structure
Appendix 5	Overview of hospital and specialist services
Appendix 6	Canterbury Clinical Network Alliance Structure
Appendix 7	Minister's Letter of Expectations
Appendix 8	Canterbury's commitment to National Health Targets
Appendix 9	DHB Performance Monitoring Framework
Appendix 10	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).

11.1 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.
ARC	Aged Residential Care	Residential care for older people, including rest home, hospital, dementia and psycho-geriatric level 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 for the best possible start for school and later life.
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 Referral 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	A shared regional clinical information system, a single repository for clinical records across the South Island.
HEEADSSS		An assessment provided to students attending teen parent units, alternative education facilities and decile 1 to 3 high schools that covers Home environment; Education/employment; Eating/exercise; Activities and peer relationships; Drugs/cigarettes/alcohol; Sexuality; Suicide/depression/mood; Safety; and Spirituality.
	Impact	The contribution made to an outcome by a specified set of goods and services (outputs), or actions, or both. Normally describes results that are directly attributable to the activity of an agency. Impact measures should be attributed to DHB outputs in a credible way and represent near-term results expected from the outputs delivered.
	Input	The resources (e.g. labour, materials, money, people, technology) an organisation uses to produce outputs.

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.
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 of Government (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 all New Zealand children from birth to age five.

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

Part 3: Section 22:

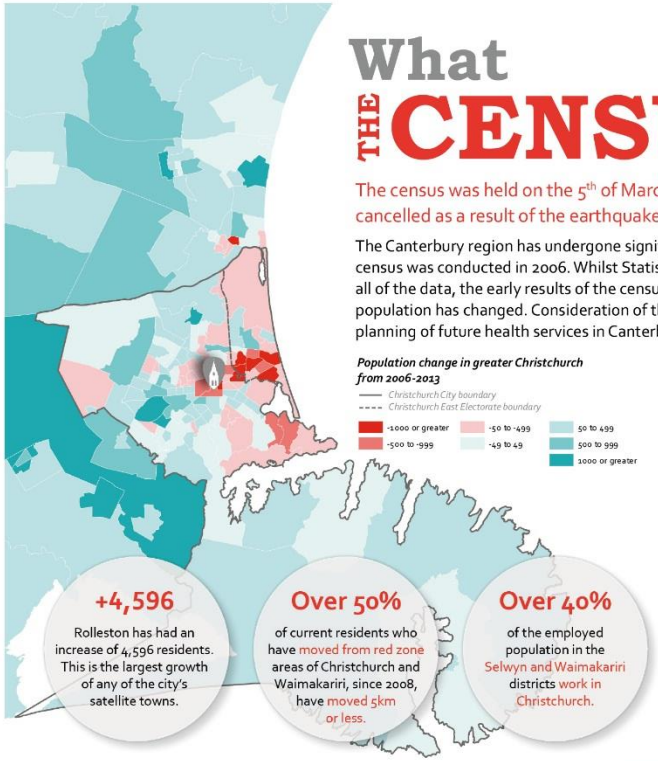
The New Zealand Public Health and Disability Act outlines the following objectives for DHBs:

- 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 arrange 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.

What THE CENSUS Tells US

The census was held on the 5th of March 2013, two years after it was cancelled as a result of the earthquake on the 22nd of February, 2011.

The Canterbury region has undergone significant changes since the previous census was conducted in 2006. Whilst Statistics New Zealand is yet to release all of the data, the early results of the census indicate how the profile of our population has changed. Consideration of these changes is crucial to the planning of future health services in Canterbury.



There has been a 2% decrease in usual residents in Christchurch City, compared with 2006. Not surprisingly, there has been a significant loss in residents from the central and eastern parts of the city.

However, the census shows that residents that have moved from red zone areas within the last five years have not tended to move far away. The majority of residents that were living in red zone areas of Christchurch and Waimakariri (including the Port Hills), in 2008, have moved five kilometres or less.

The movement to the districts surrounding Christchurch has contributed to Canterbury having three of the fastest growing districts in New Zealand: Selwyn (1st), Waimakariri (3rd) and Ashburton (5th).

9,837 fewer usual residents in the Christchurch East electorate area.

16.7% increase in the usual resident population of the Waimakariri District

32.6% increase in the usual resident population of the Selwyn District

13.4% increase in the usual resident population of the Ashburton District

Our families and households

1.2% decrease in the number of families with dependent children.

9.8% decrease in one-parent families with dependent children.

1,281 more two-or-more family households than in 2006.

There has been a change in family and household composition. There has been a small decrease in the total number of families with dependent children. Interestingly, there has been a large 9.8% decrease in the number of one-parent families with dependent children. There are also 1,281 more two-or-more family households than in 2006, indicating that more families are living together in the same house.

Our population is becoming more ethnically diverse.

We now have greater proportions of Māori, Pacific and Asian ethnicities than in 2006. The percentage of Māori has increased from 7.4% to 8.2%. Overall our Māori population are younger, with 43.7% aged 0-19 (compared to 25.5% of the total Canterbury population).

8.2% are Māori.

2.6% are Pacific.

7.5% are Asian.

15.0% of our population are aged 65 years or older, up from 13.4% in 2006.

