Canterbury
District Health Board
Te Poari Hauora ō Waitaha

DISTRICT ANNUAL PLAN

2006 – 2007

July 2006

Our Vision – Ta Matou Matakite

To promote, enhance and facilitate the health and well-being of the people of the Canterbury District. Ki te whakapakari, whakamaanawa me te whakahaere i te hauora M te orakapai o ka takata o te rohe o Waitaha

DISTRICT ANNUAL PLAN
1 July 2006 – 30 June 2007

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1 EXECUTIVE SUMMARY

Statement from Canterbury DHB Chair and Chief Executive

We are pleased to present this District Annual Plan for the Canterbury District Health Board (DHB) for the 2006/2007 financial year. It outlines the activities the Board will be undertaking to June 30th 2007.

This Plan reflects the Canterbury DHB's continued commitment to promoting, enhancing and facilitating the health and wellbeing of the people of Canterbury. In developing the Plan, the DHB recognises the national health priorities defined by the New Zealand Health Strategy and Disability Act 2000. The Plan also recognises local objectives: five Core Directions, five Strategic (Health Gain) Priorities and four Disease Priorities all selected through a comprehensive health needs assessment and community consultation process, undertaken in part when determining the long-term District Strategic Plan for the Canterbury DHB. This District Annual Plan provides a comprehensive overview of health priorities and associated projects to be pursued in 2006/2007.

In seeking to achieve ongoing strategic objectives and priorities, the single largest challenge is in maintaining financial viability. The operating environment is becoming increasingly challenging. DHBs are faced with capped budgets, have tightly placed limits on service delivery and are confronted with increasing economic and regulatory and compliance cost pressures. In the case of the Canterbury DHB, these cost pressures are further compounded by the transition to equity under Population Based Funding (PBF), which sees the Canterbury DHB receive lower funding increases than some other DHBs. PBF involves using a formula designed to distribute the available health and disability support funding between DHBs according to the relative needs of their population and the relative costs of meeting those needs. The Canterbury DHB is considered as overfunded on this basis.

The DHBs' ability to respond to pressures is restricted by the limited tools available that are acceptable to government. Service pressures are greatest in meeting the cost of growing volumes and treatment models in cancer services and cardiovascular services as well as growing acute demand. Measures to reduce these pressures are being worked on: but it will take time to put them in place. Workforce shortages and the expectations in Multi-Employer Collective Agreements (MECAs) will place additional stress on the sector in 2006/2007.

The magnitude of the challenge ahead can be considered in the context of the anticipated cost "gap" between the funding increases received by the Canterbury DHB and the potential cost growth indicated by some official forecasts of consumer (CPI) and labour cost growth.

The Ministry of Health's advice to DHBs in the 2006/2007 Planning Package[1], provides Forecast Funding Track of 2.93% in 2006/2007 and estimated increases of 2.9% and 2.1% in the 2007/2008 and 2008/2009 years respectively. In comparison to the index of New Zealands likely inflation[2], there is a significant gap between the likely costs faced by DHBs and current projected funding increases.

Given these cost pressures the Canterbury DHB will be required to make significant efficiency gains. Where actual cost growth exceeds the levels forecast in this Plan, further efficiency gains or service reductions will be needed to ensure breakeven.

The last few years have seen unprecedented levels of investment in some staff groups partly to cope with service pressures: partly to recognise anomalies and international wage rates. Past collective settlements for MECAs in the three most vital groups are already estimated to account for increases equivalent to FFT in 2006/2007. Yet those contracts will need to be re-negotiated with expectations of some increase, which, within the available funding is not affordable. Wage costs during the period 2002/2003 to 2005/2006 have increased significantly and this trend will need to be contained in future periods. The effect otherwise will be the reduction in patient services in order to pay additional levels of wages. This stark message needs to be recognised by Government, unions, staff and the people of Canterbury.

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[1] The government provides DHBs with a rolling three-year indicative funding package at the end of each year. This advice informs the planning process by providing a future view of funding on which to base long-term plans.

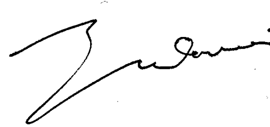
[2] MoH Requirements and Guidelines for Using Financial Templates 2006/07, December 2005, Appendix 2.

More positively, our first objective is to use our considerable resource in the best manner possible for the health and disability needs of the people we serve. In doing this we are likely to deliver some current services in different ways and in different settings.

In the last year, the Canterbury DHB has achieved significant successes across a number of areas. Amongst the more notable examples were:

- Opening the new Christchurch Women's Hospital and Day Surgery Unit, a $78.9 million project delivered on time and budget;
- Establishment of the Improving the Patient Journey initiative aimed at improving the design and management of patient care throughout the continuum of care;
- The successful implementation of the Meningococcal B Immunisation programme;
- Launch of the Healthy Eating, Healthy Living Action Plan (an initiative encouraging healthy eating, physical activity and smokefree lifestyles) and the successful implementation of Smokefree Sites with all Canterbury DHB hospital sites now Smokefree; and
- Significant efficiency initiatives over past years have assisted the DHB to reduce its $21M deficit to a breakeven position.

Our motivation is to do the very best we can to ensure our Community gets the optimum services we can deliver with the funding available. The Canterbury DHB acknowledges the importance of providing adequate leadership and information to its stakeholders as it strives to improve the health status of our community. As such, we will continue to encourage innovation, information sharing and the development of health expertise to cope with future demand whilst promoting, enhancing and facilitating the wellbeing of the people of Canterbury.



Syd Bradley
Chairman

Gordon Davies
Chief Executive

Office of Hon Pete Hodgson
MP for Dunedin North
Minister of Health
Minister for Land Information

Mr Syd Bradley
Chair
Canterbury District Health Board
PO Box 1600
CHRISTCHURCH

Dear Mr Bradley

Canterbury District Health Board: 2006/07 District Annual Plan

This letter is to advise you that I have signed Canterbury District Health Board's (CDHB's) 2006/07 District Annual Plan (DAP) for the three years 2006/07-2008/09 and the Board has my support for the implementation of this plan.

I wish to express my appreciation to the Board, management and staff for all the effort that has gone into producing the plan and the efforts made to manage your services within the funding available.

I understand that you have set yourselves challenging plans requiring the achievement of significant cost savings and efficiencies. I acknowledge and commend your intention to maintain a break even position. However, in order to address the risks around achievement of your DAP, I request that you include in the commentary that you send to the Ministry with your monthly financial results:

- explanation of any adverse variances to budget on a line item basis, and
- actions that you will be taking to reverse the trend and achieve your plan.

The Ministry will also seek further information from you on your accounting methodology and treatment of fixed assets.

CDHB will continue to receive in 2006/07 the early payment arrangements that you benefited from in 2005/06, subject to the acceptable financial performance during the year.

Risks

I note the risks you have identified. I expect CDHB to continue to manage its financial risks and live within its allocated funding. Where your DHB identifies severe

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risks of any type I expect you to notify the Ministry of Health (the Ministry) of them along with your strategies for mitigating them.

Electives

Improving elective services is a priority in 2006/07. I realise there are many challenges inherent in the management of elective services, however it is important that there is transparency in the system. People have the right to know when they have been promised surgery that they will get it within a specified timeframe, or if they cannot be offered treatment what their options are. It is also important that we deliver services in cost effective ways, so that more people can receive treatment.

I am pleased that you have been able to agree a revised recovery plan with the Ministry that will enable you to achieve compliance with the Elective Service Performance Indicators across all services by 30 September 2006 at the latest. Thank you for your commitment. The Ministry will keep me informed of your progress.

Mental Health

I note that you have received additional blueprint funding for 2006/07 and via the DAP process have outlined the proposed use of this funding. It is important that the planned use of this funding occurs and in the timeframes outlined in the DAP so service growth can be progressed and funding applied to building and strengthening mental health and addiction services for your population.

Getting ahead of the curve – The Chronic Disease Burden

I am pleased your DAP addressed the prevention and management of long-term conditions. As you are aware, the burden of chronic or long-term conditions bears most heavily on Māori, Pacific and high deprivation groups and delivers unequal health outcomes including premature death. We need to get better at preventing and managing long-term conditions among these groups. The Primary Health Care Strategy and Healthy Eating Healthy Action provide you with the basic tools to do this. I encourage you to include in your planning for 2007/08 explicit links between your plans around long term conditions prevention and management with your efforts to reduce inequalities and activity in primary care/community settings.

Capital

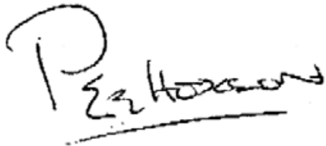
Please note that sign off on the 2006/07 DAP does not mean approval for any capital projects requiring equity or new lending, or self-funded projects that require the support of the National Capital Committee. Approval of such projects is dependent on both the completion of a sound business case, and evidence of good asset management and health service planning by your DHB. Approval for equity or new lending is managed through the annual capital allocation round also.

Service Configurations

My approval of your DAP also does not constitute approval of proposals for service changes or service reconfigurations. I expect you to comply with the requirements of the Operational Policy Framework and advise the Ministry where any proposals may require my approval.

This letter should be attached to the copy of the signed plan held by the Board and a facsimile of the letter should be attached to all copies of the Plan made available to the public or any other third party.

Yours sincerely



Hon Pete Hodgson
MINISTER OF HEALTH

2 INTRODUCTION

Who are we?

DHB were established in January 2001, under the New Zealand Public Health and Disability Act 2000. There are twenty-one across the country and their prime responsibility is to improve, promote and protect the health and independence of their populations. Funded by government, DHBs work with their communities to decide what health services are needed and how to best use the limited funding they receive. DHBs must also note government policies, particularly: the New Zealand Health Strategy 2000, New Zealand (NZ) Disability Strategy 2002 and the NZ Māori Health Strategy 2002[3].

The Canterbury DHB is the second largest of NZ's twenty-one DHBs by population and the largest by geographical area. The catchment covers rural communities from Kekerengu in the North, Rangitata in the South and Arthur's Pass in the West and comprises the Territorial Local Authorities (TLAs) of Kaikoura, Hurunui, Waimakariri, Christchurch City, Banks Peninsula, Selwyn and Ashburton.

The Canterbury DHB, through its Planning and Funding division, holds more than 800 contracts with health and disability service providers; funding most of the disability services (for older people), mental health services, Māori health, personal and family health services provided in the Canterbury district.

There are fourteen public hospitals in Canterbury, which provide hospital and specialist personal health, mental health, disability support, alcohol and drug and community health services. These are managed by the Canterbury DHB through its Provider-Arm (Hospital and Specialist Service division).

The Canterbury DHB also promotes community health and well being through population health programmes, health promotion and health protection programmes (including the services of the Medical Officer of Health), primarily through its Community and Public Health division.

As the largest funder and provider, of health and disability services in Canterbury, the DHB also encourages all health and disability support providers in the district to work in collaboration to make care more efficient and effective and to address inequalities of access to health and disability services.

2.1 Strategic Directions

2.1.1 Vision and Values

Our Vision – Ta Matou Matakite	
To promote, enhance and facilitate the health and well-being of the people of Canterbury	
Ki te whakapakari, whakamaanawa me te whakahaere i te hauora Mo te orakapai o ka takata o te rohe o Waitaha	
Our Values – A Matou Uara	
Care and respect for others	Manaaki me tekotua i etahi atu
Integrity in all we do	Hapai i a matou mahi katoa i ruk̲a i te Pono
Responsibility for outcomes	Kaiwhakarite i k̲a hua
Our Way of Working – Ka Huari Mahi	
Be people and community focused	Arotahi atu ki k̲a tak̲ata meka
Demonstrate innovation	Whakaatu whakaaro hihiko
Engage with stakeholders	Tuu atu ki k̲a uru

[3] These documents can be found on the Ministry of Health website www.moh.govt.nz.

2.1.2 Decision Making Principles

The majority of the health and disability services that the Canterbury DHB needs to fund are set out in government polices and directives. For those services for which there is a greater level of funding discretion the DHB has developed a Prioritisation Framework, identifying a set of principles to assist in making choices about funding services in the future. When making decisions about which services to provide, and at what level, the following five principles are be considered:

Effectiveness	The extent to which the health or disability service improves (benefits) quality of life by the reduction of pain, the maintenance of lifestyle, the promotion of independence or the prevention of premature death. The services that produce the most benefit are likely to be of greater priority. The level of benefit takes into account both the benefit per person and the total number of people benefiting.
Cost	The total cost of services are compared to the effectiveness of those services. This is done to ensure available funding is used to achieve the maximum possible gain.
Equity	The effectiveness of the service in improving the health of disadvantaged groups is considered. Disadvantaged groups include those on low incomes, Māori, Pacific and refugee communities, those with multiple diagnosis and those in remote areas with limited access to services.
Māori Health	In making funding decisions the Treaty of Waitangi is acknowledged and Māori participation in providing services is encouraged. Services must be appropriate and accessible to Māori.
Acceptability	The diverse expectations and values of New Zealanders are also considered when making prioritisation decisions on which services to provide and at what level.

2.1.3 Planning Assumptions

A number of planning and financial assumptions have been made within this Plan, which if not deliverable may limit the Canterbury DHB's ability to improve the health of its community or may lead to adverse financial outcomes. The financial assumptions made are outlined in the financial section of this document (Section 5) the planning assumptions are highlight below:

Operating Environment	Our short and mid-term direction and environment remains similar and current government health and funding policies remain the same.
Baseline Funding	Baseline and outyears funding increase as per funding advice from the Ministry of Health (MoH). As an over-funded DHB it is assumed that the Canterbury DHB will only receive a net increase equivalent to the annual FFT. It is assumed that any changes to the PBF formula, including funding that currently sits outside the PBF formula, will not impact adversely on future funding levels nor the period of transition to equity.
Inter-District Flows	Net Inter-District Flow revenue can be fully realised. Net Inter-District Flow volumes remain stable and do not decline significantly.
Planning Assumptions	The DHB has the ability to shift funding, where appropriate, from hospital and specialist services to community services and vice versa. Where such transfers occur, it is assumed that the provider can reasonably achieve equivalent reduction in cost.
Implementation of Strategies	The DHB is able to implement identified service reconfiguration and/or facility realignment, according to planned timeframes.
Efficiency Realisation	Where savings from efficiency gains or service re-configurations are not sufficient to achieve breakeven, that acceptable service reductions can be identified and realised in a timely manner.
New Policies and Initiatives	Any new government or MoH policies or initiatives that will result in increase expenditure are fully offset by increased funding. Any financial impact associated with changes to Disability Support Service (DSS) boundaries between age related and non-age related services and any further contract/services being devolved by MoH is cost neutral to the DHB.
Regional Workforce Flow-on	National and regional employment relations and workforce development activity will not impact negatively on regional and provider workforce outcomes or service delivery.
Salary and Wages	Increases (including auto increments and increases already committed) can be achieved within FFT (2.93%).
Non-Government Organisations (NGOs)	Contracts with NGO providers will be settled within FFT (2.93%) on average.

Age Residential Care and Home Based Support Services	Any cost increases resulting from the Aged Residential Care price review in excess of FFT will attract additional government funds. Income and Asset Testing will be funded.
Workforce Retention	The DHB can retain the appropriate number of health workers needed to provide the level and scope of services required.
Acute Demand for Hospital Services	Growth in acute medical and surgical health volumes can be managed at levels below the sector average and any increases in demand for services can be met through reducing delivery in other service areas.
Demand Driven Services	Growth of expenditure in demand driven services can be managed below the sector average and any increases in demand for services can be met through reducing delivery in other service areas.
Pharmaceutical Expenditure	Pharmac budget for community referred spending is as per agreed by DHBs and forecast savings on stats dispensing and other initiatives are achieved.
Pharmac	Pharmac budget is agreed on the basis of forecast actual 2005/2006 expenditure plus FFT.
Pandemic Drug Costs	It is assume that any increased drug costs associated with a pandemic will be nationally funded.
Impact of Income and Asset Testing	Any financial impact associated with the changes to the income and asset testing regime continue to be cost neutral to the DHB.
Lifestyle Changes	Health education and promotion initiatives can influence change in the lifestyles of our community.
Access Improvements	Improving access to primary and community care and improving chronic disease management will result in reduced hospital admissions.
Inter-Sectoral Support	Other government departments, agencies and schools are also working to improve the community's health and make it easier to stay healthy.
Sustainable Health and Disability Services	Service Providers continue to maintain an acceptable level of quality and appropriate levels of service delivery within the available resources.
Sustainable Provider-Arm Services	The DHBs Provider-Arm continues to maintain an acceptable level of quality and appropriate levels of service delivery are maintained within the available resources. Savings through service innovations are realised and the DHB achieves efficiencies and address' cost over-runs internally.
Stakeholder Satisfaction	The DHB is able to maintain a reasonable level of public and media satisfaction with regard to expectations of health service provision or service quality.

2.1.4 Ongoing Challenges

The Canterbury DHB has identified a number of long-term challenges which it will need to address over the next five to ten years in order to continue to provide health and disability services and to improve the health of its community:

Working with Funding and Financial Pressures
DHBs are funded on the basis of the PBF formula which is designed to distribute the available health and disability support funding between DHBs according to the relative needs of their population and the relative cost of meeting those needs. The Canterbury DHB is considered overfunded against this formula and will receive lower increases than other DHBs over the next few years, until its funding is equitable. At the same time we need to continue providing the required volume and range of services in our district. This pressure will be our greatest challenge.

Meeting Increasing Demand for Services
A number of factors contribute to the increasing demand on health services in Canterbury; an ageing population, the changing demographics of our community, the pressures of mental health or addiction issues, rising chronic disease levels and the changing expectations of our population. Continuing to fund a wide range of community and hospital services and investing in new health technology and resources all within our limited funding is going to be difficult. We will need to look to our community and to other DHBs for support in responding and coping with this increasing demand.

Workforce Capacity
A high performing health service is dependent on the skill and hard work of those working in the system. The challenge for the Canterbury DHB is to provide an environment which supports innovation and career development. We also need to consider wider workforce issues; the issues rural areas have in recruiting and retaining key staff and the scope we have to develop health care

beyond traditional boundaries and constraints. We will be working on a coordinated approach to building the capacity of Canterbury's health workforce.

Reducing Inequalities
Although recent statistic show that the health status of Māori and Pacific people is improving, a gap still remains. Improving the quality of ethnicity data collection is an ongoing issue. When ethnicity data collection is robust we will be better able to accurately measure whether progress is occurring in improving the health status of high-needs and high-risk groups in Canterbury. The challenge is to better understand the gaps in health status and to accurately and effectively target resources to reduce those inequalities.

Improving Access to Health Care
The Canterbury DHB will work in a number of areas over the coming years to reduce barriers to accessing health and disability services; working with Primary Health Organisations (PHOs) to improve access to primary care services and with rural service providers to address issues of equitable access for rural communities. We will also work to ensure emergency services are efficient and effective, focusing on acute demand management and avoidable hospital admissions. Managing the waitlists for elective surgery will be an ongoing process; meeting government expectations on provision of certainty for patients and for national equity to elective services. A major challenge will be the development of clinical and facilities master plans to ensure services are provided not only at the right time, but also in the right place and by the right provider.

Reducing the Impact of Lifestyle Diseases
Lifestyles influence a number of diseases including cancer, diabetes, heart disease and respiratory disease. The Canterbury DHB's challenge in working to reduce the impact of these diseases centres around health promotion, education, screening and early intervention. Much of our work will be focused on healthy eating, active living, continuing smokefree and tobacco control education and injury prevention as well as working closely with other organisations outside the health sector to address to determinants of health such as housing, income, education, transport and recreation.

Addressing the Health Issues of an Ageing Population
By 2021 nearly 20% of the Canterbury population will be over 65 years of age. Pressure on health funding will increase as more people become subject to problems of ageing; older people particularly those aged over 75 consume a significant amount of health resources. Community support demand will increase along with demand for a number of aged related services such as orthopaedics, cataracts, incontinence and dementia. We will need to look at alternative models of care and innovative service development to meet the future demands of our ageing population.

Focusing on Effective and Quality Services
The Canterbury DHB will implement the Improving the Patient Journey project over the next five years. One of the goals of this project is to reduce unnecessary waits and delays for patients by focusing on patient orientated processes, reducing variations in treatment, and encouraging collaboration between health providers; all within the resources available. As demand for services increases, along with our ageing population with multiple health issues, the continuum of care between services will become increasingly essential.

Managing Community and Staff Expectations
Advances in technology mean new levels of care are available but often at higher costs. It is always a challenge to balance the expectation and demand for new treatments. We also need to maintain positive relationships and morale in a constrained funding environment and manage salary and wages expectations from our own staff and the impact of the expectations of the community workforce. Communication, collaboration and consultation will be important tools in the coming years.

Increasing Productivity in the Hospital and Specialist Service (HSS) Division
Alongside the financial pressure associated with the move to PBF the increasing demand for services in Canterbury means that our HSS division must increase its productivity while still managing expenditure. The Improving the Patient Journey project will play a large part in meeting this challenge by streamlining and integrating services. However, this will still be a challenge for our services.

Working with Other South Island DHBs
Closer clinical and non-clinical collaboration is going to be essential for the Canterbury DHB in the future, particularly around sustainable clinical services, access to specialist services, recruitment and

retention of staff and shared savings from bulk capital investments. Maintaining close partnerships with other DHBs and working on shared planning will be an important focus.

Developing Infrastructure
The Canterbury DHB will be required to update its property and must maintain its Information Technology infrastructure. Parts of our property infrastructure are ageing and will need to be replaced to meet new building codes. In addition our ability to evaluate service models, health outcomes and measure success depends on the provision of good quality, timely information and the sharing of that information through secure and stable information systems. We will need to ensure that our infrastructure investment is sustained and effective and that the best use is made of available funding.

2.2 Priorities for 2006/2007

2.2.1 Our Core Directions and Health Gain Priorities

The Canterbury DHB undertook a strategic planning process in 2005 producing, in consultation with the Canterbury community and stakeholders, an updated District Strategic Plan; *A Healthier Canterbury: Directions 2010*. This District Strategic Plan (DSP) describes the Canterbury DHB's direction, challenges, priorities and long-term goals over the next five years. Each DHB is also required to produce Statements of Intent and District Annual Plans, which present more detail on how progress will be made in achieving the directions, priorities and long-term goals set out in their DSPs[4].

In the development of its DSP the Canterbury DHB identified five Core Directions which it believes will be essential to addressing the challenges it faces and providing a foundation for achieving our priorities and long-term goals. These Core Directions will also enable the DHB to make changes and improvements in all areas of ongoing work and to meet key national and ministerial expectations over the coming years:

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

Five Strategic 'Health Gain' Priorities were also chosen for special attention. These were based on a Health Needs Assessment (HNA) for the Canterbury district (completed in 2004), key government health strategies such as the NZ Health Strategy, Māori Health Strategy and the NZ Disability Strategy and on feedback received during consultation on the Canterbury DHB's DSP. The agreed Health Gain Priorities for focus over the coming five years are:

Three Population Priorities:

- Child and Youth Health;
- Older People's Health; and
- Māori Health.

Two Service Priorities:

- Primary Health; and
- Disease Prevention and Management.

The Canterbury DHB also identified four Disease Priorities during this process to which additional focus will be given over the next five year:

- Cancer;
- Cardiovascular (Heart) Disease;
- Diabetes; and
- Respiratory Disease.

[4] The Canterbury DHB's Accountability Documents can be found on its website www.cdhb.govt.nz.

2.2.2 The Minister of Health's Priorities and Expectations

The Government objectives for DHBs are set out in the NZ Public Health and Disability Act 2000 (NZPHD Act), NZ Health Strategy, Māori Health Strategy, the NZ Disability Strategy and other National Health Strategies. In developing its DSP the Canterbury DHB considered these overarching strategies, ensuring that its own objectives were aligned with that of the health and disability sector as a whole.

