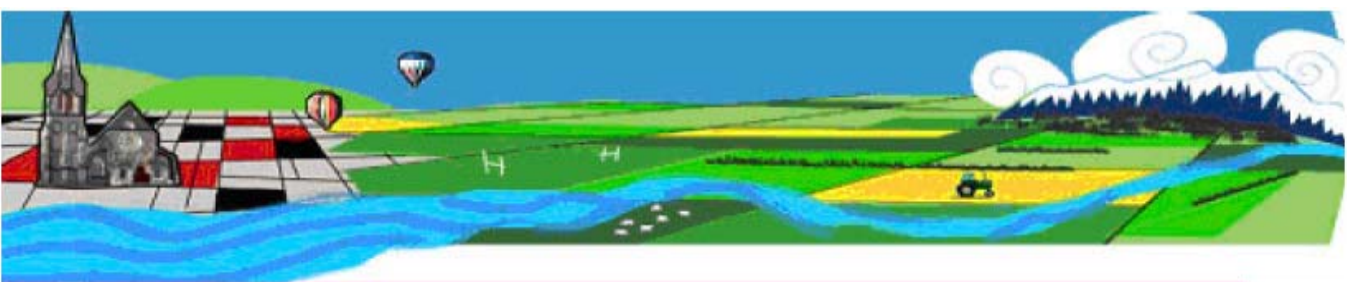


Statement of Intent 2007-2010



Canterbury District Health Board

Canterbury

District Health Board

Te Poari Hauora o Waitaha

STATEMENT OF INTENT
1 July 2007 – 30 June 2010

Produced in 2007 by the
Canterbury DHB
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OUR VISION AND VALUES

The Canterbury District Health Board (DHB) is one of 21 DHBs established on 1 January 2001, in accordance with section 19 of the New Zealand Public Health and Disability Act 2000 (NZPHD Act), and is funded by government.

As a DHB we are responsible for working with our community to decide which health services are needed and how to best use our limited funding to improve the health and well-being of our population. Funded by government we must note government policies when making these decisions, particularly the New Zealand Health Strategy 2000, New Zealand Disability Strategy 2001 and the New Zealand Maori Health Strategy 2002, *Te Korowai Oranga*.

In summary we:

- *Plan*, in consultation with stakeholders and our community, the strategic direction for health and disability services in the Canterbury region;
- *Fund* most of the health and disability services provided in Canterbury and hold more than 800 service contracts with health and disability service providers;
- *Provide* health and disability services encompassing women's and children's services, medical and surgical services, mental health, older person's health, and rural health services, laboratory and hospital support services and rehabilitation services; and
- *Promote* community health and well-being through population health, health promotion, health education and health protection programmes.

We are also the largest employer in the South Island with over 8000 staff. Working closely with tertiary providers and clinical training agencies we aim to build the capability of our health workforce, provide leadership and career development and ensure a good, safe working environment for our staff.

The Canterbury DHB intends to take a consistent approach in achieving the changes and developments we have planned over the coming years. This approach will involve looking at the way we work across a number of core areas within our organisation and across our community and includes:

- Strengthening regional relationships and national influence;
- Engaging with stakeholders;
- Ensuring effective resource utilisation;
- Improving access, particularly for those with high needs;
- Sharing population and patient focused research and information; and
- Sharing responsibility for quality health outcomes.

This approach will enable us to strengthen the foundations needed to improve the health and wellbeing of our community, to meet local needs and priorities and to meet key national objectives and ministerial expectations.

OUR VISION TA MATOU MATAKITE	OUR VALUES A MATOU UARA	WAYS OF WORKING KA HUARI MAHI
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.	Care and respect for others. Manaaki me tekotua i etahi atu. Integrity in all we do. Hapai i a matou mahi katoa i ruka i te Pono. Responsibility for outcomes. Kaiwhakarite i ka hua.	Be people and community focused. Arotahi atu ki ka takata meka. Demonstrate innovation. Whakaatu whakaaro hihiko. Engage with stakeholders. Tuu atu ki ka uru.

EXECUTIVE SUMMARY

CANTERBURY DHB CORE DIRECTIONS

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

CANTERBURY DHB HEALTH GAIN PRIORITIES

Child and Youth Health
Older People's Health
Māori Health
Primary Health
Disease Prevention and Management

CANTERBURY DHB DISEASE PRIORITIES

Cancer
Cardiovascular Disease
Diabetes
Respiratory Disease

This Statement of Intent (SOI) reflects the Canterbury DHB's continued commitment to promoting, enhancing and facilitating the health and wellbeing of the people of Canterbury.

In 2004, while developing our District Strategic Plan (DSP) to 2010, the Canterbury DHB chose five Core Directions, five Strategic Health Gain Priorities and four Disease Priorities around which to concentrate efforts. In planning our activity and strategic direction these local strategic priorities are coupled with national and regional objectives and expectations to set our long-term objectives and goals.

In seeking to achieve our objectives and commitments, our single largest challenge continues to be maintaining financial viability in a climate of increasing demand and public expectation. The DHB is committed to planning for and delivering a breakeven financial outcome. Although we are confident that this can be delivered in 2007/08 we are concerned that due to growing external factors we will face increasing difficulty in achieving this result in future years. Much will depend on receiving sustainable funding and ensuring that secondary service DHB's are able to continue to provide current services including night and weekend services and ensuring funded community services are well integrated, work well together and work effectively on issues such as chronic conditions and long term illness.

We are committed to working collaboratively with the Ministry, other DHBs and health service providers, our workforce and our community to find ways to overcome the issues and risks we face and seek support for joint problem solving, prioritisation and for implementing necessary service changes.

To date a key focus in maintaining our breakeven position has been efficiency gains made across our organisation. However in light of our ageing population, the increasing burden of chronic illness, wage and salary pressures and increasing cost pressures, we must accelerate change in order to maintain this position. We are looking at all aspects of our business to determine how we can be more cost effective while continuing to achieve our goals and priorities. Trade-offs and prioritisation will be increasingly required to ensure that our commitments are realised and the way forward includes a range of efficiency initiatives, service change and innovation and service reconfigurations.

In maintaining a breakeven position, and therefore ensuring financial viability, our motivation is to do the best we can to ensure our community gets optimum service delivery for the funding available. The accelerated pace of change required to meet our commitments will require us to work collaboratively and across sectors to alleviate acute demand and service pressures, reduce inequalities and reduce the incidence and impact of chronic illness. In doing this we are likely to deliver some current services in different ways and in different settings. Implementation of our 'Improving the Patient Journey' Programme, our established local health strategies and the recommendations from our review of Acute Demand and After Hours Cover will provide significant opportunities to make real improvements to the health status of Canterbury residents.

A robust approach to managing chronic and long-term conditions must be developed and we will be establishing a framework to initiate an organised system of care that will cross all of our identified strategic and disease priority areas. The biggest difference is that the new system is likely to involve self-management and be community based rather than hospital centred. Instead of the hospital and its specialist services being the prime port of call, management of chronic conditions will be handled through a close working partnership between GP services, relevant community health services and

the DHB. The team approach is vital in keeping people well-managed and out of hospital and also, of course, entails people understanding their condition, having practical training on how to manage that condition and being involved in the development of their care plan.

The DHB will continue to have a strong focus on the health of older people and primary health care development which we are hopeful will continue to constrain acute demand. We are committed to the continued implementation of our local *Healthy Ageing, Integrated Support* Strategy and the national Primary Care Strategy with a focus on reducing inequalities and removing barriers to accessing support and primary care services.

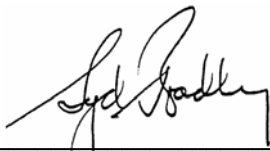
Child and Youth health and Maori health will also be a focus for the DHB with emphasis on reducing risk factors such as smoking, poor nutrition and obesity. We are committed to the implementation of the national *Healthy Eating, Healthy Activity* (HEHA) Strategy which we are hopeful will contribute to a reduction in the risk factors across identified disease priorities.

The longer-term issue of sustainability and capacity is of particular interest to the DHB. In this regard we need to promote debate at a local level with emphasis on long-term service planning and demand management. We will be looking to establish a direction for future health service delivery in Canterbury through our Health Services Planning project. We look forward to developing this work and anticipate establishing new models of care to cope with future demand and developing strategic facilities and workforce plans to make the best use of our limited resources.

Alongside this long-term work we acknowledge the importance of providing adequate leadership and information to stakeholders as we strive to make improvements in 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 opportunities for improved quality and patient safety and improving the way we currently address health issues - from the management of episodic events to the complete patient journey.

The coming years will be challenging for the DHB as we confirm our vision for the future with the plan for that vision being a catalyst for the development of a master site plan (or Facilities Master Plan) for the next twenty years. We will look to our stakeholders, clinical teams, consumers and community to help determine and implement that vision and work towards a healthier Canterbury in 2010 and beyond.

Further detail on specific actions and activity for the Canterbury DHB over the coming year can be found in our District Annual Plan (DAP), written alongside this document and in alignment with our DSP. These documents can all be found on the Canterbury DHB's website www.cdhb.govt.nz.



Signature
(Syd Bradley, Chairman)



Signature
(David Morrell, Chairman, Hospital Advisory Committee)

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1. INTRODUCTION

1.1 About the Statement of Intent

DHBs are categorised as Crown Agents under section 7 of the Crown Entities Act 2004 (CE Act 2004). The CE Act 2004 (section 49) states that the Board of a DHB must ensure that the DHB acts in a manner consistent with its objectives, with its functions, and with its current SOI.

This document is the Canterbury DHB's SOI for the three-year period 2007/08 to 2009/2010 and has been prepared to meet the requirements of Section 42 and Section 39(8) of the NZPHD Act 2000 and Section 139(1) of the Crown Entities Act 2004.

The SOI describes to Parliament and to the communities of the Canterbury region what we intend to achieve over the next three years in terms of reducing inequalities and improving the health and well being of our community. Further detail on specific actions and activity for the Canterbury DHB over the coming year can be found in our DAP 2007/08.

The SOI incorporates the activities of the three output classes or 'arms' of the DHB - Governance, Funder and Provider and includes a forecast service performance section providing performance measures and targets that we will use to evaluate the success of our intervention and activity. The performance measures presented are in the context of the government's strategic and service priorities for the public health and disability sector.

Our SOI is also aligned to and consistent with major government strategies and accountability documents including the:

- NZPHD Act 2000 and CE Act 2004;
- Public Finance Act 1989 (and subsequent amendment acts);
- DHB Crown Funding Agreement (CFA);¹
- New Zealand Health Strategy (2000) and Disability Strategy (2001);
- Maori Health Strategy, *He Korowai Oranga* (2002);
- Mental Health Strategy 2005-2015, *Te Tahuu* (2005);
- Health of Older People Strategy (2002);
- Primary Care Strategy (2001); and
- Pacific Health and Disability Action Plan (2002).

Our SOI is also closely aligned with our other major accountability documents, our DSP 2006-2010, *A Healthier Canterbury: Directions 2010*, and our DAP 2007/08, and should be read in conjunction with those documents. A Glossary is provided (Appendix 1) to expand many of the terms used throughout this SOI.

1.3 Reporting to, and Consulting with, the Minister of Health

As a Crown Entity the DHB is responsible to the Minister of Health and this accountability is monitored through a number of regular reporting streams and on an ad-hoc basis as required, including (but not limited to):

- Indicators of DHB Performance (IDPs) outlined in our DAP and reported quarterly as part of CFA reporting;
- Requirements under service contracts held with the Ministry of Health (the Ministry) and reported in accordance with those service contracts;

¹ The CFA is an agreement between the Crown and the DHB to provide funding in return for the provision of, or for arranging the provision of, specified services.

THE SOI INCLUDES

(Part 5)

A forecast of the service performance the DHB will seek to achieve, during 2007/08 and in the two subsequent years, with non-financial performance measures and targets for each output class.

(Part 6)

A financial forecast for 2007/08 and for the two subsequent financial years (1 July – 30 June).

- Information requirements contained in the Operational Policy Framework reported quarterly;
- Hospital Benchmarking Information reported quarterly; and
- Financial reporting to the Ministry's DHB Funding and Performance Directorate, reported on a monthly basis.

We also produce an Annual Report which includes a Statement of Service Performance and financial statements outlining our performance during the past year.² Auditors working on behalf of the Office of the Auditor-General compare the performance planned in the SOI with the actual performance described in the DHB's Annual Report. The Annual Report is a public document, is tabled in Parliament and is published on our website.

A number of initiatives may warrant formal consultation with the Ministry of Health, such as reconfiguration of services. We will identify any consultation needs in each instance and meet our obligations in this regard (including consulting with the Minister of Health). The NZPHD Act 2000 specifies consultation in relation to the development of, and changes to, the DSP, changes to the DAP and the disposal of land.

1.2 Maori Health Improvements and Reducing Inequalities

In accordance with the government's health strategies and policies, in particular Section 4 of the NZPHD Act 2000, *Treaty of Waitangi*, the Canterbury DHB is committed to reducing health inequalities and improving health outcomes for Maori.

We have identified a number of ways in which to enable Maori to contribute to decision-making and to participate in the delivery of health and disability services within Canterbury:

- We meet with Ngai Tahu as Manawhenua of the district, through Manawhenua ki Waitaha, a representative group which comprises the seven Ngai Tahu Runanga. In the past year a Ngai Tahu representative has also been invited to attend Board meetings as an observer;³
- We also meet with Te Runanga o Nga Maata Waka representatives and engage in both formal and informal interactions with Maori providers, agencies and community organisations;
- We appointed an Executive Director of Maori and Pacific Health to the Executive Management Team in 2004 and established Te Kahui Taumata, a group which includes senior Maori staff to provide Maori specific advice to the Chief Executive Officer (CEO). We are also pleased to welcome a new Kaumatua to the DHB who actively participates in the Te Kahui Taumata group;
- We have supported the extension of the Christchurch Hospital Maori Health Team working in key services to achieve better health outcomes for Maori patients, particularly services that require cultural protocols (Paediatrics, Oncology, the ED and the Mortuary); and
- We have also begun to provide a cultural programme to hospital staff, assisting them to understand how Maori views and values can impact on their clinical practice. It is anticipated that a specific cultural training programme for DHB contract managers and for Board members (currently under development) will be implemented in the 2007/08 year.

² The section of the Annual Report referred to as the Statement of Service Performance is essentially an evaluation Section 5 of this document – demonstrating the DHB's performance against the non-financial measures and targets set in our SOI.

³ Although this member has no voting rights their contribution to discussions is valued input for the DHB's Board.

2. OUR ENVIRONMENT

This section provides background on the environment in which we operate. It outlines our geographical location and population profile, identifies health issues for the Canterbury district and describes how our operating environment influences the choices we make.⁴

In September 2004 we completed our second comprehensive Health Needs Assessment (HNA) bringing together information describing the Canterbury population and the health status of our residents. The HNA document can be found on our website (www.cdhb.govt.nz).

2.1 Our Community - Population, Age and Ethnicity

The Canterbury DHB is the second largest DHB 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, Selwyn and Ashburton.⁵

Canterbury's usual resident population, at the 2006 Census, was 466,416 with Statistics NZ predicting that this would rise to 504,900 by 2016.

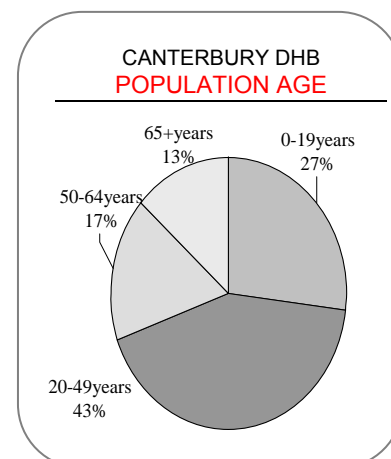
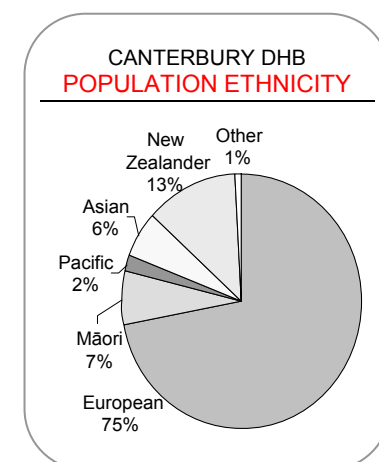
There has been some change in the ethnic mix in Canterbury over the past five years, with the latest 2006 figures showing Maori making up 7.2% of the Canterbury population, Asian people 6.1% and Pacific people 2.2%.⁶ Most people identifying as Maori, Asian or Pacific live in Christchurch City.

In the 2001 census, Ngai Tahu was the largest identified iwi in Canterbury, followed by Nga Puhī and Ngati Porou. The main Pacific ethnic groups are Samoan, Tongan, Cook Island Maori and Niuean.

The 2006 Census indicates that just over a quarter (27%), of our population live outside the urban Christchurch boundary. There are differing degrees of rurality but approximately 7,000 of our population (1.5%) live in remote areas and have to drive for more than an hour for primary health care services.

Latest 2006 figures show around 14% of our population is aged between 15 and 24 years. This is similar to the national figure. As with the national population, an increasing number of our child and youth populations are Maori, Asian and Pacific. These ethnic groups have younger populations in general and latest figures show that while 34% of the total Canterbury population is under 25 years old - approximately 55% of our Maori population is aged under 25. Around 60% of the Pacific population in Canterbury are under 30 years of age. There are proportionately almost twice as many Pacific children as non-Pacific children under the age of 10 in our region.

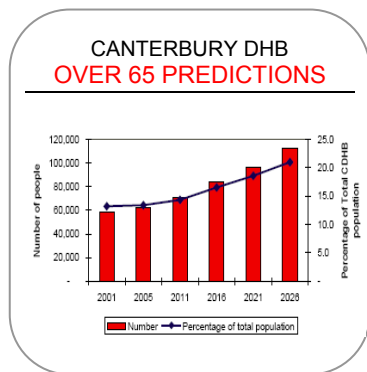
The 2006 Census shows 13% of the total Canterbury population are aged over 65 years. This is a slightly higher proportion of elderly, relative to the NZ population with latest national figures showing 12% of the country's population are aged over 65. Two of our rural areas, Kaikoura and Ashburton, continue to have even higher percentages of their populations aged over 65 (15% and 16% respectively). The 2001 Census predicted the percentage of the Canterbury population aged over 65 would increase to almost 20% by 2021.



⁴ Detailed analysis of the 2006 Census has yet to take place and the trends and baselines used in this document are taken from the 2001 Census (www.stats.govt.nz). Where updated information has been made available we have referred to this.

⁵ The Christchurch City TLA also now includes that previously known as Banks Peninsula.

⁶ Allows for double counting where individuals identify with more than one ethnic group.



While there are fewer older Maori and Pacific people in NZ, with the lower life expectancy due in part to higher morbidity rates through diabetes, stroke and cardiovascular disease, the percentage aged over 65 is projected to increase with the number of Maori over 65 expected to increase from 1.3% in 2001 to 3% by 2021.

Addressing the health needs of our ageing population is one of our key challenges over the coming years and is one of the five long-term strategic priorities identified in our DSP.

Poorer health status is linked with high degrees of deprivation and the 2001 Census showed Canterbury had around 80,000 people living in NZ Deprivation Deciles 8, 9 and 10 (the highest levels of deprivation). The percentage of Maori and Pacific people living in these areas was higher with 43% of Pacific and 30% of Maori in deciles 8, 9 and 10 compared to 17% of Asians and 15% of Europeans. 18% of Canterbury's under 15 age group were living in deciles 8, 9 or 10.

2.2 Our Health Profile - Priorities

In order to address the health needs of our community it is important for us to understand the health status of our population and the conditions and illnesses, which are prevalent in the Canterbury region. This understanding has assisted the Canterbury DHB in selecting our long-term health gain priority areas where we believe additional focus will improve our community's health status.

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).

The total number of deaths for all ages in Canterbury is also almost exactly what is expected, given the age and socio-economic deprivation of our residents. The primary causes of death in Canterbury are diseases of the circulatory system (ischaemic heart disease, stroke, heart attack), cancers and respiratory system diseases.

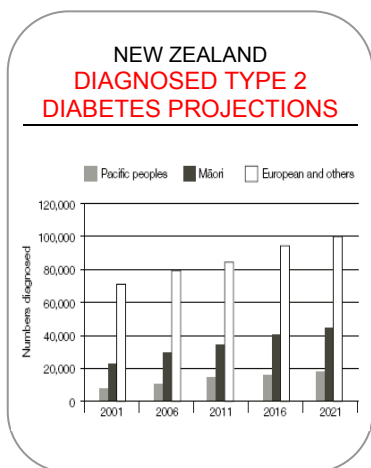
Diabetic complications (such as heart disease, blindness and kidney failure) are major contributors to the burden of disability experienced by people from middle age, particularly Maori and Pacific people, who are proportionately at higher risk of diabetes and associated complications.

The prevalence of these diseases is reflected in our choice of Cancer, Diabetes, Heart Disease and Respiratory Disease as our four identified disease priorities for the next five-ten years.

A number of conditions which result in death or disability (including diabetes) 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 2002/03 NZ Health Survey reveals that most New Zealanders believe they have very good health.⁷ 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.

⁷ The NZ Health Survey can be found on the Ministry website, www.moh.govt.nz.



Disease prevention and the management of chronic and long-term illness is one of the Canterbury DHB's five strategic priorities with emphasis on healthy eating, active living, smoking cessation, intersectoral collaboration and the development of integrated continuums of care.

Timely and consistent primary health care can help prevent disease development, complications and hospitalisations. Ambulatory sensitive admissions to hospital are those which result from diseases and conditions which are sensitive to interventions delivered through primary care. It is considered that a good percentage of these admissions are avoidable. Nationally ambulatory sensitive admission rates are rising, from 25% per 1000 people in 1995 to 28% per 1000 in 2001.

Canterbury's ambulatory sensitive admission rates, for the years 1998-2002, show a slight decrease in overall rates and lower rates than the national average. However, in Canterbury, socio-economically deprived people are hospitalised with potentially preventable conditions at almost twice the rate of those less-deprived. Canterbury's hospitalisation rates for childhood asthma are high, as are our notified rates of pertussis (whooping cough). Maori and Pacific children (an increasing percentage of our child population) also have high rates of hospitalisation for vaccine-preventable diseases, and higher rates of tooth decay and glue ear than other Canterbury children.