11.4% of the total New Zealand resident population live in Canterbury.

14.5% of those aged 15 years or older smoke regularly, down from 18.8% in 2006.

482,181* residents.

Our population growth

Our resident population has increased from 466,404 in 2006 to 482,181 in 2013. This is a rate of growth of 3.4%. Nationally there has been a 5.3% rate of growth.

2,841 more males aged 20-29 than in 2006.

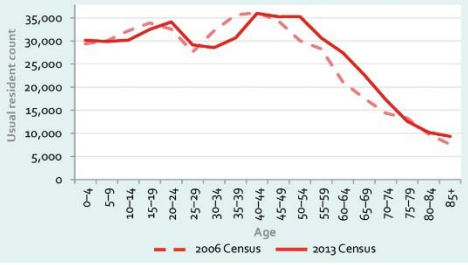
Our rebuild population

There has been a noticeable increase in the number of males aged 20-29 years of 2,841 since 2006. In comparison, there are only 228 more females of this age. This reflects the workers coming into the region for the Christchurch rebuild.

Our population is aging

Fifteen percent of our population are now aged 65 years or older. This is higher than the national percentage of people aged 65 years or older (14.3%).

CDHB usual resident count by five year age group in 2006 and 2013



What does this mean?

Our aging population

The Canterbury DHB continues to have an increasing elderly population. While progress has been made to address the needs of older people, new service models will continue to be developed.

Our rebuild population

The rebuild population will require services to meet their health needs. While most of this need will be focused on acute issues, it is important this population develops an ongoing point of access to health services by enrolment in general practice.

Population growth around Christchurch

The increased population in Christchurch's satellite towns is in both younger and older age groups. In consideration of future health services, the provision of general practice is a key requirement, as well as mobile community services that operate in people's homes and communities.

General Practice Enrolment

There was a decrease of approximately 5,000 enrolments in general practices in eastern Christchurch following the earthquakes. This is lower than the total number of residents that have left eastern Christchurch. This indicates that many people have retained general practice enrolment close to their former residence.

What we do not know*

Population estimates & projections

The current Statistics New Zealand population estimates and population projections are still based upon the 2006 Census results. Updated population estimates using the 2013 Census results will be available in August 2014. Updated population projections will be available in December 2014.

The 'real' number of rebuild workers

Our resident population only includes people that listed their usual residence as being in our region. Rebuild workers that have come from other parts of the country, or overseas, and do not consider Canterbury to be their place of usual residence, were not counted in our resident population.

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

Distance moved analysis provided by the Strategy and Planning Group – Christchurch City Council.

Canterbury District Health Board
Te Poari Hauora ō Waitaha

CENSUS

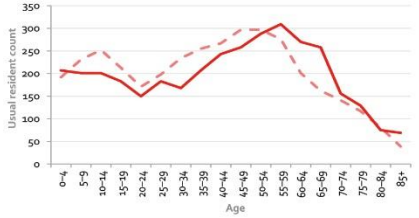
Demographic Changes By District

Canterbury District Health Board
Te Poari Hauora ō Waitaha

2006 Census — 2013 Census

Kaikoura

Usual Resident Count By Five Year Age Group In 2006 & 2013



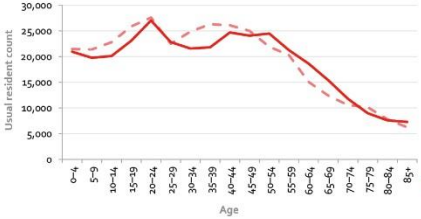
66 fewer residents in Kaikoura than in 2006.

17.8% of Kaikoura residents are Māori

65+ **19.4%** of Kaikoura residents are aged 65 years or older, up from 14.9% in 2006. This is the highest proportion of older people than any other district in Canterbury.

Christchurch

Usual Resident Count By Five Year Age Group In 2006 & 2013



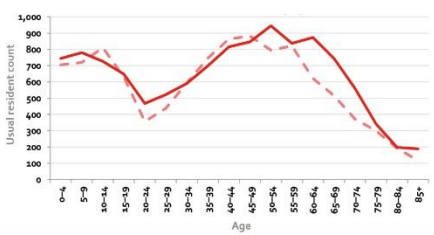
6,987 fewer residents in Christchurch than in 2006.

2,952 fewer families with dependent children in Christchurch.

5,106 fewer females in Christchurch aged 15-34 years old. There are 1,188 fewer males in the same age group.

Hurunui

Usual Resident Count By Five Year Age Group In 2006 & 2013

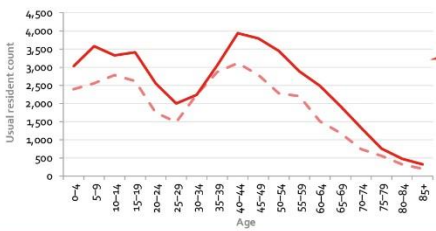


1,053 more residents in Hurunui than in 2006.

65+ **17.6%** of Hurunui residents are aged 65 years or older, up from 14.3% in 2006.