In considering the actions and activities required in 2006/2007 to progress its local Core Directions and Health Gain Priorities outlined in its DSP the Canterbury DHB also considered the Minister of Health's national Expectations, Priorities and Ongoing Priorities signalled as part of the 2006/2007 Planning Package. The Minister's Expectations and Priorities for 2006/2007 are:

Expectations of progress on National Health Strategies[5] (focusing on reducing inequalities and improving quality and safety) particularly the:

- Māori Health Strategy 2002;
- Mental Health Strategy 2005;
- Health of Older People Strategy 2002; and
- Primary Care Strategy 2001.

Priorities:

- Getting Ahead of the Curve with emphasis on progressing the Healthy Eating Healthy Action, Cancer Control and the Tobacco Control Strategies;
- Child and Youth Health Services with emphasis on hearing test for neonates, increased well child checks for preschoolers, child and adolescent mental health services, oral health services, and free primary care services for those under 6 years;
- Primary Health Care emphasis on reduced costs, focus on prevention, early detection, and broadening the range of health professionals involved in the continuum of care;
- Health of Older People emphasis on supporting older people in their own homes and continuum of care models to better support people moving from their homes to residential care, assessment treatment and rehabilitation and primary services;
- Infrastructure with a focus on the Health Information Strategy and progressing the various work-streams on health workforce issues; and
- Cost Effectiveness with emphasis on value for money and productivity gains.

Ongoing Priorities:

- Improving Elective Services including progressing the Orthopaedic and Cataract Initiatives;
- Collaborating Across Agencies focusing on minimising family violence;
- Performance Assessment and Management emphasising local initiatives that contribute to equity and access, efficiency and value for money, effectiveness, quality and intersectoral focus; and
- Building Relationships and intersectoral collaboration.

2.2.3 Treaty of Waitangi - Priorities for Māori Health

The Canterbury DHB recognises and respects the principles of partnership, participation and protection embedded in the Treaty of Waitangi. We also acknowledge the expectations of the NZPHD Act and the Crown Funding Agreement and are committed to reducing disparities and improving health outcomes for Māori and to ensuring Māori involvement in planning for these.

The Canterbury DHB has agreed a regular meeting schedule with Ngāi Tahu, as manawhenua of the district, through Manawhenua ki Waitaha; a representative group which comprises the seven Ngāi Tahu rūnanga. We also meet quarterly with Te Rūnanga o Ngā Maata Waka representatives and the Māori community and engage in numerous other formal and informal interactions with Māori providers, services and community organisations. The outcomes of these meetings feed directly into the DHB's planning processes.

A review of Canterbury DHB's current Māori Health Plan *Whakamahere Hauora Māori* was undertaken over the past year. This involved a series of community consultation forums, one-on-one

[5] Copies of national strategies can be found on the Ministry of Health's website.

meetings with Māori providers, advice and feedback from internal DHB staff and forums, and the involvement of Iwi Māori in developing the review process. The key priorities for 2006/2007 include:

- Implementation of a Memorandum of Understanding with Manawhenua ki Waitaha;
- Implementation of Ethnicity Data Collection projects at all Canterbury DHB hospital sites;
- Development of a forum for whanaungatanga and cultural development for staff and establish a cultural training programme for DHB contract managers and Board members;
- Setting of expenditure targets for all Māori health services and service-related initiatives and establish a monitoring programme that meets internal and external accountabilities for the community and the Canterbury DHB;
- Application of clinical, cultural and priority-need frameworks to ensure responsiveness to Māori;
- A review of Māori health policy and quality frameworks, within the DHB and across its community providers and support for Māori providers participation in quality improvement programmes; and
- Collating Māori health workforce data to identify project areas, developing a workplan to implement an HR strategic directional plan for Māori health workforce needs and working with the education sector to promote Māori health careers and develop recruitment strategies.

2.2.4 Key Focus 2006/2007

The key challenge for Canterbury DHB going forward is to balance the fiscal pressures faced by the DHB against the need to improve health outcomes for our population. Given the significant financial pressure faced as we transition to equity under PBF, the identification of savings to allow the ongoing achievement of breakeven will be a greater focus than in the past.

To ensure that we have the funds to meet increasing future costs, we must identify better ways of working within the funding available. The Canterbury DHB's preferences for sources of savings (in descending order) are through:

- Efficiency gains (delivering the same service in more efficient ways);
- Service re-configuration (delivering the same outcomes but delivering services in other ways); and
- Service reductions through reduced access or full cessation.

During 2006/2007 we will continue to focus on achieving budget without the need for service reductions, however consideration will be given to the identification of potential service reductions in the out years, should these become necessary to achieve budget.

Coupled with the increased fiscal focus above, the DHB will continue to focus on the reduction of inequalities in health care and support the development of new services in those areas where new government funds have been supplied, such as mental health services and PHO development.

In achieving its objectives the DHB notes a number of regulatory or contractual compliance issues that are either already generating significant fiscal pressure or are likely result in future pressure, namely:

- Current and future MECAs and in particular the compounding effect of annual “step” increases coupled with expectation of FFT based increases;
- Potential impact of the Holidays Act, Electrical Regulatory Compliance and Fire Compliance Upgrades;
- The impact of the Restraint Policy and its impact on staffing levels; and
- Other ad hoc requirements that propose a solution to high profile cases but have ongoing cost implications in their implementation.

While addressing these compliance issues through a national coordinated approach is a worthwhile goal, the cost and benefit to DHB populations is not well measured and impacts on the ability of DHBs to maintain financial viability, while addressing local priorities. A better understanding of the impact of these compliance and contractual requirements is needed so that appropriate signalling of the relative priority within any new funds available to the sector can be made.

3 ENVIRONMENT

In September 2004 the Canterbury DHB completed its second comprehensive Health Needs Assessment (HNA) bringing together information describing the Canterbury population and the health status of its residents. More detailed information from that assessment (than that which is presented here) can be found on the Canterbury DHB website www.cdhb.govt.nz.

3.1 Overview of the Canterbury Population

Canterbury's usual resident population, at the 2001 Census, was 427,089. Statistics NZ predicts that this will rise to 464,700 by 30 June 2005 (base 2000) and to 504,700 by 30 June 2021. Māori make up 6.7% of Canterbury's usual resident population, Asian people 4.4% and Pacific people 2.0%. Most people identifying as Māori, Asian or Pacific live in Christchurch City.

Just over a quarter (26%) of Canterbury's population lives outside the urban Christchurch boundary. There are differing degrees of rurality but approximately 7,000 Cantabrians live in remote areas and have to drive for more than an hour for primary health care services.

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

Poorer health status is linked with high degrees of deprivation and Canterbury has around 80,000 people living in NZ Deprivation Deciles 8, 9 and 10 (the highest levels of deprivation). The percentage of Māori and Pacific people living in these areas is higher with 43% of Pacific and 30% of Māori in deciles 8, 9 and 10 (Level 10 being the highest level of deprivation) compared to 17% of Asians and 15% of Pakeha.

Around 15% of Canterbury's population are aged between 15 and 24 years. This is the same as the national figure. As with the national population, increasing number of our child and youth populations are Māori, Asian and Pacific. These ethnic groups have younger populations in general and approximately 50% of the Māori and Pacific populations are under 25 years old.

The 2001 Census shows 13% of the total Canterbury population is aged over 65 years. This is a slightly higher proportion of elderly, relative to the NZ population as a whole. Some rural areas, namely Kaikoura and Ashburton, have particularly high proportions of their populations aged over 65 (15.3% and 16.4% respectively). The percentage of the total population in Canterbury aged over 65 is predicted to increase to almost 20% by 2021.

Addressing the health needs of our ageing population is one of the Canterbury DHB's key challenges over the next ten years and is one of the five Health Gain Priorities identified in our DSP. Child and Youth Health and Māori health have also been identified as Health Gain Priorities where a focus over the next five years will help to improve the health of our community.

3.2 Key Health Trends for Canterbury

In order to address the health needs of our community it is important to understand our health status and the conditions and illnesses which are prevalent in the Canterbury district.

The total number of deaths for all ages in Canterbury is almost exactly as expected, given the age and socioeconomic deprivation of the region. The primary causes of death in Canterbury are diseases of the circulatory system (ischaemic heart disease, stroke, heart attack), cancers and respiratory system diseases; particularly for males.

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

The prevalence of these diseases is reflected in the Canterbury DHB's choice of Cancer, Cardiovascular Disease, Diabetes and Respiratory Disease as its identified Disease Priorities for the next five-ten years.

A number of conditions which result in death or disability are attributable to risk factors: smoking tobacco, not being physically active, eating foods that are not healthy, drinking too much alcohol or using recreational drugs. The 2002/2003 NZ Health Survey[6] reveals that most New Zealanders believe they have very good health. However, more than half of all adults are overweight, half do not get thirty minutes of exercise a day and 20% of people aged over 45 have been diagnosed with heart disease.

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

Canterbury's hospitalisation rates for childhood asthma are high as is our notified rate of pertussis (whooping cough). The rate of tooth decay in five-year-old children has also increased since 1996. Māori and Pacific children (an increasing percentage of our child population) have higher rates of hospitalisation for vaccine-preventable diseases, and higher rates of tooth decay and glue ear.

Disease prevention and management is another of the Canterbury DHB's five Health Gain Priorities with emphasis on healthy eating, active living, smoking cessation and intersectoral collaboration. Primary Health is the last of the five identified Health Gain Priorities, focusing on the role of PHOs, ensuring equity of access to primary care, sustainability of services and the development of chronic care continuums.

Timely and consistent primary health care can help prevent disease development, complications and hospitalisations. In Canterbury, socioeconomically deprived people are hospitalised with potentially preventable conditions at almost twice the rate of those less-deprived. PHOs are an important resource in working with low income and high-need populations to reduce the barriers to accessing health and disability services and the health inequalities associated with socioeconomic status.

3.3 Organisation Structure

The Board of the Canterbury DHB consists of eleven members and is the governance body responsible for the operation of the DHB established in 2000 under the NZPHD Act. The Board has a delegation policy, approved by the Minister of Health, to delegate decisions on management matters to the Chief Executive. It also has the following sub committees comprised of a mix of both Board members and community representatives:

- Hospital Advisory Committee;
- Community and Public Health Advisory Committee;
- Disability Support Advisory Committee; and
- Finance, Audit and Risk Committee.

The first three are Statutory Committees, required under the NZPHD Act and the last is a Committee specific to the Canterbury DHB established by its Board in January 2001. In general, all meetings where the Board or any of its Statutory Committees make decisions are open to the public to attend, as observers. In accordance with the NZPHD Act, public notice of the date, time and venue of the meetings are available on the Canterbury DHB's website. Further information on the membership and function of all the Committees can also be found here.

The Chief Executive has delegated management responsibility for the organisation of which there are three primary divisions: Planning and Funding (P&F), Community and Public Health Services (CPH) and Hospital and Specialist Services (HSS – the Provider-Arm of the Canterbury DHB).

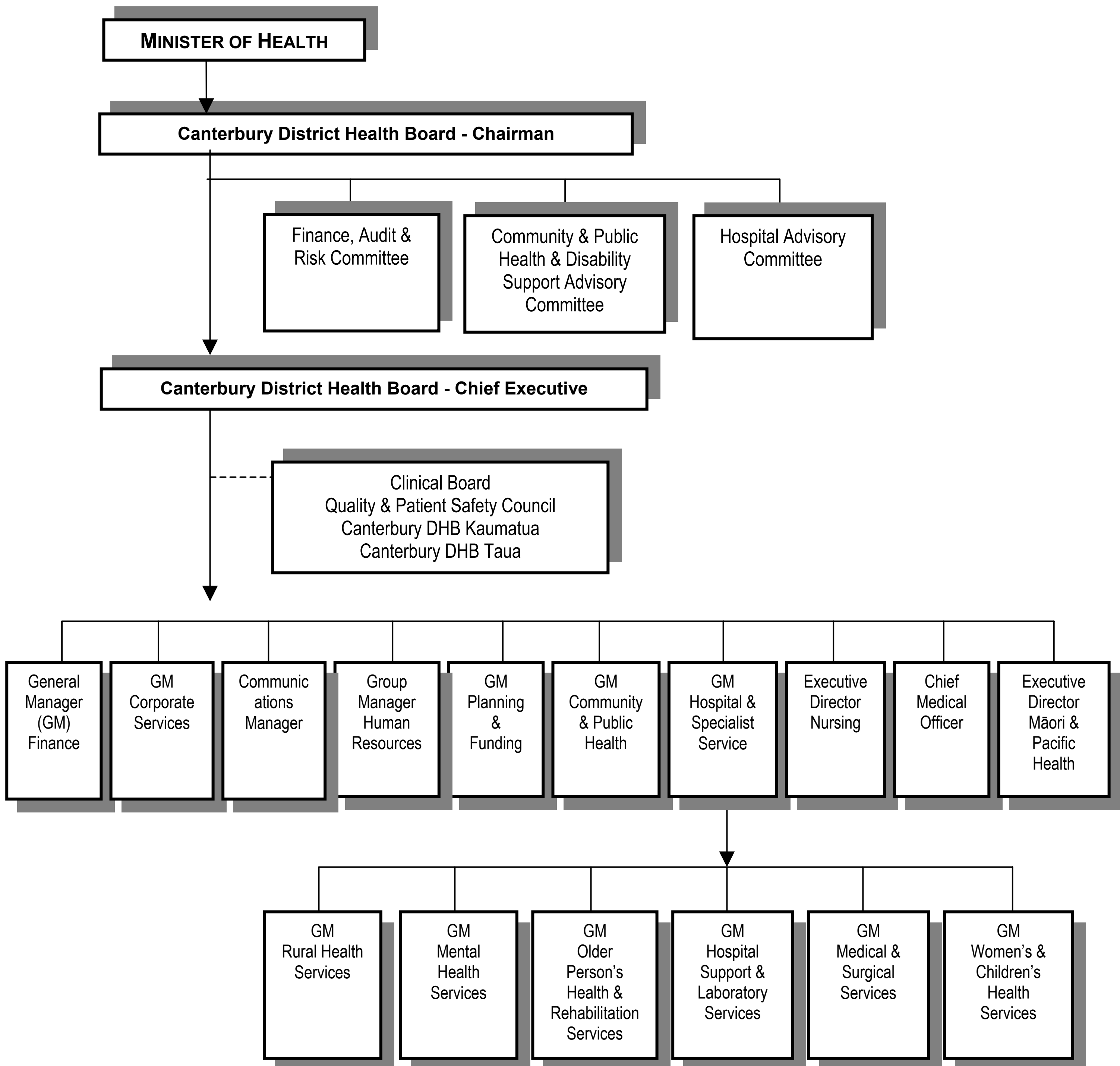
Previously the HSS had several separate (site based) operating units however its new structure (implemented in 2004) sees a number of new divisions structured along clinical lines; with a move towards a service focus rather than a site-based model. The service focused divisions are: Rural Health Services, Mental Health Services, Women's and Children's Health Services, Older Person's Health and Rehabilitation Services, Medical and Surgical Services and Hospital Support and Laboratories Services.

[6] The NZ Health Survey can be found on the MoH Website www.moh.govt.nz

The Canterbury DHB also has two fully owned subsidiaries, Canterbury Laundry Services Limited and Brackenridge Estate Limited, and has joint controlling interest in the South Island Shared Services Agency Limited (SISSAL) all of which it intends to keep operating in the medium term.

Support for these divisions is provided by the Finance, Human Resources, Corporate Services and Communications divisions. At this executive management level the Canterbury DHB also has an Executive Director of Māori and Pacific Health, an Executive Director of Nursing and a Chief Medical Officer who provide clinical and cultural leadership to all areas of the organisation and also provide oversight of patient safety and quality.

Figure 1 - Organisational Chart of the Canterbury DHB



4 ENSURING SERVICES FOR THE CANTERBURY DHB'S POPULATION

4.1 Providing Health and Disability Services

The Canterbury DHB has a number of non-negotiable obligations and responsibilities under key national health strategies, the NZPHD Act, the Treaty of Waitangi, the Crown Funding Agreement, the Minister of Health's yearly and ongoing Expectations and Priorities and its own accountability to the Canterbury community.

The DHB's vision of promoting, enhancing and facilitating the health and wellbeing of the people of Canterbury is closely aligned with key priorities identified in the NZ Health Strategy and the Minister of Health's yearly and ongoing Expectations and Priorities.

The five chosen Core Directions will provide the Canterbury DHB with the foundations to ensure it is able to meet its obligations and responsibilities and work towards its ultimate goal of promoting, enhancing and facilitating the health and well-being of its community.

The chosen Health Gain Priorities are where the Canterbury DHB will target activity to make improvements in the delivery of services. As highlighted earlier in the document, the Priorities are a mixture of population, service and disease based approaches and represent the areas where the Canterbury DHB believes there is the biggest potential for change and development.

The Board, Chief Executive and senior management have collectively determined key focus and strategies to achieve outcomes in line with each of the Canterbury DHB's five Core Directions and its mixed Health Gain Priorities over the next year. This document also outlines the Canterbury DHB's focus and strategies to progress ministerial expectations and priorities over the next year.

The approach in all of these areas will be consistent, in particular, working collaboratively with the primary care sector, our community and HSS to ensure an integrated approach to patient care and the development of chronic disease continuums. Working with providers and external stakeholders to promote messages related to lifestyle choices, physical activity, healthy eating, obesity and smoking cessation. Working to ensure services are culturally appropriate and working with providers and community agencies to reduce inequalities and increase access and uptake of services.

However, as an overfunded DHB we must be mindful of moving to equity over the coming years and living within our budget. The focus on financial, service and demand pressures have also been highlighted earlier in the document and progress on these will be central to achieving the long-term goals outlined in the Canterbury DHB's DSP. Work has already begun in a number of these areas (much under a number of the Core Directions) and ongoing work will also progress outside the scope of this District Annual Plan (DAP).

The Canterbury DHB will be looking in the coming year at the way in which it delivers and evaluates services and will be aiming to do things better within available resources. Health Services Planning and looking at the picture of health in our community and our communities' needs in the future will be central as we move forward.

Progress on the Core Directions and Health Gain Priorities will be reported to the Board and appropriate Statutory Committees throughout the year.

4.1.1 Improve the Health of Our Community - Reducing Disparities and Inequalities

The health of Canterbury residents is on average the same as or better than the national health status and Canterbury has the highest life expectancy of any DHB region. However, the changing demographics of Canterbury's population also needs to be considered in future health planning; growing Māori, Pacific and refugee communities and the increasing age of our population will mean a change in the number of high needs and high risk groups in the make-up of our population.

The Canterbury DHB is aware of the inter-relationships that exist between socio-economic status, education, employment, housing and health and will continue to work intersectorally, through groups like Strengthening Families, Healthy Christchurch and PHOs, to target and reduce inequalities and to address the determinants of health.

Reducing disparities, addressing inequalities and improving access is a focus for the Canterbury DHB and are expectations of the Minister of Health this year. The challenge will be not just identifying gaps through improved data collection but actually targeting resources towards those high needs and high-risk groups and effecting changes in health status.

During 2006/2007 we will be focusing on the following activity and intervention to reduce disparities and inequalities, building further on the foundations already put in place in the past year particular on the work done in Ashburton around rural health services and equitable access for rural communities:

What	Improve our understanding of the health needs of our community - Knowledge and Analysis.
Who	Executive Director Māori and Pacific Health
How	Progress the collection of ethnicity data throughout the Canterbury DHB and amongst community providers and use that data to evaluate access issues and better target resources: ▪ Extend the collection of Ethnicity Data through all Canterbury DHB sites and including PHOs; ▪ Develop and implement systems and process for analysis of that information; and ▪ Communicate this information to key stakeholders to enable analysis of service gaps and development of innovate models to address these gaps.
When	Presenting analysis of Ethnicity Data for at least one Health Gain Priority in 2006/2007.

What	Raise the focus on lifestyle disease prevention, lifestyle choice and pathways to change.
Who	General Manager Community and Public Health
How	▪ Provide an effective and efficient health education resource distribution service to multiple outlets (e.g. PHOs, service centres, libraries). ▪ Influence public health action in other sectors through intersectoral engagement, and provision of public health advice and advocacy. ▪ Provide relevant public health input relating to inequalities and determinants of health to all DHB strategies
When	Ongoing throughout 2006/2007

What	Optimising access and utilisation to rural hospitals and community health services – ensuring rural services are accessible, sustainable and clinically viable.
Who	General Manager, Hospital and Specialist Services General Manager, Rural Health Services (HSS) General Manager, Planning and Funding
How	Implementation of the recommendations of the Review of Health Services in Ashburton (Ashburton Integrated Model of Care Project December 2005) focusing on the development and implementation of six projects over the coming year: ▪ Collaboration and Integration with primary, community and public health services; ▪ Core Services and Specialist Led Services; ▪ Investing in Workforce Development; ▪ Health Information and Technology Systems;

	▪ Health Promotion; and ▪ Site Redevelopment and Ancillary Services. Implement the recommended activities from the Review of Rural Health Services (November 2005): ▪ Continued accreditation of Ashburton Hospital and all Rural Health Service Hospitals; and ▪ Ongoing support for Rural PHOs.
When	▪ Workforce Strategy developed for Ashburton Health Services Q1. ▪ 'Model of Care' for Kaikoura developed in consultation with the Community Q2. ▪ Waiting times for rural access to Child and Family Mental Health Service are reduced as a result of service reconfigurations Q1. ▪ Additional visiting specialist services from Christchurch available at Ashburton Hospital Q3.

Child and Youth Health

Child health and youth health are priority areas for the Canterbury DHB. Keeping our child and youth population healthy provides them better opportunities for becoming healthy adults. The Canterbury DHB aims to improve outcomes for children and youth in Canterbury, particularly those with high needs, those at risk and those in environmentally disadvantaged situations.

In 2004, the Canterbury DHB developed a Child Health and Disability Action Plan *Mahere o te Hauora Tamariki me te Hauātanga* based on the principles and key directions of the national Child Health Strategy and local community priorities. A Child Health Strategy Group was established to oversee the implementation of the Canterbury DHB's Action Plan.

Ten priorities for improving children's health are identified: access to services, child health information, hearing, immunisation, injury prevention, mental health, nutrition and physical activity, oral health, parenting and smokefree environments. In addition, more than sixty actions are outlined to improve child health outcomes, a number of these commenced in the past year including:

- Establishment of a Child and Youth Mortality Committee focused on reducing the numbers of preventable deaths;
- A pilot in twelve Early Childhood Centres designed to improve health and wellbeing; and
- A project to obtain better information about the Strengthening Families collaborative case management process in order to improve the outcomes for families/whanau who live in high risk environments.

The Canterbury DHB also successfully:

- Rolled-out the Meningococcal B Vaccination Programme and established the National Immunisation Register (NIR) in Canterbury, providing an accurate way of measuring the percentage of children who are vaccinated for each of the childhood immunisation events;
- Opened the new 134-bed Christchurch Women's and Children's Hospital and Day Surgery Unit on the Christchurch Hospital site and successfully transferred patients and staff.

Emphasis over the next year will be on the continued implementation of the Child Health and Disability Action Plan and on developing a local Youth Health Plan; developing ways to best meet the needs of young people in Canterbury:

What	Continue to implement the Child Health and Disability Action Plan, working to reduce inequalities in the health status of children and to ensure child health services are provided in an equitable and timely manner – through a coordinated community approach.
Who	Child Health Project Manager (Community and Public Health) Portfolio Manager Personal Health (Planning and Funding) General Manager Women's and Children's Division (HSS)
How	▪ Work to improve child health information systems, making them clinically useful, appropriate, up-to date and available. ▪ Work with providers to coordinate health promotion, prevention and early intervention, especially hearing screening and immunisation. ▪ Increase awareness of injury prevention in progressing Priority 5 of the Action Plan. ▪ Promote healthy eating and exercise, support effective parenting programmes, smoke-free environments and the OK Kids Project focusing on reducing childhood obesity.

	▪ Support and facilitate the adoption of healthy supporting policy measures within schools participating in the Fruit in Schools Programme. ▪ Provide tools to schools to assist them to identify and access quality health education and other health service programmes, resources and information to support health promotion in schools. ▪ Continue to promote WellChild Checks in progressing Priority 1 of the Action Plan. ▪ Participate in, and implement additional initiatives for child and youth (when funded nationally) such as: the MoH's Family Violence Guidelines on child and partner abuse and Universal Newborn Hearing Screening Programme.
When	Ongoing 2006/2007.