Primary Health is also one of our identified strategic priorities and through Primary Health Care Organisations (PHOs) the DHB intends to focus on earlier intervention, improving equity of access to health services, the management of chronic conditions and addressing acute demand.

The oral health status of Canterbury five-year-olds has declined since 1996. For 12-year-olds oral health status declined between 1999 and 2002 and is now back to where it was in 1996. Water fluoridation can reduce dental decay in children by as much as 50% - only 4% of Canterbury children receive fluoridated water compared to 96% of Wellington children.

Beginning in 2007/08 the DHB will be implementing the Ministry's oral health reform – including a move away from traditional school dental clinics towards modern community oral health services with an increased emphasis on prevention. This work has been identified under our Child and Youth Health priority.

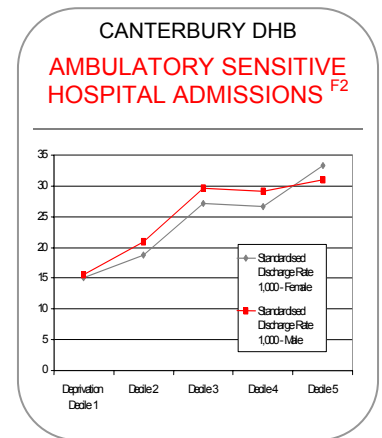
Suicide rates in Canterbury are no higher than the national average but continue to be of concern especially for males. Although not a priority area for the Canterbury DHB at this time, we continue to implement national and local solutions for improved mental health services and equity of access for consumers.

Maori and Pacific Profile

Maori admission rates for Pertussis are 2.7 times higher than that of Europeans and 3.2 times higher than Pacific people. Maori are twice as likely to develop diabetes and on average develop diabetes nine years earlier than their counterparts of other ethnicities. Maori children also have high discharge rates for asthma, particularly in Canterbury where rates for children under five are higher than national rates.

Pacific people are more likely than other ethnicities to be admitted to hospital for diseases of the skin and subcutaneous tissues, and conditions related to pregnancy. The high rate of tobacco smoking amongst Pacific youth aged 15-24, (39% for males and 45% for females), is a particular concern and much higher than the average rates in Canterbury.

Maori and Pacific health improvements are critical in Canterbury, as throughout NZ, given that on average these ethnic groups have the poorest



health status. Nationally and regionally a range of health strategies acknowledge the importance of improving Maori and Pacific health outcomes in order to reduce and eventually eliminate health inequalities that negatively affect these ethnic groups. To add local focus we have included Maori Health and Child and Youth Health amongst our Strategic Priorities.

Disability Profile

Estimates from the NZ Disability Survey indicate there are around 160,000 people with disabilities within the Canterbury region, of which approximately 58,000 have a disability requiring assistance. Maori are 1.35 times more likely than non-Maori to suffer from a disability not requiring assistance and 1.65 times more likely to have a disability requiring assistance.

We have an Action Plan for Disability, which outlines actions to reduce and eliminate barriers to health services for people with disabilities and to promote a more inclusive society. Our Board's Disability Advisory Committee monitors this Action Plan. Moves are underway, nationally, to address issues around the support workforce for people with disabilities such as remuneration, high staff turnover and training opportunities.

2.3 Our Operating Environment

Financial Challenges

Population Based Funding (PBF) involves using a formula in an attempt to allocate each DHB a fair share of the available health resources so that each Board has an equal opportunity to meet the health and disability needs of its population. The expectation is that the DHB will maintain financial viability and achieve a breakeven position.

In seeking to achieve our ongoing objectives and priorities, it is a challenge to maintain financial viability. Cost and demand growth makes this a significant challenge. DHBs are faced with capped budgets, have tightly placed limits on service delivery and are confronted with increasing economic, regulatory and compliance cost pressures. As our population ages service needs increase and increasing technology developments (including pharmaceuticals) provide newer and better, but more expensive, interventions. DHBs also face the primary pressures to increase the volume of services funded and the prices paid for those volumes and increasing expectations around wage and salary growth.

A number of these issues, or pressures, are highlighted as 'risks' to the DHB's performance and the magnitude of the challenge ahead can be considered in the context of the anticipated cost 'gap' between the funding increases we will receive and the potential cost growth indicated by some official forecasts of the Consumer Price Index (CPI) and the Labour Cost Index (LCI).⁸

Health sector non-wage costs tend to rise faster than the CPI and recent health sector wage settlements have been well above the rate of growth shown in the LCI (although the Ministry has provided special 'pay jolt' funding to DHBs to meet some of these costs). The last few years have seen unprecedented levels of investment in some staff groups partly to cope with service pressures and partly to recognise anomalies and international wage rates. Wage costs have increased significantly and this trend will need to be

⁸ *CPI – An inflationary indicator that measures the change in the cost of a fixed basket of products and services, including housing, electricity, food, and transportation.*

LCI - Measures changes in labour costs. These costs are base salary and ordinary-time wage rates, overtime wage rates and non-wage labour-related costs including annual leave and statutory holidays, superannuation, ACC employer premiums, medical insurance, motor vehicles available for private use and low-interest loans.

contained in future periods. The effect otherwise will be the reduction in patient services in order to pay additional levels of wages.

We also highlight the cost pressures of national regulatory or contractual compliance issues. These are often 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 our ability to maintain financial viability, while addressing local priorities. A clearer picture of the impact of these compliance and contractual requirements is needed so that their implementation costs and priority can be measured when new funds are available to the sector.

Although the pressure to achieve breakeven has been considerably eased in the past year (partly due to a review of the PBF formula), when we compare the funding increases provided and anticipated future cost growth there still remains a clear cost gap which the Canterbury DHB will need to address and manage.

3. THE NATURE AND SCOPE OF OUR ACTIVITY

DHBs have three key output classes 'arms' or roles: the Governance of health and disability services, the Planning and Funding of services and the Provision of services:

Governance

The Board of the DHB has all the powers necessary for the governance of the organisation and is responsible to the Minister of Health. Further detail on the governance structure is provided in Section 3.1.

Planning and Funding (Funder)

The Planning and Funding arm of the DHB is responsible for determining the health and disability service needs of the Canterbury district and for funding the provision of those services. Further details are provided in Section 3.2.

Provision of Services (Provider)

The Hospital and Specialist Service (HSS) or Provider arm of the DHB is responsible for delivery or provision of services to the Canterbury district and the wider region. Further details are provided in Section 3.3.

3.1 DHB Governance and Management

The governance structure for DHBs is set out in the NZPHD Act 2000. The Board consists of eleven members and they have overall responsibility for the operation of the DHB. Seven of the members are elected as part of the three-yearly local body election process (to be held again in October 2007) and four are appointed by the Minister of Health.

There are a number of sub committees to the Board, comprised of a mix of both Board members and community representatives. Three are Statutory Committees, required under the NZPHD Act 2000:

- *Hospital Advisory Committee (HAC)* - monitors the financial and operational performance of the hospitals the DHB owns, as well as assessing strategic issues relating to the provision of hospital and specialist services;
- *Community and Public Health Advisory Committee (CPHAC)* - provides the Board with advice on the health and disability needs of the resident population and how the services funded and/or provided by the DHB, along with the policies it adopts, will impact on that population; and
- *Disability Support Advisory Committee (DSAC)* – provides advice on the disability support needs of the population and aims to ensure that the services provided/funded, and the policies adopted by the DHB, promote the inclusion and participation of people with disabilities and maximise their independence.

The public are welcome to observe the meetings of the Board and its three Statutory Committees. The majority of these meetings are held monthly and details of the meetings (such as agendas, minutes, membership and terms of reference) are publicly available on our website www.cdhb.govt.nz.

Where appropriate, certain discussions may be held without public presence and this is allowed for under the NZPHD Act 2000.

The Canterbury DHB has also established a *Finance, Audit and Risk Committee (FARC)*, to enhance the Board's governance function by providing advice on the financial operation of the DHB. As a non-statutory committee the FARC operates in a slightly different manner to the Statutory Committee's of the Board and its meetings are not open to the public.

3.1.1 Managing Organisational Health

While the responsibility for DHB performance rests with the Board, it has a delegation policy, assigning operational and management matters to the CEO. Our Board and CEO ensure that their strategic and operational decisions are fully informed through appropriate involvement and support at all levels of the decision making process.

Executive support is provided by the Executive Management Team (EMT) which includes General Managers of Planning and Funding, HSS, Community and Public Health and Corporate Services divisions (Appendix 2 provides an Organisational Chart).

At this EMT level the DHB also has an Executive Director of Maori and Pacific Health, an Executive Director of Nursing and a Chief Medical Officer who provide clinical and cultural leadership and oversight of patient safety and quality. The CEO also receives advice and input from the DHB's Clinical Board, Quality and Patient Safety Council and Te Kahui Taumata (senior Maori staff group).

Our accountability documents (DSP, SOI and DAP) provide our public and stakeholders with an outline of the direction and goals of the DHB. Along with activity under each key priority area and core direction (set out in our DAP) the CEO and EMT are responsible for ensuring that we meet the challenges we face and the expectations of our community and stakeholders around patient safety and quality service provision, capability, capacity and value for money.

3.1.2 Quality and Safety

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

In 2003 we established a DHB-wide Quality and Patient Safety Council to ensure a coordinated approach to considering quality and patient safety. The Council's primary goal is to provide leadership in improving quality and patient safety and includes representatives from general practice, community providers, hospital staff and consumer representation.

The Council's key framework document is the DHB's Quality Strategic Plan that promotes leadership as the underlying driver of quality improvement and quality improvement as a continuum.⁹ Developed within the context of the national document *Improving Quality (IQ): A Systems Approach for the NZ Health and Disability Sector*; our Quality Strategic Plan presents five key goal areas: community participation/involvement, initiating organisational change and development, clinical risk management, instituting mechanisms for effective reporting and accountability and knowledge management for clinical services and quality.

A number of key achievements have already been made:

- The development and promotion of key quality and patient safety policies incorporating a Culture of Patient Safety policy, the No Blame Incident/Accident Reporting Policy and the Open Disclosure Policy;
- The beginning of an Incident Management Software selection project to select a standardised incident management software system. A standardised system will assist us to address the ongoing identification and mitigation of serious clinical risk to the quality and delivery of health and disability services. It will also assist and support the national approach to the consistent management of healthcare incidents;

⁹ The Canterbury DHB Quality Strategic Plan is available on www.cdhb.govt.nz.

- The completion of a stocktake of quality activities and reporting within community based services to help the Council gain a better understanding of quality initiatives in the community sector and to provide information for the Quality Strategic Plan;
- The development of quality clinical indicators for our four Disease Priorities. Diabetes and Cardiovascular Disease indicators are being developed and work continues on indicators for Respiratory Disease and Cancer; and
- The launch of an Infection Control Staff Policy Handbook for frontline staff. This Handbook is a first in NZ and is designed to be carried by staff to give them infection control policies at their fingertips. Infection control is fundamental to the way staff work in hospitals, both for their own safety and for the wellbeing of our patients.

Over the coming year our key focus will be on completing the development of the Quality Strategic Plan 2007-2010 and implementing initiatives that will assist us to achieve the goals and objectives contained within that Plan. The area of quality indicator development and reporting remains a priority along with the implementation of incident management software and building capacity at all levels to enable consumers to be more effective partners in the care process.

The Council also sponsors the DHB's annual Quality and Innovation Awards programme, designed to provide recognition of the positive contribution to patient safety and innovation made by our staff and community providers. The Awards also facilitate the sharing and retention of knowledge and learning and promote and encourage the entry of DHB projects into national and international award programmes.

3.1.3 Building Capability

Capability is defined as "what an organisation needs in terms of access to leadership, people, culture, relationships, processes and technology, physical assets and structures to efficiently deliver the outputs required to achieve its goals".¹⁰

The Canterbury DHB is committed to building health sector and workforce capability and capacity through provider relationships, inter-sector collaboration and leadership. As well as having an ongoing commitment to quality and safety, improving knowledge and information management and increasing the participation of Maori and high needs groups in service planning.

We are fortunate to have a well functioning Board whose members contribute a wide range of skills and expertise to their governance role. Governance capability and knowledge is maintained and fostered through regular forums and training and is backed by the selection of a mix of experts, professionals and consumers on the Board's advisory committees. Continued development of the Board's partnership with our Maori community will further strengthen its governance capability.

However, with funding constraints and increasing demand, the need for service planning, service reconfiguration, the development of alternative and innovative models of care and the development of more robust prioritisation mechanisms is becoming increasingly evident. To achieve our long-term objectives and goals we need to determine the most appropriate and affordable mix of services to meet the needs of our population. While we completed a HNA for the Canterbury region (in 2004), health services planning is at various stages of development within different divisions and

¹⁰ *Guidance and Requirements for Crown Entities; Preparing the 2005/06 Statement of Intent available on www.crownentities.ssc.govt.nz.*

CANTERBURY DHB
'ON AN AVERAGE DAY'

197 people are admitted to a public hospital
12 admissions were potentially preventable

225 people are seen in ED
3067 people in general practice

15 babies are born
0.9 babies are low birth weight
2 are born to teenage mothers

34 admitted for elective surgery
90% satisfied with their care

\$3 million is spent

different services of the DHB. A standard scoping exercise was seen as imperative and we began an extensive Health Services Planning Project in 2006/07. We have also begun scoping and developing a framework for managing chronic conditions within the Canterbury region.

The objectives of these projects are to:

- Develop key directions that will provide a framework for decision making regarding health investment, that includes facilities and human resources over the next 5-10 years;
- Optimise health outcomes and encourage innovation while 'living within our means';
- Develop and consolidate health care services in appropriate locations/settings, that provide sustainable levels, range, access and quality of services delivered;
- Ensure services located in hospital settings will complement community based services;
- Support a patient-centred focus for health services rather than a episodic care focus and promote the patient as leader in their own care;
- Provide a equitable distribution of services, based on the needs of our population; and
- Minimise barriers to access to services, co-locating where possible and undertake service re/development in locations that are accessible.

Once completed, this planning will present a vision which will directly support a Facilities/Site Master-plan enabling the DHB to undertake any major facility re/development in an informed manner and to reconfigure service delivery models to match the best location for the delivery of services. We will also be able to better prioritise capital expenditure and funding applications and develop a Strategic Workforce Plan through improved understanding of the future direction and the setting and location of future service delivery.

Organisational capability and capacity development is also ongoing throughout the DHB's HSS services and in 2006/07 much of the foundation work was laid for understanding and improving our capability in terms of technology and information systems, patient flow processes and quality systems, business systems and workforce management:

- The Improving the Patient Journey Programme focuses on improving patient flow processes through our hospitals;
- A review of Acute Demand and After Hours Care, in collaboration with the primary sector, has led to the development of a plan for managing acute demand and after hours cover in the region;
- A single integrated patient management system remains a high priority with the immediate focus being a Clinical Information System (CIS) Portal to enable clinical staff to access various patient information systems through a single access point;
- Improving organisational fitness projects have focused on reducing duplication, eliminating inappropriate business processes and supporting clinical services;
- Developing our workforce has included emphasis on providing targeted business skills training for frontline and middle managers through exposure to external business concepts and practices, as well as the reinforcement of existing business processes to meet today's demands. Improving decision making skills, leave management and roster activity have been a particular HSS focus; and
- Improving Business Planning has included emphasis and support in the past year on building business plans for each HSS service. The focus has been on services building their own business plans with clinical and management staff building a clear understanding of their service's future workforce, capital expenditure and service needs.

The need to increase our capability and capacity to support disease prevention, early intervention and the ongoing uptake of primary and community health services is an imperative as the Canterbury DHB faces increasing demand and an ageing population. The DHB is committed to continuing projects that have already begun and focusing on increasing its ability to deliver services.

3.1.4 Information Systems and Services

Information Services support the Canterbury DHB in the delivery of effective health services to its population, through the provision of quality information systems and services. This involves working on national, regional and local projects that promote the DHB's capability to provide effective, quality services to its population.

DHBs have adopted a collective approach to implementing the government's Health Information Strategy NZ (HIS-NZ). Regional workshops have determined a collective view of the strategic importance of Action Zones within the Strategy and have provided initial input into priorities.

Alongside our commitment to the implementation of HIS-NZ the Canterbury DHB has also established an Information Services Strategic Plan (ISSP) and, through the implementation of both these strategic documents, significant key projects and initiatives have already begun.¹¹

- Formation of a South Island Secure Health Data Network providing the network infrastructure for agencies to share information. The network, conceived and administered by the Canterbury DHB, currently connects all South Island DHBs along with other significant healthcare agencies such as Medlab South, Christchurch Radiology Group and Cashmere Medical Imaging;
- Implementation of a local Health Practitioners Index (HPI) this local index will allow us to link to the national HPI numbers once they are assigned;
- Implementation of Electronic Discharge Summaries which will allow for the summaries to be sent to GPs electronically and this initiative will significantly improve primary/secondary integration;
- Participation in the pilot of National Non-admitted Patient Collection (NNPAC) looking at the coding of outpatient visits.

In the coming year we plan to continue the implementation of our ISSP (currently being reviewed) the direction of which re-enforces the objectives outlined in national strategies and involves working closely with stakeholders to implement solutions that satisfy clinical and business requirements. Development of a CIS Portal will continue along with the upgrade of our HR Payroll (HRIS) and Rostering systems. The DHB will also look to address three key challenges over the coming 12-24 months:

- *Benefit Realisation* - Over the past year we have made significant investment into infrastructure. It is important that the benefits of this investment are realised. Significant effort will be made to ensure that the promised benefits are achieved and to put in place processes to ensure that the benefits are maintained.
- *HOMER Patient Management System (PMS)* - The PMS which is used in our acute hospital settings is approaching 'end of life'. We are expecting that the vendor will soon advise us of an end of support date as the system is designed in archaic computer language for which it is now very difficult to recruit and retain support staff. This is particularly noticeable in the current climate of high turnover and labour shortage. We will be initiating a programme of work to replace this software.

¹¹ The Canterbury DHB's ISSP is available on www.cdhb.govt.nz

- *HIS-NZ* - We will also be demonstrating our commitment to the HIS-NZ through continued implementation of the Action Zones within the national Strategy. We will be moving on to the second stage of NNPAAC and concentrating on data quality (Action Zone 2) in the immediate future.

3.1.5 Workforce Development

Workforce development and the health of our organisation are central to our ability to provide effective quality services and meet the challenges of improving our community's health. The Canterbury DHB aims to make Canterbury a preferred district for health workers in NZ by supporting flexibility and innovation and providing leadership and skill development opportunities and by being a good employer. The DHB is committed to the principles of being a good employer and has in place, as appropriate, a number of organisational policies and procedures (to promote a healthy and safe workplace) including the DHB's Harassment Policy. We will also encourage our workforce to lead by example in terms of healthier lifestyles and practices.

We have identified four major workforce goals for the coming years:

- Encourage a flexible approach to meet the changing needs of our community;
- Develop a workforce providing the 'right skills' for the best health outcome to ensure long-term capability and capacity for service provision;
- Ensure Canterbury's health sector is a 'good place to work'; and
- Create a safe health-promoting environment to support and retain staff.

The workforce we nurture must be capable of meeting the needs of our community and our workforce development activities over the coming year will include: learning and development initiatives, skills mapping, workforce redesign and participation in national workforce initiatives as we continue to support the national Future Workforce 2005/10 Strategy.¹²

Our priorities are outlined in our DAP and include:

- Identifying the likely impacts of future models of care on the health workforce to enable strategic workforce planning and development;
- Continuing to work with education providers to develop programmes for a changing health environment and encourage enrolment particularly amongst under represented groups;
- Improving workforce information and data collection to assist with workforce development and capacity planning;
- Providing leadership and career opportunities for our workforce, supporting career development; and
- Continuing the ongoing progression of Health and Safety management practices and culture.

3.1.6 Capacity, Productivity and Value for Money

The Canterbury DHB's funding is considered to be insufficient to meet projected inflationary pressures and the increasing costs of demand driven services and hence productivity and efficiency gains will continue to be key in ensuring financial breakeven while coping with increasing demand.

Preferences for sources of savings have been identified in the DHB's DSP and DAP and are (in descending order) through:

- Efficiency gains (delivering the same service in more efficient ways);

¹² *The Future Workforce Strategy is available on the Ministry's website www.moh.govt.nz.*

- Service re-configuration (delivering the same outcomes through the delivery of services in different ways); and
- Service reductions through reduced access or full cessation.¹³

To date the DHBs focus has been on efficiency gains and service re-configuration with ongoing review of infrastructure costs. Where appropriate, initiatives have been implemented to manage and/or reduce these costs resulting in our low administration component relative to the size of our organisation and assisting in improving productivity.

We also need to continue to ensure that the investments we make are returning value for money for our population and that our operations are effective and efficient. The DHB remains committed to ensuring all services funded are evidence based, and will prioritise interventions that provide the most benefits relative to the resources used.

The majority of the health and disability services that DHBs fund are set out in government policies and directives which outline the services that must be provided and what funding will be allocated. However, for services where there is a greater level of discretion we have developed a Prioritisation Framework, identifying a set of principles to assist in making choices and decisions about which services to fund/provide and at what level. Those principles are: Effectiveness, Cost, Equity, Maori Health and Acceptability.

When considering our investments a variety of productivity measures and benchmarking tools are also used to assess and promote service quality and efficiency and these will continue to be developed and applied. These measures include caseload and consultation evaluations, consumer satisfaction and complaints and timeliness. We monitor overall productivity of the DHB through resource utilisation and the value of services provided compared to the costs of providing those services.