Selwyn

Usual Resident Count By Five Year Age Group In 2006 & 2013



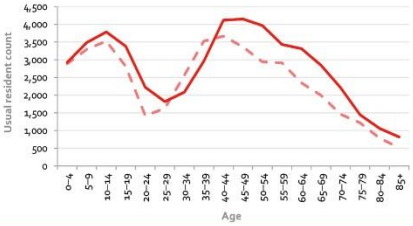
1,338 more families with dependent children in Selwyn than in 2006.

10,953 more residents in Selwyn than in 2006. This has made Selwyn the fastest growing district in New Zealand.

22.3% of Selwyn residents are under the age of 15. This is the highest proportion of any district in Canterbury.

Waimakariri

Usual Resident Count By Five Year Age Group In 2006 & 2013



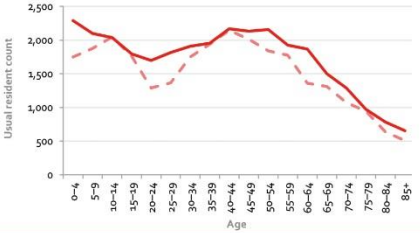
65+ **16.8%** of Waimakariri residents are aged 65 years or older, up from 13.9% in 2006.

7,155 more residents in Waimakariri than in 2006.

63% of those living in red zone areas of Waimakariri in 2008 that have moved within the last five years have stayed in the district.

Ashburton

Usual Resident Count By Five Year Age Group In 2006 & 2013



3.4% of Ashburton residents are of Pacific ethnicity, up from 1.4% in 2006. This is the highest proportion of any district in Canterbury.

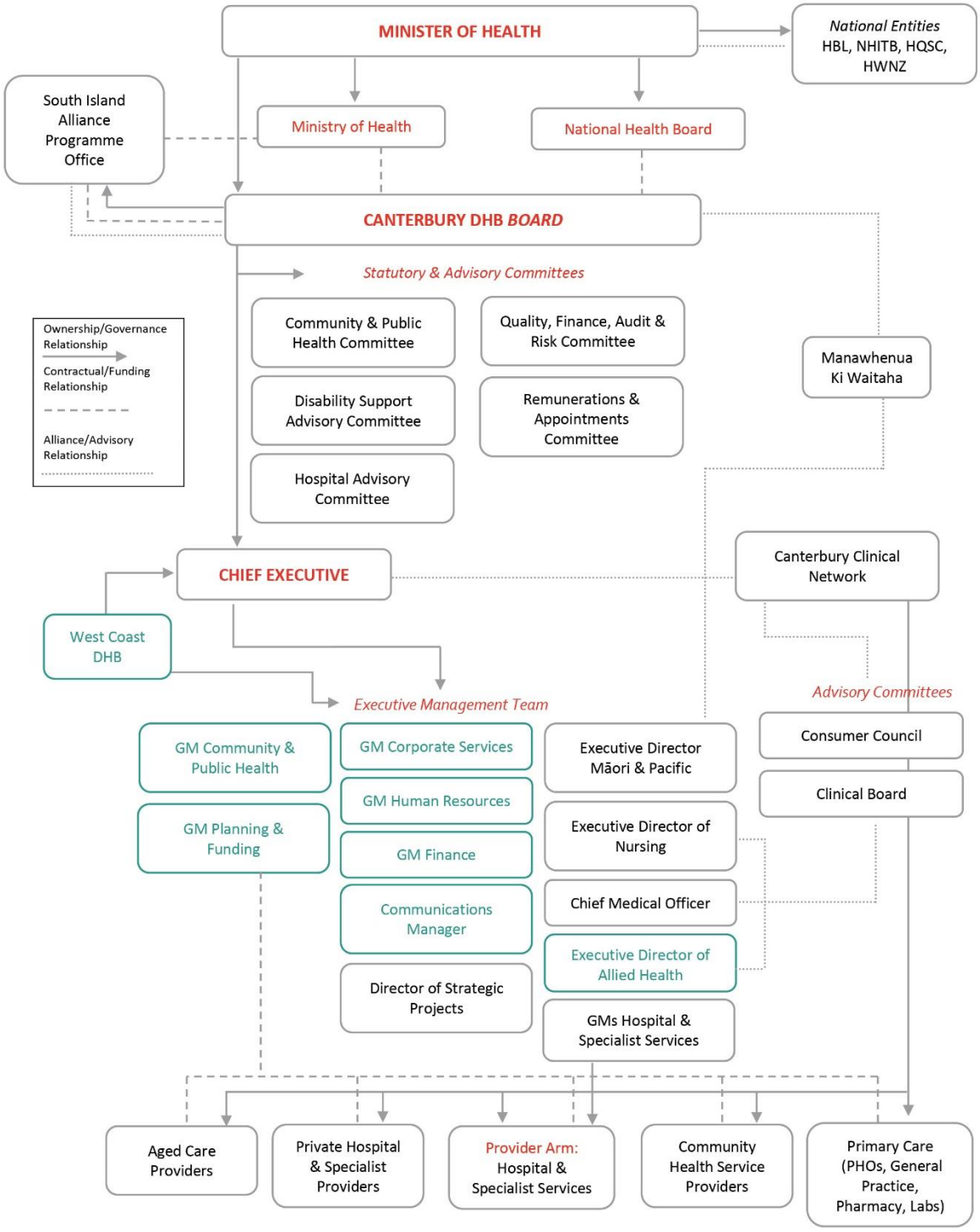
3,669 more residents in Ashburton than in 2006.