What	Ensure a coordinated community approach to youth health services to promote access, early intervention, reduction in risk activity and a population-based approach to continuums of care.
Who	Portfolio Manager Personal Health (Planning and Funding) General Manager Women's and Children's Division (HSS) General Manager, Community and Public Health
How	Develop a comprehensive local Action Plan for Youth Health and begin implementation of that Plan. In developing the Plan consider: ▪ Youth services particularly in the areas of: primary health, mental health, sexual health and school-based youth health; ▪ Māori and Pacific youth issues and inequalities in health status of Canterbury youth; and ▪ Focus on keeping youth safe and reducing risk activity and collaborating with other intersectorial agencies in working towards improving the health status of Canterbury youth.
When	Presentation of the Youth Health Plan, October 2006.

What	Increase immunisation rates of two year olds, working toward achieving target 95% fully immunised.
Who	Portfolio Manager Personal Health (Planning and Funding)
How	▪ Continued refinement of the NIR administrative processes to ensure timely and accurate newborn enrolment. ▪ Establishment of an NIR Governance Group to monitor immunisation rates and provide advice to improve immunisation coverage rates in specific ethnic, deprivation or geographical areas that have lower coverage rates. ▪ Development of strategies that maximise the use of the NIR to support providers and ensure effective utilisation of the NIR as a tool for improving immunisation rates within Canterbury.
When	Ongoing 2006/2007 The national immunisation coverage survey indicates that DHBs in the Southern region are performing better than average with an estimated 91% of children receiving DTaP dose 3 measured at one year of age and 88% of children receiving MMR vaccine dose 1 measured at 18 months of age. Consolidation of current performance and incremental improvements are anticipated for 06/07.

What	Improve school based dental health services for children and youth in Canterbury and promote good oral health practice.
Who	General Manager Older Persons Health and Rehabilitation (HSS) General Manager, Community and Public Health
How	▪ Use relevant Canterbury DHB Action Plans and contracts to ensure that oral health education is incorporated and promoted along with other 'healthy lifestyle' messages and participate in national MoH and local CPH programmes such as Healthy Eating Healthy Action (HEHA) and Healthy Eating Active Living (HEAL). ▪ Support ongoing workforce development and ensure an ongoing relationship with external education providers to support recruitment and training and address workforce issues. Continue with the current pilot project offering a refresher course for dental therapists, aimed at encouraging a return to work. ▪ Actively participate (as funding allows) in the outcomes and recommendations of the MoH School and Community Dental Clinic Review.

	▪ Carry out a health promotion project in Canterbury to improve awareness of role and value of fluoride in oral health.
When	Ongoing 2006/2007.

Health of Older People

In 2002 the MoH's national Health of Older People Strategy (HOP) was released. The primary aim being to promote wellness, improve and maintain health functioning and independence and ensure the development of an integrated continuum of care so that older people needing support can access the right services at the right time, in the right place and from the right provider. The emphasis is on flexible, holistic, quality needs based care in the community

In October 2003 the MoH devolved the funding responsibility for age related services to DHBs. DHBs are now responsible for planning and funding health and disability services for older people including residential care services, assessment, treatment and rehabilitation services, homes based support and other community services for the elderly.

The Canterbury DHB has laid a strategic platform to implement the national HOP Strategy at a local level and over the past year has:

- Developed its own local Aged Care Strategy *Healthy Ageing, Integrated Support* through full consultation with key stakeholders and the wider community and with the unanimous approval of its Board;
- Successfully transitioned rest home beds to hospital level beds to meet changes in demand;
- Begun reviewing day care options for older people with the view to increasing capacity;
- Successfully increased respite capacity and funding;
- Begun the piloting of the InterRAI assessment tool in Older Person's Health;
- Begun piloting Medication Management for 'at-risk' in the community, including older people;
- Begun building a database to assist with future capacity planning and monitoring the progress of service and funding shifts within aged care;
- Successfully developed an older people's reference group;
- Begun piloting Specialist Complex Wound Care Support in a residential care; and
- Begun a SupportCare End-of-Life and SupportCare Severe Medical Illness initiative in the community and in residential care to increase equity of access, efficiencies and quality of care.

Priorities for 2006/2007 are primarily around phasing the implementation of actions from the Older People's Services Strategy and focusing on providing care for the elderly in the community and away from institutional care:

What	Begin implementation of the Canterbury DHB Older People's Services Strategy *Healthy Ageing, Integrated Support.*
Who	Portfolio Manager, Aged Care (Planning and Funding) General Manager Older Person's Health and Rehabilitation (HSS)
How	▪ Build the capacity of home based support services to phase shifting services and funding from inpatient and residential care to community based services. ▪ Remodel and build the capacity of day care provision for the elderly including dementia and general services. ▪ Develop a holistic seamless model of care in the community - including increasing flexible medium-high packages of care in the community and the introduction of Coordinator of Services for the Elderly (COSE) services into primary care settings. ▪ Build an information infrastructure - particularly around increased analysis and accountability. ▪ Reduce access points for residential care and raise entry criteria - build the capacity of Needs Assessment Service Coordinator (NASC) services in the hospitals and community for timely assessments and increased reassessments and consider the roll-out of InterRAI comprehensive assessment tool. ▪ Begin a process of integration and coordination of community services with key stakeholder participation and maximise efficiencies for best health outcome. ▪ Heighten intersecotrial focus, relationship building and shared vision for holistic elder care

	services. ▪ Focus on Health Promotion and services - including falls prevention, strategic communication and dissemination and associability of elder friendly information on available community services and care options. ▪ Work with primary care to maximise quick response to older person's needs and challenges. ▪ Explore development of an institutional transitional care model for short-term rehabilitation. ▪ Build on and strengthen palliative care provision and promote informed choices. ▪ Identify continence issues in relation to entry into residential care and address needs.
When	Ongoing throughout 2006/2007: ▪ Home based support services strengthened through facilitating decasualisation of the home based support work force, supporting education initiatives, recruitment and retention; ▪ Multi care provision promoted with rehab focus; ▪ Service provision of stand alone general and dementia day care services in the community built up and residential care day care provision redefined; ▪ Work underway with providers to put in place a holistic seamless care model in the community; ▪ Number of older people receiving flexible medium to high care packages in community increased, numbers reflecting a reduction in residential care placement; ▪ Planning and funding information infra-structure complete and utilised to analyse progress; ▪ NASC capacity in Christchurch Hospital and COSE in the community increased; ▪ More timely regarding assessments to track care package outcomes being conducted; ▪ Support use of a comprehensive assessment tool for older people in hospitals and community; ▪ Services and potential integration of services mapped with key stakeholders; ▪ Current older person's contracts and services reviewed; ▪ Collaborative relationships with intersectorial organisations built and a common plan to help older people in the community developed; ▪ Volumes for Stay on Your Feet services increased; ▪ Work commenced with ACC with view to increasing usage of hip protectors; ▪ Commence health promotion around falls, continence and hip protectors targeting older people; ▪ SupportCare service specifications reviewed and palliative community support built up; ▪ Support the residential care sector to develop a transitional model of care to support older people staying in the community; and ▪ Work with residential care sector to promote respite care as a support to home based care.

Māori Health - He Korowai Oranga

On average Māori have the poorest health status of any group in NZ and are twice as likely to develop diabetes as European people, have a significantly shorter life expectancy and are over-represented for injuries, heart disease, Sudden Infant Death Syndrome (SIDS) and a myriad of other health status measures. A number of strategies are in place to address these concerns, both nationally and locally, and the Canterbury DHB continues to work closely with the Māori community and Māori health providers to make progress in improving the health status of Māori.

The Canterbury DHB adopted its local Māori Health Plan *Whakamahere Hauora Māori ki Waitaha* in 2002 and this was reviewed and revised in early 2006[7]. The Plan recognises the Canterbury DHB's Treaty obligations within the framework of the NZPHD Act and is consistent with the directions outlined in the national Māori Health Plan *He Korowai Oranga* and Action Plan *Whakatātaka*. Over the past year a number of achievements have been made in the area of Māori Health:

- Implementation of the Ethnicity Data Collection Pilot project at The Princess Margaret Hospital producing excellent results with a roll-out of that project now underway at all Canterbury DHB site;
- The establishment of a Māori Health Team at Christchurch Hospital to work within Paediatrics and Oncology – two high needs areas for both Māori and Pacific people. The team supports staff within these units to facilitate relationships and achieve better health outcomes for patients;
- A Whanau room opened at The Princess Margaret Hospital following the success of the Whanau room on the Christchurch Hospital site; and

[7] The draft revised Māori Health Plan is attached to this document as Appendix 2.

- Approval from the Christchurch Polytechnic Institute of Technology for the Māori mental health qualification *Tikaka Hauora*, seeking greater participation of qualified Māori in the health sector.

The key focus for 2006/2007 centres on the implementation of recommendations from the revised Māori Health Plan and around progression of plans and foundations put in place over the past year:

What	Implement the revised Canterbury DHB Māori Health Plan.
Who	Executive Director Māori and Pacific Health Portfolio Manager, Personal Health (Planning and Funding)
How	▪ Implement the Canterbury DHB Māori Model of Service Delivery providing clinical, cultural and priority-need frameworks to ensure mainstream services responsiveness to Māori ▪ Support the development of Māori Health providers through the Māori Provider Development Scheme (MPDS) and evaluate the impact of that scheme; ▪ Increase support for Māori provider capacity and capability through mental health funding and cooperation with the other South Island DHBs in Te Herenga Projects (lead by the NMDHB). Reinforce key messages: Quality, Sustainability, Collaboration, Cooperation; ▪ Maintain relative investment in Māori Health, implement expenditure targets for all Māori health services and service-related initiatives and establish a monitoring programme that meets internal and external accountabilities for the community and the Canterbury DHB; ▪ Review Māori health policy and quality frameworks, within the DHB and its community providers and support Māori providers participation in quality improvement programmes; ▪ Continue to enact, in consultation with Māori, appropriate processes to engage with the Māori community and Māori providers. Formalise the relationship that exists with Ngāi Tahi and Manawhenua ki Waitaha through the development of a Memorandum of Understanding at governance level; and ▪ Progress the Ethnicity Data Collection project to ensure that all Canterbury DHB sites collect ethnicity data and introduce processes and systems to analyse that data to determine and formalise access levels and access issues for Māori. ▪ Implement Te Puawaitanga, Māori Mental Health National Strategic Framework, and other mental health frameworks, as well as continued implementation of Mental Health Blueprint and Tuutahitia te Wero (Mental Health Workforce Development Plan).
When	Ongoing throughout 2006 in accordance with the revised Māori Health Plan Timeframes.

What	Ensuring a coordinated, population based, community approach to reducing disparities and fostering Māori community participation at all levels throughout the DHB.
Who	Executive Direction Māori and Pacific Health General Manager, Community and Public Health
How	▪ Continue collaboration around national and local strategies that promote health in areas of priority for Māori such as healthy nutrition and increased physical activity (HEHA and HEAL). ▪ Ensure Māori input into key Canterbury DHB strategies, PHO process and other integration initiatives particularly in key areas for Māori ie Child Health, Diabetes, and Cardiovascular Disease and focus on pathways of care that will lead to better outcomes for Māori. ▪ Continue regular Māori community consultation hui and participate in intersectoral Māori networking forums and initiatives that positively affect Whânau Ora. ▪ Identify and support Māori-led community development in priority areas. ▪ Continue current involvement in the activities of groups such as: Christchurch Social Policy Integration Network, the Housing Network and Strengthening Families and foster relationships with Te Puni Kokiri, Ministry of Education and the Ministry of Social Development to address environmental disparities that effect health status. ▪ Improve Māori health status by promoting smokefree lifestyles, as articulated in Auahi Kore initiatives and the Aukati Kai Paipa programme.
When	Ongoing 2006/2007.

What	Further develop the Māori health and disability workforce and work to improve the cultural responsiveness of Canterbury health services.
Who	Executive Director Māori and Pacific Health Group Manager Human Resources

How	▪ Continued development of the Canterbury DHB Māori Workforce Development Plan. The main aim is Whânau Ora with the key focus being the implementation of *He Korowai Oranga*. ▪ Develop a forum for whanaungatanga and cultural development for staff, establish a cultural training programme for contract managers and ensure Board members are also offered training. ▪ Collate Māori health workforce data to identify baseline and project areas and develop a workplan to implement a strategic directional plan for Māori health workforce needs. ▪ Work with HSS to promote Māori health knowledge and training for non-Māori staff. ▪ Work with the education sector to promote Māori health careers and to develop a Māori recruitment strategy.
When	Ongoing throughout 2006/2007: Ensure at least two cultural training days are run during 2006/2007.

Current Funding Allocations

The Māori health expenditure stocktake that the Canterbury DHB undertook during 2005/2006 identified expenditure of $8.2M for the year through a combination of Māori community providers, mainstream community providers and the Canterbury DHB's HSS. This funding included $300k of one-off funding specifically targeting Māori under the Meningococcal B Immunisation Programme.

The Māori health expenditure target for the 2006/07 financial year is set at $8.6M. Forecast targets for 2007/2008 and 2008/2009 are $8.9M and $9.1M respectively.

Progressing the New Zealand Disability Strategy

In June 2004 the Canterbury DHB approved the updated version of its Disability Strategy Action Plan 2004/2007 (Action Plan for Disability). This Plan sets out the Canterbury DHB's objectives and priorities for implementing the NZ Disability Strategy at every level of the DHB. A monitoring report on progress against the Action Plan goes to the Disability Support Advisory Committee (DSAC) every six months.

In the past year the Canterbury DHB has worked to promote and provide a non-disabling culture:

- A NZ Disability Strategy Survey of Canterbury DHB' HSS divisions was completed which outlined the key areas of progress under the NZ Disability Strategy Objectives; and
- Work is underway to conduct a survey of users of Canterbury DHB inpatient and outpatient services to better understand how the services can meet the needs of patients and consumers.

The Canterbury DHB recognises that it cannot address every barrier over night, but can take a step by step approach to practical and attitudinal changes that will benefit everyone. The Canterbury DHB sees the NZ Disability Strategy as a 'whole of government strategy' of which the Canterbury DHB forms only a part. During 2006/2007 the Canterbury DHB will work to achieve the Strategy's objectives in the areas it is able to influence through its own local Action Plan for Disability:

What	Ensure that the health concerns and needs of people with disabilities are known at a service and planning level – Knowledge and Analysis.
Who	Executive Direction of Nursing Quality Manager, Corporate Quality and Risk Chief Information Officer, Information Services
How	▪ Update the patient admission form to provide information on a patient's disability, which will include type of disability, severity, particular needs and any other information the patient deems relevant. ▪ Survey consumers with impairments who have been either inpatients or outpatients as part of the ongoing monthly consumer satisfaction surveys to assist in determining what consumers of health services want in order to improve their experience. ▪ Ensure the DSAC workplan is informed by the Disability Strategy Action Plan and the results of the Canterbury DHB's NZ Disability Strategy Questionnaire.
When	Ongoing through 2006/2007.

What	Work intersectorally with other agencies in Canterbury to eliminate barriers that New Zealanders with impairments face in their daily lives and ensure that HSS are providing accessible services and ensuring equitable access to services.
Who	General Manager Hospital and Specialist Services General Manager Corporate Services General Manager Community and Public Health
How	▪ Continue to work towards more coordinated services for people with disabilities and to work with other agencies such as Christchurch City Council and Healthy Christchurch on health and disability issues. ▪ Implement actions from the Canterbury DHB's Māori Disability Strategy Development Project to help meet disability needs of Māori, as funding allows. ▪ Continue to ensure all site redevelopment conforms to current standards of accessibility through adherence to the Canterbury DHB's Accessibility Plan. ▪ Continue to provide 24-hour interpreter services, including those for Deaf people, in all major hospitals and comply with the requirements of the NZ Speech language Bill when enacted into law, as funding allows. ▪ Participate in the scoping of a project to address issues pertaining to assessment and referral of children with disabilities. ▪ Maintain links with the community to assist disabled people to return to the community including liaison with ACC, Lifelinks, domiciliary care, equipment access etc.
When	Ongoing through 2006/2007.

4.1.2 Find Better Ways of Working – Integrated Continuums of Care

The Canterbury DHB faces the challenge of growing demand, while at the same time working within funding and financial pressures. The DHB intends to expand how it plans, funds and delivers health care in Canterbury to ensure the most effective resource utilisation and to deliver the best possible health outcomes within the limited funding allocated.

The Canterbury DHB needs to ensure that health resources are protected, sustainable and supported long-term and a focus for the coming year is to progress future health services planning through the development of clinical services plans, chronic care continuum frameworks and service models and facilities masterplans. This will mean new thinking around best provider, best location, best service but will enable us to ensure ongoing provision of health and disability services and to provide services which are better integrated and configured and that operate seamlessly across geographical, professional and service boundaries.

Improving the patient journey through the hospital system is a important part health service planning and the Improving the Patient Journey Project, already underway within the Canterbury DHB, will be rolled out to further divisions and to sectors beyond as part of the focus on effective chronic disease management continuums. This will enable us to ensure more consumer focused services and will assist the DHB to build capacity, capability and to improve productivity.

Success already evident through the work on Improving the Patient Journey includes significantly reducing CT Radiology Waiting Times. A focus of the coming year will be on capturing the degree of movement, operational and strategic impact of the Improving the Patient Journey activity. The development of Key Performance Indicators clearing stating organisational objectives are one measure of success and the development of these will be activity supported. Given the financial pressures faced by the Canterbury DHB it will also be important to measure some form of financial flow impact. Collecting, analysing and disseminating clinically and organisationally useful information will also enhance monitoring and drive performance improvement.

What	Work on the development of frameworks for Chronic Disease Management Continuums – Right Place, Right Time and Right Provider.
Who	General Manager Planning and Funding General Manager Hospital and Specialist Services
How	Link closely with Core Direction 'Working Together' (4.1.3) and enhancing partnerships with primary and community care providers working on a framework for services.

	▪ Collaborate with the wider health sector to develop and implement Chronic Disease Management Continuums focusing on Respiratory Disease, Cardiovascular Disease and Diabetes and including the range of services from self management to specialised complex care. ▪ Progress integration pilots and programmes to incorporate PHOs and General Practitioners (GPs) as key partners in the management of demand on hospital and specialist service ▪ Enhance referral guidelines and education to improve appropriate utilisation of speciality and emergency services.
When	Ongoing throughout 2006/2007.

What	Continue to implement the Improving the Patient Journey Project – Effective integrated care and improved productivity.
Who	Executive Director of Nursing Chief Medical Officer General Manager Hospital and Specialist Services General Manager Planning and Funding
How	Re-orientate and focus the Improving the Patient Journey team to concentrate its limited resources into the areas of greatest strategic and operational impact, in line with the HSS Annual Workplan. Progress the following key streams of the Improving the Patient Journey Project over the coming year: ▪ Emergency Department – refining length of stay; ▪ Acute Assessment Unit developed – process and structure; ▪ Radiology Review; ▪ Theatres Review; ▪ Out of Hours Services Review; ▪ Developing Measures for Success – Key Performance Indicators (KPIs); and ▪ Avoiding Unnecessary Hospital Admissions (driven by Planning and Funding).
When	Ongoing throughout 2006/2007: ▪ Strategy for Emergency Department length of stay in place; ▪ Daily performance tools installed for Radiology; ▪ Operational model agreed for Operating Theatres, detailed implementation plan complete; ▪ Night Team Coordinator in place and measures identified for Out of Hours service; and ▪ Measures of success defined and implemented.

What	Work to ensure optimum use of resources and investment – Future Health Services Planning.
Who	General Manager Corporate Services General Manager Hospital and Specialist Services General Manager Planning and Funding
How	The focus of future health services planning is to optimise the future use of capital within the DHB. Over the coming year work will be undertaken on: ▪ Health Services Plans – through a governance structure, including Steering Group and Project Team, Health Services Plans will be developed for departments through the DHB; ▪ Facilities Masterplan – the Health Services Plans will inform the development of a Facilities Masterplan for the Canterbury DHB; and ▪ Asset Management Plan – development of this Plan will continue, moving into greater detail and alignment with Health Services and Facilities Masterplans.
When	Ongoing throughout 2006/2007: ▪ Updated Asset Management Plan completed Q2; and ▪ Health Services Plans to inform Facilities Masterplan developed Q4

Primary Health Care

Primary care is often the first point of contact with health services and reducing barriers to accessing care helps people to stay well. Costs may be a barrier for some people; hospitalisation rates for people on lower incomes are higher than the Canterbury average. It is the intension of the NZ Primary Health Care Strategy 2001 that every New Zealander has the same ability to access Primary Care Services.

The Canterbury DHB will support the ongoing implementation of the national Primary Health Care Strategy and will aim to enhance population health by improving access to primary care and public health programmes designed to suit local needs. In the past two years a number of successes have been achieved in Canterbury through the implementation of the national Strategy:

- Establishment of five PHOs covering 98% of Canterbury, all participating in Care Plus;
- Implementation of a number of 'Services to Improve Access' programmes including: longer GP consultations, school health clinics and community nursing services;
- Implementation of a number of health promotion programmes including service mapping, smoking cessation programmes, youth oral health programmes, physical activity and nutrition programmes;
- Collaboration between the DHB and PHOs on targeted projects such as Service Maps and Winter Warming;
- Collaboration with PHOs to ensure at least a third of the PHO Boards are made up of community representatives to promote community engagement and responsiveness to community needs;
- Improved collaboration and coordination of community based services such as Home Based Support Services; and
- Review of Laboratory Services to ensure appropriate level of accessibility to services for the people of Canterbury.

In 2006/2007 the Canterbury DHB will work with the primary care sector to ensure the continued implementation of a number of projects that are currently underway. These projects will make inroads to progressing the primary care interface with hospital services and improving the coordination of primary and community services.

The DHB will also continue to work collaboratively with PHOs, pharmacy, laboratory, oral health services and home based support services to improve access to primary and community services and to improve coordination of these services:

- Continued implementation of the Mental Health Demonstration Models within primary care;
- Annual Planning for PHOs – engaging in collective stewartship and sharing of mutual ideas including community governance and the promotion of community representatives on PHO Service to improve Access (SIA) and Health Promotion (HP) Committees;
- Implementation of the Healthy Eating Active Lifestyle Project;
- Review and 24 hour cover and work with GPs and PHOs to develop an After Hours Plan for the Canterbury district; and
- Review Canterbury's rural services, incorporating rural primary care issues, supporting 24 cover, access to primary care specialist services and addressing rural workforce issues.

What	Streamline primary health care services and work with the sector to reduce the number of avoidable admissions to hospital.
Who	Portfolio Manager, Primary Care (Planning and Funding)
How	Work with PHOs, continuing to implement the NZ Primary Care Strategy; focusing on reducing the current inequalities within primary care service provision and providing support for GPs to allow them to manage the care of their enrolled populations by: ▪ Reducing co-payments for the 45-64 year old age group; ▪ Implementing PHO Health Promotion Plans; ▪ Implementing PHO Services to Improve Access Plans; ▪ Have all Canterbury PHOs enrolled in the PHO Performance Management Programme; ▪ Undertaking a review of Primary Mental Health Services and of Acute Demand Service provision.
When	Ongoing throughout 2006/2007.

What	Implement recommendations of the Canterbury DHB's Community Laboratory Services Review.
Who	Portfolio Manager, Primary Care (Planning and Funding)
How	Complete the Laboratory Services Review and implement the recommendations: ▪ Undertake a Request for Proposals (RFP) to implement the changes required; ▪ Aim to achieve the reconfiguration of service provision, increased accessibility and better data sharing of Laboratory services; and ▪ Aim to achieve increased testings and an overall reduction in hospital admissions.
When	May – September 2006.

What	Ensure access to Pharmacy Services within Canterbury.
Who	Portfolio Manager, Primary Care (Planning and Funding)
How	▪ Reduce the co-payments for 45-64 year olds enrolled within Canterbury PHOs. ▪ Work with the pharmacy sector to implement relevant addition services such as a Medicine Management Programme to improve the management of pharmaceutical needs within the Canterbury community.
When	Ongoing throughout 2006/2007.