We plan to implement and achieve a number of efficiency programmes, productivity initiatives and service reviews or reconfigurations in 2007/08 to increase our productivity and efficiency, ensure we are operating at an optimum capacity and that our process and systems allow us to maximise outcome for investment. The work to be undertaken includes:

- Ongoing HSS non-clinical support services reviews and consolidations;
- Continued implementation of the Improving the Patient Journey Programme and Patient Flow projects;
- Implementation of the results of the Community Laboratory Review;
- Continued review of clinical and non-clinical consumables usage and supply chain processes particularly around inventory and purchasing;
- Continued review of the introduction of any new treatment regimes;
- Implementation of the recommendations of the Review of Acute Demand and After Hours Cover including collaborative arrangement with external providers on elective services and acute demand management;
- Implementation of a framework for the management of chronic conditions.
- Continued review and evaluation of HSS employee cost control processes, nursing workforce costs, treatment-related costs and the costs of new technology and review of leave management and roster activity;
- Continued implementation of operational efficiency initiatives including improving the financial rigour of HSS services and improving organisational fitness through appropriate management training and the development of HSS Business Plans;

¹³ *Service reductions would only take place with the approval of our Board and (as appropriate) following consultation with our community and/or the Minister of Health.*

- Continued work within HSS Mental Health Services to streamline the patient journey through a single point of entry;
- Continued work within the HSS Older Person's Health Services to implement the *Healthy Aging Integrated Support Strategy* and the CARE Team Model;¹⁴
- Continued review of service delivery models to improve access, reduce duplication, provide for a better use of resources and increase the range of treatment options;
- Review of provider contracts, both external providers and HSS to determine whether we are achieving the best possible outcomes for the public funding invested;
- Implementation of any reviews, reconfigurations or initiatives arising from the implementation of national or local health strategies; and
- Implementation of any reviews, reconfigurations or initiatives arising from the completion of a Health Services Plan – matching best location and best provider to treatment and delivery.

In undertaking this work we will also be looking at the associated benefits which may reflect improved service quality, adoption of best practice, improved or increased service delivery and long-term service sustainability. All 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.

Over the past year effectiveness, productivity and quality programmes such as the Improving the Patient Journey Programme have enabled the DHB to reduce over-crowding and wait-times in the Christchurch Hospital Emergency Department (ED), despite an overall growth in volumes. The opening of our Acute Medical Assessment Unit is credited as making a significant difference, along with improvements in bed management systems such as daily bed meetings.

We will be seeking to further improve productivity in this manner in the coming years. Our priorities centre on maintaining service provision, ensuring equity of access to services, finding efficiencies, and ensuring effectiveness while maintaining quality standards. We will be looking to improve the patient journey not only within the hospital system but in the primary care sector with improved facilitation and a coordinated approach to the management of chronic conditions and acute demand.

3.1.7 Intersectoral Collaboration and Consultation

While we have set out our strategic objectives and priorities we realise that our vision will not be achieved through the DHB's efforts alone.

It is imperative in the current funding environment that DHBs work together throughout the sector to address national and regional challenges. The Canterbury DHB sees it has a clear role to be a lead DHB in regional and national service development and will continue to provide administrative support and clinical expertise to others.

We participate in a number of regional initiatives with other DHBs such as working with South Island DHBs on the Cancer Control Network and the implementation of national information systems. We also have a Memorandum of Understanding (MoU) with the West Coast DHB which assists in the development of closer clinical collaboration.

We have established inter-agency relationships with a wide range of government agencies including: the Mental Health Commission, Child, Youth

¹⁴ *The CARE Team Model – Coordinates, Assesses and Rehabilitates the Elderly.*

and Family, Police, Housing NZ, the Ministries of Justice, of Education and of Social Development, ACC and the Department of Corrections.

We work collaboratively with the TLAs and regional council in the Canterbury region along with Canterbury schools, the NZ Diabetic and Cancer Societies, the Heart Foundation, the regional Sports Trust and many other Non-Government Organisations (NGOs) in our region. We also actively support a number of collaborative ventures which endeavour to improve our environment and the health of our residents.

Our relationships with the five Primary Health Organisations (PHOs) in Canterbury are important to us and we work closely on acute demand management, after hours care and health promotion and population health initiatives. These partnerships also involve many NGO health and disability service providers in the region and we work hard to build collaborative relationship with all our external providers through regular provider meetings, reference groups and issue based forums.

We work with a number of educational institutions in particular the Christchurch School of Medicine, Christchurch Polytechnic Institute of Technology and the Clinical Training Agency. This work supports the growth of capability and capacity in our health workforce.

At a national level we work closely with the Ministry, participating in national projects including national benchmarking exercises and national pricing projects. We support District Health Boards NZ (DHBNZ) and participate in DHBNZ activities in areas including primary health, industrial relations, prioritisation tools, workforce development and information sharing.¹⁵

Directions agreed in our key accountability documents and local strategies ensure our continued involvement in collaborative projects both nationally and regionally.

Community Participation

Interaction with our community occurs on a number of levels. At a governance level, seven of the Board's members are elected by our community and additional community members are appointed to the Board's Statutory Committees.

We actively engage with providers of health services working with them in a cooperative way for the benefit of our population. In important areas of policy development or for significant projects we seek input from our community and our providers. This may be in the form of providing opportunities for input on early development of papers/ideas or involvement in working parties.

We have established, or are involved with, a number of consumer and community reference groups, working parties and advisory groups which provide advice and input on the development of strategy, policy and direction for the Canterbury DHB. We also work closely with Maori and Pacific communities to ensure Maori and Pacific input into the development of strategies, policy and initiatives to improve health care access and delivery.

Over the past year we have undertaken considerable consultation on a number of key strategies and plans. It is important to us that the long-term direction being set through these key strategies are relevant to, and supported by, users, our community and our staff and that any change will have a positive impact on the health status of our community. Our commitment to collaborative participation in setting direction and policy is outlined in our DSP and actions in our DAP demonstrate this continued commitment.

¹⁵ DHBNZ is the national representative body for all twenty-one DHBs.

3.1.8 Associate and Subsidiary Companies

The Canterbury DHB is a joint shareholder in the South Island Shared Services Agency Limited (SISSAL), which is wholly owned by the six South Island DHBs: Nelson Marlborough, West Coast, Southland, Otago, South Canterbury and the Canterbury DHB. SISSAL provides a consultancy service to the DHBs and works in partnership with them on health planning and funding issues providing services such as: contract and provider management, audit and analysis, strategy and service development and project management. SISSAL is funded by the DHBs to provide these services with an annual budget of around \$3.1m.

SISSAL produces its own SOI outlining its intentions and expected performance over the coming years. The key goals identified in SISSAL's SOI for 2007/10 are: to work in a supportive consultancy capacity, to provide outputs of consistent quality, to provide a forum for DHB's to work together collaboratively and to add value through having good knowledge of DHB business, establishing excellent relationships and sharing learning with the South Island DHB's.

The Canterbury DHB also has a 50% share in the NZ Centre for Reproductive Medicine Limited, a regional fertility service provider.

In addition to these interests, the DHB also has two subsidiary companies, which as wholly owned subsidiaries, have their own Board of Directors and report on a regular basis to the DHB as their shareholder.

Brackenridge Estate Limited

Incorporated in 1998, Brackenridge Estate Limited provides residential care services and day programmes to people with intellectual disability and high dependency needs. Established with the objective of developing and operating a specialised residential care facility for former residents of the Templeton Centre, fourteen houses are now located on the Brackenridge site and 20% of residents are community referrals.

Funding of Brackenridge comes from two sources; a contract directly with the Ministry and contracts with Child, Youth and Family Services. Future direction for Brackenridge includes consideration of growth in community settings and a commitment to the NZ Disability Strategy and the 2003 National Health Committee report, '*To Have An Ordinary Life*'.

Canterbury Laundry Services

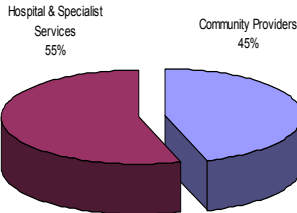
Canterbury Laundry Service Limited was incorporated as a company in February 1993. The Company acquired the laundry and linen supply operation from the former Canterbury Area Health Board - the shareholding was originally owned equally by the former Canterbury Health Limited and Healthlink South Limited. The Canterbury DHB now owns all shares. The Canterbury DHB appoints two directors to the Laundry Services Board.

The land and buildings used by the Company are located at Sylvan Street, Addington, Christchurch, and ownership was transferred to the Canterbury DHB early in 2003. Plant and equipment, motor vehicles and the rental linen pool are now the major fixed assets of the Company. A rental is paid for the use of the land and buildings to the Canterbury DHB, which provides the majority of the Company's revenue.

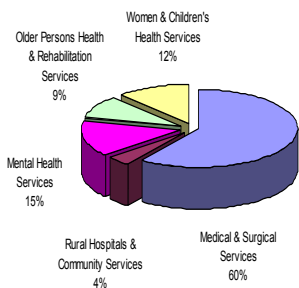
3.2 DHB Planning and Funding of Services

The DHB is responsible for planning and funding the public health and disability services provided in Canterbury in accordance with national health and disability strategies, national policies and the needs of the people in our region.

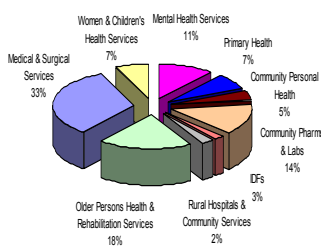
CANTERBURY DHB
FUNDING ALLOCATION



CANTERBURY DHB
HSS FUNDING ALLOCATION



CANTERBURY DHB
FUNDING ALLOCATION ALL PROVIDERS BY SERVICE



The Planning and Funding division of the DHB is the division responsible for determining what health and disability services are needed in Canterbury and how best to use the funding the DHB receives. This involves analysing the region's health needs and, in consultation with our stakeholders and community, deciding on the mix, range and volume of services to be provided.

The Planning and Funding division puts together the SOI and other key accountability documents and undertakes a regular HNA for the Canterbury region. This division also sees that our community and stakeholders are involved in the planning that we do.

Using the funding available from government, the DHB (through the Planning and Funding division) then contracts with the organisations or individuals who can best provide the services our community needs. The services contracted include primary care services, mental health services, support services for people with aged related disabilities (including residential services), Maori health services, Pacific health services and hospital and specialist services.¹⁶

Our Planning and Funding division manages the service contracts or agreements, initiates specific health improvement projects and builds partnerships with our community, our providers and with other DHBs to develop integrated continuums of care, promote innovation, develop services to meet any identified gaps in service delivery and improve overall health outcomes for our community.

The Planning and Funding division is also responsible for ensuring Canterbury residents have access to specialist services that are not delivered in our region and for monitoring and managing the flow of funds for these 'out of district' services.

The division's core activities also include monitoring and evaluating service delivery, including audits, and accounting to the Ministry for the DHB's performance. The Planning and Funding division ensures that any advice it provides to the Board matches national strategies and government policy and that funding is also carried out within national policy boundaries, such as those provided by the National Service Framework, which sets out national criteria for access to services.

Our Strategic Priorities and Core Directions assist the Planning and Funding division to develop subsequent improvement plans, objectives and targets going forward.

There are a number of core health services, which are critical to safe health service provision for the population. It is a priority to continue to fund these services, together with those which meet the strategic priorities of the DHB. Discretionary funding may result from changes in service delivery, contracting options or purchasing methods and resources may be shifted to reflect priorities. However, given the funding outlook for the DHB over the next three years there is unlikely to be significant discretionary funding available.

The key priorities for the Planning and Funding division over the next three years are focused on:

- Improving control of demand driven primary care expenditure;
- Ensuring continued close working relationships with PHOs and NGOs;
- Contributing to provider service development and facilities planning;
- Ensuring best use of Mental Health Blueprint Funding;

¹⁶ Funding for public health and under-65s' disability support services is not provided by the DHB but is directly funded by the Ministry to the organisations that provided these services.

- Facilitating the implementation of the Aged Care Strategy, *Healthy Ageing Integrated Support* and the CARE Team Model;
- Completing the Health Services Planning Project;
- Completing and implementing a framework for the management of chronic conditions focusing initially on respiratory disease, cardiovascular disease, diabetes and depression;
- Implementing the national Healthy Eating, Healthy Activity (HEHA) Strategy at a local level;
- Implementing the recommendations of the Review of Acute Demand and After Hours Cover;
- Implementing the direction and recommendations from the Youth Health Position Paper;
- Reviewing Diabetes Services, implementing Plans for Immunisation Services and Maternity Services and implementing additional Electives Services funding;
- Evaluating the implications of national initiatives and developing appropriate implementation plans to meet Ministry requirements;
- Ensuring appropriate value for money pricing for service delivery volumes and appropriate target volumes;
- Supporting the health gain priorities as outlined in our DSP; and
- Reviewing and evaluating existing contracts and services for value for money and considering re-prioritisation of funding.

3.3 DHB Provision of Services

3.3.1 Primary Care Services

A strong primary health care system (as outlined in the national Primary Care Strategy) is central to improving New Zealanders' health overall, and to reducing health inequalities between different groups. NZ is experiencing a growing prevalence of chronic conditions, such as diabetes and cardiovascular disease. Some groups of New Zealanders suffer from these conditions disproportionately: e.g. Maori, Pacific people and those on low-incomes. Chronic conditions require increased focus to ensure that they are recognised and managed effectively.

The three national goals from the national Primary Care Strategy are:

- *Transparent National Priorities* - DHBs, PHOs and the Ministry focused on national health priorities and working collaboratively to improve sector performance.
- *Collective Stewardship and Governance* - Community and PHOs engaged to identify population needs and target responses consistent with national priorities.
- *Enhanced Delivery* - A continuum of accessible services focused on reducing the incidence and impact of chronic conditions.

Currently the Canterbury region has five PHOs operating, all of which are providing CarePlus services to their enrolled population. The goal of CarePlus is to develop individualised programmes for those people within General Practice with two or more chronic conditions - specific goals are set for each person and monitored on a quarterly basis.

Funding has been made available for PHOs to provide improved access to services, targeted at those who are not currently enrolled or those who experience barriers to accessing services. A number of services to improve access have been implemented including longer GP consultations for some patients, School Health Clinics and community nursing services.

CANTERBURY PHOS

Canterbury Community PHO
 Rural Canterbury PHO
 Hurunui Kaikoura PHO
 Partnership Health PHO
 Christchurch PHO

PHOs have also been funded to provide Health Promotion messages to their enrolled populations and we have collaborated closely on emphasising national priorities and improving sector performance. Health Promotion activities have focused on physical activity and nutrition, smoking cessation, oral health, mental health and diabetes. The DHB and Canterbury PHOs have recently been successful in gaining support from the Ministry for community nutrition services as part of the national Cancer Control Strategy, have successfully implemented the Meningococcal B Vaccination Campaign and developed a nutritional cookbook for older people

Having identified Primary Care as one of our Strategic Priorities, we intend to continue to support Canterbury PHOs in the delivery of quality services. Our key priorities in working with Canterbury's PHOs are to:

- Support the collaboration between primary health, secondary care and public health through ongoing integration projects including managing acute demand and the development and implementation of mental health demonstration models within primary care.
- Support PHOs in the growth of a multi-disciplinary approach to care encourage a population health focus and a collective approach to the management of chronic conditions;
- Support PHOs in the most effective use of their workforce and associated diagnostic and therapeutic services;
- Support PHOs to develop links with other social agencies to ensure appropriate supports are included in the integrated continuum of care;
- Continue the development of service utilisation information to measure the uptake of primary health services by the people of Canterbury; and
- Continue to develop audit process for PHOs to enhance better ways of working and support the PHO Performance Management Programme.

The Canterbury DHB recognises the primary care sector as a vital contributor to the health of the region and will continue to ensure that the primary care sector is involved with the planning for future health services and initiatives and shares targets for improving the health of our community. The DHB will also encourage the involvement of communities in PHO governance.

In addition to the work being done to implement the Primary Care Strategy we have been working to improve access to all primary care services including pharmacy and laboratory services, oral health services, community mental health services and home support services. In 2006/07 the DHB:

- Continued the evaluation of the role of Pharmacy within the primary care environment, driven by the pilot of the Pharmacy Based Medicine Management Service where positive evaluation has resulted in a DHB wide implementation of the service; and
- Completed a Review of Community Laboratory Services resulting in retention of the multi-provider structure, adoption of a risk-sharing funding model and development of a Laboratory Reference (Stakeholders) Group.

This work will continue with emphasis on the effective management of demand, the collaborative development of disease management tools such as disease registers and on the development of integrated care continuums for chronic conditions and the management of long-term illness.

3.3.2 Mental Health Services

The Canterbury DHB provides mental health and addiction services on the basis of the national Mental Health Strategy, *Te Tahuhu – Improving Mental Health 2005-2015*, which outlines ten leading challenges for the mental health sector.

The ten challenges of *Te Tahuhu* have led to the development of a draft local Strategic Framework that aligns the ten challenges with the strategic

objectives of Canterbury DHB and with our Mental Health and Addictions Plan (2004). It suggests priorities for action for the next three years and feedback from the sector will help to influence our future direction.¹⁷

Our current local Mental Health and Addictions Strategy is consistent and complimentary to national and regional work and emphasises a 'System of Care' model based on advancing recovery for people with serious mental illness. This marks a shift away from tertiary and secondary services towards a community-based system of care with increased collaboration between providers, service users and their families/whanau.

The majority of additional mental health funding has been invested in the community/primary sector and has greatly expanded the range of services available to those in our population with serious mental illness. The additional funding has provided a platform from which the sector can address issues such as how to improve access and ensure services are responsive to the needs of consumers. However, issues must, for the main part, be addressed within existing resources therefore necessitating that services be reconfigured. Decisions about any reconfiguration of services will be made according to local priorities and national direction, primarily *Te Tahuu*, its associated Implementation Plan, *Te Kokiri* and our own Mental Health and Addictions Strategy.

Over the past year we have furthered the implementation of our Strategy with projects that improve access and responsiveness within mental health services and focus on national initiatives to improve patient care:

- Bottlenecks have been pin-pointed within our HSS Mental Health Service in both adult and child and youth services and work has begun to streamline the patient journey through a single point of entry to improve access, reduce duplication, provide for a better use of resources and increase the range of treatment options;
- Investment in Peer Support Services has led to the development of a telephone support service for people with mental illness, and a Strengths Based Peer Support Service;
- The District Nursing Medication Service established as a demonstration service has expanded as has the Consult Liaison Function through HSS to support NGO providers and the primary care sector;
- A joint initiative was undertaken with the Christchurch City Council to identify service gaps and partnership opportunities between specialist mental health services and tenants of Council Social Housing; and
- A Kaupapa Maori scoping project was completed to identify the level of need and potential models for service delivery in Canterbury.

The DHB is also conscious of workforce and recruitment issues within the sector and a number of projects and initiatives were undertaken in 2006/07 which the DHB will continue to support:

- A Canterbury Child and Adolescent Mental Health Services Placement Project was established as a demonstration project between the Werry Centre and the DHB to support recruitment into the child and adolescent mental health sector;
- A NGO Mental Health Workforce Development (MHWD) Plan is currently being completed to identify MHWD priorities, develop a training calendar and scope an NGO supervision brokerage service.

Blueprint Funding

The proportion of funding that DHB's receive for mental health and addiction services are tagged or 'ringfenced' specifically for those services. The mental health Blueprint dictates the level of service that DHBs are expected

TE TAHUHU

10 LEADING CHALLENGES

Promotion & Prevention
Building Mental Health Services
Responsiveness
Workforce & Culture for Recovery
Māori Mental Health
Primary Health Care
Addiction
Funding Mechanisms for Recovery
Transparency & Trust
Working Together

¹⁷ The framework is currently with the DHB's mental health sector for consultation.

to provide (services levels that ensure access for the 3% of the DHB's resident population - those considered most in need).

New Blueprint Funding is allocated to ensure provision of targeted service levels to that 3% and the Canterbury DHB will receive an additional \$1.6M (of ringfenced mental health and addition funding) in 2007/08 to increase service levels. This additional Blueprint funding will be focused on:

- Increasing investment in community services and primary care services;
- Supporting and developing Peer Support Services;
- Progressing cultural responsiveness of mainstream services and the development of the Kaupapa Maori Mental Health Sector; and
- Supporting increased flexibility and innovation in service delivery.

The DHB is committed to supporting flexible mental health support options particularly around youth and Maori mental health services and will continue to 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.

In 2005/06 a number of demonstration services were funded in response to identified local need, outside of the National Service Framework and it is anticipated a portion of new spending will continue to be invested in this way.

3.3.3 Health and Disability Support Services

Older People's Health Services

The Canterbury DHB is progressively implementing the national Health of Older People Strategy (HOP). Implementing the HOP Strategy by 2010 will require DHBs to review and refocus services to better meet the needs of older people now and in the future.

As one of our five Strategic Priorities, the health of older people is a particular focus for us and our local aged care strategy, *Healthy Ageing, Integrated Support* formalises the national Strategy into a workable context for our region. Our local Strategy aims to improve the health of older Cantabrians through the development of more integrated health and disability services that are responsive to older people's varied and changing needs.

Over the past year implementation of our local Strategy has resulted in:

- Further development of home care packages as alternatives to residential care and transitioning of rest home beds to hospital level to meet changes in demand;
- A review of community day support options, with increases in capacity for general and dementia stand-alone day activity centres;
- Development of a database which identifies entry, exit and length of stay trends in residential care and that will assist with future capacity planning;
- Completion of the two year trial of the geriatric assessment tool, International Resident Assessment Instrument (InterRAI), with approval for wider use of the tool within our HSS Older Person's Health Service. This tool aims to improve coordinated clinical assessment by avoiding duplication and using one integrated plan for each patient;
- Continuation of the 'Stay Your Feet' fall prevention programme. Funding has enabled the employment of a Programme Coordinator;
- Utilisation of Mental Health Blueprint funding for re-establishing a Psychiatric Service for the Elderly Memory Assessment Clinic and completion of an HSS Community Stroke Service pilot, resulting in improved outcomes for older people and their families; and

- Completion of a pilot to explore the needs of older Maori with particular focus on those admitted to inpatient units which contributed to the development of our Maori Health Plan for Older People, *Te Huanui*, and the employment of a dedicated Maori Health Worker.

Our ongoing priorities are the continued implementation of both our local Strategy and the national HOP Strategy. We will focus on:

- Collaborating with primary and community providers to develop integrated continuums of care for older people, focusing on a smooth transition between services and a restorative/rehabilitation approach;
- Continuing to support older people in the community and away from institutional care through the introduction of flexible packages of care and the development of new care coordination and case management models;
- Implementing the CARE Team Model presenting a interdisciplinary team approach to Needs Assessment/Service Coordination for inpatient and community services;
- Increasing community based services, with the introduction of Community Support Worker roles and an increase in stand alone day support facilities;
- Working with providers, particularly around capacity and capability issues, quality improvement, workforce development and fair employment practices; and
- Supporting improved management of elective services and increasing access to orthopaedic and cataract surgery to benefit older people.