1,050 more residents in Ashburton aged 15-34 years old than in 2006.

Please note: *Due to the difference in resident populations the scale of each graph varies.*

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

11.4 Canterbury DHB organisational and system governance structure



11.5 Overview of hospital and specialist services

HOSPITAL SUPPORT AND LABORATORY SERVICES

Cover support services such as: medical illustrations, specialist equipment maintenance, sterile supply, patient and staff food services, cleaning services and travel and waste contracts. These Services also cover the provision of diagnostic services through Canterbury Health Laboratories (CHL) for patients under the care of the Canterbury DHB and offer a testing service for GPs and private specialists. More than 20 public and private laboratories throughout NZ refer samples to Canterbury Health Laboratories for more specialised testing, and 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.

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.

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. The Burwood Procedure Unit also provides a 'see and treat' service for skin lesions in conjunction with primary care.

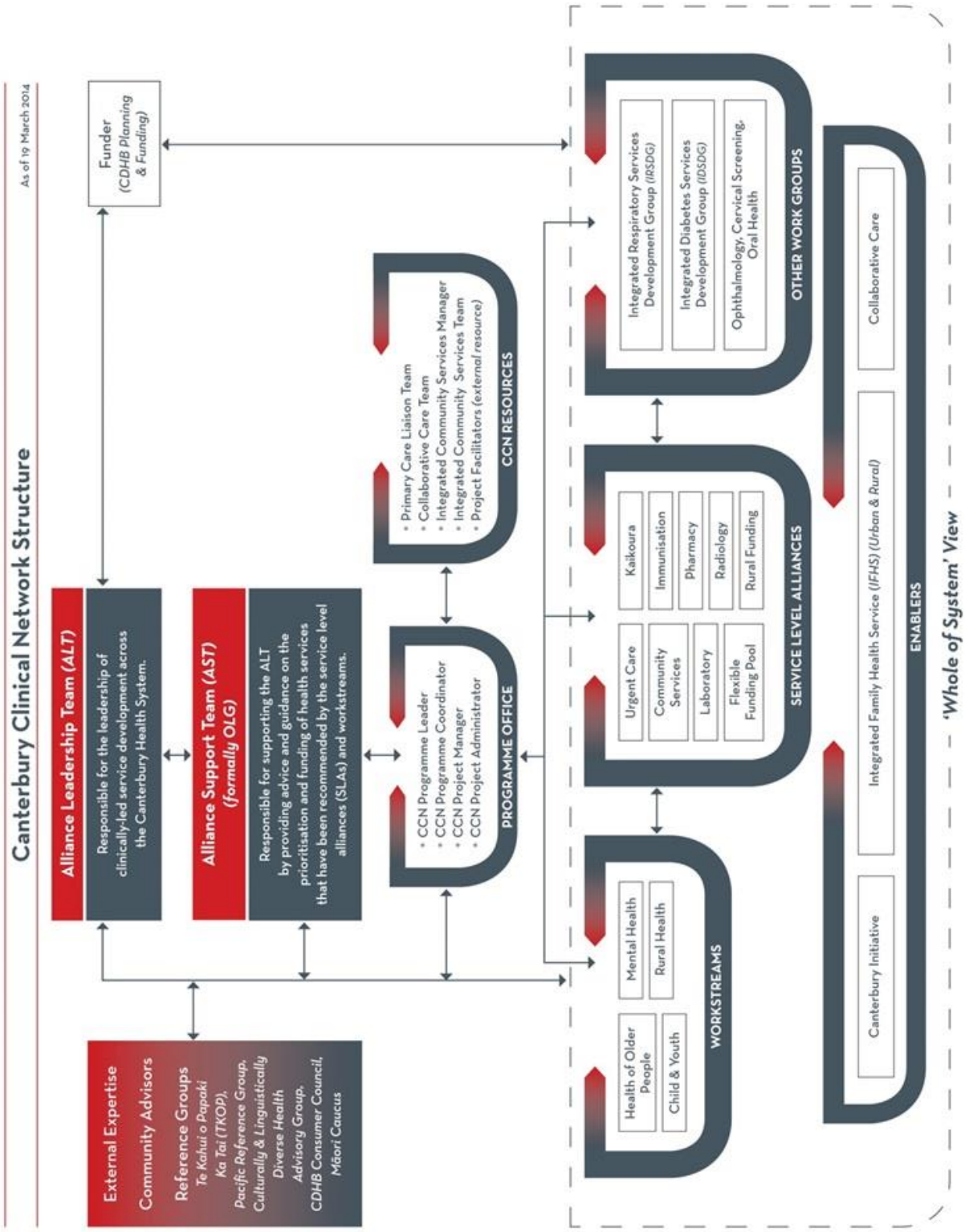
ASHBURTON AND RURAL HEALTH SERVICES

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.