What	Ensure that Home Support Services are targeted at the population of most need and work to ensure a streamlined, effective and efficient approach to service provision through improved coordination of services.
Who	Portfolio Manager, Primary Care (Planning and Funding) Portfolio Manager, Older Peoples Health (Planning and Funding) General Manager, Older People's Health and Rehabilitation Services (HSS)
How	▪ Implement the recommendations of the Canterbury DHB's Aged Care Strategy, *Healthy Ageing, Integrated Support.* ▪ Work with providers to develop strategies to assist in the retention and recruitment of carers to ensure a workforce that is flexible and available to provide the services required. ▪ Review the role of District Nurses within the community and determine the need for 24-hour nursing cover. ▪ Consider the possible development of Acute Care Teams to assist with targeting of services to high needs groups and reducing avoidable admissions to hospital.
When	Ongoing throughout 2006/2007.

Disease Prevention/Management

Population health programmes are key to achieving healthier people and communities. There is a need for an increased focus on programmes that target healthy eating, physical activity and smokefree lifestyles, especially among high needs groups.

Smoking contributes to a number of preventable illnesses resulting in a large burden of disease and is currently the single major cause of preventable death in NZ. However inactivity, poor nutrition and rapidly rising obesity rates are beginning to rival tobacco as the leading cause of preventable disease. All give rise to cardiovascular disease, diabetes, poor psychosocial outcomes and reduced life expectancy. In the past year all Canterbury DHB sites successfully achieved Smokefree status

A complex range of environmental influences affect the lifestyle choices of our community. Hence, a comprehensive multi-sector approach is needed to promote change and influence improved health status. A number of successes over the past year have contributed to a solid foundation for moving forward in the promotion of health, including the implementation of the HEAL Plan.

The Canterbury DHB has chosen four Disease Priorities; Cancer, Cardiovascular Disease, Diabetes and Respiratory Disease. All of these are influenced by lifestyle choice and public health education can make a difference in the health status of our community in all of these areas. As the Canterbury DHB moves towards a focus on chronic disease management continuums it will be important to

ensure that a public health and education focus is incorporated into those continuums. Priorities for 2006/2007 will focus on a number of areas that will assist in improving the health of our community:

What	Assist our community to make healthy choices through supportive physical, social, economic and policy environments and commitment to improved health and wellbeing.
Who	General Manager Community and Public Health
How	Contribute to and advocate for the development of standards, policies and practices which will create safer and healthier environments in the primary and community health sector, the NGO sector, the housing sector and in DHBs (Healthy Hospitals). Work collaboratively with Territorial Local Authorities (TLAs), Healthy Christchurch, Healthy Inangahua, Early Childhood Centres and with Māori and Pacific health organisations and intersectorial agencies. Develop and distribute health information and resources relating to health and wellbeing issues through intersectoral partners. Identify and work with other intersectoral agencies to explore the extent that public health/health promotion issues are being addressed and the opportunity for these issues to be placed on their policy/strategy agenda. Participate in the development, implementation and monitoring of intersectoral action plans to deliver social environment initiatives that address the determinants of health in geographic localities.
When	Ongoing throughout 2006/2007.

What	Promote a population-based approach to improving screening and awareness of risk activity and disease prevention activity across the DHB's four Disease Priorities.
Who	General Manager Community and Public Health
How	▪ Reduce the incidence of cancer through primary prevention, supporting PHOs to implement smokefree and QUIT smoking programmes. ▪ Continue to support programmes focusing on improving nutrition, smokefree lifestyles, limiting alcohol intake, increasing exercise and sun protection campaigns. ▪ Provide advice and expertise to facilitate the implementation of the Smokefree Environments Act 1990 and amendments to the legislation and strengthen community awareness and action to address retail sales and supply of tobacco to minors. ▪ Support the implementation and maintenance of Smokefree environments in schools within the context of Health Promotion in Schools. ▪ Work in partnership with other organisations, to develop programmes that encourage smokefree environments in the Māori community including homes, Marae and Kura Kaupapa Māori. ▪ Promote both local and national smoking cessation programmes, including cessation programmes targeting the Māori population (Aukati Kai Paipa smoking). ▪ Work in partnership with other organisations, developing, implementing and supporting public education, media and social marketing campaigns to raise public awareness of the health risks of tobacco use and to promote Smokefree lifestyles. ▪ In collaboration with other sectors, support and facilitate the development and implementation of nutrition and physical activity policies in key settings including preschools/schools, Kura Kaupapa Māori, Māori and Pacific settings, high need settings and within DHBs. ▪ Work with the education sector (through supporting Health Promotion in Schools, Fruit in Schools and other initiatives) to improve access to healthy food in preschools/schools, Kura Kaupapa Māori, particularly those with high levels of highest need. ▪ Identify and use opportunities to increase the profile of healthy food choices and physical activity in media, advertising and promotion. ▪ Support existing and (as appropriate) new community based education programmes aimed at increasing knowledge of community members, about nutrition and physical activity. ▪ Strengthen and develop networks between primary health care and public health to promote nutrition and physical activity issues ensuring effective participation from high needs groups. ▪ Develop and maintain district-level alliances and networks between health agencies and TLAs to inform and influence district planning.
When	Ongoing throughout 2006/2007.

Cancer

The Canterbury DHB works very closely with community providers to promote health initiatives that reduce cancer, such as improving nutrition, promoting smoke-free lifestyles and increasing exercise. Over the past year this collaborative work with other agencies had led to a number of success:

- Cancer Society/Laural Whitford Charitable Trust Information and Learning Centre established at Christchurch Hospital; providing on-site support and information to cancer patients and their families along with professional development resources for health professionals;
- Launch of the Cancer Society's Colossal Colon to help educate the public on the importance of a healthy lifestyle in preventing bowel cancer;
- Beginning collaborative work with the Cancer Society and Otago School of Medicine to help the Tissue Bank become financially self-sufficient; and
- All Canterbury DHB worksites, facilities and grounds are now smokefree.

The Canterbury DHB's approach to cancer builds on a number of national policies and strategies as well as focusing on issues raised in its Palliative Care Strategy (2003) and the review of Oncology Services (2002). Primarily, the Canterbury DHB is committed to implementing the NZ Cancer Control Strategy (2005-2010) and meeting the priorities outlined in that document[8].

In 2005 the South Island DHB General Managers (P&F) commissioned a stock take of cancer services in the South Island with the aim to bench mark existing services and then develop knowledge and skills to assist in the implement of the NZ Cancer Control Strategy. This regional plan works towards implementing and achieving the actions outlined in goals two through to five of the NZ Cancer Control Strategy by building upon existing cancer control strategies within DHBs through the provision of shared learning and providing the opportunity for consistency across regions.

This project will inform the actions taken over the coming year to progress the NZ Cancer Control Strategy. Treatment availability and cost are continuing challenges and together with community providers and agencies we will also be looking at ways to improve patient flow from diagnose through treatment to cure or palliative care. The Canterbury DHB's priorities for the 2006/2007 year are:

What	Work with other South Island DHBs to identify options for improved collaboration in delivering cancer treatment services and to progress the NZ Cancer Control Strategy.
Who	General Manager Planning and Funding General Manager Hospital and Specialist Services
How	▪ Reduce inequalities between DHB populations and within DHB populations. ▪ Align DHB and regional cancer services with the National Cancer Strategy. ▪ Work to ensure consistent DHB service development, with the ability to meet local needs. ▪ Work to ensure efficient use of resources in the development and planning of cancer services. ▪ Share information and ideas through regional collaboration (Regional Collaboration Network). ▪ Achieve radiation therapy waiting times. ▪ Establish service standards and develop multi-disciplinary teams to ensure effective diagnosis and treatment of cancer – through treatment advisory groups and tumour boards.
When	Ongoing throughout 2006/2007: ▪ A report outlining the current activity being undertaken within goals 2-5 of the NZ Cancer Control Strategy provided to all South Island DHBs 2006; and ▪ Recommendations for future alignment of DHB and regional cancer services with the NZ Cancer Strategy service development provided 2007.

What	Review Palliative Services in Canterbury.
Who	Portfolio Manager, Personal Care, Planning and Funding
How	▪ Undertake a review of all Palliative Services ensuring duplication/gaps identified and remedied. ▪ Implement the SupportCare packages of care into the community.
When	Ongoing throughout 2006/2007.

[8] The NZ Cancer Control Strategy is available on the Ministry of Health website www.moh.govt.nz.

Cardiovascular (Heart) Disease

The incidence of Cardiovascular Disease (CVD) is likely to increase as our population ages and is usually linked with diabetes and strongly influenced by lifestyle choice. Māori and Pacific have higher rates of CVD than other ethnicities.

A plan for minimising the effects of CVD on Canterbury's population was approved by the Canterbury DHB Board in 2004. The Canterbury Heart Health Strategy was developed in consultation with Canterbury DHB's Cardiovascular Steering Group consisting of both provider and user representatives and recommended a number of actions to improve heart health in Canterbury. The Strategy highlighted the importance of population-based strategies for reducing the impact and incidence of CVD and the importance of improving rehabilitation and community treatment after acute heart events.

Over the past year the Canterbury DHB has worked collaboratively to make gains in CVD and introduced a memorandum of understanding with the National Health Foundation as a means of examining ways to work together to improve heart health in Canterbury. Other successes over the past year will provide a good foundation for change and improvement over the coming year:

- Being chosen as one of five pilot sites for the National Health Foundation's *Heart Guide Aotearoa,* a home-based phase two rehabilitation programme scheduled to begin this year. The programme will be delivered by practice nurses in six large practices in Christchurch and the surrounding area and enables the Canterbury DHB to work collaboratively with general practice linking patients back into primary care for ongoing CVD management; and
- Beginning a primary care based CVD risk assessment project in Rangiora. Looking at the health status of the whole population as determined by their GPs. Information will be gathered in a standardised way over the coming year and will help shape the health promotion needs of the whole community.

In addition to these pilot programmes, challenges for the coming year include curbing and stabilising childhood obesity rates through community, school and early childhood centre programmes. There will also be a focus on increasing the numbers of partnerships, collaborations and alliances across the health sector in order to develop future initiatives to reduce the risk of heart disease:

What	Implement the actions associated with the *Canterbury Heart Health Strategy* , covering the continuum from health promotion, disease prevention, treatment, rehabilitation and palliative care.
Who	General Manager, Community and Public Health Portfolio Manager, Secondary Care (Planning and Funding) General Manager, Hospital and Specialist Services
How	▪ Develop a comprehensive approach to reducing the incidence and impact of CVD including progressions of HEAL and HEHA. ▪ Support strategies to address heart health in Māori and Pacific communities especially through primary and community care. ▪ Continue to review current interventions being used for CVD and introduce specific interventions to meet indicator targets for cardiac surgery and angioplasty. ▪ Continue to work with key stakeholders and health promotion providers to promote messages related to physical activity, healthy eating, weight reduction, smoking cessation. ▪ Work to ensure services are culturally appropriate and work with Māori and Pacific communities to support prevention, early detection, and service uptake. ▪ Continue to work with primary care and hospital services to ensure and integrated approach to patient care and support the development of chronic disease management continuums. ▪ Coordinate actions with national guidelines on management of cardiovascular risk, stroke, and diabetes.
When	Ongoing throughout 2006/2007.

Diabetes

Diabetes is a Health Gain Priority area for the Canterbury DHB, with the incidence of both type 1 and type 2 diabetes increasing in Canterbury. The Canterbury DHB will work closely with community and

primary care providers over the coming year to progress a coordinated community approach, to ensure access to services and to promote timely intervention.

The Canterbury DHB continues to support the Local Diabetes Team (a representative group of health professionals, community providers and consumer representatives) which provides advice and information to the DHB and reports on annual diabetes screening and management targets.

Work also continues on population-based interventions to promote healthy eating and increase physical activity with the teams from Nutrition and Physical Activity (CPH), Diabetes Life Education and Pacific Health Promotion merging their services at the end of 2005 in order to maximise their resources and effectiveness.

Future plans for the Canterbury DHB's Diabetes Services include the construction of new premises adjacent to the Christchurch Hospital. This new facility will house the Diabetes Centre, Home Dialysis Training Centre, meeting and education rooms and enlarged clinics to improve patient facilities.

In 2004 the Diabetes Action Plan *Disease Prevention and Management: CDHB Diabetes Actions,* updated progress on recommendations made in the 2002 Interim Diabetes Plan and proposed further areas for focus. There were a number of successes over the past year:

- Access to community podiatry services was promoted for high risk feet through a funded podiatry service in primary care;
- A Paediatric Diabetes Endocrinologist was appointed to increase consultant availability and improve timing of transition to adult services;
- The Canterbury DHB's HEAL Plan was introduced and activities were successfully linked with the MoH's national HEHA Strategy;
- Activities were also successfully linked with Cardiovascular Disease and Heart Health Plans; and
- Construction began on a new Diabetes and Dialysis Centre.

A number of local Canterbury DHB action plans and national health strategies incorporate actions that contribute to improved outcomes for diabetes including HEHA and HEAL, Māori health strategies and Pacific health strategies. The Canterbury DHB will continue to progress these over the coming year and will work closely with the Local Diabetes Team to focus gains in this area. The key priorities for the coming year are:

What	Coordination of services within the community to improve access and intervention.
Who	Portfolio Manager Personal Health (Planning and Funding) Portfolio Manager Primary Health (Planning and Funding)
How	▪ Progress work with all diabetes providers to ensure a sustainable coordinated approach. ▪ Continue to work in collaboration with the Local Diabetes Team to raise diabetes awareness and to progress shared goals and initiatives. ▪ Progress work with primary care teams to identify people with type 2 diabetes earlier to ensure early treatment. ▪ Support PHOs to provide health promotion in physical activity and healthy eating and to increase the number of people with diabetes getting annual checks and the number of patients with adequate glycaemic control. ▪ Continue to work with Māori and Pacific providers and communities to support prevention, early intervention and ongoing uptake of services. ▪ Work with community podiatry services on access for those with uncomplicated high risk feet. ▪ Progress a coordinated approach to access to community podiatry and retinal screening. ▪ Work to ensure all annual review data is collected for regional/national databases.
When	Ongoing throughout 2006/2007: ▪ Publication of the Local Diabetes Annual Report by the Local Diabetes Team; and ▪ Establishment of a single database under a 'lead' PHO for improved diabetes data collection.

Respiratory Disease

Diseases of the respiratory system are a leading cause of death in both Canterbury and in NZ. Chronic respiratory diseases, particularly asthma and smoking related diseases such as chronic obstructive pulmonary disease (COPD) and emphysema, represent a significant public health problem.

Nationally, asthma hospitalisations are higher for Māori than non-Māori despite asthma prevalence being similar in Māori and non-Māori children. Asthma self-management can significantly reduce hospital admissions. Over the past year the Canterbury DHB has laid foundations to reduce the incidence of respiratory disease:

- Completion of the 'Baxter Bear' programme (in conjunction with the Canterbury Asthma Society) aimed specifically at children in the community with asthma. This programme was funded through the Canterbury DHB's Strategic Health Investment Fund; and
- Role-out of CarePlus through Canterbury PHOs, Respiratory Disease is one of the Chronic Diseases that will be targeted over the coming year.

Priorities for 2006/2007:

What	Addressing risk activity that impacts on respiratory disease.
Who	General Manager, Community and Public Health
How	▪ Continue with Smokefree Activities and smokefree cessation promotion. ▪ Work collaboratively with intersectorial agencies on the 'Warm Homes' project – to ensure adequate home heating for older people to keep them healthy in their own homes. ▪ Improve the self management of respiratory disease through enhanced provision of education and support to patients, families/whanau and caregivers.
When	Ongoing throughout 2006/2007.

What	Improve the health status of Canterbury's residents who are at risk of developing respiratory disease, provide appropriate and timely treatment and work to improve the quality of life for those with respiratory disease.
Who	General Manager Hospital and Specialist Services General Manager Planning and Funding
How	▪ Provide links to the development of Chronic Disease Management Continuums to ensure that the treatment of Respiratory Disease is considered when the framework around continuums is developed. ▪ Utilise Health Round-table Benchmarking and International Comparisons to recognise clinical best practice and measure the Canterbury DHB against other DHBs to assist in improving patient care and ensuring best practice standards are met. ▪ Scope and develop an Acute Medical Assessment Unit to assist with the assessment and management of short-term stay patients.
When	Ongoing throughout 2006/2007.

Cost Effectiveness, Efficiency and Value for Money

The Canterbury DHB is committed to continuous efficiency improvement. We have a responsibility to seek to improve the efficiency of the services we provide, while maintaining or improving service delivery. This has been highlighted through the DSP process as one of the DHB's greatest challenges.

The Canterbury DHB has an ongoing process to review its infrastructure costs and, where appropriate, initiatives are implemented to manage and/or reduce these costs. Efficiency initiatives over past years have resulted in the Canterbury DHB having a low administration component relative to the size of the organisation and assisting with improving productivity. The DHB has successfully made substantial improvements in its financial management and achieved in excess of $50m in efficiency gains since its inception.

In developing new strategies and initiatives or undertaking reviews the Canterbury DHB will continue to identify areas where integration, efficiencies, re-configuration or earlier intervention can produce

better value and outcomes from available funding. We are committed to ensuring that opportunities of this nature continue to be identified and acted upon to realise health gains for our community. We will also be looking at the benefit associated with efficiency gains or service re-configurations which may equally reflect improved service quality, adoption of best practice, improved or increased service delivery and long-term service sustainability.

What	Continue to review and evaluate employee cost control processes.
Who	General Manager Hospital and Specialist Services
How	Review and develop a full range of approvals and monitoring systems for: ▪ Recruitment advertisements; ▪ Replacement staff, additional staff, bureau and relief staff and academic appointments; ▪ Overtime; ▪ The management of leave and sick leave; and ▪ Service costs. Continue to develop and implement training programmes for staff on 'Workforce Management Rostering Systems' (WMRS).
When	Ongoing throughout 2006/2007.

What	Continue to review and evaluate nursing workforce costs.
Who	General Manager Hospital and Specialist Services Executive Director of Nursing
How	▪ Analysis of the use of nursing workforce to develop an understanding of the dynamics of staff cost drivers and use of bureau staff. ▪ Review of social nurses and models of care. ▪ Consideration and investigation of MECA compliance costs.
When	Ongoing throughout 2006/2007.

What	Continue to review and evaluate treatment-related costs.
Who	General Manager Hospital and Specialist Services
How	▪ Analysis and understanding of the costs of clinical supplies beginning with Oncology and discussions through the Clinical Board on frameworks and next steps. ▪ Review clinical practice in other centres and DHBs including benchmarking and best practice. ▪ Review clinical guidelines. ▪ Review approval and purchasing processes.
When	Ongoing throughout 2006/2007.

What	Continue to review and evaluate new technology.
Who	General Manager Hospital and Specialist Services Chief Medical Officer
How	▪ Approval processes to be formally enhanced and required. ▪ Communicate with key clinical leaders and staff and work with the Canterbury DHB's internal Health Technology Assessment Committee in establishing frameworks.
When	Ongoing throughout 2006/2007.

What	Continue to review and evaluate annual leave reduction plans.
Who	General Manager Hospital and Specialist Services
How	▪ Overall objective to approve level up-front and review alternatives – not catching effects/sites.

	▪ Enhance utilisation of Workforce Management and Rostering Systems (WMRS). ▪ Monitor top 100 annual leave users and develop, implement and monitor targeted personal annual leave reduction plans.
When	Ongoing throughout 2006/2007.

The Planing and Funding division of the Canterbury DHB currently manages over 800 contracts with health and disability services providers and over the 2006/2007 year ongoing review will be undertaken on these contracts to ensure opportunities for efficiencies and streamlining processes are taken.

Specific operational efficiency initiatives for the HSS for 2006/2007 are centred on their Strategic Workplan which outlines HSS focus and priority projects. Regular progress reports are provided to the Board's Hospital Advisory Committee[9] on these various HSS projects along with financial reports on expenditure and volumes.

What	Implement operational efficiency initiatives in line with the HSS Strategic Workplan.
Who	General Manager Hospital and Specialist Services
How	There are a number of sub-projects within the following areas designed to improve efficiency and effectiveness and to optimise cost control and revenue enhancement over the coming year: ▪ Improving Financial Rigour; ▪ Changing Clinical and Patient Processes; ▪ Review of Clinical Services; ▪ Infrastructure Improvement; and ▪ Improving Organisational Fitness and Training of Managers
When	Ongoing throughout 2006/2007.

Elective Services, Orthopaedic and Cataract Initiatives

Meeting demand for elective services is a primary focus for the Canterbury DHB and a high priority nationally for the Minister of Health. The DHB's Elective Services Steering Committee continues to monitor compliance against national Elective Services Performance Indicators (ESPIs) which are reported regularly to the MoH. The key objectives with regard to elective services are to:

- Deliver services within contracted volumes and improve capacity within existing resources;
- Communicate to patients and referrers of the likelihood of service;
- Continue to develop strategies to deliver elective services within current resources and improve milestones;
- Continue to collect information to identify future demand/need; and
- Identify and develop new initiatives.

The Canterbury DHB is also committed to implementing government initiatives around electives in particular areas with national projects currently underway in both Orthopaedic and Cataract services. Over the past year the DHB has made a number of significant achievements:

- ESPI Recovery Plan in place for all elective specialties;
- Contract volumes achieved in elective services;
- New elective services initiative funding projects implemented;
- ESPI Recovery Plan milestones achieved for both Orthopaedic and Cataract initiatives;
- Volume targets achieved for both the Orthopaedic and Cataract initiatives;
- Access threshold for cataract surgery lowered;
- Continue Quality Improvement (CQI) reporting compliance in Orthopaedic Service achieved and CQI Patient Flow Reports now provided to Orthopaedic clinicians to inform consistent patient selection; and

[9] The HSS Workplan and papers from the HAC meetings are available on the Canterbury DHB website.

- Clinicians now involved in CQI compliance and setting of promise levels for Cataract Initiative.

Productivity and Efficiency Successes:

- ‘Did Not Attend’ policy in place and monitored monthly;
- Guidelines and booking system reviewed for diagnostics;
- ESPI reports available to staff;
- Day Surgery and Day of Surgery Admission percentages increased;
- Process mapping informed a complete redesign of model of care from referral to pre-admission. ‘Bottlenecks’ quantified and solutions identified for Orthopaedic Initiative;
- Orthopaedic GP Liaison appointed;
- Orthopaedic operating theatre utilisation up 30%;
- Nurse led Orthopaedic admissions commenced, agreement for Nurse led pre-admission to commence 2006/2007;
- Both General Practitioners and Optometrists now pre-screening and scoring Cataract patients with training provided to up-skill General Practitioners in eye treatment and procedures;
- Nurse led follow up Glaucoma clinics commenced; and
- Process map of elective Cataract patient journey completed.

In addition to progressing the commitment to projects already underway the priorities for Elective Services 2006/2007 are to:

What	Work to improve access to First Specialist Assessments (FSAs) and aim to provide 100% of patients their first specialist assessment within six months.
Who	General Manager, Medical and Surgical Division (HSS) General Manager, Women’s and Children’s Health (HSS)
How	▪ 100% of first specialist assessments seen within six months in surgical, medical and gynaecology. ▪ Continue to improve the matching of promises to capacity in all services. ▪ Work to continue with primary sector to further develop alternative options in the community. ▪ Utilisation of clinical time to be monitored. ▪ Continue monitoring “did not attend” rates to reduce wastage of clinical time. ▪ Further develop nurse led initiatives. ▪ A review of sleep studies with alternative treatment being implemented in the community. ▪ Ongoing development of improved primary access to diagnostics. ▪ Reduce the number of follow-ups required in targeted specialties. ▪ Review of induction and training process for new staff working with booking system. ▪ Discharge follow-ups back into the community in a timely manner. ▪ Prioritise recommendations from outpatient audit.
When	Ongoing throughout 2006/2007: ▪ ESPI management Q1; ▪ Matching priority is integrated into all service function Q2; ▪ Implement recommendation from outpatient audit Q2; ▪ Increase nurse led initiatives Q3; and ▪ Monitor clinical utilisation Q4.