Disability Services

The services provided for people with disabilities are designed around the NZ Disability Strategy. The Canterbury DHB's vision is to have a fully inclusive community, where people with disabilities can live in a society that highly values them and continually enhances their full participation.

The implementation of our vision for disability services is presented in our Disability Strategy Action Plan 2004/2007 which sets out objectives and priorities for implementing the NZ Disability Strategy at a local level. In the past year we have worked to implement the principles of the Strategy including:

- Completing a survey of our HSS divisions which outlined the key areas of progress under the NZ Disability Strategy;
- Participating in the scoping of a project to address issues pertaining to assessment and referral of children with disabilities; and
- Conducting a survey of consumers of our services to better understand how the services can meet the needs of patients and consumers.

Building new facilities (Christchurch Women's Hospital, the Diabetes Centre and redevelopment of Burwood Hospital) has offered us an opportunity to upgrade service delivery in terms of the needs of people with disabilities through implementation of our DHB Accessibility Plan.

Our HSS Rehabilitation Health Service has also successfully implemented a Circuit Training Programme. The aim being to reduce physiotherapy outpatient waiting times and improve the efficiency of delivery without increasing therapist case loads. The programmes aims also include increasing participant satisfaction, improving reporting and auditing and improving therapist satisfaction and morale - therefore assisting with staff recruitment and retention. This change in the model of service delivery will mean the same resources can be allocated differently and allow a more flexible service that best meets the needs of our patients.

In developing our Disability Action Plan, we recognised that we cannot address every barrier over night but can take a step by step approach to practical and attitudinal changes that will benefit everyone. We see the NZ Disability Strategy as a 'whole of government strategy' of which we form only a part and during the coming year we will continue to work to achieve our objectives in the areas we are able to influence.

3.3.4 Maori Health Services

The national Maori Health Action Plan 2002, *Whakatataka* sets out to achieve change within DHBs. DHB activities are directed at improving Maori health rather than efforts being concentrated on ad-hoc programmes and initiatives. The Action Plan seeks to build on the strengths within whanau and Maori communities and contains four pathways for action.

These pathways for action are integral to ongoing work within the Canterbury DHB. Four priority areas have been identified within the DHB: building quality data and monitoring Maori health; developing whanau ora based models; increasing Maori participation at all levels of the health and disability sector – particularly workforce development and governance; and improving access to primary health care.

Our local Maori Health Plan, *Whakamahere Hauora Maori ki Waitaha*, is consistent with the national Action Plan. While our Plan is currently under review, a number of achievements have been made in implementing the direction set out in the Plan including:

- Extension of the Christchurch Hospital Maori Health Team working in key services to achieve better health outcomes for Maori patients, particularly services that require cultural protocols (Paediatrics, Oncology, Sexual Health, the Emergency Department and the Mortuary).
- Provision of a cultural programme to Burwood Hospital staff, assisting them to understand how Maori views and values can impact on their clinical practice. It is anticipated that a specific cultural training programme for DHB contract managers and for Board members (currently under development) will be implemented in the 2007/08 year;
- Collaboration with Partnership Health PHO in developing a smoking cessation service targeting Maori women and their families to improve the health of this at risk population; and
- Collaboration with local Maori groups to implement a smokefree marae campaign with several local marae now having designated smoking areas and one becoming smokefree.

Anticipating approval of the revised Maori Health Plan, focus over the coming year and beyond will be around:

- Implementing a Maori model of service delivery providing clinical, cultural and priority-need frameworks to ensure mainstream services are responsive to Maori;
- Supporting the development of Maori health providers through the Maori Provider Development Scheme (MPDS), mental health funding and cooperation with the other South Island DHBs in Te Herenga Projects;
- Continuing to support appropriate processes to engage with the Maori community and Maori providers and formalise the relationship that exists with Ngai Tahu and Manawhenua ki Waitaha through an agreed MoU (or formal relationship agreement) at governance level; and
- Progressing ethnicity data collection to introduce processes and systems to analyse the data collected and to determine and formalise access levels and access issues for Maori.

We will also continue to work on capability and capacity issues through the South Island Maori Managers Network, *Te Herenga Hauora o te Waka a*

IMPLEMENTING
WHAKATĀTAKA
PATHWAYS FOR ACTION

Te Ara Tuatahi
Developing whānau, hapū, iwi &
Māori communities

Te Ara Tuarua
Increasing participation
throughout the health and
disability sector

Te Ara Tuatoru
Creating effective health &
disability services

Te Ara Tuawhā
Working across sectors

Maui, where a number of projects have been developed to support Maori service provision in Canterbury. These include:

- The development of a Maori Health Workforce Development Plan, *Te Waipounamu*, now in the final stages of consultation;
- The development of a South Island regional Maori workforce recruitment project to enhance the Maori health workforce in our region;
- The development of a Maori health training and education opportunities directory, currently being distributed to Maori health providers; and
- A review of the MPDS, results are being discussed with the Ministry with recommendation expected to be released for implementation in 2007/08.

3.3.5 Pacific Health Services

The NZ Pacific Health and Disability Action Plan 2002 sets out the direction and actions for improving health outcomes for Pacific people and reducing inequalities between Pacific and non-Pacific peoples. It is directed at the health and disability service sectors and Pacific communities, and aims to provide and promote affordable, effective and responsive health and disability services for all New Zealanders.

The Canterbury DHB is in the process of reviewing and updating its local Pacific Health and Disability Action Plan, in alignment with the national Plan. Specific focus over the coming years will be in response to the recommendations of that review and is likely to be around:

- Continuing to involve Pacific people in health service development, progressing the project on Responsive to Pacific People in our hospital and HSS Mental Health Services;
- Building and supporting the capacity and capability of Pacific providers through the implementation of the Canterbury DHB Pacific Health Workforce Plan (assisting to develop a competent and qualified Pacific health and disability workforce) and ongoing facilitate of the Pacific Provider Development Fund; and
- Working (through the Ethnicity Data Collection Project) to ensure that data on Pacific needs and health outcomes exists and that initiatives are implemented to inform policy, planning and services development.

3.3.6 Hospital and Specialist Services

The Provider-arm or HSS division of the Canterbury DHB provides inpatient and outpatient services, community services and day programmes, across six service divisions (refer to Appendix 3 for an overview of the services provided by each of the HSS service divisions).

The Canterbury DHB owns 14 hospitals in the Canterbury region, which are managed by the HSS division and while the majority of HSS services are provided from these hospitals, some specialist services are delivered from community bases or through out-reach clinics. A significant proportion of our HSS mental health services are provided in community settings.

Our HSS face material challenges now and in future years through increasing demand, increasing costs of technology and treatment, complexity of conditions, expectations of service, compliance with legislation, increasing labour costs and a minimal increase in funding. The HSS division has a range of strategies to cope with current and future challenges.

The key priorities for HSS over the next 12-24 months are focused on:

- Continued review of service delivery models to improve access, reduce duplication, provide for a better use of resources and increase the range of treatment options;

PACIFIC HEALTH & DISABILITY ACTION PLAN

PRIORITY AREAS

- Pacific child & youth health
- Promoting Pacific healthy lifestyles & well-being
- Pacific primary health care & preventive services
- Pacific provider development & workforce development
- Promote participation of disabled Pacific peoples
- Pacific health & disability information & research

CANTERBURY DHB HSS SERVICE DIVISIONS

- Medical and Surgical Services
- Mental Health Services
- Rural Health Services
- Women's & Children's Services
- Older Person's Health and Rehabilitation Services
- Hospital Support and Laboratory Services

- Continued implementation of the DHB's Strategic Plans and projects to improve capability and capacity including: the Improving the Patient Journey Programme, the Health Services Planning Project, a framework for the management of chronic conditions, the recommendations of the review of Acute Demand and After Hours Cover and patient flow projects;
- Continued advocacy for funding mechanisms that recognise the additional cost of providing tertiary services to populations outside of Canterbury;
- Championing the use of tools such as clinical costing and marginal analysis to facilitate informed discussion on prioritisation and continued review/adoption of best practice approaches to the delivery of services;
- Continued review of clinical and non-clinical consumables usage and supply chain processes particularly around inventory and purchasing;
- Continued review and evaluation of HSS employee cost control processes, nursing workforce costs, treatment-related costs, costs of new technology and review of leave management and roster activity;
- Continued implementation of operational efficiency initiatives including improving the financial rigour of HSS services and improving organisational fitness through appropriate management training and the development of HSS Business Plans;
- Implementation of any reviews, reconfigurations or initiatives arising from the implementation of local health strategies or the completion of a Health Services Plan for the Canterbury DHB – matching best location and best provider to treatment and delivery.

Our HSS are primarily funded through our Planning and Funding division (who hold a service contract with the HSS division just as they do with all service providers - referred to as the Price Volume Schedule (PVS)).¹⁸ As part of this contract HSS agree to provide certain 'outputs' or volumes these are summarised in the following table:

CANTERBURY DHB - KEY CONTRACTED SERVICE OUTPUTS

Contracted Output or Service Level	Measure/Unit	Volumes		Variance
		2006/07	2007/08	
Medical In-patient	Case weights ¹⁹	33,102	33,878	2.3%
Surgical In-patient	Case weights ²⁰	37,357	39,635	6.1%
Medical Out-patient	Attendances/Procedures	161,681	164,623	1.8%
Surgical Out-patient	Attendances/Procedures	101,976	101,253	-0.7%
Mental Health	Full Time Equivalent	325.9	334.9	2.8%
Mental Health	Bed days ²¹	87,308	87,308	0.0%
Emergency Department	Attendances	82,696	82,696	0.0%
Maternity	Attendances/Procedures	5,283	5,550	5.1%
Disability Support Services	Bed days	68,708	68,811	0.2%
Disability Support Services	FTE	None	None	None
Personal/Community Health	Complete measures as per contract	1,133,457	1,056,851	-6.7%

¹⁸ The PVS is the contract between the DHB's Funder and its Provider specifying the service volumes to be delivered and the prices to be paid for those volumes.

¹⁹ Case weights are a relative measure of the cost of a procedure.

²⁰ Does not include elective volumes to be delivered via contracts with NGO Providers.

²¹ Bed days describe how many hospital beds are occupied by patients and for how long.

Elective Services (i.e. booked surgery)

The Canterbury DHB is committed to meeting the Government's expectations around elective services, particularly in the three key policy areas of:

- *Patient Flow Management* - The DHB has made a commitment to achieve and maintain compliance with all Elective Services Patient Flow Indicators (ESPis);
- *Level of Service (volumes, case weighted discharges, standardised intervention rates/standardised discharge ratios)* - We will ensure delivery of services in line with the agreed PVS. We are committed to delivering on our commitments in respect of the Orthopaedic and Cataract initiatives and to providing additional elective services volumes and we will review our rates for key elective procedures (operations) to ensure we are delivering the right level of service for our population; and
- *Order of Service (Prioritisation)* – We are committed to ensuring that patients are assessed and prioritised for surgery on a consistent basis, and that they receive surgery according to the priority they are given.

Over the past year we have made a number of significant achievements:

- ESPI compliance was achieved at a DHB level and additional electives funding was secured for the majority of elective services;
- The primary/secondary interface was strengthened with additional GP Liaison resources and collaboration commenced on a variety of patient flow initiatives;
- There was a renewed focus on referral management and prioritisation practices at clinician level and delivery of more timely information at service level to inform improved process and match promises to capacity;
- The Improving the Patient Journey Programme delivered improvements in theatre utilisation and resource allocation that reduced the impact of trauma overload on elective volume delivery;
- The Orthopaedic Continuous Quality Improvement (CQI) initiative delivered increased utilisation of resourced theatres, and reduced reliance on Registered Medical Officers (RMOs) through Nurse Led activity;
- A patient 'Road Map' has been designed for patient (by patients);
- Cataract scores can now be applied by GPs, Optometrists and Ophthalmologists and cataract patients are 'pooled' on the treatment lists to improve equity of access across all referral sources and the DHB has ongoing liaison with GPs in primary care regarding referral completeness and access to services; and
- An initiative was completed to improve the management of Post Operative Follow-up Patients with an increase in the number of patients discharged directly to their GP supported by appropriate clinical management guidelines.

During the process of achieving ESPI compliance in 2006/07 it was identified that a more robust system was necessary for sustaining compliance and achieving the principles of clarity, timeliness and fairness. An *Elective Services Sustainable Compliance Plan*, incorporating an *Accountability Framework* was developed and approved. The purpose of the framework is to provide a transparent and accountable system of electives management, where roles and responsibilities are defined, performance is monitored and measured and improvements achieved and sustained in a structured and supported manner.

An Elective Services Steering Group has also been re-established with clinical and management representation from PHOs, the DHB and the Ministry and dedicated Elective Services Manager and Elective Service Analyst roles have also been approved and advertised. During 2007/08 this framework will continue to be devolved throughout the organisation.

4. ADVANCING OUR STRATEGIC PRIORITIES

This section outlines the objectives Canterbury DHB hopes to achieve over the next three years. The national outcomes or objectives listed are based on government policy and describe how our DHB will contribute to the government's policy directions for the whole of NZ. The DHB's local Directions and Strategic Priorities were developed through a HNA process and a public consultation process during the development of our DSP.

Details on the specific actions and activity the DHB will undertake to implement policy and contribute to outcomes and objectives both nationally and locally are provided in our DAP for the 2007/08 year.

4.1 National Strategic Objectives for DHBs

The national outcomes to which the Canterbury DHB will contribute are set out in the NZPHD Act 2000:

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

4.2 National Priorities for 2007/08 (Government Policy)

In addition to long-term national objectives DHBs are provided with a yearly Planning Package which includes the expectations of the Minister of Health for each year. The Minister's 'Letter of Expectations' for 2007/08 identifies the following specific priorities which DHBs are expected to contribute to:

Continued progress on national strategies - with emphasis on quality, safety and reducing inequalities:

- Elective surgery;
- Breast screening;
- Community mental health services;
- Maori health service provision;

- Pacific health service provision;
- The 'Get Checked' programme for Diabetes Mellitus;
- Pandemic preparedness;
- Working within budget;
- Ensuring Board members have the requisite governance skills;
- The NZ Health Strategy 2000;
- The NZ Disability Strategy 2001;
- The Maori Health Strategy 2002 *He Korowai Oranga*;
- The Mental Health Strategy 2005 *Te Tahuhu: Improving Mental Health*;
- The Health of Older People Strategy 2002;
- The Primary Care Strategy 2001; and
- The Pacific Health and Disability Action Plan 2002.²²

Progress on addressing specific 2007/08 Priorities:

- Chronic Disease;
- Child and Youth Services;
- Primary Health;
- Health of Older People;
- Infrastructure; and
- Value for Money.

4.3 Canterbury DHB Core Directions and Strategic Priorities

As highlighted throughout this document, the Canterbury DHB will continue its efforts to deliver the best results possible in all areas of service delivery. However we, like all DHBs, have limited funding and will therefore be working hard to prioritise and reallocate that funding to provide the Canterbury community with ongoing, effective and quality services within our funding constraints. The DHB will be focussed on improving the way we provide and deliver services rather than on increasing the money spent.

We have identified a number of Core Directions or 'tools' by which we will improve our function and performance. These Core Directions will provide the DHB with the foundations needed to target activity in priority areas, to make improvements in the delivery of ongoing services, to implement national strategies and to meet the Minister of Health's expectations. The Core Directions are reflected in the way that we work and underline a number of the key strategies to improve health in areas of priority for the DHB:

- Improve the health and wellbeing of our community;
- Find better ways of working;
- Work together;
- Develop our health care workforce; and
- Be a leader in health.

Five Strategic Priorities have been chosen where specific effort will be focused over the coming years. These priorities are a mixture of population and service based approaches and they represent the areas in which the DHB believes there is the biggest potential for change and development:

- Child and Youth Health;

²² As with all national strategies referred to in this document these strategies are available through the Ministry website www.moh.govt.nz

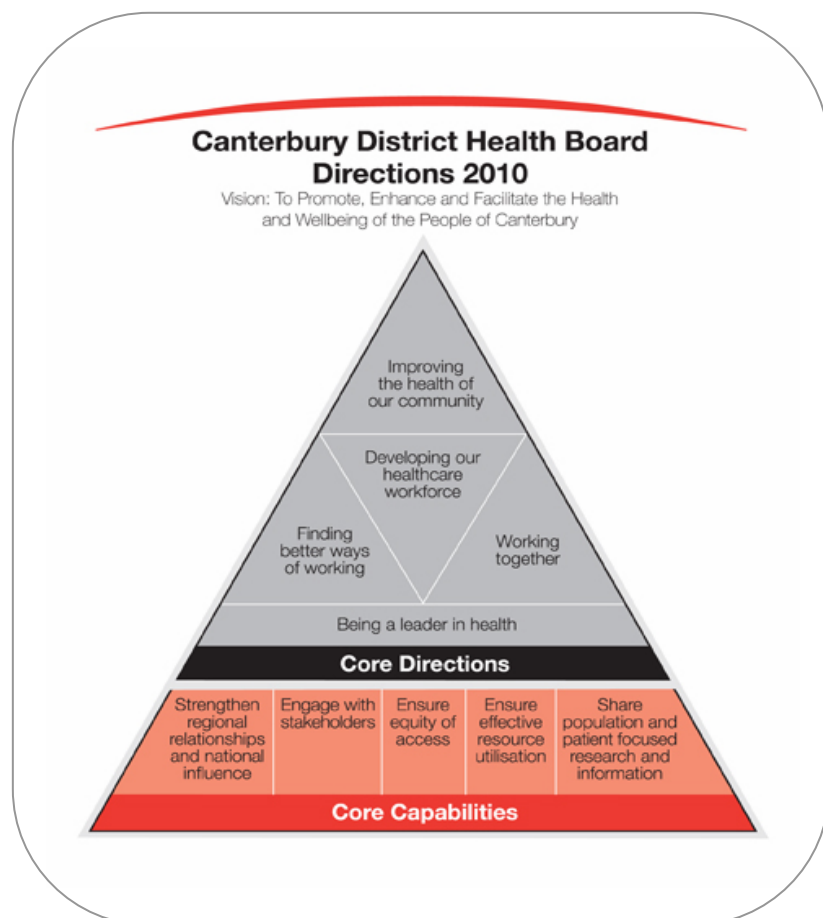
- Older Person's Health;
- Maori Health;
- Primary Health; and
- Disease Management/Prevention.

As a subset, four Disease Priorities have also been highlighted for particular focus. These are diseases that significantly reduce the quality of life for the sufferer, their families and the community - yet there are opportunities for prevention, early intervention and treatment programme development:

- Cancer;
- Cardiovascular Disease;
- Diabetes; and
- Respiratory Disease.

The Canterbury DHB's approach in all its priority areas will be consistent: focusing on strengthening regional relationships and national influence, engaging with stakeholders and promoting messages related to lifestyle choices, working to ensure effective resource utilisation, improved access, culturally appropriate service delivery, an integrated approach to patient care and the development of a integrated continuums of care. The DHB will also focus on and sharing the responsibility for health outcomes and sharing population and patient focused information to better understand the gaps in health services and to address inequalities in health.

A detailed outline of the actions and activity planned by the Canterbury DHB over the long-term and in the coming year can be found our latest DSP and DAP documents, available on our website.



5. FORECAST SERVICE PERFORMANCE MEASURES

One of the functions of the SOI, and in particular, the forecast performance measures and targets in this section (the Statement of Forecast Service Performance) is to demonstrate how what the Canterbury DHB achieves will be measured. These measures and targets will be subject to an annual review by auditors appointed by the Office of the Auditor General.

These measures are not a comprehensive list but reflect activity in the priority areas identified in the Canterbury DHB's DSP and by the Minister of Health. This activity requires the DHB to find better ways of working, to develop collaborative models of service delivery, develop its health care workforce and to provide leadership in the sector. The performance measures also include national measures that are consistent across all twenty-one DHBs.

The Ministry has identified a particular set of national 'core health targets' in order to focus DHBs efforts and make more rapid progress on key priority areas. These core health targets have been included in our selected set of measures and have been clearly identified in our DAP for 2007/08.

Where possible we have included past performance along with each target to give context and future targets to demonstrate how the DHB intends to continue to improve outcomes over the next three years. The targets provided here are based on the assumption that, notwithstanding funding and financial pressures, the DHB will be able to maintain current levels of service provision. With limited funding available the scope for service expansion is limited and therefore the Canterbury DHB's performance targets tend to reflect the objective of maintaining current performance levels in some areas while improving performance in others.

Where possible, and relevant, the DHB has also included the latest national performance levels to indicate comparative performance alongside other DHBs.

Specific detail around the DHB intended actions and activity related to each Strategic Priority can be found in the DHB's DAP for 2007/08.

The DHB notes that the following set of performance measures does not include measures around Respiratory Disease - one of the DHB's identified Disease Priorities. The Board's Quality and Patient Safety Council is currently scoping the development of key indicators for this priority area and the DHB intends to include these key indicators in future SOIs.

Child and Youth Health

Long Term Objective: Improve the health status of Canterbury's Child and Youth populations. By keeping young people healthy we give them a better chance of becoming healthy adults.

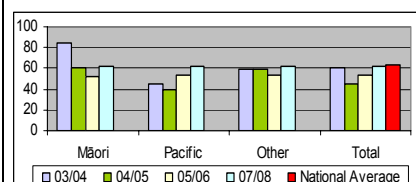
The Canterbury DHB completed a Child Health and Disability Action Plan to address the specific health issues of children in Canterbury in June 2004. The Action Plan targets ten key priorities: access, information, hearing, immunisation, injury prevention, mental health, nutrition and physical activity, oral health, parenting and smokefree environments. In April 2007 the DHB produced its Youth Health position paper, focusing on providing a safer and more supportive environment for young people, a measurable improvement in young people's mental health and a measurable improvement in their physical health. These two strategic documents will lead the direction for change and activity over the coming year.

The DHB's commitment to implementing the national HEHA Strategy; promoting physical activity and improved nutrition will assist in improving the health of our younger populations. Our HSS Women's and Children's Service's focus on the *Baby Friendly* hospital initiative and Smokefree Pregnancy Services contribute as another positive step in promoting a healthy start in life. In addition, a DHB-wide Immunisation Plan will be developed, our oral health focus will recognise oral health as a precursor to on-going well-being in adulthood and improved utilisation of primary health services should result in a reduction in preventable hospitalisation for these younger population groups.