11.6 Canterbury Clinical Network structure



11.7 Minister's Letter of Expectations

Office of Hon Tony Ryall

Minister of Health
Minister for State Owned Enterprises

30 JAN 2014

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

Dear Mr Cleverley

Letter of Expectations for DHBs and subsidiary entities 2014/15

Public and patient confidence in the health service continues to grow strongly. Thank you to your team. This achievement is built on the four objectives of the Government's health plan: *helping families stay healthy, better performance, best use of every dollar, and a strong and trusted workforce*. In the next year we expect continued strong focus on successful implementation.

New Zealand has come through the global financial crisis in much better shape than most other countries. That's because of this government's careful and prudent financial management. Our approach has been to protect the most vulnerable in our society, and rebuild the economy's capacity to create jobs, higher incomes and security.

Despite the toughest of times, we are providing better public services within careful funding increases. This government now invests an extra $2.5 billion a year more into the public health service. And this year's budget will again see more investment in Health.

Better Public Services: Results for New Zealanders

Of the Prime Minister's ten whole-of-government key result areas, DHBs are expected to actively engage and invest in increased infant immunisation, reduced incidence of rheumatic fever, and reduced assaults on children.

It is important Boards work closely with other social sector organisations and initiatives including Whanau Ora, Children's Action Plan and Youth Mental Health. The government values the contribution of NGOs and DHBs must work with them.

National Health Targets

The national health targets have proven very successful at driving major improvements for patients: more elective surgery, faster access to emergency and cancer care, and better prevention. DHBs will provide clear and specific plans for achieving all national health targets in their Annual Plans.

In particular further work is required to achieve the three preventive targets. You must demonstrate appropriate performance management arrangements for PHOs. Poor performance must be rectified and not ignored. You should again show your local primary care networks are involved in and explicitly endorse your target achievement plans.

Your DHB is expected to help patients by meeting our objectives of shorter waiting times for surgery, diagnostics, cardiac and cancer care.

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand. Telephone 64 4 817 6804 Facsimile 64 4 817 6504

Care Closer to Home

New Zealanders are living longer, more sedentary lives. This means more of us have chronic conditions like diabetes, asthma, dementia, cancer and mental health disorders. The sooner doctors and nurses can detect, treat or prevent these conditions, the better they can reduce the significant burden these conditions put on both patients and the health system.

A major strategy to do this is *clinical integration* – providing joined-up care across primary and secondary services. With resources and interventions flowing to where they are most effective. So patients get their care sooner and closer to home.

DHBs must focus strongly on service integration across the health system, including integrated family health centres, primary care direct referral for diagnostics, clinical pathways and sharing of patient controlled health records.

Health of Older People

Your DHB is expected to continue working with primary and community care to deliver integrated services for older people to support their continued safe, independent living at home; particularly important are avoiding a hospital admission and care after a hospital discharge. You should continue working with the Ministry to implement our commitments to improving home care, stroke services and dementia care pathways.

Regional and National Collaboration

DHBs are expected to make further progress on implementing Regional Service Plans including workforce, IT and capital objectives. DHBs are expected to strongly support the implementation of the key Health Benefits Ltd savings programmes. Further gains in quality, efficiency and cost control will also come from your work with Pharmac, Health Workforce NZ and the Health Quality and Safety Commission. The new patient satisfaction survey is one example.

Strong clinical leadership and engagement is important and remains essential.

Living Within Our Means

To support New Zealand's recovery your DHB must keep to budget. Your DHB must have detailed and effective plans to improve financial performance year on year. Equity and capital remain constrained. 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. You and your Board must monitor and hold your CEO accountable against these expectations.

Appreciation

Again, thank you for the considerable effort you and your team are making. This makes a real difference to the quality of life of many thousands of New Zealanders. Please share this letter with your clinical leaders and local primary care networks.

Yours sincerely

Tony Ryall
Minister of Health

Attached: PM's Key Result Areas and National Health Targets

Appendix 1: Prime Minister's Key Result Areas and DHB Health Targets for 2014/15

Prime Minister's Key Result Areas – Supporting Vulnerable Children

Increase immunisation rates

Increase infant immunisation rates so that 95 percent of eight-month-olds are fully immunised by December 2014 and this is maintained through to 30 June 2017.

Rheumatic Fever

Reduce the incidence of rheumatic fever by two thirds to 1.4 cases per 100,000 people by 2017.

Assist to reduce the number of assaults on children

By 2017, halt the rise in children experiencing physical abuse and reduce current numbers by 5%.

National Health Targets for 2014/15

Shorter stays in Emergency Departments

95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours.

Improved access to elective surgery

The volume of elective surgery will be increased by at least 4,000 discharges per year.

Shorter waits for cancer treatment / transitioning to Faster Cancer Treatment

All patients ready-for-treatment, wait less than four weeks for radiotherapy or chemotherapy.

Faster cancer treatment.

The 62-day faster cancer treatment indicator that is currently a developmental measure, will transition into a full policy priority accountability measure, and will become the next cancer health target during 2014/15. Further details including the health target definition, DHB performance expectations for 2014/15, and the process for transition will be provided at the end of February 2014.

Increased immunisation

90 percent of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time by July 2014 and 95 percent by December 2014.