What	Implement systems to improve access to elective surgery across all population groups – Improving the Patient Journey, Theatre Module.
Who	General Manager, Medical and Surgical Division (HSS)
How	▪ Reviewing theatre utilisation and future requirements in regard to acute/elective sessions. ▪ Analyse “bottlenecks” and “delays”. ▪ Increase the utilisation of pre-admission clinics. ▪ Examining theatre staff roster and shift patterns. ▪ Measuring time of admission to time to theatre.

	▪ Maximising the current resourced theatre time with the ability to increase the resource in the future. ▪ Increase day surgery percentages and day of surgery admission percentages. ▪ Review the skill mix required for each theatre session. ▪ Continue to monitor recruitment and retention of skilled theatre staff.
When	Ongoing throughout 2006/2007: ▪ Benchmark Australia and New Zealand theatre staffing models Q1; ▪ Allocate theatre scheduled sessions in line with contracted volumes Q2; ▪ Improve patient pathway from admission to theatre Q2; ▪ Implement pre-admission procedures for all specialties to increase day of surgery admission and day surgery Q3; ▪ Implement alternative staff rosters and shifts where applicable Q4; and ▪ Increase capacity for orthopaedic and cataract initiatives Q4.

What	Achieve consistent prioritisation for patients in all services with a focus on the link between assignment of priority and treatment decisions by clinicians.
Who	General Manager, Medical and Surgical Division (HSS)
How	▪ Work with surgeons to further delineate patient need and ability to benefit. ▪ Collaborate with the Clinical Priority Assessment Criteria (CPAC) review consortium to implement effective score tools in general and vascular surgery. ▪ Identify opportunities for local score tool develop and implement where there is no national tool. ▪ Regularly review consistency of prioritisation through Ministry of Health scatter plots and give feedback to clinicians.
When	Ongoing throughout 2006/2007: ▪ Review scatter plots Q1; ▪ Implement a monthly monitoring system for clinicians and managers Q1; ▪ Engage in decision making with clinicians and consortium team Q2; and ▪ Develop and implement local score tools where appropriate Q4.

What	Progress and implement the national Orthopaedic initiative within the Canterbury DHB.
Who	General Manager, Older Persons Health and Rehabilitation (HSS)
How	Maintain ESPI compliance and continue to improve the matching of promises to capacity for both outpatient and in-patient treatment: ▪ GP Liaison to focus on the referral gateway and communication with primary care. Build additional public sector capacity for hip and knee replacement to meet the target intervention rate by 2007/2008: ▪ Timely completion of Stage Two Redevelopment of the new Burwood Hospital surgical ward/ theatres /PACU/ day surgery and admitting unit with a supporting workforce plan in place. Achieve consistent prioritisation for patients with focus on link between assignment of priority and treatment decision by clinicians: ▪ Work with surgeons to further delineate patient need and ability to benefit; and ▪ Ensure that matching priority given to a patient with the order in which patients are treated, at an individual clinician level, becomes an integrated function within the service. Work alongside primary care and the Canterbury DHB's Planning and Funding division to support and monitor a greater range of options to help manage demand on secondary services. Focus on Nurse led pre admission and develop competency framework to support all nurse led Elective Orthopaedic activity.
When	Ongoing throughout 2006/2007: ▪ Completion of Burwood Hospital redevelopment Q4; ▪ Matching priority is integrated into service function Q4. Streamlining programmes underway to help manage demand on secondary services: ▪ ESPI Management Q1; ▪ Pre Admission and Discharge Planning redesign Q2;

	▪ Optimise Outpatient Capacity and Capability Q3; ▪ Burwood Theatre Planning and Utilisation Q4; and ▪ Workforce Utilisation and Planning Q4.

What	Progress and implement the national Cataract Initiative within the Canterbury DHB.
Who	General Manager Medical and Surgical Services (HSS)
How	100% of FSA and In-patient treatment list patients seen within six months and additional capacity for cataract surgery built to meet the target intervention rates by 2007/2008: ▪ Continue to improve the matching of promises to capacity; and ▪ Facilitate interim solutions to current capacity issues while concurrently developing longer term plans for increasing public sector Ophthalmology capacity in Canterbury. Achieve consistent prioritisation for patients with a focus on the link between assignment of priority and treatment decisions by clinicians: ▪ Provide clinicians with regular information showing scoring patterns and links between priority and treatment decision. Focus on streamlining the Cataract Patient Journey from referral to pre-admission: ▪ Analyse “bottlenecks” and identify solutions; and ▪ Further development of Nurse led initiatives.
When	Ongoing throughout 2006/2007: ▪ Clinicians will be provided with scoring pattern information Q2; ▪ Interim solutions to capacity issues implemented Q4; and ▪ Solutions to bottlenecks identified Q4.

Progressing the Mental Health Strategy and Mental Health Blueprint

Completion of the Canterbury DHB Mental Health and Addictions Strategy in May 2004 provided a local framework for managing access to and delivery of a ‘System of Care’ model based on advancing recovery for service users. Two directions have been established and these are:

- Improving access for people experiencing mental illness, alcohol and other drug problems; and
- Introduce an improved ‘System of Care’ that is integrated, responsive and available in the consumer’s chosen community.

The Canterbury DHB’s Mental Health and Addictions Strategy is consistent and complimentary to existing work at national and regional levels (particularly the Government’s Mental Health Strategy; *Te Tahuhu* Improving Mental Health 2005-2010) and is clear that service reconfiguration must occur within resources. Its vision is ‘Improving the health and well-being of people experiencing mental illness and alcohol and other drug problems’.

The Canterbury DHB was allocated $2.8 million additional Blueprint funding in 2005/2006. This provided an opportunity for significant investment in new services for the Canterbury District. The following services have been, or are in the process of being established as a result of this additional funding:

- Māori Mental Health Services for Child and Youth (MHCS.39)
  The Kaupapa Māori Mental Health Services Review identified a need for additional Youth Services, and Child and Youth Services are identified as a priority area for Canterbury DHB. An increasing percentage of Māori are under the age of 30; therefore, there is an increasing need for youth services in Canterbury. Quarterly statistics have shown that access rates to mental health services for Māori Children and Youth are disproportionately low relative to population. The Canterbury DHB will contract with a Kaupapa Māori NGO to provide clinical child and youth services, the resource for this proposal is equivalent to four Full-Time Equivalents (FTEs).
- Addiction Treatment Options for Women (MHCS.01.A)
  AOD providers report significant difficulty accessing treatment options for women, that are flexible enough to meet the needs of women re child care etc, therefore resource was allocated to increase addiction treatment options for women in Canterbury (up to $100,000).
- Alcohol and Other Drug (AOD) Advocacy / Peer Support (MHCS.21.A.*consumer*)

Ensuring that mental health services are recovery oriented is a requirement of Te Tahuhu – the national Mental Health Plan. The Recovery philosophy recognises that service users lead their own recovery, have personal power and have a valued place in their whanau and community. service users must also have formalised positions within the mental health system to assist with the systemic development of recovery focussed and responsive services. The resource for this service is equivalent to two FTEs

- Pacific Mental Health Services for Child and Youth (MHCS.21.7)
  Child and Youth Services are a priority area for Canterbury DHB. Quarterly statistics have shown that access rates to mental health services for Pacific Children and Youth are disproportionately low relative to population. The resource for this service is equivalent to four FTEs.
- Respite Services for Adults(MHRE.01.*planner*) (MHRE.01.*crisis*)
  A shortage of community respite beds was reported as a significant contributing factor to this increased demand for inpatient services, therefore resource was allocated to increase respite services. The resource for this service is equivalent to six beds.
- Specialised Areas of Mental Health (MHCR.09)
  Community Support Workers provide non-clinical support to assist service users to maximise and maintain recovery within the community. Some service user groups have specific needs that require more intensive support than what providers of generic Community Support Workers can offer. The resource for this service is equivalent to five FTEs.
- Community Integration Service (MHWD.01)
  The purpose of these service is to work with individuals in existing residential services and inpatient services and facilitate the move on to more independent arrangements by building packages of care around individuals that do not 'fit neatly' into traditional services. This service will include a Transition Fund that will be managed by the Community Integration Service staff in partnership with the DHB's Contract Manager. This fund is available to fund one-off expenses that will assist a service user to move into more independent accommodation. The resource for this service is equivalent to five FTEs, with additional resource for a Transition Fund.
- Peer Support Services (MHCD.21.1)
  Service user run services are a key component of a recovery oriented mental health system. The DHB will contract for a programme where service users support other users in their recovery and the resource for these services is equivalent to three FTEs.
- Mobile Medication Service (MHWD.01)
  This is a demonstration mobile outreach service that operates outside normal business hours and targeted to those who have been most difficult to engage in mainstream service delivery. The resource for this service is equivalent to two FTEs.
- Primary Mental Health Initiatives (MHCS06A)
  Development of Mental Health Liaison Worker positions that are based in primary care, supporting GPs and liasing with mental health services.
- Pyschogeriatric Services (MHCS.06.A.PSE)
  Resource was allocated to a memory clinic. This service provides early assessment and support for dementia.
- Increased Maternal Mental Health Services (MHCS.06.B)
  An additional 0.5 FTE Consultant Psychiatrist for Maternal Mental Health.

Many of these services have been established as demonstration programmes for a period of 18-24 months. During this time qualitative and quantitative information will be collected by service providers which will be used to develop future contracts. This will ensure that planning and funding decisions regarding future service or sector reconfigurations will be aligned to the needs of service users and their families and their required mental health outcomes.

The coming year will also provide opportunities for service expansion with a further $1.6m additional Blueprint funding allocated to Canterbury. This investment will focus on developing Peer Support Services ($500,000) (MHCD.21.1), supporting Primary Care ($260,000) (MHCS06A) and the remainder providing flexible mental health support options based on the experience of the demonstration programmes in 2005/2006.

Despite this additional funding a number of providers of mental health services are under some financial pressure. These pressures include pay equity demands as a flow on effect of the nurses' salary agreement, difficulties with recruitment and retention in a highly competitive environment and infrastructure/technology issues. In order to respond to these issues the Canterbury Mental Health Sector, led by P&F, must closely examine the current range and mix of mental health services to better understand effectiveness, efficiency and how responsive services are to the needs of service users and their families.

National Mental Health Workforce Development Programmes and Centres provide numerous resources and opportunities for mental health providers, service users and whanau. The Canterbury Mental Health Sector will continue to participate in and support these national and regional initiatives that are relevant to local issues and support participation by local providers.

The Canterbury DHB will also continue to pursue the goals of Te Puawaitanga and progress cultural responsiveness of mainstream mental health services and the development of the Kaupapa Māori Mental Health Sector.

What	Improve and support flexibility and responsiveness in mental health services.
Who	Portfolio Manager, Mental Health (Planning and Funding) General Manager, Mental Health Services (HSS)
How	Fund demonstration services that improve service flexibility and accessibility for service users: ▪ Assess the outcomes of these demonstration services; ▪ Identify improvements that can be attributed to funding approaches; and ▪ Select the demonstration services that will continue. Provide information to the mental health sector about the ways of working that are expected to be achieved through the aforementioned demonstration services and in general to support the flexibility of mental health services. Continue to support Te Korowai Hinengaro Oranga Ki Waitaha as a key mechanism for developing and strengthening the Kaupapa Māori Mental Health Sector, and supporting regional initiatives like Te Roopu Awhiowhio to improve the responsiveness of mainstream services. Implement the recommendations of the Child and Adolescent Family Mental health Services Review and the Review of the Model of Care in Adult General Mental Health Services, to promote improvements in the patient journey and increased flexibility and responsiveness.
When	Ongoing throughout 2006/2007: ▪ Assessment of demonstration services in Q1 and Q2. Services selected as effective (eg, because of consumer outcomes) will then be funded on an ongoing basis; and ▪ Regular meetings with mental health providers for information sharing and discussion to ensure clarity of expectations and remedy any difficulties.

What	Support cohesiveness and collaboration between mental health providers and stakeholders.
Who	Portfolio Manager, Mental Health (Planning and Funding)
How	Ensure all providers with Canterbury DHB contracts have information about and opportunities to discuss how the System of Care model is intended to work.
When	Ongoing throughout 2006/2007: ▪ Q2 and Q3 hold regular provider meetings with mental health service providers where P&F will provide information and direction; and ▪ Use provider specific clauses in contracts, as required, to clarify responsibilities and key linkages within the System of Care model.

What	Continue to support and develop recovery orientation in the mental health sector.
Who	Portfolio Manager, Mental Health (Planning and Funding)
How	Include recovery specification in provider specific clauses of contracts. Use information from the Recovery Systems Project led by the SISSAL to inform funding decisions.
When	Ongoing throughout 2006/2007: ▪ Q2 specification included on renewal or variation of mental health provider contracts.

Progressing the Health Information Strategy

Significant Information Services activity is already underway throughout the Canterbury DHB. In addition to the implementation of both the Information Services Strategic Plan (ISSP) and the Health Information Strategy NZ (HIS-NZ), significant changes are being made to Information Services infrastructure and regional collaboration is a primary focus.

This year's activities build on the considerable investigation and analysis work from 2004/2005 and the foundation work undertaken in 2005/2006. Some of that work undertaken in the past year includes:

- Successful signing of South Island Telecommunications Contract with facilitation of contract price and service level being made available for all South Island DHBs;
- Successful upgrade of Oracle Financial Business Systems which provide improved financial management and reporting for the organisation;
- First step upgrade of Stargarden HR and Payroll systems successfully completed, ensuring the technology platform is appropriately supported throughout the DHB;
- Successful implementation of information technology infrastructure on the new Christchurch Women's Hospital and Day Surgery site. This included some innovation technology to improve voice communications in the clinical setting;
- Voice and Data Networks across the DHB successful upgrade to streamline communications, reduce costs and allow improved internal communication links; and
- Successful implementation of NIR system and school based vaccination systems.

The Canterbury DHB's ISSP re-enforces the objectives outlined in national strategies and our Information Services are committed to working closely with stakeholders (locally, regionally and nationally) to implement solutions that satisfy clinical and business requirements. The focus over the coming year will be delivering projects that have been in planning for the last year:

What	Continued implementation of the Canterbury DHB's ISSP and delivery of a robust infrastructure framework.
Who	General Manager Corporate Services Chief Information Officer, Information Services
How	Complete Infrastructure Stabilisation Programme of Work. Implement first stage Clinical Information System: ▪ Implement a clinical portal to give an aggregated view of clinical information including a Patient Master Index, National Provider Index integration and Electronic Discharge Summaries; and ▪ Formulate a strategy to move to a single Patient Administration System. Progress the upgrade of HR Payroll and Rostering systems. Support the implementation of an Oral Health information System. Complete the implementation of MH-SMART. Implement National Non-admitted Patient Collection (NNPaC).
When	▪ Complete implementation of data capture forms for MH-SMART Q1. ▪ Implementation of NNPaC Q1. ▪ Infrastructure Programme complete Q4. ▪ Clinical Information System roll-out underway Q4. ▪ HRIS and Rostering Business Case and implementation Planning Study complete Q1-Q4.

What	Actively participate in HIS-NZ, the development of standards defined in HIS-NZ projects.
Who	General Manager Corporate Services Chief Information Officer, Information Services
How	▪ Progress collaborative networks to address information system needs at local, regional and South Island levels (Action Zone 1 – National Network). ▪ Actively participate in NHI promotion and work on the continuous improvement of data quality (Action Zone 2 – NHI Promotion). ▪ Implement single South Island Regional Network to provide access to clinical information at other DHBs and to other significant health or health service providers (Action Zone 1).

	▪ Provide access to PACs services (where they exist) at other South Island DHBs for Canterbury DHB staff treating tertiary referred patients (Action Zone 1). ▪ Provide access to Clinical Information Systems (where they exist) at other South Islands DHBs for Canterbury DHB staff treating tertiary referred patients (Action Zone 1). ▪ Implement 'Client' Health Practitioner Index (HPI) (Action Zone 3 – HPI Implementation). ▪ Lead in the implementation of phase one of the National Non-Admitted Patient Collection (NNPaC) (Action Zone 9 – National Outpatient Collection).
When	▪ Active participation in at least three National Action Zones. ▪ Regional DHB Network set up within South Island by Q1. ▪ NNPaC implemented (Phase1) by Q1. ▪ Discharge Summaries implemented at Christchurch Hospital by Q3. ▪ NHI Promotion ongoing monitoring of data quality and targeted training to improve. ▪ Implementation of 'Client' HPI at Canterbury DHB by Q3. ▪ Each DHB is able to retrieve PACS images from other DHBs by Q3. ▪ Each DHB has access to the clinical information systems at other DHBs by Q3.

4.1.3 Work Together

The Canterbury DHB realises that its vision will not be achieved through its efforts alone. By looking outside of our organisation, establishing partnerships with other agencies and with other sectors, as well as with our community and consumers, the DHB can work to influence the determinates of health and enhance the continuum of care needed to achieve improved health outcomes.

The Canterbury DHB plans to continue to emphasise the importance of working collaboratively with its own workforce and to encourage work across professional and organisational boundaries to optimise the use of combined health resources and to challenge traditional roles to improve health outcomes for patients and consumers.

The Canterbury DHB will also begin to work on the development of a Framework for Primary and Community Care over the next year. The intention is that this framework will be used to assess service or funding proposal as to their 'fit' within the direction of service development. The framework will look at the continuum in the community from 'wellness' at one end to 'unwellness' at the other and work to 'recentre' the health sector onto primary care as the first line and consistent tread throughout the patient journey. The expected outcomes are early detection and intervention, continuity and coordination of care, better and more timely information and workforce changes.

What	Share responsibility for quality health outcomes with our community.
Who	General Manager, Community and Public Health
How	Maintain an intersectoral focus continuing ongoing work with external agencies to address the determinants of health and to share vision for improving outcomes: ▪ Support for the Canterbury Intersectoral Physical Activity and Nutrition Group; ▪ Development of PHOs Health Promotion Plans; ▪ Continue involvement in the Poverty Project with Healthy Christchurch; ▪ Involvement in the development of Long Term Community Council Plans (LTCCPs); ▪ Continued involvement in the Housing Forum; ▪ Support for Health Impact Assessments (HIAs); ▪ Continued involvement in the Regional Land Transport Committee; ▪ Support the development of an Urban Development Strategy for Greater Christchurch; ▪ Continued involvement in and support for Healthy Christchurch; and ▪ Continued involvement in and support for Pandemic Planning.
When	Ongoing throughout 2006/2007.

What	Enhance partnerships between our clinical workforce and management - considering the changing mix of skills required for future service provision and changing models of care.
Who	Chief Medical Officer Executive Director of Nursing
How	Work to challenge the roles and mix of health care workers and the models of services delivery for the benefit of patients, consumers and service users: ▪ Continue current work at Burwood Hospital looking at the changing role of health professionals. Successfully admitting patients to hospital for elective surgery without direct RMO involvement; and ▪ Continue working on the development of a 'Night Team' to improve the quality of care, improve the work experience and training of RMOs and to change the role of health professionals at night. Review sustainability of services in rural services and specific workforce issues: ▪ As part of Review of Health Service in Ashburton (Ashburton Model of Care Project) develop and implement initiatives around the replacement of traditional RMO roles with generalist medical officers including some uptake of responsibility by nurses. Continue to develop and implement professional development and recognition programmes.
When	Ongoing throughout the 2006/2007 year.

What	Enhance partnerships with primary and community care providers – working on the development of a Framework for Primary and Community Services to ensure long-term capacity.
Who	General Manager Planning and Funding
How	▪ Collaborate with the wider health sector to develop and implement Chronic Disease Management Continuums focusing on Respiratory Disease, Cardiovascular Disease and Diabetes and including the range of services from self management to specialised complex care. ▪ Progress integration pilots and programmes to incorporate PHOs and GPs as key partners in the management of demand on hospital and specialist service. ▪ Enhance referral guidelines and education to improve appropriate utilisation of speciality and emergency services.
When	Implementation of changes to be ongoing throughout 2006/2007.

4.1.4 Develop our Health Workforce

A sustained, skilled and flexible health care workforce is central to the Canterbury DHB's ability to provide effective quality services and meet the challenge of improving our community's health. We aim to maintain our workforce capacity by supporting flexibility and innovation, encourage training and skills development and providing recognition and leadership opportunities within the organisation.

The Canterbury DHB has endorsed, in principle, District Health Board New Zealand's (DHBNZ's) Future Workforce 2005-2010 Strategy.[10] The Strategy identifies the following eight priority areas: fostering supportive environments and positive cultures; enhancing people strategies; education and training; models of care; primary health workforce; Māori health workforce; Pacific health workforce and non-regulated and voluntary health and disability workforce.

In Promoting a healthy workplace environment the Canterbury DHB will also encourage its workforce to lead by example in terms of healthier lifestyles and practices. In October 2006, Canterbury will host the DHB Health and Safety Conference, themed *'Working Well Together'* profiling the importance of a shared responsibility for safety and wellness. This builds on the success of the popular Wellness Days and the development of a Health and Safety management system. Other successes include:

- Centralisation of the Human Resources Group and establishment of key positions responsible for Workforce and Strategy Portfolios;
- A centralised accident reporting and recording system;
- ACC Partnership Programme for the management of workplace injuries;

[10] Refer to *Future Workforce 2005 – 2010* by DHBNZ Workforce Development Group for more detail.

- A dedicated Rehabilitation Advisor to support staff return to work from non-work injuries and health related events;
- Establishment of an Occupational Health Service for staff;
- Development and commencement of the HR competency development programme;
- Dedicated Organisational Development Framework (ODF) projects to improve recruitment and selection practices, remuneration practices, performance reviews, change management and management and leadership development; and
- Review of HR systems to improve workforce data and reporting capability.

Over the following year the key priorities for the Canterbury DHB with regard to developing its health workforce and maintaining workforce capacity are a combination of local and national priorities:

What	Encourage a flexible approach to reflect the changing needs of our community.
Who	Group Manager, Human Resources
How	Identify the likely impacts of future models of care on the health workforce to enable strategic workforce planning and development: ▪ Re-establish the Canterbury DHB Workforce Steering Group (WSG) to identify future activities as appropriate; ▪ Support and participate across identified year 1 Future Workforce projects as per the national *Future Workforce* programme; and ▪ Support and Participate in 2006/2007 employment relations priorities and projects (pay and employment equity review, bargaining activity and negotiations) as determined by DHBNZ project scopes.
When	Q2: Reconvene Workforce Steering Group. Throughout 2006/2007 the Canterbury DHB will participate in national initiatives and projects in accordance with the project plans and timeframes provided national, where appropriate: – As per *Future Workforce* Year 1 Project Plans; and – As per project scopes provided by DHBNZ for WAP.

What	Develop a workforce providing the ‘right skills’ for the best health outcome to ensure long-term capacity for service provision.
Who	Group Manager, Human Resources
How	Continue to work with education providers to develop programmes for a changing health environment and encourage enrolment particularly amongst under represented groups: ▪ Continue support for the development of Māori Workforce through the Tikaka Hauora initiative. Improve workforce information and data collection to assist with workforce development and capacity planning: ▪ Participate as a key stakeholder in the DHB-wide Human Resources Information System (HRIS) project, contributing to system configuration and process design, and to the development of change management approach for implementation, as required; ▪ Develop and enhance in-house HR business systems to facilitate the use of workforce data and reporting; and ▪ Support the identified priority areas for the 2006/07 HWIP, including specific workforce forecasting, modelling and analysis initiatives.[11]
When	Q3: Implement the Tikaka Hauora Development Programme. Q4: Implementation of regional e-recruitment solution. Q2: Streamlining of HR reporting frameworks.

What	Ensure Canterbury’s health sector is a ‘good place to work’.
Who	Group Manager, Human Resources
How	Provide leadership and career opportunities for our health care workforce and support career

[11] Refer to Health Workforce Information Programme by DHBNZ Workforce Development Group for more detail

	development: ▪ Development and implementation of identified management and leadership programmes; ▪ Implementation deliverables of the Performance Review project; ▪ Investigate and scope projects for succession planning and reward and recognition; ▪ Consideration and alignment of identified Workforce Steering Group activity – incorporating local tertiary providers and collaboration through established forums; ▪ Development and implementation of the DHB's collaborative Leadership Framework Model; and ▪ Participate and support Health Sector Branding Initiative as per the project scope from DHBNZ.
When	Ongoing throughout 2006/2007 as per the ODF project scopes and as per the project scopes provided by DHBNZ.