Key Performance Measures	Actual 05/06	Target 07/08	Target 08/09	Target 09/10	Improved Child and Youth Health
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Maintain the number of babies born (in a public hospital) with low birth weight (birth weight <2,500g) below the national average – as a mean of reducing a major cause and association of infant mortality.²³

Number of babies born (in public hospitals) with low birth weight - rate per 1000 births.		Actual	Target	Target	Target
Maori		52	<62	<62	<62
Pacific		53	<62	<62	<62
Other		54	<62	<62	<62
Total		54	<62	<62	<62



Improve Breastfeeding Rates – helping to maximise children's health.²⁵

% of children exclusively/fully breast fed at 6 weeks.	Actual	Target	Target	Target
% of children exclusively/fully breast fed at 6 weeks.	67%	>69%	>71%	74%
% of children exclusively/fully breast fed at 3 months.	57%	>57%	>57%	>57%
% of children exclusively/fully breast fed at 6 months.	32%	>27%	>27%	>27%

Improve Vaccination Rates - reducing impact of vaccine preventable disease.²⁶

% of children fully immunised on day they turned...	Age Group	Actual	Target	Target	Target
% of children fully immunised on day they turned...	6 mths	80%	88-92%	-	-
	12 mths	-	88-92%	-	-
	18 mths	-	85-88%	-	-
	24 mths (2 years)	-	85-88%	-	95%

²³ Infants born under 2500gm are more likely to have poor health outcomes and increased disabilities and are more susceptible to serious illness during infancy, early childhood and adulthood.

²⁴ The DHB's aim is to maintain rates below the national average across all ethnicities. While targets have been lower in the past the small population numbers of Pacific and Māori can alter results greatly year on year.

²⁵ These targets reflect our commitment to nationally accepted rates for breastfeeding, in line with Ministry expectations. Our 6 month rates are already above national expectations and the targets may look as if the DHB is aiming to reduce performance, however this is not the case - the aim is to reflect the intention to focus on the age groups where performance can be improved.

²⁶ While the DHB's long-term target is to work towards 95% of two year olds immunised – at this point in time, without more baseline data, the DHB is reluctant to set specific targets for immunisation coverage beyond the immediate 2007/08 year.

Key Performance Measures		Actual 05/06	Target 07/08	Target 08/09	Target 09/10	Improved Child and Youth Health – continued ...
Improve Oral Health Rates – helping to maximise on-going health. ²⁷						
% of adolescents utilising oral health services.		69.9%	74.2%	76.4%	78.7%	
% of children caries free (no holes or fillings) at age 5.	Maori	33%	19-39%	19-39%	19-39%	
	Pacific	20%	16-36%	16-36%	16-36%	
	Other	54%	60%	60%	60%	
	Total	51%	51%	51%	51%	
Average proportion of Missing or Filled teeth of Year 8 children.	Maori	2.56	2.30-2.82	2.30-2.82	2.30-2.82	
	Pacific	2.62	2.30-2.82	2.30-2.82	2.30-2.82	
	Other	1.43	1.46	1.46	1.46	
	Total	1.55	1.6	1.6	1.6	
Reduce Ambulatory Sensitive Admission Rates - as an indication of access to, and effectiveness of, primary care services. ²⁸						
Ambulatory Sensitive Admissions for those aged 0-4 years per 1000 population.	Maori	78	<76	<76	<76	
	Pacific	141	<114	<98	<98	
	Other	83	<74	<69	<69	
	Total	84	<73	<68	<68	
Ambulatory Sensitive Admissions for those aged 5-14 years per 1000 population.	Maori	18	<24	<24	<24	
	Pacific	44	<31	<28	<27	
	Other	19	<21	<21	<21	
	Total	20	<21	<21	<21	
SOI Performance Measures						
Maintain national average number of babies born with low birth-weight						DAP POP 08 POP 11 POP 05 POP 04 POP 09 POP 09
Increase the % being exclusively/fully breast fed at ...6wks, 3&6mths						
Increase the % fully immunised at ... 6,12,18 & 24mths						
Increase the % of adolescents utilising oral health services						
Increase the % of children caries free at 5						
Decrease the proportion of children with missing or filled teeth at Year 8						
Reduce Ambulatory Sensitive Admissions for those ages 0-4 years						
Reduce Ambulatory Sensitive Admissions for those aged 5-14 years						
						Sponsor Funder/Provider Funder/Provider Funder Provider Provider Provider Funder Funder
						Strategic Links HEHA Strategy HEHA Strategy Child Health Plan Oral Health Plan Oral Health Plan Oral Health Plan Primary Care Strategy Primary Care Strategy

²⁷ Increased oral health promotion for under 5s is prioritised for 2007/08, but it will take 2-4 years for changes to manifest. The DHB's targets remain static but it expects measurable improvements beyond 2009.

²⁸ Ambulatory Sensitive Admissions are based on admissions for 37 combined conditions including: Asthma, Dehydration, Diabetes, Ruptured Appendix, Stroke, Angina, Gastroenteritis and 'Failure to Thrive'. The DHB is currently undertaking analysis of its rates and determining areas where it is performing below national averages, the reasons for admissions and the areas where targeted activity might influence change. However, at this point in time, the DHB has reconsidered its targets in terms of its inability to directly manage these admissions and in consideration of the joint approach that will need to be developed to understand and influence change in this area. In considering the small population numbers involved the DHB has also used confidence levels to determine its targets for the coming years. These targets reflect the DHB's intention to move towards the national average for all age groups in line with Ministry expectations. In some cases the DHB is already achieving better than national averages and the targets may look as if the DHB is aiming to reduce performance, however this is not the case - the aim is to reflect the intention to focus on those groups where performance is poor in comparison to other DHB regions.

Older Person's Health

Long Term Objective: Maintain/improve the health and independence of our older population, within available resources.

With the implications of an ageing population, the health of older people has been identified as an area of specific focus by the Canterbury DHB. As people get older their health needs increase their health problems are also more likely to be complicated, the impact more severe and prolonged and they are also more likely to suffer from chronic conditions.

In 2005/06 the DHB began the implementation of its local Aged Care Strategy *Healthy Ageing, Integrated Support* as a means of implementing the national *Health of Older People Strategy*. This work is aligned with the DHB's Core Direction *Finding Better Ways of Working* and with the development of an integrated continuum of care and framework for the management of chronic conditions. The emphasis is on flexible, holistic, quality and needs-based care provided in the community to assist older people to stay well and to age in place (in their own homes).

Promoting influenza vaccinations and reducing the rates and impact of falls are seen as a means of keeping older people well. Increasing access to primary and preventative care is expected to improve health outcomes for older people, while aging in place is enabled through the provision of more flexible services in the community and in the home.

Key Performance Measures	Actual 05/06	Target 07/08	Target 08/09	Target 09/10	Improved Older Person's Health												
Build the Focus on Health Promotion – as a means of maximising the health of older people and helping them to staying healthy in their own homes. ²⁹																	
Influenza Vaccination Rates.	72%	> 75%	> 75%	> 75%													
Numbers referred to the Stay On Your Feet (SOYF) Home Exercise Programme.	287	>270	>290	>300													
Maintain Access to Primary Care Services – as a means of maximising ongoing health and well-being. ³⁰																	
% of Canterbury population over 65 enrolled with PHOs.	97.4%	> 95%	> 95%	> 95%													
% of enrolled population over 65 accessing High User (HUHC) or CarePlus (Care+) services. ³¹	HUHC 10.1% Care+ 1.7%	>5% combined	>5% combined	>5% combined													
Reduce Ambulatory Sensitive Admission Rates – as an indication of access to, and effectiveness of primary care services.																	
Ambulatory Sensitive Admissions for those aged 65-74 years per 1000 population.	Maori 80 Pacific 149 Other 54 Total 56	<84 <114 <66 <66	<84 <114 <66 <66	<84 <114 <66 <66													
SOI Performance Measures																	
Increase the numbers receiving SOYF education on falls prevention				DAP													
Increase the Influenza Vaccination Rates for over 65s																	
Maintain high % of older population enrolled with PHOs																	
Maintain high % of older population accessing PHO CarePlus services																	
Reduce Ambulatory Sensitive Admissions for those aged 65-74 years				POP 09													
					<table border="0"> <tr> <td>Sponsor</td> <td>Strategic Links</td> </tr> <tr> <td>Funder/Provider</td> <td>Aged Care Strategy</td> </tr> <tr> <td>Funder/Provider</td> <td>Aged Care Strategy</td> </tr> <tr> <td>Funder</td> <td>Primary Care Strategy</td> </tr> <tr> <td>Funder</td> <td>Primary Care Strategy</td> </tr> <tr> <td>Funder</td> <td>Primary Care Strategy</td> </tr> </table>	Sponsor	Strategic Links	Funder/Provider	Aged Care Strategy	Funder/Provider	Aged Care Strategy	Funder	Primary Care Strategy	Funder	Primary Care Strategy	Funder	Primary Care Strategy
Sponsor	Strategic Links																
Funder/Provider	Aged Care Strategy																
Funder/Provider	Aged Care Strategy																
Funder	Primary Care Strategy																
Funder	Primary Care Strategy																
Funder	Primary Care Strategy																

²⁹ In defining Older People the DHB refers to 65+ for European and Other and to 50+ for Māori and Pacific Peoples.

³⁰ Older People face particular barriers to accessing primary care services. They are more likely to lack transport and to have difficulty meeting user part charges, reducing barriers to access is expected to result in improved health outcomes.

³¹ The goal of Care+ is to develop individualised programmes for those people with two or more chronic conditions - specific goals are set for each person and monitored on a quarterly basis – older people tend to have more complicated conditions.

Maori Health

Long Term Objective: Whanau Ora, Maori are supported to achieve their maximum health and wellbeing.

Evidence of Maori health disparities is well known and to address these health disparities, the DHB has developed a Maori Health Plan, *Whakamahere Hauora Maori Ki Waitaha*. This Plan has recently been reviewed and updated after consultation with the Canterbury Maori community and identifies a number of key areas where the DHB will focus its efforts over the coming years. These include: monitoring of Maori health outcomes, Maori participation in health planning, Maori participation in service provision and development of the Maori health workforce, assurance of culturally appropriate and high quality services and working across sectors to ensure a continuum of care.

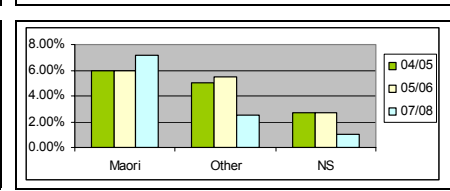
The DHB's activity is consistent with the national Maori Health Strategy *Te Korowai Oranga* and with the national Primary Care Strategy. As Maori have traditionally been low users of health services, increased involvement in planning the direction of these services is expected to lead to improved utilisation and improved health outcomes for Maori.

The DHB is also conscious of higher percentage of child and youth in our Maori population and the DHB's focus on breast-feeding, immunisation, well-child checks, nutrition, healthy lifestyles and smoking cessation are all expected to have a positive affect on reducing inequalities and improving Maori health outcomes.

Key Performance Measures	Actual 05/06	Target 07/08	Target 08/09	Target 09/10	Improved Maori Health
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Improve Ethnicity Data Collection – as a means to reduce barriers to identifying inequalities in health status and monitoring of Maori health outcomes.

% of Inpatients with ethnicity recorded. ³²		Actual	Target	Target	Target
Maori		6.0%	>7.2%	>7.2%	>7.2%
Other		5.5%	<2.5%	<2.5%	<2.5%
NS		2.7%	<1.0%	<1.0%	<1.0%



Increase Maori participation in service provision and the health workforce – as a means of improving the cultural responsive of our health services.³³

DHB (i) staff identifying as Maori (i)	176	For Information Only		
(ii) Maori staff working in Maori roles.	61	For Information Only		
CCCCThe percentage of staff with ethnicity disclosed.	70%	>75%	>75%	>80%

DHB Comment – The DHBs focus is on monitoring these staffing levels and on increasing the number of staff with disclosed ethnicity to improve the robustness of this data over time – hence no targets have been set for increasing staffing levels as this is for information only.

Increase Maori engagement/participation in health planning and decision making – as a means of improving the cultural responsive of our health services.

Implement an MoU (or formal relationship agreement) with Manawhenua ki Waitaha. ³⁴				Complete
% of Board members receiving Treaty of Waitangi training.	0%	100%	100%	100%
% of PHOs with agreed Maori Health Plans in Place.	0%	100%	100%	100%

SOI Performance Measures	DAP	Sponsor	Strategic Links
Improved inpatient ethnicity reporting		Provider	Maori Health Strategy
Monitor the % of staff identifying as Maori and working in Maori roles	HKO 02	Governance	Maori Health Strategy
Increased the % of staff with ethnicity on record		Governance	Maori Health Strategy
Implement an MoU with Manawhenua ki Waitaha		Governance	Maori Health Strategy
Increase the % of Board members receiving Treaty of Waitangi training	HKO 01	Governance	Maori Health Strategy
Increase the % of PHOs with agreed Maori Health Plans	HKO 01	Funder	Primary Care Strategy

³² The aim is to reduce the number classified as 'other' or 'not stated'.

³³ The DHBs focus is on monitoring these staffing levels and on increasing the number of staff with disclosed ethnicity to improve the robustness of this data over time – hence no targets have been set for increasing staffing levels as this is for information only.

³⁴ This MoU indicator was in the previous years SOI. Although informal relationships exist the aim of this indicator is to establish a formal relationship agreement with Manawhenua ki Waitaha. Although not completed in 2006/07 establishing a formal relationship agreement remains a key priority.

Primary Health

Long Term Objective: Reduce barriers to primary health care services and improve utilisation of services.

During the 2007/08 year the DHB will continue to focus its primary care activities on the implementation of the national Primary Care Strategy through the ongoing development of PHOs in Canterbury. Older People and those in low socio-economic groups face particular barriers to accessing primary care services. They are more likely to lack transport and to have difficulty meeting user part charges. Reducing barriers for these groups is expected to result in improved health outcomes for our community. The DHB will also focus on addressing these needs through the implementation of services to improve access, to improve population health promotion for PHOs' enrolled populations and improve Maori and Pacific utilisation of primary care services.

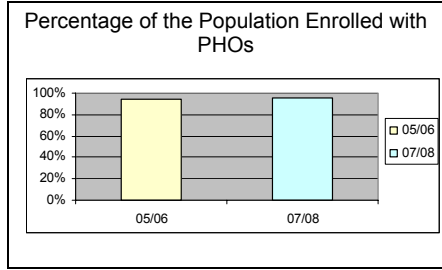
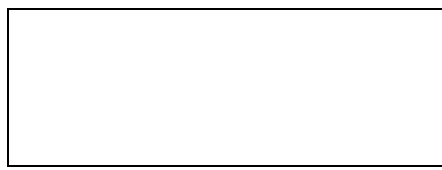
Key Performance Measures	Actual 05/06	Target 07/08	Target 08/09	Target 09/10	Improved Primary Health
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Continue PHO Development – as a means of ensuring continuums of care are developed in line with DHB priorities and ongoing health needs assessment.

% of PHOs with Health Promotion plans and Services to Improve Access plans in place.	60%	100%	100%	100%
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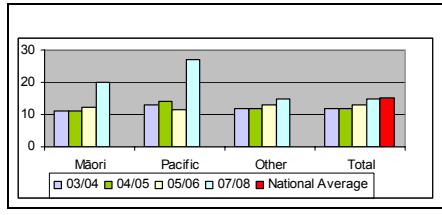
Reduce Barriers to Primary Care – as a means of maximising ongoing health and wellbeing.

% of the Canterbury population enrolled in PHOs.	Maori	73%			
	Pacific	93%			
	Other	96%			
	Total	94%	>95%	>95%	>95%
The % of the eligible enrolled PHO, enrolled in Care+ services.		47%	>80%	>80%	>80%



Reduce Ambulatory Sensitive Admission Rates - as an indication of access to, and effectiveness of, primary care services.

Ambulatory Sensitive Admissions for those aged 15-24 years per 1000 population.	Maori	12	<20	<20	<20
	Pacific	11	<27	<27	<27
	Other	13	<15	<15	<15
	Total	13	<15	<15	<15



SOI Performance Measures	DAP
All PHOs have Health Promotion and Services to Improve Access plans	
Maintenance of the % of the Canterbury population enrolled in PHOs	
Increase in the % of the PHO enrolled population enrolled in Care+	SER 02
Reduce Ambulatory Sensitive Admissions for those aged 15-24 years	POP 09

Sponsor	Strategic Links
Funder	Primary Care Strategy
Funder	Primary Care Strategy
Funder	Primary Care Strategy
Funder	Primary Care Strategy

Disease Prevention and Management

Long Term Objective: Reduce the risks associated with chronic conditions and improve the management of long-term illness and promote well-being.

Chronic conditions cover any ongoing, long-term or recurring health problems that can have a significant impact on a person's life. Chronic conditions are a major health burden both now and into the foreseeable future and account for around 70% of health service expenditure. The DHB is committed to establishing a framework for managing chronic conditions to ensure people are better supported by services that are patient centred and coordinated.

Chronic conditions tend to have common risk factors – inactivity, unhealthy diets, obesity, stress, depression, smoking and alcohol misuse. The DHB aims to reduce the incidence of chronic conditions through population health approaches to reduce risk factors including promoting healthier lifestyles and healthy environments and by supporting the implementation of the national HEHA Strategy and our own local *Healthy Eating, Active Living* (HEAL) Action Plan. The DHB will also work with PHOs to increase access to primary care and identify and screen those most at risk.

The DHB has identified four Disease Priorities (Cancer, Cardiovascular Disease, Diabetes and Respiratory Disease) which it plans to give additional focus to over the next five years. Risk reduction and the prevention of chronic conditions are interlinked whereby the reduction of a risk factor for one condition can assist in the prevention of another and the DHB recognises this interplay in its focus on disease prevention. Reducing obesity and smoking for example are crucial components in the prevention of a number of chronic conditions.

The indicators under the DHB's separate Disease Priorities focus primarily on reducing the impact of these diseases rather than on prevention. However, actions such support of smokefree legislation, reducing smoking rates, increasing physical activity levels, improving nutrition and supporting healthy environments will have positive affects as will the development of continuums of care and a framework for the management of chronic conditions; highlighted this section.

Key Performance Measures ³⁵	Actual 05/06	Target 07/08	Target 08/09	Target 09/10	Improved Disease Prevention and Management
Reduce the trend in obesity rates – as a means of reducing a key risk factor for chronic conditions.					
* The proportion of the Canterbury population who are obese. ³⁶	21%	-	-	<21%	CDHB Comment: The DHB's aim in 2007/08 is to confirm the baseline data and set targets for achievement for this indicator.
Increase the proportion of the Canterbury population undertaking regular physical activity – as a means to reducing the trend in obesity rates and improving health and well-being.					
* The % of the population who are regularly active. ³⁷	Maori 50%	-	-	-	CDHB Comment: The DHB's aim in 2007/08 is to confirm the baseline data and set targets for achievement for this indicator.
	Non-Maori 51%	-	-	-	
	All 51%	-	-	>56%	
Increase the proportion of fruit and vegetables consumed per day by adults (15 years+) in the Canterbury region – as a means to reducing the incidence of obesity and improving overall health and well-being.					
* The % of the population having two or more servings of fruit per day.	Maori 53%	-	-	-	CDHB Comment: The DHB's aim in 2007/08 is to confirm the baseline data and set targets for achievement for this indicator.
	Non-Maori 58%	-	-	-	
	All 58%	-	-	>62%	
* The %having three or more servings of vegetables a day.	Maori 61%	-	-	-	
	Non-Maori 66%	-	-	-	
	All 66%	-	-	>70%	

³⁵ For those indicators marked with an asterisk (*) the DHB's only measurement is using statistics from the NZ Health Survey collected nationally by the Ministry. This survey was undertaken in 2004 and is currently being collected for the second time - it will be repeated every three years. The DHB sees these indicators as an important means to monitor the impact of activity around the HEHA and HEAL strategies, however is reluctant to set targets without recent data (the survey having only been collected once before). It is the intention to present targets in the 2008/09 SOI once the results of the next survey are available.

³⁶ Obese is defined as having a Body Mass Index (BMI) of >30.0 or >32.0 for Māori or Pacific.

³⁷ Regular Activity is defined as at least 30 minutes of moderate physical activity on five or more days of the week.

Key Performance Measures	Actual 05/06	Target 07/08	Target 08/09	Target 09/10	Improved Disease Prevention and Management continued ...
Decrease the smoking rates for people 15 years and above - as a means of reducing a key risk factor for chronic conditions.					CDHB Comment: The DHB's aim in 2007/08 is to confirm the baseline data and set targets for achievement for this indicator.
* Smoking rates in Canterbury.	Males 22.5%	-	-	<15%	
	Females 21.5%	-	-	<15%	
Increase the number of Canterbury schools working within the Health Promotion in Schools (HPS) framework – as a means to reducing the incidence of obesity, lowering smoking rates and improving overall health and well-being.³⁸					
The % of schools working within the HPS framework.	27%	>33%	>35%	>40%	
SOI Performance Measures				DAP	Sponsor
Reduce the proportion of the Canterbury population that are obese					Funder/Provider
Increase the % of HPS in the region					Funder/Provider
Increase the % of the population who are physically active					Funder/Provider
Increase fruit consumption					Funder/Provider
Increase vegetable consumption					Funder/Provider
Decrease the smoking rates in Canterbury for those over 15 years					Provider
					Strategic Links
					HEHA Strategy
					HEHA Strategy
					HEHA Strategy
					HEHA Strategy
					HEHA Strategy
					Tobacco Control Strategic Action Plan

³⁸ The DHBs definition of HPS considers HPS as a framework to be used to address health issues. The DHBs approach is based on activities within the school setting that can impact on health: the provision of health services, the inclusion of health education in curricula, and the creation of a healthy environment. As such, the HPS definition includes schools promoting Fruit in Schools and Active Schools.

Cancer

Long Term Objective: Improved health status for those at risk of developing cancer and appropriate and timely treatment for those that do develop cancer.

The incidence of cancer is increasing, but cancer survival rates are improving. Many cancers are potentially preventable and with more health promotion and prevention of risk behaviours the rates can be reduced. Improved screening and early treatment along with coordinated and accessible support and palliative care services care greatly reduce the impacts of cancer on patients and their families.