Better help for smokers to quit

95 percent of hospitalised patients who smoke and are seen by a health practitioner in public hospitals and 90 percent of enrolled patients who smoke and are seen by a health practitioner in General Practice are offered brief advice and support to quit smoking. Within the target a specialised identified group will include:

- progress towards 90 percent of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice or booking with Lead Maternity Carer are offered advice and support to quit.

More heart and diabetes checks

90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years.

11.8 Canterbury's commitment to the National Health Targets

Shorter Stays in Emergency Departments

Government expectation

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

Canterbury contribution – see page 29

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

Improved Access to Elective Surgery

Government expectation

More New Zealanders have access to elective surgical services, with at least 4,000 additional discharges nationally every year.[105]

Canterbury contribution – see page 31

17,484 elective surgical discharges will be delivered in 2014/15.

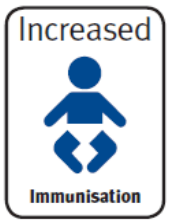
Shorter Waits for Cancer Treatment

Government expectation [106]

All people ready for treatment wait less than four weeks for radiotherapy or chemotherapy.[107]

Canterbury contribution – see page 41

100% of people ready for treatment wait less than four weeks for radiotherapy or chemotherapy.



Increased Immunisation

Government expectation

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

Canterbury contribution – see page 48

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

Better Help for Smokers to Quit

Government 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.

Canterbury contribution – see page 41

90% of smokers seen in primary care and **95%** hospitalised smokers will receive advice and help to quit.
Progress towards **90%** of pregnant smokers being offered advice and help to quit smoking.

More Heart and Diabetes Checks

Government expectation

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

Canterbury contribution – see page 35

Progress towards **90%** of the eligible population having had their CVD risk assessed.

[105] *The national health target definition of elective surgery excludes dental and cardiology services.*

[106] *This national health target will change in Quarter 2 2014/15 to the Faster Tests and Cancer Treatment health target.*

[107] *The national health target definition excludes Category D patients, whose treatment is scheduled with other treatments or part of a trial.*

11.9 DHB performance monitoring framework

PERFORMANCE MEASURE	PERFORMANCE EXPECTATION		CANTERBURY TARGET	NATIONAL TARGET	REPORTING FREQUENCY	PAGE REFERENCE
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%	N/A	Quarterly	45
		Age 20-64	≥3.1%			49
		Age 65+	N/A			-
PP7 Improving mental health services using transition (discharge) planning and employment.	% of clients discharged with a transition (discharge) plan.	Child & Youth	95%	95%	Quarterly	45
	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	45
		8wks	95%	95%		45
	% of young people (0-19) referred for non-urgent **addictions** services seen within 3 weeks and within 8 weeks.	3wks	80%	80%		49
		8wks	95%	95%		49
PP10 Oral Health DMFT Score at Year 8.	DMFT score at Year 8.	2014	1.0	NA	Annual	43
		2015	0.82			
PP11 Children caries-free at age 5 years.	% caries-free at age 5.	2014	63%	NA	Annual	17
		2015	65%			
PP12 Utilisation of DHB-funded dental services by adolescents.	School Year 9 up to and including age 17 years.	2014	85%	≥85%	Annual	43
		2015	≥85%			
PP13 Improving the number of children enrolled in DHB-funded dental services.	% of children (age 0-4) enrolled.	2014	75%	≥95%	Annual	43
		2015	85%			
	% of children (0-12) not examined according to planned recall.	2014	≤10%	NA		43
		2015	≤10%			
PP18 Improving community support to maintain the independence of older people.	% of older people receiving long-term home support who have had a comprehensive clinical assessment and an individual care plan.		95%	≥95%	Quarterly	46
PP20 Improved management for 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 – Management.	% of enrolled people aged 15-74 with acceptable glycaemic control (HbA1c ≤64mmol/mol).		Improve or, where high, maintain percentages.			36
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%		40
	% of patients presenting with ACS who undergo angiography and have completion of registry data collection within 30 days		≥95%	≥95%		40
Focus area 4: Stroke services.	% of potentially eligible stroke patients thrombolysed.		6%	6%		48
	% of stroke patients admitted to a stroke unit or organised stroke service with a demonstrated stroke pathway.		80%	80%		48
PP21 Immunisation coverage.	% of two-year-olds fully immunised.		95%	95%	Quarterly	44
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	29