What	Create a safe and health-promoting environment to support and retain staff.
Who	Group Manager, Human Resources
How	Continue the ongoing progression of Health and Safety management practices and culture: ▪ Progress the local healthy workplace and employee wellbeing programme. Develop and implement one hazard management system: ▪ Host the 2006 National DHB Health and Safety Conference; and ▪ Participate and support identified national initiatives arising from the national Health and Safety Managers Forum. Support, participate and collaborate in national activity related to the Healthy Workplace Stocktake[12].
When	Ongoing throughout 2006/07. Occupational Health Service implemented and operating. Q2: Health and Safety Conference programme developed and conference successfully hosted.

4.1.5 Be a Leader in Health

In order to affect change the Canterbury DHB needs to provide leadership to its community and develop a stable infrastructure to support the improvements it plans to make. The DHB will continue supporting expertise in health, encouraging innovation and promoting quality health care service delivery.

One of the challenges in making improvements in the health status of our community is influencing people and organisations to listen and learn from one another. The Canterbury DHB will work on encouraging debate and sharing information with our community to foster creative solutions to cope with future demand and improve the health of our community.

What	Enhance Clinical Governance process and systems.
Who	Chief Medical Officer
How	▪ Review the financial and clinical implications of new technology and new therapies or high cost treatments and support the work of the Clinical Review Committee in reviewing the evidence for cost effective clinical improvements. ▪ Work towards the development of frameworks for use of new technology and therapies and benchmarks for treatment-related costs. ▪ Extend the role of the Canterbury DHB's Health Technology Assessment Committee to cover all Canterbury DHB services and to become a procedural requirement.
When	Ongoing throughout 2006/2007.

What	Encourage innovation, development and research.
Who	General Manager, Planning and Funding Chief Medical Officer

[12] Refer to DHBNZ Healthy Workplace Stocktake 2005 report & Summary of Responses

	Executive Director of Nursing
How	▪ Review the Canterbury DHB's Strategic Investment Funding to ensure allocation of investment funding to advance projects around integration and innovative change to improve access to health services. ▪ Continue to hold the Canterbury DHB Quality and Innovation Awards Annually and to review and develop the awards programme.
When	Regular updates to the Executive Management Team - Quarterly.

What	Increase the level of community action amongst health sector and intersectoral partners to improve the knowledge and skills base to implement a population health approach.
Who	General Manager Community and Public Health
How	▪ Provide health promotion and public health training for the sectors influencing health and community groups, and organisations to ensure they have the capacity to enable them to develop community based public health action. ▪ Influence public health action in other sectors through intersectoral engagement, provision of public health advice and advocacy.
When	Ongoing throughout 2006/2007

Quality and Safety

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

We have a DHB-wide Quality and Patient Safety Council which takes a coordinated approach to considering quality and patient safety. The Council is supported by the Canterbury DHB Quality and Risk Team and its primary goal is to provide leadership in improving quality and patient safety in the health services covered by the Canterbury DHB.

The Quality Strategic Plan is the Council's key document providing a framework that promotes leadership as the underlying driver of quality improvement and quality improvement as a continuum. Developed within the context of the MoH document Improving Quality (IQ): *A Systems Approach for the NZ Health and Disability Sector*; the Plan presents ten initiatives grouped into five goal areas. These areas are: community participation/community involvement, initiating organisational change and development, clinical risk management, instituting mechanisms for effective reporting and accountability and knowledge management for clinical services and quality.

The Council monitors the implementation and progress towards the quality initiatives and promotes quality improvement. There have been a number of key successes over the past year including:

- The development and promotion of key quality and patient safety policies including the Culture of Patient Safety and No-Blame Incident/Accident Reporting policies;
- Significant success in Quality and Innovation Awards Programmes, winning State Services Sector award in the 2005 BearingPoint Innovation Awards, two finalists in the Champion Canterbury Awards 2005, 2005 Individual Award Winner and 2005 Organisations Highly Commended Award in the 2005 New Zealand Health Innovation Awards, finalist in the Quality Health New Zealand/Baxter Quality Improvement Awards 2005 and a highly commended for Excellence in the Use of Information Technology at the Computerworld Excellence Awards 2005;
- The continued development of the Canterbury DHB's own Quality and Innovation Awards Programme, promoting a systematic approach to project work throughout the organisation by encouraging people to write up projects and by running Applicant Information Sessions. By encouraging our staff to record their quality improvements and innovations we have also fostered the sharing of information both internally and externally. Roadshows have also been run to facilitate the sharing and learning gained from the applicants project activities;
- The CDHB Restraint Approval Monitoring Group (now into its second year) developed and implemented a common restraint register within the HSS and developed HSS procedures for the use of bedrails. A new Restraint Clinical File Audit tool was introduced and implemented. A self-learning package for use of physical restraints was developed for staff; and

- A Root Cause Analysis training programme was hosted by DHB, with very positive feedback. This was an initiation of the National Quality and Risk Managers group with training delivered through the NSW Clinical Excellence Commission.

What	Continue to implement the Canterbury DHB's Quality Strategic Plan – reviewing and realigning the Quality Strategic Plan with the DSP for 2006-2010.
Who	Executive Director of Nursing Chief Medical Officer Quality Manager, Corporate Quality and Safety
How	▪ The new Quality Strategic Plan and Quality and Patient Safety Council's workplan is implemented with cohesive quality and risk management structures in place across the DHB. ▪ Continue to develop quality and patient safety policies. ▪ Hold the Canterbury DHB Quality and Innovation Awards Annually and continue to review and develop the awards programme. ▪ Progressing the work on developing a set of quality indicators and implementing regular reporting to the Board. ▪ Select and implement a new incident management software system for the HSS with a view to offering this system to our community based providers in the future.
When	Develop an open disclosure policy and education programme for staff in the HSS. Pilot a new component to the current Quality and Innovation Awards programme. Consider the needs of the HSS and gauge Community Based Providers interest in a new incident management software system and: – Initiate, oversee and evaluate tender process; – Select software option that best suits our requirements; and – Implementation of new software across the HSS.

Consultation and Community Participation

A number of initiatives may warrant formal consultation, such as reconfiguration of services. The Canterbury DHB will identify consultation needs in each instance and meet its obligations in this regard. The NZPHD Act specifies consultation in relation to the following matters:

- The District Strategic Plan;
- Changes to the Annual Plan; and
- The disposal of land.

The Canterbury DHB works closely with Māori and Pacific communities, meets regularly with Manawhenua ki Whaitaha and pacific community groups and holds regular consultation hui to ensure input into the development of strategies and initiatives to improve health care access and delivery. In addition the Canterbury DHB works closely with the ACC on areas such as the development of the Orthopaedics Initiative and the development of an Occupational Health Service and the feedback from this work also feeds into the District Annual Plan.

One of the Canterbury DHB's key objectives is to continue facilitating increased community participation in the assessment, planning and funding of health and disability services in Canterbury.

Regional and National Health Emergency Planning

In the past year the Canterbury DHB has successfully taken part in a number emergency exercises, placing particular emphasis on the involvement and preparation of community health providers. A number of PHOs and community health providers being involved in exercises during 2005.

The Canterbury DHB continues to participate in the South Island Regional Health Emergency Plan in conjunction with the Ministry of Health, St John Ambulance and the other South Island DHBs. This Plan covers a multi-DHB response to any emergency. The Canterbury DHB also maintains its own major incident and emergency plans identifying how essential health services will continue to be delivered in the event of a national health-related emergency.

In response to National Pandemic Planning the Canterbury DHB has taken part in a cooperative planning process involving:

- Public Health
- Primary Care
- Hospital Services
- Rural Health Services
- Community Nursing Services
- Civil Defence Emergency Services
- Information Services
- Local Territorial Authorities and other relevant agencies.

The Canterbury DHB Influenza Pandemic Plan is under development (as at 1 March 2006) and includes cooperation and input from the above organisation. When complete the Plan will be based on a commitment by the participants that they can achieve the aims and objectives at a practical level.

4.2 Funding Health and Disability Services

4.2.1 Service Coverage

Within available resources, the Canterbury DHB will:

- Facilitate timely and equitable access to appropriate health services, in accordance with Crown Funding Agreement requirements
- Undertake service development to ensure that the health service outcomes, as outlined in the NZ Health Strategy and the NZ Disability Strategy, are taken into consideration
- Fund in 2006/2007 a range of services similar to those funded in 2005/2006.
- Ensure, where appropriate, that the Nationwide Service Framework is applied when entering into service agreements, including utilising nationally consistent service specifications and/or prices.
- Ensure that the service coverage requirements of the Operational Performance Framework and Service Coverage Schedule requirement are met (refer to Attachment E for Exceptions).
- Ensure that ring-fenced mental health funding is spent funding mental health services (including alcohol and other drug services).

The Canterbury DHB is working to foster the development of Māori capacity for meeting the health needs of Māori. As with other DHBs, Canterbury provides Māori health and disability services via a mixture of explicit Māori health funding and funding allocated to mainstream services. A process is underway to revise indicators of performance as part of the revision of the DHB's Māori Health Plan.

The Canterbury DHB is working within national and regional arrangements relating to the funding impact of Inter-District Flows (IDFs).

4.2.2 Service Delivery

Volume Schedules for services to be provided in 2006/2007 are detailed in Attachment D.

4.2.3 Service Monitoring and Evaluation

Financial management of the Canterbury DHB is organised into three sections:

- Overall Canterbury DHB financial management (including subsidiaries);
- Funding; and
- In-house provider.

The purpose of the above separation is to provide transparency between the financial performance of the two key functions of the Canterbury DHB (the funding and the in-house provider) while keeping an overall view of the whole organisation and related subsidiaries. Separate financial and activity reports are prepared for each of the above three sections monthly, to facilitate monitoring at management level as well as to the Board's Finance Audit and Risk Committee (FARC).

A comprehensive Risk Register has been developed to identify the financial and non-financial risks for both the Canterbury DHB in-house provider and externally funded providers. The Canterbury DHB continues to enhance systems to manage both financial and non-financial service risks.

The Canterbury DHB will actively monitor and assess the quality of services provided by both the Canterbury DHB in-house provider (HSS) and the externally funded providers; via service agreements. Monitoring includes appropriate procedures for reporting adverse incidents as well as routine reporting against standards (such as Health and Disability Safety Standards 2001) and processes. In addition, the Canterbury DHB monitors provider service quality through a programme of routine quality audits, service reviews and issues-based audits.

Activity in HSS Mental Health Division will continue to have a focus on quality of service delivery including specific interventions for service users such as: regular review of treatment and support processes (including risk management plans), individual crisis plans for long term patients, relapse prevention plans and consumer outcomes.

The Canterbury DHB's ethnicity data collection methods are the subject of work particularly at Christchurch Hospital, The Princess Margaret Hospital and with PHOs, and relates to the policy and implementation work noted earlier in this and previous DAPs.

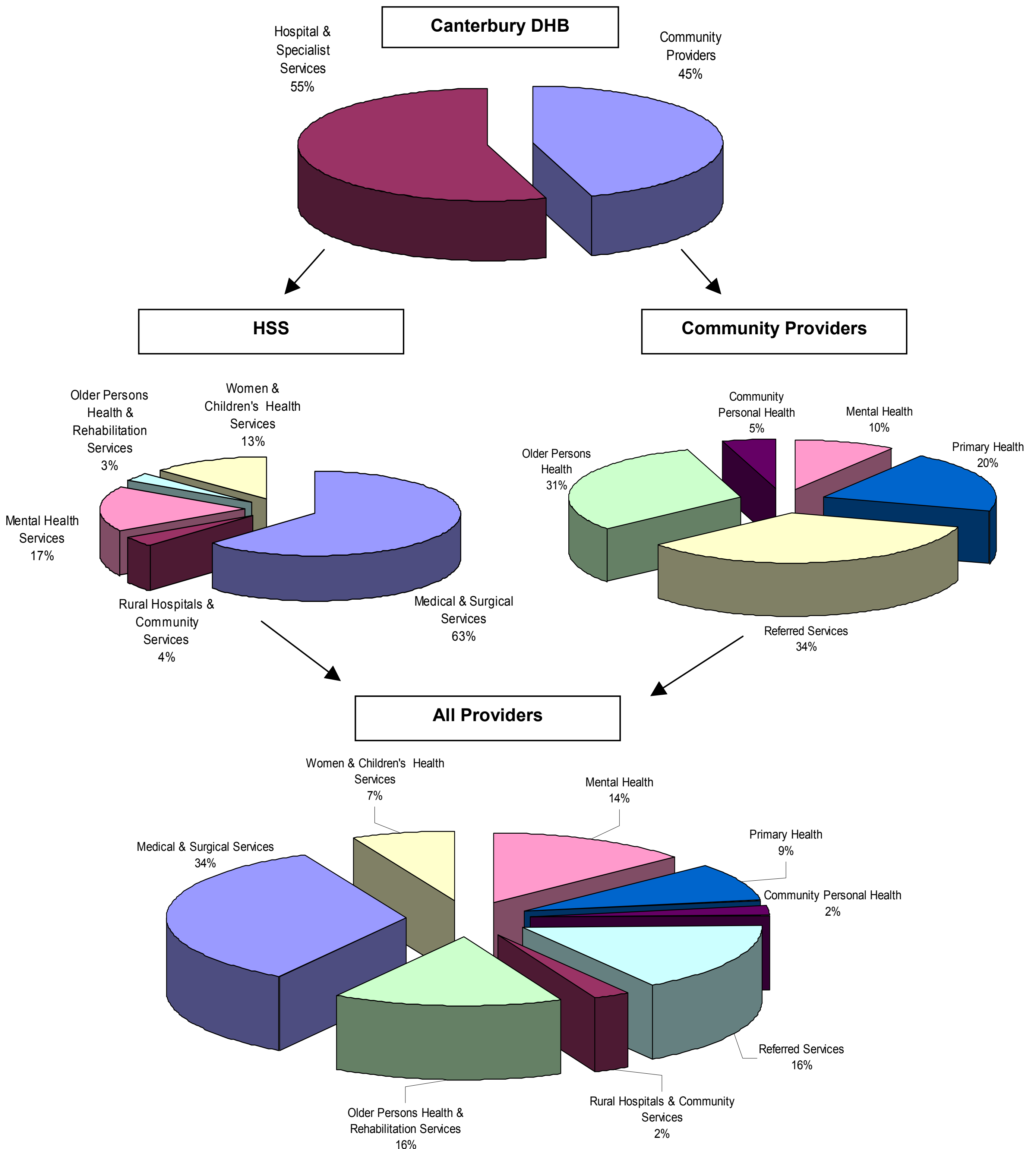
Collaboration with the SISSAL, and Health Payments Agreements and Compliance (HealthPAC) in collecting, summarising and analysing contract information is vital to the ongoing success of the Canterbury DHB in providing relevant information for decision making.

Service monitoring is in line with individual contractual arrangements, and new requirements contained in the Crown Funding Agreement, Service Coverage Document and Operational Policy Framework, will be worked into new service agreements over time.

As in 2005/2006 a Service Level Agreement will be put in place between the Canterbury DHB's Planning and Funding (P&F) and HSS divisions to monitor internal performance of DHB funded service agreements. The performance of the HSS is the subject of a monthly report by P&F to the Hospital Advisory Committee (HAC).

4.2.4 Current Funding Allocations

Together with contracting processes including the use of Request for Proposal processes the Canterbury DHB works hard to treat provider arm and NGO providers equitably. The following diagram indicates how current funding is allocated by the Canterbury DHB:


Canterbury DHB
Hospital & Specialist Services 55%
Community Providers 45%
HSS
Community Providers
Older Persons Health & Rehabilitation Services 3%
Women & Children's Health Services 13%
Mental Health Services 17%
Rural Hospitals & Community Services 4%
Medical & Surgical Services 63%
Community Personal Health 5%
Mental Health 10%
Primary Health 20%
Older Persons Health 31%
Referred Services 34%
All Providers
Women & Children's Health Services 7%
Mental Health 14%
Primary Health 9%
Medical & Surgical Services 34%
Community Personal Health 2%
Referred Services 16%
Rural Hospitals & Community Services 2%
Older Persons Health & Rehabilitation Services 16%

4.2.5 Additional Funding Responsibilities

The major funding changes expected in 2006/2007 will be limited to an additional $1.6m in new Blueprint funding for Mental Health Services. The MoH has not identified any other additional funding for the Canterbury DHB for health services in 2006/2007.

4.2.6 Future Funding Pressures

The factors driving funding pressures faced by the Canterbury DHB are similar to those faced by other DHBs, namely reflecting the pressure to increase both volumes and prices paid to providers. However with the Canterbury DHB's current funding being estimated at above its 'equitable' funding share, the Canterbury DHB will receive a lower than average DHB sector funding increase from which these pressures must be managed. With lower than average funding increases the Canterbury DHB will face significantly greater funding pressures than those experienced by some other DHBs.

With PBF, benchmark pricing is used in the funding of providers. The Canterbury DHB's current over-target funding is considered to be primarily reflective of higher volume delivery rather than over pricing.

During the transition to PBF equity the Canterbury DHB as a funder of health services will need to continue to:

- Constrain growth in prices to less than the levels indicated by the MoH Consumer Price Index (CPI) adjustments; and
- Re-allocate volumes between discretionary and non-discretionary services to meet demand driven growth, while providing incentives to providers to minimise and manage growth in demand.

As a provider of health services the Canterbury DHB will need to continue to:

- Constrain the growth in the cost of service delivery to enable the provider to deliver the desired mix of services within the available funding; and
- Manage growth in demand for acute hospital services via the ongoing development of the interfaces with primary care and other providers. This will include the ongoing management of the introduction of new treatment regimes and technologies.

The DHB works as part of national forums such as the national pricing programme and on the aged residential care agreement to find better ways of dealing with funding issues.

Summary of HSS Issues

The Canterbury DHBs HSS has a number of specific funding and pricing issues:

- Clinical Training Agency prices do not cover the total cost of training and prices do not take into account nor keep pace with the National staff collective awards increases.
- Brain Injury Rehabilitation Pricing - the DHB's concerns have been raised with the MoH and we are currently preparing to escalate the matter. This largely relates to patients under 65 years of age and therefore is an issue for the HSS and the MoH.
- New Cancer Drug - Impact of new cancer drug has not been included in 2006/2007 IDF charging/washup. This issue will be discussed with the other DHBs.
- MoH support for initiatives such as Late Effects Programme - funding for three years and then exiting. Clinicians and MoH expect DHB to then pick up the funding. The Canterbury DHB will not have the funds nor would it rate this in top five priorities.
- Intellectual Disability/Mental Health - significant issues with DSS MoH re inappropriate placements in Mental Health Services and also inadequate response regarding appropriate placement of Intellectually Disabled patients in community settings.

4.2.7 Service Reconfigurations 2006/2007

As discussed throughout this document, while we continue to receive increases in funding, the level of those increases will be less than the sector average until our funding is seen to be in line with our population share (transition to equity). The increases we receive are considered to be insufficient to meet projected inflationary pressures and the increasing costs of demand driven services and hence productivity gains have been key in ensuring financial breakeven. Preferences for sources of savings (in descending order) are through:

- Efficiency gains (delivering the same service in more efficient ways);
- Service re-configuration (delivering the same outcomes through the delivery of services in different ways); and
- Service level reductions in access or rate of service delivery.

Service reconfigurations anticipated in 2006/2007 are:

- Implementation of ministerial or national reviews, initiatives or reconfigurations to ensure consistency in systems and process, equity of access and improved health outcomes such as:
  - Review of School Dental Clinics and Dental Services Model of Care;
  - Implementation of Cataract and Orthopaedic Initiatives;
  - Implementation of the NZ Cancer Control Strategy;
  - Continued implementation of the Government's Primary Health Care Strategy; and
  - Ongoing review and allocation of Mental Health Blueprint Funding.
- Implementation of Canterbury DHB reviews, initiatives or re-configurations to address fitness of the organisation, ensure efficiency, best practise, quality and safety, improved health outcomes and sustainability of service delivery. In addition to those already reflected in the document, these would include:
  - Review the interface between General Practice and the Hospital Emergency Department to ensure patients are managed in the most appropriate setting. This would include review of the current Acute Management Project;
  - Continued implementation of the Improve the Patient Journey project to review patient processes, reduce unnecessary waits and delays and to improve patient flows;
  - Implementation of the Healthy Ageing Integrated Support Strategy;
  - Implement the recommendations of the Child and Adolescent Family Mental Health Services Review;
  - Implement the recommendations of the Review of the Model of Care in Adult General Mental Health Services;
  - Implementation of the Review of Health Services in Ashburton (Ashburton Model of Care Project);
  - Progression of the Primary Health Care Strategy;
  - Completion and implementation of the Community Laboratory Review, including changes to funding mechanisms and demand management;
  - Completion and implementation of the Palliative Care Review;
  - Reconfiguration of service delivery models to match the best location for the provision of treatment and care with a full health service review which will information the completion of a facilities master plan; and
  - Review of support services processes to align to best practices eg: warehousing, distribution and purchasing processes.
- Consideration of service reconfigurations or service level reductions to achieve a breakeven position beyond 2008/2009:
  - Work with other DHBs to reduce the costs to our organisation on a national and regional level
  - Consider the provision of services to allow hospitals to focus only on emergency and serious illness
  - Consider models of care where services are (or could be) provided in the community
  - Consider the clinical and financial sustainability of some rural and metropolitan services
  - Review staff skill mix in obstetric services and consider alternative models of care
  - Consider reductions in non-essential services to levels in line with other DHBs and manage these costs
  - Identify those services that are least cost effective and consider alternative models of care.
  - Establish service benchmarks with other DHBs to identify services not funded by other DHBs.

Some reviews will be implemented in 2006/2007, while others will be in preparation for changes and developments in the 2007/2008-year and beyond. Further detail with regard to operational efficiency and productivity initiatives is provided in the Canterbury DHB's DSP.

Service reconfigurations will involve consultation with hospital or community based service providers, to determine appropriate solutions that best meet the needs of the Canterbury DHB's community. These solutions will then be actioned to meet the Canterbury DHB's adjusted funding levels. Where service reconfigurations are in the area of Mental Health the ringfence requirements will be maintained and reconfiguration processes will comply with Section 5 of the Operational Policy Framework.

5 MANAGING FINANCIAL RESOURCES

5.1 Managing Within Operating Budget

Canterbury DHB will receive a net funding increase of approximately 2.9% for 2006/2007 from the government. The funding increase has an efficiency factor built in. This means that, all things being equal, DHBs are required to be more efficient so as to operate within the funding received.

Canterbury DHB faces significant financial pressures each year and the coming years present additional pressures as the flow-on implication of the nurses pay settlement on other Canterbury DHB's occupational groups and community providers are expected. The significant increase in cost of cancer drugs, regulatory and legislative compliance costs, rising emergency department attendances together with ongoing service demands both in the community and hospital settings are financial risks facing the DHB.

The Canterbury DHB is budgeting for a deficit of $2.5M in 2006/2007 as a result of additional funding for the out-years financial impact of PSA MECA being paid 'in advance' to the DHB in 2005/2006. The Canterbury DHB will need to recognise this 'advance' funding in its 2005/2006 accounts, while the cost will only be incurred or recognised in out-years accounts. Hence the DHB will be expecting to report a 'surplus' for 2005/2006 equivalent to this 'advance' funding and accordingly will be budgeting for a deficit for 2006/2007 of a similar amount – the impact being $2.5M. Once this mis-matching between revenue and expenditure is taken into account the Canterbury DHB is in effect budgeting for a 'breakeven' position - an objective expected by the Minister of Health.