The DHB is currently in the process of developing a local strategy for implementing the national Cancer Control Strategy and a regional approach in collaboration with the other South Island DHBs. While much of the DHB approach centres on population based risk reduction, supporting and encouraging healthy lifestyles the DHB will also work on individual approaches to reduce the impact of cancer including ensuring timely access to specialist cancer treatment services and developing clear pathways for treatment and the management of cancer.

Key Performance Measures	Actual 05/06	Target 07/08	Target 08/09	Target 09/10	Improved Cancer Management										
Improve access to Radiation Therapy treatment – as a means of reducing the impact of Cancer.					<table border="1"> <caption>Bar Chart Data: Patients waiting no more than eight weeks for Radiation Therapy treatment</caption> <thead> <tr> <th>Year</th> <th>Percentage</th> </tr> </thead> <tbody> <tr> <td>03/04</td> <td>88%</td> </tr> <tr> <td>04/05</td> <td>98%</td> </tr> <tr> <td>05/06</td> <td>95%</td> </tr> <tr> <td>07/08</td> <td>100%</td> </tr> </tbody> </table>	Year	Percentage	03/04	88%	04/05	98%	05/06	95%	07/08	100%
Year	Percentage														
03/04	88%														
04/05	98%														
05/06	95%														
07/08	100%														
Patients waiting no more than eight weeks for Radiation Therapy treatment. ^{39 40} 31 people waited more than 8 weeks.	96.8%	100%	100%	100%											
SOI Performance Measures Reduce the % of patients waiting more than 8 weeks for treatment				DAP POP 10	Sponsor Provider										
					Strategic Links Cancer Control Strategy										

³⁹ The delay to radiotherapy is defined as the time between the specialist decision to commence radiotherapy and the start of treatment. The measure reflects groups A, B and C - group D patients have planned treatment (either as part of a trial or because of given protocols) and therefore may have to wait to start treatment these patients are not included in targets.

⁴⁰ The DHB intends to meet the Ministry target of 100% of patients accessing radiation therapy on time, however achievement of this target will be dependant on full recruitment of radiation and oncology therapists and no strike action impact as was experienced by the DHB in 2006/07.

Cardiovascular Disease (CVD)						
<p>Long Term Objective: Improved health status for those at risk of developing cardiovascular conditions and appropriate and timely treatment for those that do develop cardiovascular disease.</p> <p>In September 2004, the DHB produced its <i>Canterbury Heart Health Strategy</i>, which outlines key priorities to reduce the incidence and impact of cardiovascular disease. These priorities include: improving access to cardiovascular services, improving information with respect to heart health and developing an information strategy, committing to training and research, improving the quality of care after acute events and devolving supported impact reduction of cardiovascular disease to primary and community care providers. The DHB continues to focus on implementing the recommendations of that Strategy.</p>						
Key Performance Measures	Actual 05/06	Target 07/08	Target 08/09	Target 09/10	Improved Cardiovascular Disease Management	
Maintain access for those requiring treatment - as a means of reducing the impact of Cardiovascular Disease.						
Standardised CABGs ⁴²	1.08	>1	>1	>1		
Discharge Rate. ⁴¹ Angioplasties	1.37	>1	>1	>1		
Improve the quality of care after acute events – as a means of reducing the impact of Cardiovascular Disease. ⁴³						
% attending a cardiac rehabilitation outpatient programme (as a % of total who have suffered an event).	-	Establish baseline and set targets.				
% admitted to an organised stroke service (as a % of total who have suffered an event).	-	Establish baseline and set targets.				
SOI Performance Measures				DAP	Sponsor	Strategic Links
Maintain Standardised Discharge Rates for Cardiac Procedures					Provider	Heart Health Strategy
Increase the % attending cardiac rehabilitation outpatient programme				POP 02	Provider	Heart Health Strategy
Increase the % admitted to an organised stroke service				POP 03	Provider	Heart Health Strategy

⁴¹ If all DHBs were providing services at the same level, the standardised discharge rate would all be at 1. A rate higher than 1 indicates that the DHB is providing more than the average NZ rate and a rate lower than 1 indicates that the DHB is providing less than the average rate. Intervention analysis does not necessarily indicate what the right rate might be, but compares individual DHBs with the national mean, taking DHB population demographics into account.

⁴² CABGs - Coronary Artery Bypass Grafts

⁴³ These indicators are seen as good measures for this priority area and as such the DHB has chosen to introduce these to its statement of performance. However, the aim for 2007/08 is to establish clear definitions and baselines for these indicators. The DHB will present targets for achievement for this indicator in the 2008/09 SOI.

Diabetes

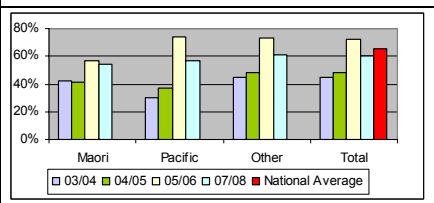
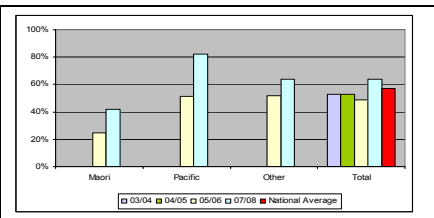
Long Term Objective: Improved health status for those at risk of developing diabetes and appropriate and timely treatment for those that do develop diabetes.

To reduce the incidence and impact of diabetes a number of areas of action exist: promoting healthy lifestyle choices and healthy environments, health promotion, early detection, regular screening, effective treatment and improved patient awareness and self management. In Canterbury the greatest benefit is considered to be gained through a range of actions, which include early diagnosis, regular screening for eye problems and foot problems, improved access to primary care and improved screening for Maori and Pacific populations (those most at risk of diabetes). The DHB intends to continue to focus its activities on encouraging early detection and self management of diabetes, improving retinal screening and reducing the inequalities in health status for Maori and Pacific with regards to diabetes.

Key Performance Measures	Actual 05/06	Target 07/08	Target 08/09	Target 09/10	Improved Management of Diabetes
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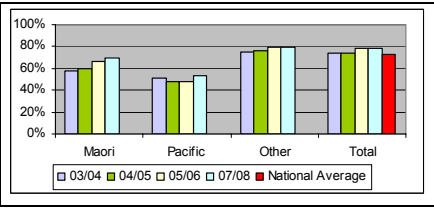
Improve the detection and review of those at risk of Diabetes - as a means of reducing the impact of Diabetes.⁴⁴

Number of Annual Reviews.		6052	Information Only		
The % of expected diabetics who received their Annual Review. ⁴⁵	Maori	24%	>42%	-	
	Pacific	51%	>81%	-	
	Other	52%	>64%	-	
	Total	49%	>64%	-	
The % of those having Annual Reviews who have had their eyes screened (in the past two years). ⁴⁶	Maori	57%	54%	-	
	Pacific	74%	57%	-	
	Other	73%	61%	-	
	Total	72%	60%	-	



Improve the management of Diabetes - as a means of reducing the impact and complications of Diabetes.

The % having Annual Reviews who have good diabetes control (HBA1c<=%).	Maori	66%	70%	-	
	Pacific	48%	53%	-	
	Other	79%	79%	-	
	Total	78%	78%	-	



Reduce the complications of Diabetes – maximising health and wellbeing.⁴⁷

Rate of admissions due to short-term diabetes complications per 1000 population (aged 19+).	0.24	Confirm baseline and set targets.
Rate of lower extremity amputations due to diabetes complications per 1000 population (aged 19+).	0.23	Confirm baseline and set targets.

SOI Performance Measures	DAP	Sponsor	Strategic Links
Increase the % of expected diabetics who receive their Annual Review	POP 01	Funder	
Increase the % of diabetics who have had their eyes screened	POP 01	Funder/Provider	
Increase the % of diabetics who have good diabetes control HBA1c<8%	POP 01	Funder	
Decrease the admissions due to short-term diabetes complications		Provider	
Decrease lower extremity amputations due to complications of diabetes		Provider	

⁴⁴ The DHB has chosen not to set targets for out-years as the data is provided via a third party and the DHB has concerns in relation to data accuracy. An -evaluation of diabetes services undertaken by the DHB in 2007/08 will focus on data clarity.

⁴⁵ All diabetics are entitled to an annual review. The number of reviews relative to the number of expected diabetics gives an indication of how well diabetics are being identified and diagnosed.

⁴⁶ This indicator is one of those where the DHB has particular concerns and believes that the 2005 data is overstated. The targets have been set based on historical levels and not on the 2005 information – data clarity is being worked on.

⁴⁷ These are new indicators being developed through the DHB's Quality and Patient Safety Council. While a positive addition to the set of measures for this priority area, no targets have been set as baseline data is still being confirmed.

Improved Service Delivery

Long Term Objective: Improved health status for Canterbury's residents via the provision of services in a timely manner, within available resources, for those with the greatest level of need.

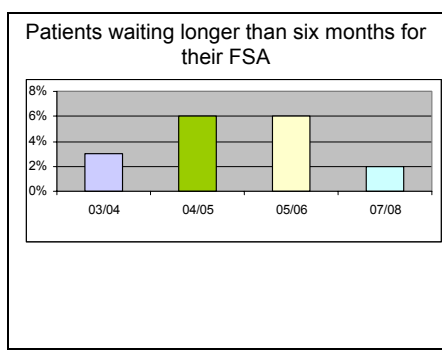
Elective services are provided to patients whose condition does not require immediate action and whose treatment can be planned. Improving access to elective services, certainty for patients about their treatment, timeliness of that treatment and fairness of treatment prioritisation. Within the DHB there is a focus on improving performance of elective services booking and prioritisation systems (measured by Elective Services Patient Flow Indicators (ESPIs)).

The DHB is also committed to ensuring access to mental health services with a focus on increasing capacity and improving access to specialist treatment, on improving flexibility in mental health service delivery and on providing community based services for those most at risk and in need. The DHB will also work with PHOs to develop primary mental health services and support for people affected by mild-moderate mental illness and addictions.

Key Performance Measures	Actual 05/06	Target 07/08	Target 08/09	Target 09/10	Improved Service Delivery
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Improve delivery of Elective Services – through continued compliance with the Ministry's eight ESPIs as a means of improving expectation, clarity and access issues around treatment and services.

Compliance with ESPI 2 – Patients waiting longer than six months for their FSA. ⁴⁸	6%	<2%	<2%	<2%
Compliance with ESPI 5 – Patients given a commitment but not treated within six months.	22%	<5%	<5%	<5%
Monthly compliance with all eight of the Ministry's ESPIs.	n/a	100%	100%	100%



Improve delivery of Mental Health Services – as a means of improving access to treatment and support services for those with severe mental illness.⁴⁹

The % within each age group, accessing mental health treatment and support services.	Maori				
0-19	0.4%	2%	2%	2%	2%
20-64	1.3%	2.5%	2.5%	2.5%	2.5%
Other					
0-19	0.6%	2%	2%	2%	2%
20-64	1.0%	2.5%	2.5%	2.5%	2.5%
Total					
0-19	0.6%	2%	2%	2%	2%
20-64	1.0%	2.5%	2.5%	2.5%	2.5%

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SOI Performance Measures	DAP	Sponsor	Strategic Links
Decrease the % waiting longer than six months for their FSA		Provider	
Decrease the % given a commitment but not treated within six months		Provider	
Maintain compliance with all eight of the Ministry's ESPIs		Provider	
Increase the %s accessing mental health treatment and support services	POP 08	Funder/Provider	

⁴⁸ FSA is the first appointment a patient has with a specialist following referral.

⁴⁹ The data for this indicator is collected through a system that covers HSS and a limited number of NGOs. The activity of many of our NGO community providers, who work with high needs and at risk groups, is not reflected under this measure. The DHB has set targets to increase and then maintain access levels however the focus in out-years will be on flexible service delivery and increased access to community based services outside those covered by this indicator.

Improved Efficiency, Effectiveness and Quality

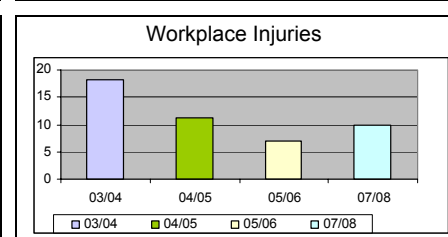
Long Term Objective: Provision of efficient, effective and quality health services and optimal use of available resources to maximise the health status of Canterbury's residents.

The Canterbury DHB is the major provider of health services to Canterbury residents. As a provider of health services the DHB must ensure that the services provided are of a high quality and that patient safety is maximised. To remain clinically and financially sustainable the DHB must ensure that it continues to improve operating efficiency and effectiveness and that it retains its ability to attract suitably skilled staff and maintain appropriate staffing levels.

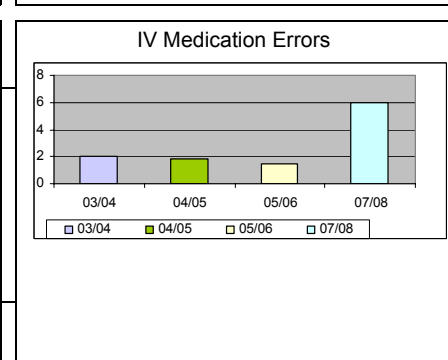
Key Performance Measures	Actual 05/06	Target 07/08	Target 08/09	Target 09/10	Improved Efficiency, Effectiveness and Quality
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Initiating Systems and Processes to Ensure Quality Service Provision – as a means of maintaining patient satisfaction with services.				
Inpatient Overall Satisfaction.	89%	>90%	>90%	>90%
Outpatient Overall Satisfaction.	91%	>90%	>90%	>90%

Maintain Performance as a Good Employer – as a means of establishing a healthy working environment and fostering positive partnerships between staff and management.				
Sick Leave Rate.	2.8%	<3.2%	<3.2%	<3.2%
Workplace Injuries (per million hours).	6.9	<10	<9	<8
Staff Retention/Turnover.	12.4%	<13%	<13%	<13%



Maintain Appropriate Levels of Clinical Quality – as a means to maintain patient safety and quality within our HSS services.				
Hospital Acquired Bacteraemia rate per 100 inpatients. ⁵⁰	0.16	=<0.16	=<0.16	=<0.16
Pressure Ulcers rate per 1000 inpatient days.	0.24	<0.25	<0.25	<0.25
Patient Falls (causing moderate or serious injury) rate per 1000 inpatient day equivalents. ^{51 52}	0.16	=<0.16	=<0.16	=<0.16
IV Medication Errors rate per 1000 inpatient day equivalents. ⁵³	1.3 ⁵⁴	>3	>3	>3



SOI Performance Measures	DAP
Increase the % of Overall Inpatient Satisfaction	
Increase the % of Overall Outpatient Satisfaction	
Maintain low Sick Leave Rates	
Decrease the number of Workplace Injuries	
Maintain low Staff Retention/Turnover Rates	
Decrease the Hospital Acquired Bacteraemia rate	
Maintain low numbers of Pressure Ulcers in the hospital setting	
Maintain low rates of Patient Falls (causing moderate or serious injury)	
Increase the IV Medication Error Rate	

Sponsor	Strategic Links
Provider	Quality Strategic Plan
Provider	Quality Strategic Plan
Governance	
Governance	
Governance	
Provider	Quality Strategic Plan
Provider	Quality Strategic Plan
Provider	Quality Strategic Plan
Provider	Quality Strategic Plan

⁵⁰ Excludes HSS Mental Health Division.

⁵¹ Past analysis of total falls has included many minor events that cause little or no harm; the CDHB includes only those falls associated with moderate or serious injury to provide a direct measure of injury caused.

⁵² Inpatient Day Equivalents reflect the total inpatient days plus half the total day patient attendances.

⁵³ The targets are set to increase the rate of reported errors, in line with DHB policy of emphasising the responsibility of staff to report error - previously set at 6 or more the target has been adjusted to reflect a more achievable increase in reporting levels

⁵⁴ This figure is different to that reports in the last Annual Report (1.5) because of a data collection error (the reported figure included events not directly related to a medication error and these have been removed).

6 MANAGING OUR FINANCIAL RESOURCES

6.1 Financial Environment – Our Budget

The Canterbury DHB will receive a funding increase of approximately \$62M for 2007/08. Of this funding increase, \$32M is tagged for specific health services or previous years commitments, such as PHO funding, additional elective services funding and Holidays' Act commitments. In addition, non-base revenue and one-off revenue will reduce by \$19M. This leaves \$11M available for general price increases and acute demand growth.

Costs are assumed to increase at the same rate as baseline funding increases received from the Ministry. This is forecast to be around \$22M. This leaves a funding shortfall of \$11M to be filled by operational efficiencies for the DHB to breakeven. The 2007/08 forecast is summarised as follows:

	\$M (GST excl)
Overall Net Increase in Funding/Revenue (include non-Base)	37
<i>Less</i>	
Increase in Expenditure (external and CDHB Provider service)	(44)
Incremental Interest, Depreciation and Capital Charge	(4)
Estimated 2006/07 Operating Shortfall	(11)
Required Annual Efficiencies/Revenue Enhancement	11
Budget Net Result After Efficiencies	-

In budgeting for a breakeven position, the DHB has assumed that the sector will be able to manage cost increases, especially personnel costs, within the baseline funding increase. In addition, efficiencies will be realised from the improved management of chronic conditions and long-term illness, improved management of acute demand, service changes flowing from the Improve the Patient Journey Programme and realisation of 'gain on sale' from the approved disposal of surplus assets.⁵⁵

6.1.1 Outyears Scenario

The DHB expects funding increases for outyears to be 2% for 2008/09 and 2% for 2009/10. The DHB has also assumed that expenditure will increase at the same rate as the funding from the Ministry. In previous years we have relied on 'gain on sale' from approved surplus assets to address some of the financial operating gaps. As the DHB is unlikely to have any gain on sale in 2008/09 further efficiencies will be required to achieve breakeven.

All assumptions carry risks. Whilst the DHB will always seek to re-configure services and change how services are delivered to yield efficiencies, ultimately we may need to reduce services so that we can operate within the funding we receive. A Health Services Planning Project has begun, with a view to completing our Facilities Master Plan. This project will also greatly assist the DHB to better understand where, what and how many services need to be provided in the future, thus providing the information needed by the DHB to assist it to operate within available funding while providing maximum health care to the population of Canterbury.

The outyears' scenario position if the assumptions are achieved will be as follows:

⁵⁵ For further information refer to Section 3.1.6 of this document.

	2007/08 \$M	2008/09 \$M	2009/10 \$M
Overall Net Increase in Funding/Revenue (include non-Base)	37	15	23
Less: Estimated Net Annual Cost Increase	(48)	(24)	(23)
Estimated Operating Shortfall	(11)	(9)	-
Estimated Annual Efficiencies	11	9	-
Budget Net Result after Efficiencies	-	-	-

6.1.2 Key Financial Assumptions and Risks

The key assumptions to achieve the breakeven budget for 2007/08 include the following:

- Our short and mid-term direction and environment will remain similar and current government health and funding policies will remain static.
- Interest rates will remain within Treasury forecasts.
- Baseline/outyears funding will increase as per Ministry funding advice.
- Any future changes to the Population Based Funding formula will not impact adversely on future funding levels.
- Demographic funding will be received in future years
- The growth in demand for services can be managed within the available resources or any increases in demand can be met through reducing delivery in other service areas.
- Contracts with NGO providers will be settled within baseline Future Funding Track (FFT) on average including increases in service demand.⁵⁶
- The introduction of new drugs or technology will be within the technology adjuster funding provided to the DHB.
- The average increase in non-employee related expenditure can be kept within baseline FFT.
- Capital charge will not apply to donated assets and will remain at 8%.
- Net IDF revenue can be fully realised, volumes will remain stable and not decline significantly and neighbouring DHBs will not change their referral patterns without adequate notification in advance.
- Planned savings through service innovations are able to be realised and the DHB has the capability and capacity to achieve efficiencies and address cost over-runs.
- The DHB will be ESPI compliant enabling it to retain early payment status as well as receive additional elective funding. Loss of early payment would reduce interest income by around \$3M which could further reduce elective services.
- National industrial action does not result in financial penalty to the DHB and/or the DHB can recover contract volumes after cancelled elective surgeries as a result of any action.
- The financial impact associated with any new government or Ministry legislative, regulatory or compliance policy/initiative will be fully offset by increased funding or within any funding received.
- Any financial impact associated with changes to Disability Support Service boundaries between age related and non-age related services and any further contracts or services devolved by the Ministry are cost neutral to the DHB.

⁵⁶ FFT is the annual percentage price increase to DHBs from the Ministry.

- Any impact of future asset revaluation under FRS-3 will be cost neutral to the DHB.⁵⁷
- Collective employment agreements will be settled within the baseline FFT increase, inclusive of automatic step movements and flow-on impact from previous year's multi-Employee Collective Agreement (MECA) settlement.
- Projected proceeds from approved sale of surplus assets can be realised as planned.
- The Pharmac budget for community referred pharmaceuticals is as agreed by the DHB (on the basis of forecast actual expenditure plus baseline FFT) and any forecast savings are achieved

The assumptions underlying the SOI can be found in the Canterbury DHB's DAP 2007/2008.

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 and/or facility realignment or service reductions, according to planned timeframes and the inability to achieve efficiencies and address cost over-runs internally.

6.1.3 Capital Expenditure

The estimated capital expenditure budget for 2007/08 is \$30M and will be mainly for normal asset replacement and priority new equipment. Detailed requirements of recent Building Act changes are yet to be finalised by TLAs and these may require some buildings to be rebuilt.

As mentioned above, a Health Services Planning Project is in progress. This project will guide the development of the DHB's Facilities Master Plan. Accordingly, we now forecast that the building replacement as part of that legislative compliance will take place after 2009/10. 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 when the full implications of legislative requirements are known.

6.1.4 Disposal of Land

As outlined above, disposal of significant surplus assets over the next three years includes the Canterbury DHB owned sites at Hanmer Springs and potentially the former Christchurch Women's Hospital site.

The Minister of Health has given approval for the sale of the Hanmer Springs and Hillmorton sites. The timing of the sales are subject to negotiations with the purchaser. Due process will be undertaken with regard to any sale of the site of the former Christchurch Women's Hospital site. The financial assumptions include the estimated proceeds from surplus asset sale/s expected.

The Canterbury DHB's policy is that it will not dispose of any estate or interest in any land without having first obtained the consent of the responsible Minister and completed required public consultation.