PERFORMANCE MEASURE	PERFORMANCE EXPECTATION		CANTERBURY TARGET	NATIONAL TARGET	REPORTING FREQUENCY	PAGE REFERENCE
PP23 Improving wrap-around services – health of older people.	Report on delivery of the actions and milestones identified in the Annual Plan.				Quarterly	46
PP24 Improving waiting times – cancer multidisciplinary meetings.	Report on delivery of the actions and milestones identified in the Annual Plan.				Quarterly	41
PP25 Prime Minister's youth mental health project.	Report on delivery of the actions and milestones identified in the Annual Plan.				Quarterly	45
PP26 The Mental Health & Addiction Service Development Plan.	Report on status for a minimum of 8 actions to be completed in 2014/15 and for any actions which are in progress/going into 2014/15.				Quarterly	49
PP27: Delivery of Children's Action Plan.	Report on delivery of the actions and milestones identified in the Annual Plan.				Quarterly	43
PP28: Reducing rheumatic fever.	Provide a progress report against the region's rheumatic fever prevention plan.				Quarterly	44
	Undertake a root cause analysis on any new rheumatic fever case and provide a report to the Ministry on lessons learn and actions taken.					
	Acute rheumatic fever rate of hospitalisation per 100,000.	South Island rate	< 0.3 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).		90%	90%	Monthly	40
	% of accepted referrals for CT and MRI scans will receive scans within 6 weeks (42 days).	CT Scan	90%	90%	Monthly	38
		MRI Scan	80%	80%		38
	% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within 2 weeks (14 days).		75%	75%	Monthly	38
	% of people accepted for a diagnostic colonoscopy will receive their procedure within 6 weeks (42 days).		60%	60%	Monthly	38
	% of people waiting for a surveillance colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date.		60%	60%	Monthly	38
PP30: Faster cancer treatment	% of patients referred urgently with high suspicion of cancer receiving their first cancer treatment within 62 days.		85% by July 2016	85% by July 2016	Quarterly	41
	(<10% of records submitted by the DHB are declined).		<10%	<10%	Quarterly	41
	% of people ready for treatment wait less than four weeks for radiotherapy or chemotherapy		100%	100%	Quarterly	41
SI1 Ambulatory sensitive (avoidable) hospital admissions.	DHB rate vs. national rate (per 100,000).	Age 0-4	<111%	NA	Six-monthly	29
		Age 45-64	≤95%			
		Age 0-74	≤95%			17
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 (per 10,000).		21	21	Annual	39
	Cataract Procedures (per 10,000).		27	27		39
	Cardiac surgery (per 10,000).		6.5	6.5	Quarterly	40
	Percutaneous revascularisation (per 10,000).		12.5	12.5		40
	Coronary angiography services (per 10,000).		34.7	34.7		40

PERFORMANCE MEASURE	PERFORMANCE EXPECTATION	CANTERBURY TARGET	NATIONAL TARGET	REPORTING FREQUENCY	PAGE REFERENCE
SI5 Delivery of Whānau Ora.	Report progress on planned activities with providers to improve service delivery and develop mature providers.			Annual	51
OS3 Inpatient length of stay.	Elective LOS.	≤3.18	3.18	Quarterly	56
	Acute LOS.	≤3.86	3.86		46
OS8 Acute readmissions to hospital.	% total population.	<8.6%	NA	Quarterly	46
	% population aged 75+.	<12.5%	NA		
OS10 Improving the quality of identity data within the national health index and data submitted to national collections. Focus area 1: Improving quality of identify data.	New NHI registrations in error (Group A).	2-4%	2-4%	Quarterly	-
	Recording on non-specific ethnicity (set to 'Not stated' or 'Response Unidentifiable').	0.5-2%	0.5-2%		
	Updating of specific ethnicity value in existing NHI record with a non-specific value.	0.5-2%	0.5-2%		
	Validated address unknown.	76-85%	76-85%		
	Invalid NHI data updates causing identity confusion.	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 File Success Rate.	>95%	>95%	Quarterly	-
	PRIMHD data quality.	Routine audits undertaken with appropriate action where required.			
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	53

11.10 Statement of accounting policies

The prospective financial statements in this Statement of Intent for the year ended 30 June 2014 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 Statement of Intent:

(i) Cautionary Note

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

(ii) Nature of Prospective Information

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

(iii) Assumptions

The main assumptions underlying the forecast are noted in Section 8 of the Statement of Intent.

REPORTING ENTITY AND STATUTORY BASE

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

Canterbury DHB has designated itself and its subsidiaries, as public benefit entities, as defined under New Zealand Equivalents to International Financial Reporting Standards (NZ IFRS). 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.

The consolidated financial statements of Canterbury DHB consist of Canterbury DHB, its subsidiaries-Canterbury Linen Services Ltd (formerly Canterbury Laundry Service Ltd) (100% owned) and Brackenridge Estate Ltd (100% owned).

The Canterbury DHB will adopt the following accounting policies consistently during the year and apply these policies for the Annual Accounts.

BASIS OF PREPARATION

Statement of compliance

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

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 New Zealand dollars.

Changes in accounting policies

The accounting policies set out below have been applied consistently to all periods presented in these consolidated financial statements.

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

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

- NZ IFRS 9 *Financial Instruments* will eventually replace NZ IAS 39 *Financial Instruments: Recognition and Measurement*. NZ IAS 39 is being replaced through the following 3 main phases: Phase 1 Classification and Measurement, Phase 2 Impairment Methodology, and Phase 3 Hedge Accounting. Phase 1 on the classification and measurement of financial assets has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial instruments (its business model) and the contractual cash flow characteristics of the financial assets. The financial liability requirements are the same as those of NZ IAS 39, except for when an entity elects to designate a financial liability at fair value through the surplus/deficit. The new standard is required to be adopted for the year ended 30 June 2016. However, as a new Accounting Standards Framework will apply before this date, there is no certainty when an equivalent standard to NZ IFRS 9 will be applied by public benefit entities.
- The Minister of Commerce has approved a new Accounting Standards Framework (incorporating a Tier Strategy) developed by the External Reporting Board (XRB). Under this Accounting Standards Framework, Canterbury DHB is classified as a Tier 1 reporting entity and it will be required to apply full public sector Public Benefit Entity Accounting Standards (PAS). These standards are being developed by the XRB and are mainly based on current International Public Sector Accounting Standards. The effective date for the new standards for public sector entities is expected to be for reporting periods beginning on or after 1 July 2014. This means Canterbury DHB expects to transition to the new standards in preparing its 30 June 2015 financial statements. As the PAS are still under development, Canterbury DHB is unable to assess the implications of the new Accounting Standards Framework at this time.
- Due to the change in the Accounting Standards Framework for public benefit entities, it is expected that all new NZ IFRS and amendments to existing NZ IFRS will not be applicable to public benefit entities. Therefore, the XRB has effectively frozen the financial reporting requirements for public benefit entities up until the new Accounting Standards Framework is effective. Accordingly, no disclosure has been