Break-even has been achieved through partial funding of the financial impact of legislative changes eg holiday's Act and FRS3, but some risk remain in 2006/2007. The Canterbury DHB will seek to engage in discussions with the MoH to ensure any further directives or guidelines issued can be implemented in a fiscally sustainable manner. The budget is also dependent on the achievement of additional efficiencies, the need to undertake a number of infrastructure and service reconfigurations to align services to the funding and realisation of 'gain on sale' from the approved disposal of surplus assets.

The following sets out the summary budget estimations for 2006/2007:

Table 1.

	$M (GST excl)
Overall Net Increase in Funding/Revenue (include non-Base)	42.8
Less:	
Increase in Expenditure (external and CDHB Provider service)	(49.9)
Incremental Interest, Depreciation and Capital Charge	(10.2)
Estimated 2006/07 Operating Shortfall	**(17.3)**
Estimated Annual Efficiencies/Revenue Enhancement	14.8
Budget Net Result After Efficiencies - Surplus/(Deficit)	**(2.5)**

5.1.1 Outyears Scenario

As an overfunded DHB it is expected that the increase in funding Canterbury DHB will receive over the next few years will be minimal. The MoH has signalled that the expected funding increase for

Canterbury DHB for outyears will be 2.9% for 2007/2008 and 2.1% for 2008/2009. The gap between funding increase and expected 'normal' expenditure growth to maintain existing services is significant.

In the past two years Canterbury DHB had relied on 'gain on sale' from approved surplus assets to address some of the financial operating gap and this will continue for 2006/2007 and 2007/2008. Whilst the DHB's first approach will be to continue to seek to re-configure services and change how services are delivered these are unlikely to yield a level of efficiencies to eradicate the operating gap. Hence the DHB may need to reduce services to enable a breakeven position in 2008/2009 as outlined in Table 2.

Table 2. Outyears Financial Scenario with service reductions to meet funding shortfall

	2006/07 $M	2007/08 $M	2008/09 $M
Estimated Net Annual Funding/Revenue Increase	42.8	27.5	19.0
Less: Estimated Net Annual Cost Increase	(60.1)	(37.0)	(36.5)
Estimated Annual Operating Shortfall	**(17.3)**	**(9.5)**	**(17.5)**
Estimated Annual Efficiencies	14.8	9.5	10.1
Estimated Annual Value of Incremental Service Reductions	-	-	7.4
Annual Budget Financial Results after Service Reductions	**(2.5)**	-	-

Notes: Table 2 includes forecast financial impact of asset revaluation and the partial funding for increased capital charge and depreciation arising from the asset revaluation. The "Estimated Annual Projected Costs" take into account service reductions are likely to occur in a 'phased' manner.

A full health service review is to be undertaken, with a view to completing our facilities master plan. There will be a need for further consultation with our community as DAPs are reshaped to make efficiency gains and where appropriate service reductions.

The Canterbury DHB has also developed a draft Asset Management Plan (AMP)[13] which outlines its capital intentions over the next ten years. Financial implications of the AMP, if any, have been included in the financial statements of the Canterbury DHB's DSP. This includes the need to consider options for the replacement of the Riverside Block of Christchurch Hospital in the latter years of this Strategic Plan period.

5.1.2 Key Financial Assumptions and Risks

The key assumptions to achieve the breakeven budget for 2006/2007 include the following:

- Baseline funding as per Minister of Health's funding advice;
- Net Inter-District flow volumes and revenue will be fully realised;
- Financial impact associated with the changes to legislative, regulatory and compliance policy changes is cost neutral to the DHB;
- Financial impact associated with changes to DSS boundaries and any further contracts/services being devolved by MoH is cost neutral to the DHB;
- Collective employment agreements are settled on average at the funds available after step and committed wage increases have been deducted from the 2006/2007 inflation funding received. Additional costs to move to national rates per government directive, if any, will be cost neutral to the DHB;
- No significant change to previous year's service contract volumes, except where additional funding has been provided to the DHB (e.g. Mental Health ring-fence funding and/or Orthopaedic Initiative);

[13] The Canterbury DHB's draft Asset Management Plan will be updated in October 2006 in accordance with MoH regulations.

- Pharmac budget for community referred spending is as per agreed by DHBs and forecast savings on stat dispensing and other initiatives are achieved;
- Interest rates are within Treasury's forecast;
- Average increase in non-employee expenditure is within CPI recognising efficiencies that will be required in this area, including blood products;
- Spending of national haemophilia pool will be similar to amounts as advised to the DHBs;
- Growth in acute medical and acute mental health volumes will be minimal;
- Costs associated with pandemic planning, including additional stock and/or obsolescence and capital charge will be fully funded by the Crown;
- Efficiency initiatives, and service reconfigurations are achieved as planned;
- Projected proceeds from approved sale of surplus assets are realised as planned;
- Capital charge will not apply to assets donated after 1 July 2005 and will remain at 8%; and
- The reduction in funding transitional funding pool is equivalent to demographic funding increases.

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

5.1.3 Property Valuations

In June 2003, the Canterbury DHB's properties were revalued as part of the Financial Reporting Standards Number 3 (FRS3) requirements. The revaluation resulted in a write-up of asset value of approximately $77M.

We have assumed that Canterbury DHB will undertake a revaluation of its property related assets as at 30 June 2006 and an estimated financial impact has been incorporated in the forecast financial statements. We have also assumed that the additional capital charge and depreciation arising from this revaluation exercise will only be partially funded in accordance with the methodology as advised to DHBs by the Ministry of Health. The partial funding methodology is likely to result in the need for additional efficiencies by the DHB to meet its financial target.

5.1.4 Business Cases

With the need to operate within the available funding, service reconfigurations and facility realignments are likely to take place and service reductions may need to be included to ensure breakeven in the outyears. The Minister of Health's approval will be obtained in accordance with the government's guidelines.

Business cases relating to information technology and other significant capital projects will include Regional Capital Committee, Ministry of Health and National Capital Committee review and endorsement, where appropriate. Business cases that will be presented in 2006/2007 include the replacement of the outdated legacy rostering, payroll, and human resources information system (HRIS) and some of the initiatives outlined in Section 4.2.7.

5.1.5 Capital Expenditure

The estimated capital expenditure budget for 2006/2007 is $36M and consists of:

- $11M for balance of Burwood Hospital Stage II Redevelopment.
  This capital project was approved by the Minister early in 2005 and commenced in mid 2005.
- $25M for normal asset replacement and priority new equipment.
  Details for the $25M will be established following an internal prioritisation process involving clinicians and management. This process is expected to be completed in late June 2006. Some of the key items are outlined in the draft AMP.

Estimated funding for the capital expenditure will be:

- $9M additional credit facility for the Burwood Hospital Stage II Redevelopment
- $27M from operating cashflow

Detailed requirements of recent Building Act changes are yet to be finalised by Territorial Local Authorities and these may alter the priority and scope of future projects. Current 2008/2009 estimates include building replacement as part of that legislative compliance and the estimated capital expenditure for 2008/2009 is $85.5m. Several projects will require internal resourcing and prioritisation as well as regional and national prioritisation. Funding for these significant projects will be discussed with the Ministry of Health when the full implications of legislative requirements are known.

The proposed disposal of significant surplus assets over the next three years includes the Canterbury DHB owned sites at Hanmer Springs, Hillmorton Hospital and the old Christchurch Women's Hospital. Both the Board and the Minister of Health's approval has been received for the Hanmer and Hillmorton site disposals and a business case will be put forward for the proposed disposal of the Christchurch Women's Hospital site as part of the due process. The financial assumptions include the estimated proceeds from surplus asset sale/s expected in 2006/2007 and outyears.

5.1.6 Debt and Equity

The Canterbury DHB's estimated total term debt is expected to remain at $79M as at June 2006 and increase to $105M by June 2009. It is assumed that the available cashflow from depreciation funding will be applied to fund capital expenditure, thus deferring the need to increase loans until the major property rebuilding projects in 2008/2009 and out years.

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

The Canterbury DHB is complying with the banking covenants required of its loans. The key covenants together with forecast ratios for 2006/2007 based on the forecast financial statements are:

Required		**Forecast Ratio**
Interest cover ratio:	**>2.75 times**	**Approx 7.2 times**
Debt/Debt plus Equity ratio:	**<50%**	**Approx 27.2%**

5.1.7 Efficiencies and Service Reconfigurations

In budgeting for break-even results, Canterbury DHB will be planning to implement and achieve a number of efficiencies and/or service reconfigurations to close the operating gap. These have been outlined earlier in this plan. Examples of the initiatives to be undertaken include:

- Ongoing HSS non-clinical support services reviews and consolidations;
- Implementation of 'Improving the Patient Journey' and 'Patient Flow' projects;
- Hospital and community laboratory services review;
- Review and alignment of hospital sites to service needs;
- Clinical and non-clinical consumables usage review;
- Review of processes by which new treatment regimes could be introduced;
- A full health services review and completion of facilities masterplan matching best location for the provision of treatment and care; and
- Collaborative arrangement with external providers on elective services.

In addition, gain on sale from the disposal of surplus assets, as approved by the Minister of Health, is an integral part of the efficiency target. Some of the initiatives are longer term and are only expected to generate major savings in future years. Early planning is essential to ensure the implications of the reduction in transitional funding in outyears are adequately addressed.

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

5.1.8 Accounting Policies

The accounting policies adopted are consistent with those in the prior year. A full statement of accounting policies is contained in the Canterbury DHB's 2006/2009 Statement of Intent.

5.2 Forecast Financial Statements - Years Ending 30 June 2006/07 to 2008/09

5.2.1 Forecast Group Statement Financial Performance

	2004/05 Actual $'000	2005/06 Forecast $'000	2006/07 Forecast $'000	2007/08 Forecast $'000	2008/09 Forecast $'000
Operating Revenue					
MoH Revenue	900,187	960,049	994,542	1,024,171	1,046,124
Patient Related Revenue	27,851	28,445	29,298	29,884	32,036
Other Revenue	14,475	18,295	25,754	23,003	17,857
Total Operating Revenue	942,513	1,006,789	1,049,595	1,077,058	1,096,017
Operating Expenditure					
Employee Costs	369,683	388,217	417,600	433,660	446,273
Treatment Related Costs	98,947	104,216	101,748	101,740	102,757
External Providers & IDF	352,053	400,596	410,229	420,726	423,710
Strategic Investment Fund	1,000	1,000	1,000	-	-
Non Treatment Related & Other Costs	54,905	51,411	52,477	51,522	51,517
Total Operating Expenditure	876,588	945,440	983,054	1,007,648	1,024,257
Result before Interest, Depn & Cap Charge	65,925	61,349	66,540	69,410	71,760
Interest, Depreciation & Capital Charge					
Interest Expense	(4,183)	(5,653)	(6,696)	(7,446)	(8,196)
Capital Charge Expenditure	(21,862)	(15,348)	(18,072)	(16,892)	(16,892)
Depreciation	(39,519)	(37,848)	(44,272)	(45,072)	(46,672)
Total Interest, Depreciation & Capital Charge	(65,564)	(58,849)	(69,040)	(69,410)	(71,760)
Net Operating Results	**361**	**2,500**	**(2,500)**	**(0)**	**(0)**

5.2.2 Summary of Revenue and Expenses by Output Class

Funding Arm

	2004/05 $'000	2005/06 $'000	2006/07 $'000	2007/08 $'000	2008/09 $'000
Revenue					
MoH revenue	869,927	926,517	954,565	982,248	1,002,875
Total Revenue	869,927	926,517	954,565	982,248	1,002,875
Expenditure					
Other - Personal Health	627,125	658,612	679,711	699,424	714,112
Other - Mental Health	102,896	108,219	110,452	113,655	116,042
Other - Disability Support	135,272	154,170	160,538	165,193	168,661
Other - Public Health	341	1,778	-	-	-
Other - Maori Health	883	406	432	444	454
Other - Governance & Admin	3,291	3,332	3,432	3,532	3,606
Total Expenditure	869,808	926,517	954,565	982,248	1,002,875
Net Surplus/(Deficit)	**119**	-	-	-	-

Governance & Funder Admin

	2004/05 $'000	2005/06 $'000	2006/07 $'000	2007/08 $'000	2008/09 $'000
Revenue					
MoH revenue	3,291	3,332	3,432	3,532	3,606
Total Revenue	3,291	3,332	3,432	3,532	3,606
Expenditure					
Personnel	2,085	2,369	2,436	2,507	2,560
Depreciation	16	18	24	24	24
Interest & Capital charge					
Other	875	945	972	1,001	1,022
Total Expenditure	2,976	3,332	3,432	3,532	3,606
Net Surplus/(Deficit)	**315**	-	-	-	-

Provider Arm

	2004/05 $'000	2005/06 $'000	2006/07 $'000	2007/08 $'000	2008/09 $'000
Revenue					
MoH revenue	543,724	555,121	579,881	599,913	618,808
Patient Related Revenue	27,851	28,445	29,298	29,884	32,036
Other	14,475	18,295	25,755	23,003	17,857
Total Revenue	586,050	601,861	634,934	652,800	668,701
Expenditure					
Personnel	367,598	385,848	415,164	431,153	443,713
Depreciation	39,503	37,830	44,248	45,048	46,648
Interest & Capital charge	26,045	21,001	24,768	24,338	25,088
Other	152,977	154,682	153,254	152,261	153,252
Total Expenditure	586,123	599,361	637,434	652,800	668,701
Net Surplus/(Deficit)	**(73)**	**2,500**	**(2,500)**	-	-

In House Elimination

	2004/05 $'000	2005/06 $'000	2006/07 $'000	2007/08 $'000	2008/09 $'000
Revenue					
MoH revenue	(516,755)	(524,921)	(543,336)	(561,522)	(579,165)
Total Revenue	(516,755)	(524,921)	(543,336)	(561,522)	(579,165)
Expenditure					
Other	(516,755)	(524,921)	(543,336)	(561,522)	(579,165)
Total Expenditure	(516,755)	(524,921)	(543,336)	(561,522)	(579,165)
Net Surplus/(Deficit)	-	-	-	-	-

Consolidated

	2004/05 $'000	2005/06 $'000	2006/07 $'000	2007/08 $'000	2008/09 $'000
Revenue					
MoH revenue	900,187	960,049	994,542	1,024,171	1,046,124
Patient Related Revenue	27,851	28,445	29,298	29,884	32,036
Other	14,475	18,295	25,755	23,003	17,857
Total Revenue	942,513	1,006,789	1,049,595	1,077,058	1,096,017
Expenditure					
Personnel	369,683	388,217	417,600	433,660	446,273
Depreciation	39,519	37,848	44,272	45,072	46,672
Interest & Capital charge	26,045	21,001	24,768	24,338	25,088
Other	506,905	557,223	565,455	573,988	577,984
Total Expenditure	942,152	1,004,289	1,052,095	1,077,058	1,096,017
Net Surplus/(Deficit)	**361**	**2,500**	**(2,500)**	-	-

5.2.3 Forecast Group Statement Financial Position

	30/06/05 Actual *$'000*	30/06/06 Forecast *$'000*	30/06/07 Forecast *$'000*	30/06/08 Forecast *$'000*	30/06/09 Forecast *$'000*
Public Equity					
Opening Equity	199,344	251,705	243,205	226,205	211,705
Equity Repayment		(11,000)	(14,500)	(14,500)	
Net Result for the period	361	2,500	(2,500)	(0)	(0)
Total Public Equity	**199,705**	**243,205**	**226,205**	**211,705**	**211,705**
Current Assets					
Cash & Bank (OD)	10,109	(269)	3	(715)	(43)
MoH Debtor	8,522	8,522	8,522	8,522	8,522
Other Debtors & Other Receivables	7,312	8,000	8,000	8,000	8,000
Prepayments	507	600	600	600	600
Stocks	6,594	7,000	7,000	7,000	7,000
Total Current Assets	33,044	23,853	24,125	23,407	24,079
Current Liabilities					
Creditors & Accruals	71,653	74,509	69,509	59,509	66,509
Capital charge payable	7,371	4,500	4,500	4,500	4,500
GST	2,632	3,000	3,000	3,000	3,000
Interest Accrual	369	400	400	400	400
Staff Entitlement	66,929	67,914	67,914	59,624	59,624
Short Term Borrowings					
Total Current Liabilities	148,954	150,323	145,323	127,033	134,033
Working Capital	(115,910)	(126,470)	(121,198)	(103,626)	(109,954)
Investments	311	311	311	311	311
Restricted Assets - Trust Fund	8,405	8,405	8,405	8,405	8,405
Fixed Assets	391,767	446,609	430,337	408,265	424,593
Total Non Current Assets	400,483	455,325	439,053	416,981	433,309
Term Staff Entitlement	(6,218)	(7,000)	(7,000)	(7,000)	(7,000)
Term Loans	(78,650)	(78,650)	(84,650)	(94,650)	(104,650)
Total Non Current Liabilities	(84,868)	(85,650)	(91,650)	(101,650)	(111,650)
Net Assets	**199,705**	**243,205**	**226,205**	**211,705**	**211,705**

5.2.4

Movement in Public Equity

	30/06/05 Forecast *$'000*	30/06/06 Forecast *$'000*	30/06/07 Forecast *$'000*	30/06/08 Forecast *$'000*	30/06/09 Forecast *$'000*
Public Equity					
Opening Equity	199,344	199,705	243,205	226,205	211,705
Add/(Less):					
Equity Injection / (Repayment)	-	(11,000)	(14,500)	(14,500)	-
Revaluation of Property		52,000			
Net Result for the period	361	2,500	(2,500)	(0)	(0)
Total Public Equity	**199,705**	**243,205**	**226,205**	**211,705**	**211,705**

Forecast Group Statement Cashflow

	2004/05 Actual *$'000*	2005/06 Forecast *$'000*	2006/07 Forecast *$'000*	2007/08 Forecast *$'000*	2008/09 Forecast *$'000*
Cashflows from Operating Activities					
Cash provided from:					
MOH Receipts	905,739	960,049	994,542	1,024,171	1,046,124
Other Receipts	46,670	39,452	46,053	47,887	49,893
	952,409	999,501	1,040,595	1,072,058	1,096,017
Cash applied to:					
Employee Costs	354,144	386,450	417,600	441,950	446,273
Supplies & Expenses	498,730	554,866	570,455	583,988	570,984
Capital Charge Payments	20,301	18,219	18,072	16,892	16,892
Finance Costs	4,023	5,622	6,696	7,446	8,196
Taxes Paid	1,934	(368)	-	-	-
	879,132	964,789	1,012,822	1,050,276	1,042,345
Net Cashflow from Operating Activities	**73,277**	**34,712**	**27,772**	**21,782**	**53,672**
Cashflows from Investing Activities					
Cash provided from:					
Sale of Assets	70	7,110	17,000	10,000	
Interest Received	1,268	3,000	-	-	-
	1,338	10,110	17,000	10,000	-
Cash applied to:					
Advance to JV/Trust Investments	645	-	-	-	-
Purchase of Assets	47,076	44,200	36,000	28,000	63,000
	47,721	44,200	36,000	28,000	63,000
Net Cashflow from Investing Activities	**(46,383)**	**(34,090)**	**(19,000)**	**(18,000)**	**(63,000)**
Cashflows from Financing Activities					
Cash provide from:					
Equity Injection					
Loans Raised	-	-	6,000	10,000	10,000
	-	-	6,000	10,000	10,000
Cash applied to:					
Loan Repayment	15,950				
Equity Repayment re FRS-3		11,000	14,500	14,500	-
	15,950	11,000	14,500	14,500	-
Net Cashflow from Financing Activities	**(15,950)**	**(11,000)**	**(8,500)**	**(4,500)**	**10,000**
Overall Increase/(Decrease) in Cash Held	10,944	(10,378)	272	(718)	672
Add Opening Cash Balance	(835)	10,109	(269)	3	(715)
Closing Cash Balance	**10,109**	**(269)**	**3**	**(715)**	**(43)**

6 MEASURING SUCCESS

6.1 Consolidated List of Indicators of DHB Performance (IDP)

The MoH has established a set of DHB Accountability Indicators to focus DHBs on priority health objectives identified in the NZ Health Strategy, monitor activity and compare DHB performance, and to hold DHBs accountable. The Canterbury DHB is committed to performance improvement, both as a funder of services and as a provider of services. Progress toward achieving the Accountability Indicator targets will be reported as part of Canterbury DHB's quarterly performance reports.

Accountability Indicators

The accountability indicators reflect the accountability that Canterbury DHB has for securing improved health status for its population. As responsibility for funding some services is yet to be devolved to DHBs, there are indicators where the DHB's ability to influence the outcome is not through direct funding but through influencing other funders.

Due to the evolving nature of DHBs and their responsibility for funding, the actions taken by the Canterbury DHB to influence the direction of performance in relation to specified targets is of as much importance as the match between actual performance and the indicator itself.

Qualitative Accountability Indicators

Performance against the qualitative indicators will be measured on the basis of reporting deliverables rather than numeric targets. Performance will be assessed not only on provision of reports that meet the stated content requirements but also compliance with the reporting timeframes.

Quantitative Accountability Indicators

The majority of the quantitative indicators are aimed at measuring DHB performance in addressing cardiovascular disease, diabetes, oral health and well child services – four priority areas within the New Zealand Health Strategy.

For each of the quantitative indicators set out in this plan targets have been set for the 2006/2007 year. The setting of those targets has been based on:

- Expectations expressed by the MoH;
- The latest national data; and
- The latest Canterbury DHB specific data

It should be noted that for many indicators historical data is poor. Consequently there are some indicators for which a target is unable to be set at this stage. It is the intention of the Canterbury DHB to gather the required baseline data to allow for targets to be set for future plans. It is noted that the MoH will be using results outside 90% or 99% confidence intervals to trigger further analysis for a number of indicators.

Indicator results and targets have been stated for three population groupings, Māori, Pacific People and Other[14]. The overall targets for the Canterbury DHB reflect these ethnic specific results and the demographic characteristics of the Canterbury region.

The intent of this section is to recognise that Canterbury DHB understands the need to look at the health of the Canterbury DHB population although many factors affecting health care directly is outside its control.

The Canterbury DHB's Accountability Indicators for 2006/2007 follow and are in addition to:

- Existing reporting requirements under service contracts;
- Information requirements contained in the Operational Policy Framework;
- The Balanced Scorecard for the Provider Arm; and
- Monthly financial reporting to the MoH's DHB Funding and Performance Directorate.

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[14] For more information on Ethnic Groupings, refer to the MoH, Ethnicity Data Protocols for the Health and Disability Sector, 2004.

IDP No.	Description	Target/Deliverable	Reporting Period
EFFECTIVENESS			
HKO-01	Local Iwi/Māori are engaged and participate in DHB decision-making and the development of strategies and plans for Māori health gain	A quantitative report providing: 1 The number of PHOs with Māori Health Plans (MHPs) that have been agreed to by the DHB as a percentage of the total number of established PHOs. **Target:** 100% of PHOs will have MHPs 2 Total number of DHB Board members that have undertaken Treaty of Waitangi training as a percentage of the total number of DHB members A qualitative report describing: 3 Achievements against the MoU between a DHB and its local Iwi/Māori health relationship partner, including other initiatives achieved that are an outcome of engagement between the parties and a copy of the MoU. 4 How (mechanisms and frequency of engagement) local Iwi/Māori are supported by the DHB to participate in the development and implementation of the strategic agenda, service delivery planning, development, monitoring and evaluation (including a section on PHOs). *Either* 5 How MHPs are being implemented by the PHOs and monitored by the DHB (include a list of the names of the PHOs with MHPs) *Or* 6 Progress in the development of MHPs for newly established PHOs, including a list of the names of these PHOs. All newly established PHOs will have Māori Health Plans 7 When Treaty of Waitangi training (including any facilitated by the Ministry) has taken, or will take place for Board members.	Six-monthly in Q2 and Q4.
POP-12	Progress towards the national target of 95% of two year olds fully immunised	**A) DHB NIR Enrolled Populations** 1. The number of newborns born and enrolled during the reporting period as a percentage of the number of children born during the reporting period*. 2. The number of newborns born and enrolled during the reporting period of each ethnicity as a percentage of the number of children born during the reporting period of each ethnicity (Māori, Pacific, Asian, Other). 3. The number of newborns born and enrolled during the reporting period of each level of deprivation as a percentage of the number of children born during the reporting period of each deprivation quintile. 4. The number of children on the NIR less than two years of age with an 'Opt-Off' status as at the report date as a percentage of the number of children less than two years of age on the NIR as at the report date. **Target:** The DHB will report actual performance during 2006/2007 for A1-4. Targets will be established from 2006/2007 baselines. **B) Progress towards the national target of 95% of two year olds fully immunised** The DHB will identify a four to six percent improvement in overall immunisation coverage, if its current annual immunisation coverage is less than 90 percent. The DHB will report coverage quarterly using (where possible) the following two reporting periods: a) The most recent quarter b) The previous 12 months.	The indicator will be measured quarterly and annually.