6.1.5 Debt and Equity

The DHB's estimated total term debt is expected to be \$88M as at June 2007. 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 outyears.

⁵⁷ *FRS-3 is the Property, Plant and Equipment Accounting Standards*

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.

We comply with the banking covenants required of our loans. The key covenants together with forecast ratios for 2007/08 based on the forecast financial statements are:

REQUIRED	FORECAST RATIO
Interest cover ratio: >2.75 times	Approx 9.83 times
Debt/Debt plus Equity ratio: <50%	Approx 24.5%

We are not repaying equity and are instead retaining and investing the funds to meet future building replacement as indicated in Section 6.1.3.

6.1.6 Activities for which Compensation is Sought

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

6.1.7 Acquisition of Shares

Before the Canterbury DHB or any associate or subsidiary subscribes for, purchases, or otherwise acquires shares in any company or other organisation, the Board will consult the responsible Minister/s and obtain their approval.

6.2 Financial Statements

Accounting Policies

The accounting policies adopted are consistent with those in the prior year for a full statement of accounting policies refer to Appendix 4.

6.2.1 Forecast Group Statement Of Financial Performance

	2005/06 Actual \$'000	2006/07 Forecast \$'000	2007/08 Forecast \$'000	2008/09 Forecast \$'000	2009/10 Forecast \$'000
Operating Revenue					
MoH Revenue	972,575	1,054,030	1,096,676	1,124,093	1,152,195
Patient Related Revenue	31,224	32,846	33,536	34,374	35,234
Other Revenue	19,843	23,963	26,259	18,619	18,988
Total Operating Revenue	<u>1,023,642</u>	<u>1,110,839</u>	<u>1,156,471</u>	<u>1,177,086</u>	<u>1,206,417</u>
Operating Expenditure					
Employee Costs	406,846	430,631	444,945	450,748	461,946
Treatment Related Costs	109,289	106,213	115,187	116,541	119,430
External Providers & IDF	381,660	447,621	462,314	472,871	484,693
Non Treatment Related & Other Costs	55,602	54,840	55,992	56,891	58,314
Total Operating Expenditure	<u>953,397</u>	<u>1,039,305</u>	<u>1,078,437</u>	<u>1,097,052</u>	<u>1,124,383</u>
Result before Interest, Depn & Cap Chrg	70,245	71,534	78,034	80,034	82,034
Interest, Depreciation & Capital Charge					
Interest Expense	(4,936)	(5,032)	(5,932)	(5,932)	(5,932)
Depreciation	(47,372)	(46,905)	(50,405)	(52,405)	(54,405)
Capital Charge Expenditure	(15,076)	(22,097)	(21,697)	(21,697)	(21,697)
Total Interest, Depreciation & Capital Charge	<u>(67,384)</u>	<u>(74,034)</u>	<u>(78,034)</u>	<u>(80,034)</u>	<u>(82,034)</u>
Net Operating Results	<u>2,861</u>	<u>(2,500)</u>	<u>0</u>	<u>0</u>	<u>0</u>

6.2.2 Forecast Group Statement Of Financial Position

	30/06/06 Actual \$'000	30/06/07 Forecast \$'000	30/06/08 Forecast \$'000	30/06/09 Forecast \$'000	30/06/10 Forecast \$'000
Public Equity					
Opening Equity	199,705	287,326	269,972	269,972	269,973
Revaluation	106,760				
Transition to IFRS		(14,854)			
Equity Repayment	(22,000)				
Net Result for the period	2,861	(2,500)	0	0	0
Total Public Equity	287,326	269,972	269,972	269,973	269,973
Current Assets					
Cash & Bank (OD)	12,838	14,577	14,282	12,188	7,093
MoH Debtor	8,525	9,000	9,000	9,000	9,000
Other Debtors & Other Receivables	15,965	16,000	16,000	16,000	16,000
Prepayments	901	800	800	800	800
Stocks	7,196	7,000	7,000	7,000	7,000
Total Current Assets	45,425	47,377	47,082	44,988	39,893
Current Liabilities					
Creditors & Accruals	67,901	64,000	60,000	55,000	50,000
Capital charge payable	3,738	4,500	4,500	4,500	4,500
GST	6,178	5,000	5,000	5,000	5,000
Interest Accrual	377	377	377	377	377
Staff Entitlement	78,136	81,744	76,744	71,744	71,744
Total Current Liabilities	156,330	155,621	146,621	136,621	131,621
Working Capital	(110,905)	(108,244)	(99,539)	(91,633)	(91,728)
Investments	375	14,875	29,375	43,875	58,375
Restricted Assets - Trust Fund	8,110	8,110	8,110	8,110	8,110
Fixed Assets	477,905	460,500	437,295	414,890	400,485
Total Non Current Assets	486,390	483,485	474,780	466,875	466,970
Term Staff Entitlement	(9,509)	(9,509)	(9,509)	(9,509)	(9,509)
Trust Funds Liabilities		(8,110)	(8,110)	(8,110)	(8,110)
Term Loans	(78,650)	(87,650)	(87,650)	(87,650)	(87,650)
Total Non Current Liabilities	(88,159)	(105,269)	(105,269)	(105,269)	(105,269)
Net Assets	287,326	269,972	269,972	269,973	269,973

6.2.3 Forecast Group Statement of Movement in Equity

	30/06/06 Forecast \$'000	30/06/07 Forecast \$'000	30/06/08 Forecast \$'000	30/06/09 Forecast \$'000	30/06/10 Forecast \$'000
Public Equity					
Opening Equity	199,705	287,326	269,972	269,972	269,973
Add/(Less):					
Equity Injection / (Repayment)	(22,000)	-	-	-	-
Revaluation of Property	106,760				
Transition to IFRS		(14,854)			
Net Result for the period	2,861	(2,500)	0	0	0
Total Public Equity	287,326	269,972	269,972	269,973	269,973

6.2.4 Forecast Group Statement Of Cashflow

	2005/06 Actual \$'000	2006/07 Forecast \$'000	2007/08 Forecast \$'000	2008/09 Forecast \$'000	2009/10 Forecast \$'000
Cashflows from Operating Activities					
Cash provided from:					
MOH Receipts	983,919	1,053,555	1,096,676	1,124,093	1,152,195
Other Receipts	44,340	47,028	48,049	49,247	50,476
	1,008,259	1,100,583	1,144,725	1,173,340	1,202,671
Cash applied to:					
Employee Costs	392,601	433,767	449,945	455,748	461,946
Supplies & Expenses	549,811	612,278	637,492	651,304	667,437
Capital Charge Payments	4,928	21,335	21,697	21,697	21,697
Finance Costs	19,955	5,032	5,932	5,932	5,932
Taxes Paid	(3,557)	1,178	-	-	-
	983,738	1,073,590	1,115,066	1,134,681	1,157,012
Net Cashflow from Operating Activities	44,521	26,993	29,659	38,659	45,659
Cashflows from Investing Activities					
Cash provided from:					
Sale of Assets	6,650	12,500	10,800	-	-
Interest Received	3,102	3,746	3,746	3,746	3,746
	9,752	16,246	14,546	3,746	3,746
Cash applied to:					
Advance to JV/Trust Investments	(231)	14,500	14,500	14,500	14,500
Purchase of Assets	29,775	36,000	30,000	30,000	40,000
	29,544	50,500	44,500	44,500	54,500
Net Cashflow from Investing Activities	(19,792)	(34,254)	(29,954)	(40,754)	(50,754)
Cashflows from Financing Activities					
Cash provide from:					
Equity Injection	-	9,000	-	-	-
Loans Raised	-	9,000	-	-	-
Cash applied to:					
Loan Repayment	22,000	-	-	-	-
Equity Repayment re FRS-3	22,000	-	-	-	-
Net Cashflow from Financing Activities	(22,000)	9,000	-	-	-
Overall Increase/(Decrease) in Cash Held	2,729	1,739	(295)	(2,095)	(5,095)
Add Opening Cash Balance	10,109	12,838	14,577	14,282	12,188
Closing Cash Balance	12,838	14,577	14,282	12,188	7,093

6.2.5 Summary of Revenue and Expenses by Output Class

Funding Arm	2005/06	2006/07	2007/08	2008/09	2009/10
	\$'000	\$'000	\$'000	\$'000	\$'000
Revenue					
MoH revenue	932,035	1,007,707	1,056,985	1,083,410	1,110,495
Total Revenue	932,035	1,007,707	1,056,985	1,083,410	1,110,495
Expenditure					
Other - Personal Health	661,256	727,366	767,500	786,687	806,354
Other - Mental Health	107,837	109,937	114,566	117,430	120,366
Other - Disability Support	150,475	164,849	169,524	173,762	178,106
Other - Public Health	3,166	977	684	701	719
Other - Maori Health	935	936	960	984	1,009
Other - Governance & Admin	3,332	3,642	3,751	3,845	3,941
Total Expenditure	927,001	1,007,707	1,056,985	1,083,410	1,110,495
Net Surplus/(Deficit)	5,034	-	-	-	-
Governance & Funder Admin					
	2005/06	2006/07	2007/08	2008/09	2009/10
	\$'000	\$'000	\$'000	\$'000	\$'000
Revenue					
MoH revenue	3,333	3,642	3,751	3,845	3,941
Total Revenue	3,333	3,642	3,751	3,845	3,941
Expenditure					
Personnel	2,225	2,436	2,507	2,570	2,634
Depreciation	16	50	50	50	50
Interest & Capital charge					
Other	1,057	1,156	1,194	1,225	1,257
Total Expenditure	3,298	3,642	3,751	3,845	3,941
Net Surplus/(Deficit)	35	-	-	-	-
Provider Arm					
	2005/06	2006/07	2007/08	2008/09	2009/10
	\$'000	\$'000	\$'000	\$'000	\$'000
Revenue					
MoH revenue	582,549	602,767	630,611	646,376	662,536
Patient Related Revenue	31,224	32,846	33,536	34,374	35,234
Other	19,843	23,963	26,259	18,619	18,988
Total Revenue	633,616	659,576	690,406	699,369	716,757
Expenditure					
Personnel	404,621	428,195	442,438	448,178	459,312
Depreciation	47,356	46,855	50,355	52,355	54,355
Interest & Capital charge	20,012	27,129	27,629	27,629	27,629
Other	163,835	159,897	169,984	171,207	175,461
Total Expenditure	635,824	662,076	690,406	699,369	716,757
Net Surplus/(Deficit)	(2,208)	(2,500)	-	-	-
In House Elimination					
	2005/06	2006/07	2007/08	2008/09	2009/10
	\$'000	\$'000	\$'000	\$'000	\$'000
Revenue					
MoH revenue	(545,342)	(560,086)	(594,671)	(609,538)	(624,776)
Total Revenue	(545,342)	(560,086)	(594,671)	(609,538)	(624,776)
Expenditure					
Other	(545,342)	(560,086)	(594,671)	(609,538)	(624,776)
Total Expenditure	(545,342)	(560,086)	(594,671)	(609,538)	(624,776)
Net Surplus/(Deficit)	-	-	-	-	-
Consolidated					
	2005/06	2006/07	2007/08	2008/09	2009/10
	\$'000	\$'000	\$'000	\$'000	\$'000
Revenue					
MoH revenue	972,575	1,054,030	1,096,676	1,124,093	1,152,195
Patient Related Revenue	31,224	32,846	33,536	34,374	35,234
Other	19,843	23,963	26,259	18,619	18,988
Total Revenue	1,023,642	1,110,839	1,156,471	1,177,086	1,206,417
Expenditure					
Personnel	406,846	430,631	444,945	450,748	461,946
Depreciation	47,372	46,905	50,405	52,405	54,405
Interest & Capital charge	20,012	27,129	27,629	27,629	27,629
Other	546,551	608,674	633,492	646,304	662,437
Total Expenditure	1,020,781	1,113,339	1,156,471	1,177,086	1,206,417
Net Surplus/(Deficit)	2,861	(2,500)	-	-	-

7 APPENDICES AND REFERENCES

- Appendix 1: Glossary of Terms.
- Appendix 2: Organisational Chart
- Appendix 3: Hospital and Specialist Services Overview
- Appendix 4: Statement of Accounting Policies.

References

All Canterbury DHB documents referenced in this SOI are available on the Canterbury DHB website, (www.cdhb.govt.nz) or in hard copy from the Planning and Funding division by telephoning (03) 364 4160.

All Ministry documents referenced in this SOI are available on the Ministry's website (www.moh.govt.nz).

The following two documents referenced in this SOI are available on the Treasury website (www.treasury.govt.nz):

- Crown Entities Act 2004; and
- Public Finance Act 1989.

Appendix 1.

GLOSSARY OF TERMS USED IN THIS DOCUMENT		
	Access	Ability of people to reach or use health care services. Barriers to access can be: (1) a persons locality, income or knowledge of services available; or (2) the acceptability or availability of existing services
ACC	Accident Compensation Corporation	Crown Entity set up to provide comprehensive, 24hour, no-fault personal accident cover for all New Zealanders.
	Acute Care	The provision of appropriate, timely, acceptable and effective management of conditions with sudden onset and rapid progression that require attention.
	Ambulatory Sensitive Admissions	Hospitalisation or death due to causes which could have been avoided by preventive or therapeutic programme
AT&R	Assessment Treatment and Rehabilitation	These are specialist health services for older people provided by teams of health professionals specially trained to treat illness, rehabilitate and maintain the older person's ability and mobility so that they can retain an independent lifestyle.
ALOS	Average Length of Stay	ALOS is the sum of bed days for patients discharged in the period (ie lengths of stay) divided by the number of discharges for the period.
	Blueprint Funding	Blueprint funding is allocated by Government to work to ensure the development of mental health services for the 3% of the total NZ population with moderate to severe mental illness. Service development is based on the service levels set out in the Mental Health Commission's Blueprint for Mental Health Services in New Zealand: How Things Need to Be (1998).
CAPEX	Capital Expenditure	Spending on land, buildings and larger items of equipment.
CCC	Christchurch City Council	Local Council in the Christchurch region.
COPD	Chronic Obstructive Pulmonary Disease	A progressive disease process that most commonly results from smoking. Chronic obstructive pulmonary disease is characterised by difficulty breathing, wheezing and a chronic cough.
CNS	Clinical Nurse Specialist	Registered nurses with an advanced degree in a particular area of patient care; e.g., neurosurgery clinical nurse specialist.
	Crown Agent	A Crown Entity that must give effect to government policy when directed by the responsible Minister.
	Crown Entities	A generic term for a diverse range of entities referred to in the Crown Entities Act 2004, namely: statutory entities, Crown entity companies, Crown entity subsidiaries, school boards of trustees, and tertiary education institutions. Crown entities are legally separate from the Crown and operate at arms length from the responsible or shareholding Minister(s); they are included in the annual financial statements of the Government.
CE Act	Crown Entities Act	The Act which governs Crown Entities set out in 2004.
CTA	Clinical Training Agency	The CTA provides funding for Post Entry Clinical Training programmes, are nationally recognised by the profession and/or health sector and meet a national health service skill requirement rather than a local employer need.
COSE	Co-ordinator of Services for the Elderly	An Elder Care Canterbury initiative, running in two areas of Christchurch since October 2000. Staff, working alongside GPs, are responsible for co-ordinating packages of care for older people in the community. The most important outcome of the COSE project has been the provision of an overall link between any hospital and any provider service and the GP in Christchurch.
CWD	Case Weighted Discharge	Relative measure of a patient's utilisation of resources
	Credentialling	A process used to assign specific clinical responsibilities to health professionals on the basis of their training, qualifications, experience and current practice, within an organisational context. Credentialling is part of a wider organisational quality and risk management system designed primarily to protect the patient.
CFA	Crown Funding Agreement	This is an agreement by the Crown to provide funding in return for the provision of, or arranging the provision of, specified services.
DOSA	Day of Surgery Admission	DOSA is a patient who is admitted on the same day on which they are scheduled to have their elective surgery. The admission can be as either a day case or an inpatient.

	Determinants of Health	The range of personal, social, economic and environmental factors that determine the health status of individuals or populations.
DSS	Disability Support Services	Services provided for people who have been identified as having a disability, which is likely to continue for a minimum of six months and results in a reduction of independent function to the extent that ongoing support is required.
	Disparity (or deprivation)	Socio-economic or health inequality or difference relative to the local community or wider society to which an individual, family or group belongs.
DAP	District Annual Plan	This document sets out what the DHB intends to do over the year to advance the outcomes set out in the Strategic Plan, the funding proposed for these outputs, the expected performance of the DHB provider arm and the expected capital investment and financial and performance forecasts.
DHBNZ	District Health Board New Zealand	National representative body for all twenty-one DHBs.
DSP	District Strategic Plan	The role of the DSP document is to identify how the DHB will fulfil its objectives and functions over the next five to ten years by: identifying the significant internal and external issues that impact on the DHB and affect its ability to fulfil its mandate and purpose, acknowledging societal outcomes and identifying appropriate system outcomes as they relate to DHB population outcomes and outlining major planning and capability building
ESPIs	Elective Services Patient flow Indicators	The ESPIs have been developed by the Ministry to assess whether or not DHBs are on the right track with the Government policies on elective services.
	Equity Lens	A tool to assess planned service development targets against the needs of those who face health inequalities
EMT	Executive Management Team	Senior Management Team of the Canterbury DHB who report directly to the Chief Executive.
FSA	First Specialist Assessment	(Outpatients only) First time a patient is seen by a doctor for a consultation in that speciality for that reason, this does not include procedures, nurse appointments, diagnostic appointments or pre-admission visits.
	Follow-ups	Further assessments by hospital specialists.
	Fono	Samoan word for 'meeting'.
FTE	Full Time Equivalent	Means an Employee who works an average minimum of 40 ordinary hours per week on an ongoing basis.
FFT	Future Funding Track	FFT is the annual percentage price increase to DHBs from the Ministry.
HbA1c	Haemoglobin A1c; also known as glycated haemoglobin.	The level of HbA1c reflects the average blood glucose level over the past 3 months.
HIS-NZ	Health Information Strategy– New Zealand	The Government's Health Information Strategy for all DHBs.
HNA	Health Needs Assessment	A process designed to establish the health requirements of a particular population
	Health Outcomes	A change in the health status of an individual, group or population which is attributable to a planned programme or series of programmes, regardless of whether such a programme was intended to change health status.
HealthPAC	Health Payments Agreements and Compliance	Formed from the merger of Health Benefits and the Shared Support Service Group within the Ministry. HealthPAC undertakes a number of activities based on a Service Level Agreement with the Ministry, and also provides information to several health agencies.
HPI	Health Practitioner Index	The HPI will be a comprehensive source of trusted information about health practitioners for the NZ health and disability sector. The HPI will uniquely identify health providers and organisations. This will allow health providers who manage health information electronically to do so with greater security. It will help our health sector to find better and more secure ways to access and transfer health-related information.
HPCA	Health Practitioners Competency Assurance	The purpose of the HPCA Act, which came into force on 18 September 2004, is to protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practice their professions.
HWAC	Health Workforce Advisory Committee	Committee who advises the Minister on how to ensure an adequate and responsive professional health workforce
HEAL	Healthy Eating Active Living 'Action Plan'	This Plan provides us with the platform to implement the national HEHA Strategy at a local level.