made about new or amended NZ IFRS that exclude public benefit entities from their scope.

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 intra-group 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

Intra-group balances and any unrealised gains and losses or income and expenses arising from intra-group 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 or deficit. Non-monetary assets and liabilities that are measured in terms of historical cost in a foreign currency are translated using the exchange rate at the date of the transaction. Non-monetary assets and liabilities denominated in foreign currencies that are stated at fair value are translated to NZD at foreign exchange rates ruling at the dates the fair value was determined.

Budget figures

The budget figures are those approved by Canterbury DHB in its Annual Plan and included in the Statement of Intent 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 building
- plant, equipment and vehicles
- work in progress

Owned assets

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

Land, buildings and building fitout are revalued to fair value as determined by an independent registered valuer, with sufficient regularity to ensure the carrying amount is not materially different to fair value, and at least every five years. Any increase in value of a class of land and buildings is recognised directly to equity unless it offsets a previous decrease in value recognised in the statement of comprehensive income. 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 income. Additions to land and buildings between valuations are recorded at cost.

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

Additions

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

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

Subsequent costs

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

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

Depreciation

Depreciation is charged to the 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 & Fit Out	10 – 50	2 - 10%
Leasehold Building	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 depreciated.

Intangible assets

Software development and acquisition

Expenditure on software development activities, resulting in new or substantially improved software and processes, is capitalised if the product or process is technically and operationally feasible and Canterbury DHB has sufficient resources to complete development. The expenditure capitalised includes the cost of materials, direct labour and an appropriate proportion of overheads. Other development expenditure is recognised in the surplus or deficit 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 years	50%

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.

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. Where inventories are acquired at no cost or for nominal consideration, the cost is the current replacement cost at the date of acquisition.

Other inventories are stated at cost (calculated using the weighted average method).

Cash and cash equivalents

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

Impairment

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

If the estimated recoverable amount of an asset is less than its carrying amount, the asset is written down to its estimated recoverable amount and an impairment loss is recognised in the surplus or deficit.

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

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

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

Estimated recoverable amount of other assets is the greater of their fair value less costs to sell and value in use. The value in use is the depreciated replacement cost for an asset where the future economic benefits or service potential of the asset are not primarily dependent on the asset's ability to generate net cash

inflows and where Canterbury DHB would, if deprived of the asset, replace its remaining future economic benefits or service potential.

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

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

An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised.

Restricted assets and liabilities

Donations and bequests received with restrictive conditions are treated as liabilities 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 with any difference between cost and redemption value being recognised in the surplus or deficit over the period of the borrowings on an effective interest basis.

Employee benefits

Defined contribution plans

Obligations for contributions to defined contribution plans are recognised as an expense in the 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 yearend 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.

Provisions

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

ACC Partnership Programme

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

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

Trade and other payables

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

Derivative financial instruments

Canterbury DHB uses foreign exchange and interest rate swaps contracts to hedge its exposure to foreign exchange and interest rate risks arising from operational and financing activities. 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 remeasured to fair value at each balance date. The gain or loss on remeasured to fair value is recognised immediately in the surplus or deficit.

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 income

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

Operating lease payments

Payments made under operating leases are recognised in the 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 judgements in applying Canterbury DHB's accounting policies

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 programmes;
- Review of second-hand market prices for similar assets;
- Analysis of prior asset sales.

In light of the Canterbury earthquakes, Canterbury DHB has reviewed the carrying value of land and buildings, resulting in an impairment of land and buildings. 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.

Our Mission

TĀ MĀTOU MATAKITE

To promote, enhance and facilitate the health and wellbeing of the people of Canterbury.

Ki te whakapakari, whakamanawa me te tiaki i te hauora mō te oranga pai o ngā tāngata o te rohe o Waitaha.

Our Values

Ā MĀTOU UARA

- Care and respect for others.
  Manaaki me te whakaute i te tangata.
- Integrity in all we do.
  Hāpai i ā mātou mahi katoa i runga i te pono.
- Responsibility for outcomes.
  Te Takohanga i ngā hua.

Our Way of Working

KĀ HUARI MAHI

- Be people and community focused.
  Arotahi atu ki te tangata me te hapori.
- Demonstrate innovation.
  Whakaatu te ihumanea hou.
- Engage with stakeholders.
  Kia tau ki ngā tāngata whai pānga.

our health system