		NIR Immunisation coverage at 6, 12, 18 and 24 months of age: 1. The number of children on the NIR up-to-date with immunisation on the day they turned a specified age (6, 12, 18, 24 months) during the reporting period as a percentage of the number of children on the NIR who turned a specified age (6, 12, 18, 24 months) during the reporting period. **Target:** 6&12 months 86-91% 18&24 months 85-88% 2. The number of children on the NIR of each ethnicity (Māori, Pacific, Asian, Other) up to date with immunisation on the day they turned a specified age (6, 12, 18, 24 months) during the reporting period as a percentage of the number of children on the NIR of each ethnicity who turned a specified age (6, 12, 18, 24 months) during the reporting period. **Target:** Ethnicity not currently reliably identified 3. The number of children on the NIR of each deprivation quintile up to date with immunisation on the day they turned a specified age (6, 12, 18, 24 months) during the reporting period as a percentage of the number of children on the NIR of each deprivation quintile who turned a specified age (6, 12, 18, 24 months) during the reporting period. **Target:** Ethnicity not currently reliably identified 4. The number of children on the NIR up-to-date with MMR immunisation on the day they turned 18 months during the reporting period as a percentage of the number of children on the NIR who turned 18 months during the reporting period. **Target** 85-88%% Note: This target is within the 'achieved' rating as advised within the IDPs.	
SER-02	Care Plus Enrolled Population	The number of each PHO's Care Plus enrolled population as a percentage of each PHO's expected Care Plus enrolled population. This indicator applies only to persons enrolled in PHOs, and excludes casual visits (Data Source: MoH via HealthPAC). CarePlus + High Use Health Card enrolled population is 5% **Target:** 100% of the eligible population enrolled	Quarterly. PHOs are required to report quarterly.
SER-03	Primary Health Organisations participating in the PHO Performance Management Programme	The number of PHOs participating in the PHO Performance Management Programme as a percentage of the total number of PHOs that have been operational for more than one quarter. Data Source: MoH via HealthPAC. **Target:** 100%	Six-monthly at the end of Q2 and Q4.
PAC-02	Engagement and participation of Pacific peoples in DHB decision-making and the development of strategies and plans that include goals for Pacific health gain	A qualitative report demonstrating: 1. How Pacific peoples are engaged and participate in DHB decision-making, on equity, accessibility and resource allocation, at a governance and management level in the DHB organisation. 2. The development of strategies and plans which include goals for Pacific health gain. 3. The number, purpose and outcomes of any community participation activities that have been conducted during the reporting period. The report includes, as appropriate, information about how Pacific people are engaging with decision-making about the implementation, monitoring and evaluation of service delivery and planning documents, including the following: • DSP, DAP, HNA; • District Pacific Health (DPH) and Disability Action Plan; • DPH and Disability Workforce Development Plan; and • Pacific Provider Development Fund Purchasing Strategy.	Six-monthly in Q2 and Q4.

<table>
<tr><th colspan="4">EQUITY AND ACCESS</th></tr>
<tr>
<td>HKO-02</td>
<td>Development of Māori health workforce and Māori health providers</td>
<td>A quantitative report which completes Table 1 below providing:

1. The number of (i) management, (ii) clinical, (iii) administrative and (iv) other FTEs held by Māori divided by the total numbers of (i) management, (ii) clinical, (iii) administrative and (iv) other FTEs in the DHB respectively.

Table 1.
<table>
<tr><th>FTEs</th><th>Management</th><th>Administration</th><th>Clinical</th><th>Other</th></tr>
<tr><td>Māori workforce #</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Non-Māori workforce #</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Total workforce #</td><td></td><td></td><td></td><td></td></tr>
</table>

A qualitative report which includes:
2. A copy of the DHB Māori Health Workforce Plan (or agreed regional Māori Workforce Plan), or the timeframe to complete the Plan.
Either
3. A report on achievements based on key deliverables in the DHB (or Regional) Māori Workforce Plan;
Or
4. If the Plan is being developed, a description of at least two key DHB Māori health workforce initiatives that have been achieved.

If possible, a reporting template based on the key points above will be developed.</td>
<td>Six-monthly in Q2 and Q4.</td>
</tr>
<tr>
<td>HKO-04</td>
<td>DHBs will set targets to increase funding for Māori Health and disability initiatives</td>
<td>A report which completes Table 2 below which includes:

1. Actual expenditure on Māori Health Providers by GL code.
2. Actual expenditure for Specific Māori Services provided within mainstream services targeted to improving Māori health by Purchase Unit (PU).
3. Total actual expenditure for Iwi/Māori-led PHOs.
4. Actual expenditure for mainstream PHO services targeted at improving Māori health
5. Total actual expenditure on DHB Māori Workforce or Provider Māori Workforce Development initiatives, which are not funded through the Māori Provider Development Scheme.
6. Where information is available, a comparison between expenditure for the above measures for 2005/06 (in addition to mandatory reporting against 2006/07 expenditure).

Table 2: DHB Māori Expenditure
<table>
<tr><th>Measure</th><th>GL Code</th><th>PU</th><th>2005/06 Actual</th><th>2006/07 Actual</th><th>Variance</th></tr>
<tr><td>Māori health providers</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Specific Māori services</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Iwi/Māori-led PHOs</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Mainstream PHO services</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Māori workforce or provider funding</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Total expenditure</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Projected</td><td></td><td></td><td>$8.2m</td><td>$8.6m</td><td></td></tr>
</table></td>
<td>DHBs to undertake six-monthly reports to the Ministry (not part of the monthly financial reporting template).</td>
</tr>
<tr>
<td>POP-01
POP-02
POP-03</td>
<td>Diabetes
Cardiovascular disease
Stroke</td>
<td>Outcome 1: Reduced development of contributory risk factors
Indicator: Risk reduction – Obesity
How to measure:
The number of schools using the health promoting schools framework as a percentage of the total number of schools within the DHB (as part of the Healthy Eating Healthy Action strategy).
Target: 33%

Indicator: Risk reduction - Smoking
How to measure:
The number of enrolled persons aged over 14 years with smoking status on record as a percentage of the total number of enrolled persons aged over 14 years. Data source: PHO Performance Monitoring.

Outcome 2: Increased early recognition and response to individuals with chronic conditions</td>
<td>Annually in Q3.</td>
</tr>
</table>

Indicator: CVD Risk recognition
How to measure:
The number of people in each target group who have had their five-year absolute CVD risk recorded in the last five years as a percentage of people in each respective target group.
Target groups:
1 Māori/Pacific & Indian subcontinent men >35 years of age
2 Māori/Pacific & Indian subcontinent women >45 years of age
3 European & other men >45 years of age
4 European & other women >55 years of age.
Indian subcontinent are defined as level 2 codes 43 Indian and 44 Other Asian as per the ethnicity data protocols for the H&D Sector.
Data Source: PHO monitoring framework.

Outcome 3: Slowed rate of progression, reduced incidence of avoidable complications
Indicator: Diabetes follow-up
How to measure:
The number of unique individuals with type I or type II diabetes mellitus on a diabetes register, whose date of their free annual check is during the reporting period as a percentage of the expected number of unique individuals to have type I or type II diabetes mellitus, as at the end of the reporting period (Data sources: LDT Annual Report & MoH).
Target:
Māori 80%
Pacific 120%
Other 84%
Total 84%

Indicator: CVD follow-up - Statins
How to measure:
The number of persons where CVD risk is greater than or equal to 15% where statins have been prescribed in the past year as a percentage of the total number of persons where CVD risk is greater than or equal to 15 % (Data source: DHBs via PHO Performance Monitoring).

Outcome 4: Increased co-ordination across providers, processes and community resources
Indicator: Diabetic retinopathy screening
How to measure:
The number of people with type I or type II diabetes mellitus on a diabetes register that have had retinal screening or an ophthalmologist examination in the last two years, and the date of the free annual check is during the reporting period as a percentage of the number of people with type I or type II diabetes mellitus on a diabetes register whose date of their free annual check is during the reporting period (Data source: LDT Annual Report).
Target:
Māori 45%
Pacific 38%
Other 80%
Total 75%

Indicator: Cardiac Rehabilitation Programme
How to measure:
The number of people who have suffered a CVD event who attend a cardiac rehabilitation outpatient programme as defined below as a percentage of the number of people who have suffered a CVD event who were admitted and discharged from hospital. A CVD event is defined in patients with coronary heart disease, specifically those following an acute myocardial infarction/unstable angina), coronary artery bypass surgery and angioplasty. (2002 NZGG cardiac rehabilitation guidelines) [ICD 10 – 120-125].
Target: 50%

Indicator: Organised Stroke Services
How to measure:
The number of people who have suffered a stroke event who have been admitted to organised stroke services and remain there for their entire

		hospital stay as a percentage of the number of people who have suffered a stroke event. Stroke event is defined as *'a clinical syndrome typified by rapidly developing signs of focal or global disturbance of cerebral function, lasting more than 24 hours or leading to death, with no apparent cause other than of vascular origin'*. (Stroke Guidelines Nov 2003) [ICD 10 – 161, 163, 164]. **Target:** 100% **Outcome 5: Strengthened self-management capability of individuals, family and whanau** **Indicator:** Diabetes Management **How to measure:** The number of people with type I or type II diabetes mellitus on a diabetes register that had an HBA1c equal, to or less than, 8% at their free annual check during the reporting period as a percentage of the number of people with type I or type II diabetes mellitus on a diabetes register whose date of their free annual check is during the reporting period (Data Source: LDT Annual Report – note they report HBA1c > 8%). **Target:** Māori 39% Pacific 45% Other 20% Total 23%	
POP-05	Oral health – Percentage of children caries free at age five years	The total number of caries free children at the first examination after the child has turned five years, but before their sixth birthday, examined by the DHB School Dental Service as a percentage of the total number of children who have been examined in the age five group, in the year to which the reporting relates. This will be reported by ethnic group (Māori, Pacific, Other) and by fluoridation status of the school area the child attends. Data source: SDS and other oral health providers. **Target**: 51%	Annually in Q3 for the period 1 January to 31 December 2006.
POP-06	Oral health – Mean DMFT score at year eight	The total number of permanent teeth of Year eight children, Decayed, Missing (due to caries) or Filled at the commencement of dental care, at the last dental examination, before the child leaves the DHB SDS divided by the total number of children who have been examined in the Year eight group, in the year to which the reporting relates. This will be reported by ethnic group (Māori, Pacific, Other), fluoridation status of the school area the child attends and mean components of the DMF index (ie. D-teeth, M-teeth, F-teeth). Data source: SDS and other oral health providers. **Target:** 1.6	Annually in Q3 for the period 1 January to 31 December 2006.
POP-08 (a)	Improving the health status of people with severe mental illness (Total)	Access to services The average number of people domiciled in the DHB region, seen per year rolling every three months being reported (the period is lagged by three months) for: • Children and youth aged 0-19 • Adults aged 20-64 • Older people aged 65+ Specified for Māori, Other and in Total, as a percentage of the projected population of DHB region by age and ethnicity. Target: Māori Other Total 0-19 2 2 2 20-64 2.5 2.5 2.5 65+ Targets not established for over 65 as service historically funded by DSS.	Quarterly.
POP-08 (b)	Reducing repeat acute mental health admissions	Methodology	Six-monthly Q2 and Q4.
POP-13	Ambulatory sensitive admissions - Children and older people - discharge rate per 1000 population	A report providing the total number of hospital discharges considered being ambulatory sensitive per 1000 current census populations, projected to 2005/06 using medium projection as at the end of the reporting period.	Six-monthly in Q2 and Q4. Results

		Age bands reported on are children <5, 5 to 14, 15 to 24 and older people 65 to 74. Ethnicity groups Māori, Pacific peoples, Other and in total for all age groups. **Target:** Māori Pacific Other Total 0-4 6.3 8.8 7.0 7.0 5-14 1.4 1.8 1.5 1.5 15-19 1.1 1.1 1.1 1.1 65-74 8.8 9.3 5.4 5.4 Where the DHB region and ethnic rate is significantly greater than the total NZ (all ethnicity rate) national rate (99% confidence interval) the DHB will provide information on the current and planned initiatives likely to influence future outcomes specifically for the effected population group(s).	based on most complete previous 12 months' data.
POP-14	Radiation oncology and chemotherapy treatment waiting times	*Part 1:* Monthly templates that measure the interval between the patient's referral from a medical practitioner to the oncology department, and the beginning of radiation/chemotherapy treatment, are supplied on time and complete from each DHB (or from cancer center for contributing DHBs as agreed). (Including provision of information by DHB of domicile.) **Target:** Start on time – Gp A 100%, Gp B 100% Gp C 98% 2% Gp C wait 4-8weeks 0% Gp A,B, or C wait 8-12 or >12 weeks *Part 2:* Each of the six cancer centre DHBs (Auckland, Waikato, MidCentral, Capital and Coast, Canterbury and Otago) provide a report updating on progress towards ensuring all patients receive oncology megavoltage radiation treatment and chemotherapy treatment according to nationally agreed standards. This report is to be agreed with all the peripheral DHBs whose populations have used the service during the quarter. In the fourth quarter, this report should include information that demonstrates the cancer center has undertaken a data audit of its waiting time data and is satisfied that high quality data is being provided. Interpretation issues: As 2006/07 will be the first year of collection of chemotherapy waiting times at a national level, targets in relation to waiting times will be set, and 2006/07 will act as the year for the establishment of baselines. Expectations in relation to chemotherapy will relate to supply of data.	Part 1 Monthly. Part 2 Quarterly.
RIH-01	Progress toward further incorporating health inequalities concepts and actions into overall policy, planning, funding and service provision	A qualitative report that shows: 1. Key areas of inequalities that are identified within its HNA; and 2. Actions/steps taken to address the identified inequalities using an appropriate equity tool (eg the Reducing Inequalities Intervention Framework, the Health Equity Assessment Tool, etc).	1: Q1. 2: Q33.
RIS 01	Service Coverage	A report providing the following information: Progress achieved during the quarter towards resolution of gaps in service coverage identified in the DAP and not approved as long term exceptions, and any other gaps in service coverage identified by the DHB or MoH through: *Analysis of explanatory indicators, media reporting, risk reporting, formal audit outcomes, complaints mechanisms or sector intelligence.*	Quarterly.
SER-01	Accessible and appropriate services in Primary Health Organisations	The ratio of the age-standardised rate of GP consultations per high need person to the age-standardised rate of GP consultations per non-high need person. This indicator applies only to persons enrolled in PHOs, and excludes casual visits. Data source: MoH via HealthPAC. **Target :** 1.2 to 1	Quarterly.
SER-04	Low or reduced cost access to first level primary care services	The ratio of the number of PHO practices that demonstrate that all increased subsidies translate into low or reduced cost access for eligible patients to the number of PHO practices in a DHB region. This indicator	Quarterly.

		applies only to persons enrolled in PHOs, and excludes casual visits. Data source: DHBs quarterly fee reporting. Demonstration is achieved by compliance with the government policy for access and interim PHOs across all groups, where the subsidies apply and where this is approved by the DHB and the MoH.	
PAC-01	Progress towards the implementation of priority areas identified in the Pacific Health and Disability Action Plan	A report providing information on the following key points: 1. Pacific child and youth health Initiatives that have been implemented and progressed to improve and protect the health of Pacific children (0-14 years) Initiatives that have been implemented or progressed to improve the health of Pacific youth (15-25 years) 2. Promoting Pacific healthy lifestyles and wellbeing Initiatives that have been implemented or progressed to encourage and support healthy lifestyles 3. Pacific primary health care and preventative services Initiatives that have been implemented or progressed to ensure that there are locally available Pacific primary health providers that effectively meet the needs of their local Pacific communities 4a. The Pacific Health and Disability Workforce Development Plan Initiatives that have been implemented or progressed to develop a competent and qualified Pacific health and disability workforce that will meet the needs of Pacific peoples 4b. Pacific Provider Development Initiatives that have been implemented or progressed to develop and support Pacific health providers capacity and capability to effectively deliver health services 5. Promote participation of disabled Pacific peoples Initiatives that have been implemented or progressed to deliver disability support and health services that will enable disabled Pacific peoples to participate fully in their communities 6. Pacific health and disability information and research Initiatives that have been implemented or progressed to inform policy, planning and service development? *(Note that this component of the indicator only applies to the seven DHBs with relatively high numbers of Pacific peoples in comparison to other regions in the country: Capital and Coast, Hutt, Canterbury, Waikato, Counties Manukau, Auckland and Waitemata DHBs.)*	Six monthly, in Q2 and Q4.
INTERSECTORAL FOCUS			
POP-01 POP-02 POP-03	Diabetes Cardiovascular disease Stroke	Risk reduction – Obesity Risk reduction – Smoking	
QUALITY			
HKO-03	Improving mainstream effectiveness	A report on the following information for the DHB's provider arm: 1 Describing the reviews of pathways of care that have been undertaken in the last 12 months that focused on improving access to effective services for Māori. 2 Example of actions taken to address issues identified in the reviews. If possible, develop a reporting template based on the key points above.	Six monthly, in Q2 and Q4. Annual in Q3.

[15] Reporting should exclude HealthPAC audits.

		The DHB provider arm demonstrates an organisational wide commitment to quality improvement and effective clinical audit by reporting: A high level summary (list) of key quality improvement and clinical audit initiatives and results, focusing on those that are effective and/or ineffective[15] against the Goals in *Improving Quality (IQ): A Systems Approach for the New Zealand Health and Disability Sector*. ***Table 1 - Reporting template - quality improvement and clinical audit initiatives*** *Note - The template below provides guidance on how to map a range of current initiatives to the IQ goals it does not encompass all possible initiatives, and is not intended to restrict the range of initiatives reported. All initiatives undertaken by the DHB should be reported.* **Goal** **Describe personal health initiatives** **Describe effectiveness of initiative** 1.There are more effective service outcomes for Māori by acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi and applying the principles of participation, partnership and protection. *Include…ethnicity data audits.* 2. There is a shared vision towards safe and quality care that is engendered through committed leadership at all levels, which supports constant maintenance and improvement in service quality, and takes into account Māori aspirations and priorities. *Include…Quality committee initiatives and Initiatives to implement/improve structures and processes.* 3. People are encouraged and supported to participate in the planning, delivery and assessment of health and disability services and programmes, including the active participation of Māori. *Include… H&D code of rights, Pacific caucus and consumer feedback activities.* 4.There is widespread awareness, understanding and commitment to a quality improvement culture at all levels of the health and disability sector. *Include… High level policy development, Awards systems for quality improvement/innovation and Involvement in local or national quality initiatives.* 5. There is evolutionary redesign of systems of care to support delivery of quality services. *Include…Prioritisation activity, Discharge planning, Specific service based clinical development, eg, BFHI, Clinical audits, Infection control activity and Patient flow activity.* 6. Unexpected adverse outcomes are managed in an open and supportive manner that build trust and confidence in the system and are fair to all participants. *Include… Internal health and safety activity such as hazard identification, Mortality/morbidity meetings, Risk registers and risk management initiatives, Energy audits and Medical waste audits.* 7. There is effective and open communication, co-ordination and integration of service activities that recognise the value of teamwork. *Include… Service/sector wide forums and meetings, Improvements in organisation- wide processes, eg, debriefing processes across services and Career pathway development.* 8. There is a supportive and motivating environment that provides the workforce with appropriate tools, including cultural competency tools, for continuous learning and ongoing improvement in planning, delivery and assessment of health and disability services.	

		Include… Staff and workplace safety activities, Systems for maintenance of clinical quality, eg, credentialing, Competency up-skilling and Activities to implement magnet initiatives. 9. Useful knowledge and information, including Māori satisfaction information and clinical evidence, is readily available and shared to support a quality-conscious culture. *Include… Information audits, Clinical records audits and Documentation audits.* 10. Regulatory protections that assure safe care are in place to support people and service providers. *Include…All 3rd party audits, Accreditation and certification activity, Labs and pharms audits andFood hygiene regs audit.*	
QUA 01 (b)	Results for People with enduring severe mental illness	A report providing: 1. The number of adults (20 – 64 years) with enduring serious mental illness (two years or more in treatment*, since the first contact with any mental health service. (* in treatment = at least one provider arm contact every three months for two years or more.) 2. The number (and percentage) of long-term clients with up-to-date crisis prevention plans (NMHSS criteria 16.4) and describe how this is assured. **Target:** 98% 3. The number (and percentage) of long-term clients in full time work (> 30 hours). **Target**: 2.5% 4. The number (and percentage) of long-term clients with no paid work. **Target:** 85% 5. The number (and percentage) of long-term clients undertaking some form of education e.g. University, Polytechnic.	Annual in Q2.
SER-06	Continuous Quality Improvement – Elective services.	A quantitative report providing: Standardised Discharge Ratios (SDRs) for 11 elective procedures as published on the MoH website each quarter (excluding hip and knee replacements and cataracts covered by separate initiatives). A qualitative report demonstrating: 1 For any SDR that is more than 5% below the national average of one, ie, a rate of less than 0.95, the analysis that has been undertaken to review the appropriateness of its rate. 2 The reason that the DHB considers the rate to be appropriate for its population, or an action plan as to how it will address its relative under delivery of that procedure.	Six monthly, based on Q2 and Q4 results.
EFFICIENCY AND VALUE FOR MONEY			
SER-05	The proportion of laboratory test and pharmaceutical transactions with a valid NHI	1 The number of government subsidised community pharmaceutical items dispensed by pharmacies in the DHB district with a valid NHI submitted as a proportion of the total number of government subsidised community pharmaceutical items dispensed by pharmacies in the DHB district. **Target:90%** 2 Laboratory tests: The number of tests carried out by community laboratories in the DHB district with a valid NHI submitted as a proportion of the total number of tests carried out by community laboratories in the DHB district. **Target:92%** Data source: MoH via HealthPac.	Quarterly.

7 REFERENCES

The Canterbury DHB has developed key documents that have been referenced throughout this District Annual Plan. These documents can be accessed via the Canterbury DHB website www.cdhb.govt.nz or by contacting the Canterbury DHB's Planning and Funding Division on (03) 364 4159.

- District Strategic Plan: *A Healthier Canterbury: Directions 2006.*
- Canterbury DHB Statement of Intent 2006/2009.
- Health Needs Assessment for Canterbury, 2004.
- Canterbury DHB Quality Strategic Plan 2004/2006.
- Rural Health Action Plan: *Rural Health in Canterbury DHB 2002.*
- Child Health and Disability Action Plan 2004/2007.
- Canterbury DHB Aged Care Strategy: *Healthy Ageing, Integrated Support 2005.*
- Disability Strategy, Action Plan for Disability 2004/2007.
- Healthy Eating, Active Living Plan 2005/2010.
- Canterbury DHB Information Strategy Strategic Plan 2005.
- Canterbury Heart Health Strategy, September 2004.
- Oral Health Strategy, September 2003.
- Pacific Health Action Plan, March 2002.
- Diabetes Strategy Action Plan (Interim), 2002.
- Mental Health and Addiction Strategy, May 2004.

8 APPENDICES

Appendix 1. Glossary of Terms.
Appendix 2. Revised Canterbury DHB Māori Health Plan (draft).

9 MOH ATTACHMENTS

Attachment A. DAP Financial Template.
Attachment B. Mental Health Plan Template.
Attachment C. Revenue Reconciliation.
Attachment D. Volumes Schedules for Service Provision 2006/2007.
Attachment E. Service Coverage Expectations.