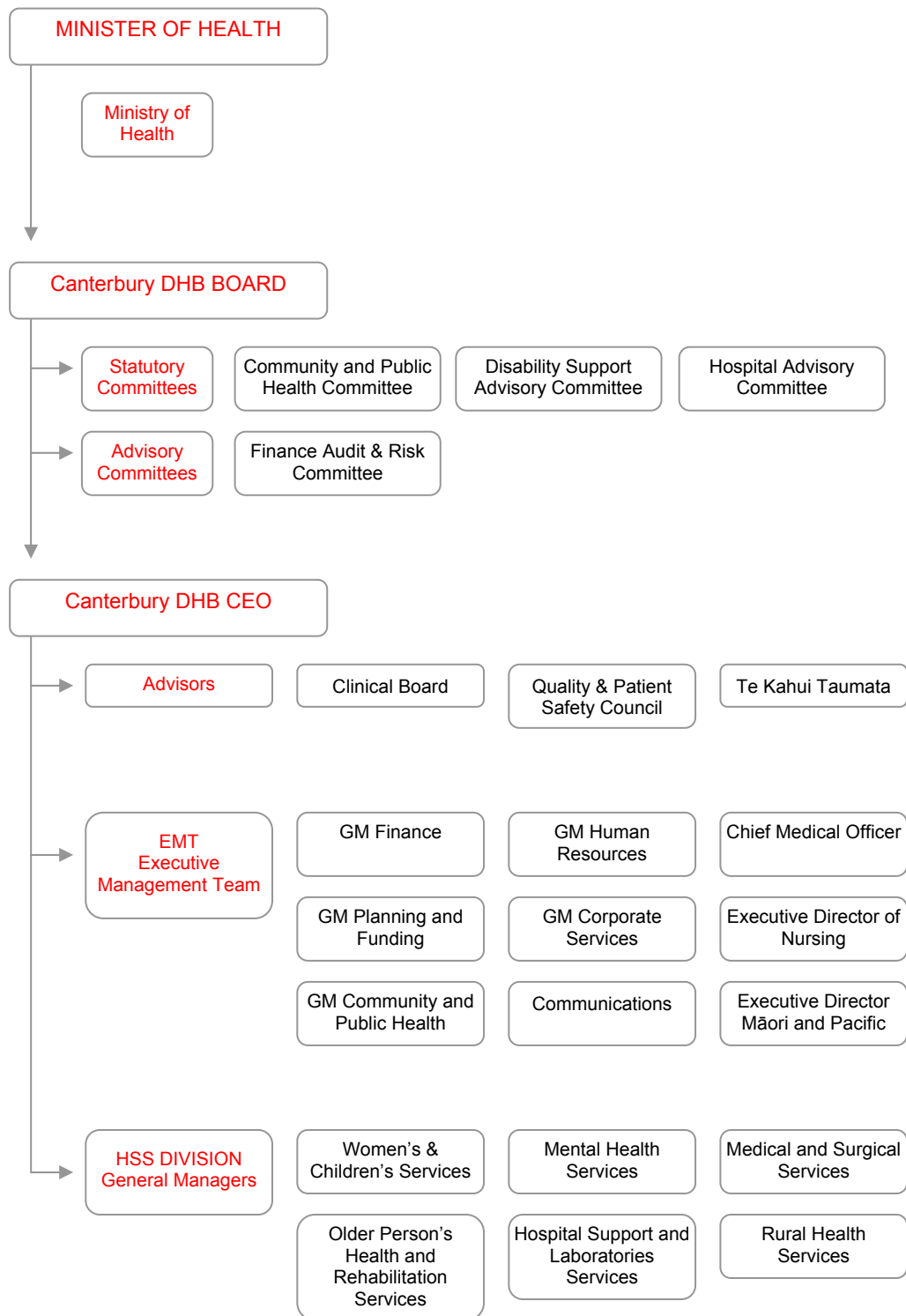
HEHA	Healthy Eating Healthy Action 'Strategy'	HEHA is the Ministry's strategic approach to improving nutrition, increasing physical activity and achieving healthy weight for all New Zealanders.
HSS	Hospital and Specialist Services	The Provider-arm of the Canterbury DHB.
	Hui	Maori word for a meeting or gathering of people for a specific reason.
	Improve the Patient Journey Project	Project with the goal of reducing unnecessary waits and delays within the patient continuum of care through innovation, reducing variation, focusing processes on patient orientated processes and collaboration.
ISSP	Information Services Strategic Plan	The Canterbury DHB's Plan for information services – in line with the national Health Information Strategy.
IDFs	Inter District Flows	An IDF is a service provided by a DHB to a patient whose 'place of residence' falls under the region of another DHB. Under PBF each DHB is funded on the basis of its resident population therefore the DHB providing the IDF will recover the costs of that IDF from the DHB who was funded for that patient.
InterRAI	International Resident Assessment Instrument	Comprehensive geriatric assessment tool.
	Iwi	Tribe
KPIs	Key Performance Indicators	KPIs are quantifiable measurements, agreed to beforehand, that reflect the critical success factors of an organisation.
LEAP	Late Effects Assessment Programme	LEAP is a clinic (and programme) for children and adolescents with cancer established to help monitor and support children and adolescents who have completed active cancer therapy.
LOS	Length of Stay	LOS is the time from admission to discharge, less any time spent on leave. It is normal to exclude boarder patients when calculating length of stay.
LTCCP	Long Term Council Community Plan	Plan that sets out the type of community the people of a region would like to live in, and the things they would like to see for their community. It shows how the Council (for that region) and other organisations will work to build that community.
	Medical Credentialing	Medical credentialing refers to the process of permitting an individual physician to practice in a particular hospital, clinic or other medical practice setting
MoU	Memorandum of Understanding	An agreement of cooperation between organisations defining the roles and responsibilities of each organisation in relation to the other or others with respects to an issue over which the organisations have concurrent jurisdiction.
MeNZB™	Meningococcal B	Meningococcal disease is a bacterial infection. It causes severe illnesses including: meningitis (an infection of membranes that cover the brain) and septicaemia (a serious infection in the blood). There are several different strains of bacteria which cause meningococcal disease including A, B and C.
MVS	Meningococcal B Vaccine Strategy	MeNZB™ vaccine has been developed to protect against the strain of meningococcal B causing the NZ epidemic.
MHINC	Mental Health Information National Collection	The national database of mental health information held by the NZ Health Information Service (NZHIS) to support policy formation, monitoring and research.
MH-SMART	Mental Health Standard Measures of Assessment and Recovery	The aim of the MH-SMART initiative is to support recovery by promoting and facilitating the development of an outcomes-focused culture in the mental health sector. The principle means of achieving this will be by implementing a suite of standard tools to measure changes in the health status of mental health service users that is responsive to the needs of Maori and other cultures within a recovery framework.
	Morbidity	Illness, sickness.
	Mortality	Death.
NHI	National Health Index	The NHI number is a unique identifier that is assigned to every person who uses health and disability support services in NZ. A person's NHI number is stored on the NHI along with that person's demographic details. The NHI and associated NHI numbers are used to help with the planning, co-ordination and provision of health and disability support services across NZ.
NIR	National Immunisation Register	The NIR is a computerised information system that has been developed to hold immunisation details of NZ children and assist to improve immunisation rates.
NNPAC	National Non-admitted Patient Collection	Coding of outpatients – a pilot project under the national Health Information Strategy.

NASC	Needs Assessment & Service Co-ordination	NASC assists older people with long-term disabilities/ health problems (i.e. longer than 6 months) to remain living at home, safely and independently, for as long as possible. Needs Assessors complete an assessment of needs with the older person, and Service Coordinators use this assessment to develop care packages of support services to assist at home.
NZBS	New Zealand Blood Service	Manages the donation, collection, processing, and supply of blood, controlled human substances, and related or incidental matters
NZHIS	New Zealand Health Information Service	A group within the Ministry responsible for the collection and dissemination of health-related data. NZHIS has as its foundation the goal of making accurate information readily available and accessible in a timely manner throughout the health sector.
NGO	Non- Government Organisations	There are many ways of defining NGOs. In the context of the relationship between the Health and Disability NGOs and the Canterbury DHB, NGOs include independent community and iwi/Maori organisations operating on a not-for-profit basis, which bring a value to society that is distinct from both Government and the market. In reality this will mean that any profits are put back into the organisation, rather than distributed to shareholders.
NZIFRS	NZ Equivalents to International Financial Reporting Standards	Accounting Standards, which will come into use from 1 July 2007.
OPF	Operational Performance Framework	The OPF is one of a set of documents known as the 'Policy Component of the DHB Planning Package' which sets out the accountabilities of DHBs. The OPF is endorsed by the Minister of Health and comprises the operational level accountabilities that all DHBs must comply with. These are given effect through the Crown Funding Agreements between the Minister and the DHB.
PP	Pacific Peoples	The population of Pacific Island ethnic origin (for example, Tongan, Niuean, Fijian, Samoan, Cook Island Maori, and Tokelauan) incorporating people of Pacific Island ethnic origin born in NZ as well as overseas.
PPDF	Pacific Provider Development Funds	The PPDFs are provided for initiatives to improve the overall health and reduce social inequalities for Pacific people. There are four priority areas: strengthening existing Pacific providers, development of the existing workforce, workforce and leadership scholarships best practice and research. The funds are allocated by the Ministry in consultation with DHBs and the Ministry of Pacific Island Affairs.
PMS	Patient Management System	PMS (secondary-care usage), or Practice Management System (primary-care usage). The system used to keep track of patients. In the case of secondary care the focus is usually on tracking the admissions, discharges or transfers of patients. In the case of primary care, the focus is on maintenance of the register.
PHARMAC	Pharmaceutical Management Agency	Agency which secures, for eligible people in need of pharmaceuticals, the best health outcomes that are reasonably achievable from pharmaceutical treatment and from within the amount of funding provided.
PACS	Picture Archiving and Communications System	A picture archiving and communications system is a versatile system that enables the transfer of digital images and patient information throughout the organisation. In broad terms, PACS is a technology, system and process for handling medical images (X-rays, CT, ultrasound etc) without the need for film. Images are stored on computer as digital information and displayed on computer screens for viewing.
PBF	Population Based Funding	Involves using a formula to allocate each DHB a fair share of the available resources so that each Board has an equal opportunity to meet the health and disability needs of its population.
	Primary Care	Primary Care means essential health care based on practical, scientifically sound, culturally appropriate and socially acceptable methods. It is universally accessible to people in their communities, involves community participation, is integral to, and a central function of, the country's health system, and is the first level of contact with the health system.
PHO	Primary Health Organisation	A new development in service delivery PHOs encompass the range of primary care and practitioners and are funded by DHBs to provide of a set of essential primary health care services to those people who are enrolled in that PHO.
	Public Health	The science and art of preventing disease, prolonging life and promoting health and efficiency through organised community effort. A collective effort to identify and address the unacceptable realities that result in preventable and avoidable health outcomes, and it is the composite of efforts and activities that are carried out by people committed to these ends.

	Quality Assurance	Formal process of implementing quality assessment and quality improvement in programmes to assure people that professional activities have been performed adequately
RMO	Resident Medical Officer	This is another name for a House Officer or Registrar.
	Risk Factor	An aspect of personal behaviour or lifestyle, an environmental exposure, or an inborn or inherited characteristic that is associated with an increased risk of a person developing a disease.
	Secondary Care	Specialist care that is typically provided in a hospital setting
SMO	Senior Medical Officer	This is another name for a Consultant.
SIMHN	South Island Mental Health Network	SIMHN is a forum of mental health representatives appointed by the six DHBs and is assisted in its work by the South Island Shared Services Agency Ltd (SISSAL).
SISSAL	South Island Shared Services Agency Ltd	SISSAL provides a consultancy service to the South Island DHBs, and works in partnership with them on health planning and funding issues. SISSAL is funded by the DHBs on an annual budget basis to provide these services. The main services provided include contract and provider management, audit, strategy and service development, analysis, and project and change management.
SOI	Statement of Intent	The SOI covers three years and is the DHB's key accountability document to Parliament. It is a statutory obligation under the Public Finance Act. It has a high level focus similar to an executive summary, of the DHB's key financial and non-financial objectives and targets.
TLA	Territorial Local Authority	Local Council also known as: Regional Councils; District Councils; Territorial Local Authorities; Unitary Authorities; City Councils; Councils
	Tertiary Care	Very specialised care often only provided in a smaller number of locations
	Treaty of Waitangi	NZ's founding document. It establishes the relationship between the Crown and Maori as tangata whenua and requires both the Crown and Maori to act reasonably toward each other and with utmost good faith
	Well-child / Tamariki ora Services	Term used to describe all activities that promote health and prevent disease that are undertaken in the primary care setting for children and their families and whanau
	Whanau	Family
WMRS	Workforce Management and Reporting System	The WMRS tool analyses fortnightly, year-to-date and previous year's payroll data against phased budgets and is designed to give management at all levels a means of detecting cost trends at an early stage as well as highlighting areas where more intense planning and monitoring is required.
YTD	Year to Date	The 12 month period immediately prior to the date given.

Appendix 2.

ORGANISATIONAL CHART OF THE CANTERBURY DHB



Appendix 3.

CANTERBURY DHB

HOSPITALS AND SPECIALIST SERVICE - OVERVIEW

HOSPITAL SUPPORT AND LABORATORY SERVICES

Covers support services such as: medical illustrations, specialist equipment maintenance, sterile supply and hospital maintenance. It also covers the provision of diagnostic services through Canterbury Health Laboratories (CHL) for patients under the care of the Canterbury DHB and offers a testing service for GPs and private specialists. CHL is utilised by more than 20 public and private laboratories throughout NZ that refer samples for more specialised testing and is recognised as an international referral centre.

MEDICAL AND SURGICAL SERVICES

Covers medical services: cardiology/lipid disorders, endocrinology/diabetes, respiratory, rheumatology/immunology, infectious diseases, oncology, gastroenterology, clinical haematology, neurology, hyperbaric medicine and sexual health and surgical services: vascular, cardiothoracic, orthopaedics and neurosurgery, urology, plastic and cardiac surgeries and the services of the day surgery unit. Services also cover: emergency investigations, outpatients, anaesthesia, intensive care, radiology, nuclear medicine, clinical pharmacology, pharmacy, medical physics and allied health services. The Christchurch Hospital has the busiest Emergency Department in Australasia treating almost 72,000 patients per annum.

MENTAL HEALTH SERVICES

Our Mental Health Service is one of the two largest providers in NZ covering: child and youth, adult specialty, community services and rehabilitation services, forensic (regional), acute psychiatric and alcohol and drug services, long-term care, assessment, treatment and rehabilitation and psychiatric services for adults with intellectual disabilities. A number of community based services and mobile teams also provide mental health services (including alcohol and drug services) throughout Canterbury.

OLDER PERSON'S HEALTH AND REHABILITATION SERVICES

Covers assessment, treatment and rehabilitation services, psychiatric services for the elderly and psychiatric needs assessment, generic geriatric outpatients, specialist osteoporosis clinics, meals on wheels, community therapy services and needs assessment service co-ordination. The Older Person's Health Service also operates a geriatric day hospital. Rehabilitation health services cover the spinal injuries unit, musculoskeletal services, brain injury rehabilitation services, pain management and orthopaedic rehabilitation. The Burwood Spinal Unit is one of only two such units in the country, treats 60% of NZ's spinal injury patients and is involved in leading international research to help patients rehabilitate and adjust.

RURAL HEALTH AND COMMUNITY SERVICES

Covers a wide range of services provided in rural areas generally based out of Ashburton Hospital but also covering services provided by the smaller rural hospitals. Services include: general medicine and surgery, palliative care, maternity services, assessment treatment and rehabilitation services for the elderly and long-term care for the elderly including specialised dementia care and diagnostic services. Also offered are rural community support services: day care services, district nursing, home support, meals on wheels, clinical nurse specialist in respiratory, cardiac education and stoma therapy. The Rural Health Service also operates Tuarangi Home a facility providing hospital care for the elderly in Ashburton.

WOMEN AND CHILDREN'S HEALTH SERVICES

Covers acute and elective gynaecology services, primary, secondary and tertiary obstetric services, neonatal intensive care services, pregnancy terminations (at Lyndhurst Hospital) and primary maternity services through Lincoln Maternity, Rangiora Hospital and the Burwood Birthing Unit. This service also covers children's health: paediatric oncology, paediatric surgery, child protection services, cot death/paediatric disordered breathing, community paediatrics and paediatric therapy, public health nursing services and vision/hearing screening services. The Services' neonatal intensive care unit and staff are involved in world-leading research investigating improved care for pre-term babies.

Appendix 4.

STATEMENT OF ACCOUNTING POLICIES.

The Canterbury DHB will adopt the following accounting policies consistently during the year and apply these policies for the Annual Accounts. In accordance with the Institute of Chartered Accountants of NZ Financial Reporting Standard 29, the following information is provided in respect of the Statement of Intent:

(i) Cautionary Note

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

(ii) Nature of Prospective Information

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

(iii) Assumptions

The main assumptions underlying the forecast are noted in Part 5 of the SOI.

New Zealand Equivalents to International Financial Reporting Standards (NZIFRS)

The financial reporting standard about preparing prospective financial statements (FRS-42) says that the (prospective) forecast statements for an upcoming financial year should be prepared using the same standards as the statements at the end of that financial year.

The prospective (forecast) financial statements in this SOI have been prepared in accordance with the New Zealand Equivalents to International Financial Reporting Standards (NZIFRS).

A. REPORTING ENTITY

The Canterbury DHB is a Crown entity in terms of the Public Finance Act 1989.

The group currently consists of the Canterbury DHB, its subsidiaries Canterbury Laundry Service Ltd (100% owned) and Brackenridge Estate Ltd (100% owned), and associate entities, NZ Centre for Reproductive Medicine Ltd (50% owned) and SISSAL (47% owned).

The financial statements of the Canterbury DHB have been prepared in accordance with the requirements of the NZ Public Health and Disability Act 2000 and the Public Finance Act 1989.

In addition, funds administered on behalf of patients have been reported as a note to the financial statements.

B. MEASUREMENT BASE

The financial statements have been prepared on a historical cost basis, modified by the revaluation of certain fixed assets.

C. ACCOUNTING POLICIES

The following particular accounting policies, which materially affect the measurement of results and financial position, have been applied:

i) Revenue from Contracts for Services

Revenue from MoH to the Funder arm of the CDHB is recognised as revenue in the financial year. Revenue from contracts for services where funding is still the responsibility of MoH, is recognised based upon the percentage of completion of the contract performance targets.

ii) Specific Purpose Grants and Specific Service Sales

Specific purpose grants and specific service sales are recognised as revenue when the primary conditions attached to those grants or services have been complied with.

iii) Fixed Assets

Fixed Assets Vested from the Hospital and Health Service

Under section 95(3) of the NZ Public Health and Disability Act 2000, the assets and liabilities of Canterbury Health Ltd were vested in the CDHB on 1 January 2001. Accordingly, assets were transferred to the Canterbury DHB at their net book values as recorded in the books of CHL. In effecting this transfer, the Canterbury DHB has recognised the cost/valuation and accumulated depreciation amounts from the records of Canterbury Health Ltd. The vested assets will continue to be depreciated over their remaining useful lives.

Fixed Assets acquired since the establishment of the Canterbury DHB

Assets acquired by the Canterbury DHB since its establishment are recorded at cost except for land, buildings and fitout plant and equipment that are revalued every five years. This includes all appropriate costs of acquisition and installation, including materials, labour, direct overheads, financing and transport costs.

Revaluation of land, buildings and fitout plant and equipment

Land, buildings and fitout plant and equipment are revalued every five years. The fair value of land, buildings and fitout plant and equipment is determined by an independent registered valuer by reference to the highest and best use of these assets or, if sufficient market based evidence is not available, by reference to their depreciated replacement cost. Additions between revaluations are recorded at cost. The results of revaluing land, buildings and fitout plant and equipment are credited or debited to assets revaluation reserve for that class of asset. Where a revaluation results in a debit balance in the asset revaluation reserve, the debit balance will be expensed in the statement of financial performance.

iv) Depreciation

Depreciation is charged on a straight-line basis so as to write off the cost or valuation of fixed assets above \$2,000 to their estimated residual value over their expected economic life. Assets below \$2,000 are written off in the month of purchase. The estimated economic lives of major classes of assets are as follows:

	Years
Freehold Buildings	20 - 50
Leasehold Building & Fitout	3 - 20
Fitout Plant and Equipment	5 - 50
Plant and Equipment (incl pool)	5 - 12
Office Equipment	8 - 10
Furniture and Fittings	10
Computer Equipment and Software	2 - 5
Motor Vehicles	5

Work in progress is not depreciated. The total cost of a project is transferred to buildings and/or equipment on its completion and then depreciated.

v) Goods and Services Tax

The financial statements have been prepared exclusive of goods and services tax (GST) with the exception of receivables and payables that are stated with GST included. Where GST is irrecoverable as an input tax, it is recognised as part of the related asset or expense.

vi) Donated Assets

Donated assets are recorded at the best estimate of net current value. Donated assets are depreciated over their expected lives in accordance with rates established for other fixed assets.

vii) Stocks

Stocks are valued at the lower of cost or net realisable value. Cost is principally determined on a weighted average cost basis. Full provision has been made for all defective and obsolete stocks.

viii) Accounts Receivable

Accounts Receivable is stated at the estimated realisable value after providing against debts where collection is doubtful.

ix) Investments

The investment in the Associate Companies is stated at the fair value of the net tangible assets at acquisition plus the movement in the share of post acquisition reserves on an equity accounted basis. Other investments are stated at the lower of cost and net realisable value. Dividend and interest income is accounted for on an accrual basis.

x) Taxation

The Canterbury DHB and its subsidiaries are a public authority under the NZ Public Health and Disability Act 2000 and are exempt from income tax under Section CB3 of the Income Tax Act 1994.

Income tax expense is charged in the group statement of financial performance in respect of the subsidiaries current year's earnings after allowance for permanent differences. Deferred taxation is determined on a comprehensive basis using the liability method. Deferred tax assets attributable to timing differences or tax bases are only recognised where there is virtual certainty of realisation.

xi) Research and Development

Research and Development costs are expensed as incurred except in the case of development expenditure where future benefits are expected to exceed those costs. Where development expenditure is deferred, the expenditure is amortised over the period of expected benefits.

xii) Foreign Currencies

Foreign currency transactions are recorded at the exchange rates in effect at the date of the transaction. Where forward currency contracts have been taken out to cover forward currency commitments, the transaction is translated at the rate contained in the contract.

Monetary assets and liabilities arising from trading transactions or overseas borrowings are valued at closing rates. Gains and losses due to currency fluctuations on these items are included in the Statement of Financial Performance.

xiii) Leased Assets

Leases under which the Canterbury DHB assumes substantially all the risks and rewards incidental to ownership are classified as finance leases and the related lease assets are capitalised.

The asset and corresponding liability are recorded at inception of the lease at the fair value of the leased assets, or if lower, at the discounted present value of the minimum lease payments including residual values.

Capitalised leased assets are depreciated over their expected economic lives in accordance with rates established for other similar assets.

Finance charges are apportioned over the terms of the respective leases using the actuarial method.

Operating lease payments are charged as expenses in the period in which they are incurred.

xiv) Finance Costs

Where interest rate swap contracts have been taken out to hedge specific borrowing, the rates contained in the swap contracts have been used to calculate interest payable. For general hedges, accrued swap payments and receipts due at balance date are recognised as finance costs.

xv) Provision for Staff Entitlements

Provision is made in respect of the Canterbury DHB's liability for annual leave, long service leave, retirement gratuities, parental leave, sabbatical leave and conference leave. Gratuities and long service leave have been calculated on an actuarial basis at current rates of pay whilst the other provisions have been estimated based on an entitlement basis.

xvi) Statement of Cash Flows

Cash means cash balances on hand, held in bank accounts, demand deposits and other highly liquid investments in which the group/company invests as part of its day-to-day cash management.

Operating activities include cash received from all income sources of the Canterbury DHB and record the cash payment made for the supply of goods and services.

Investing activities are those activities relating to the acquisition and disposal of current and non-current securities and advances (other than securities and advances included within cash) and any other non-current assets.

Financing activities are those activities relating to changes in equity and debt capital structure of the entity and those activities relating to the cost of servicing the entity's equity capital.

xvii) Donations and Bequests

Donations and bequests received with restrictive conditions are treated as income when received. Until the conditions attached have been fulfilled, the assets received are treated as restricted assets.

xviii) Financial Instruments

The Canterbury DHB is party to financial instrument arrangements as part of its everyday operations, including both instruments which have been recognised in the Statement of Financial Position and those off-Balance Sheet. Off-Balance Sheet financial instruments include foreign currency forward exchange contracts and interest rate swaps.

The following methods and assumptions were used to value each class of financial instruments:

- Accounts Receivable is recorded at expected realisable value.
- Investments are recorded at the lower of cost or market value.
- All other financial instruments, including term loans, cash and bank, and accounts payable are recognised at their fair value.

While off-Balance Sheet financial instruments are subject to risk that market rates may change subsequent to the purchase of the financial instruments, the opposite effects on the items being hedged would generally offset such changes. For interest rate swaps, the differential to be paid or received is accrued as interest rates change and is recognised as a component of interest expense over the life of the swaps.

xix) Basis of Consolidation

The consolidated financial statements include the parent Canterbury DHB and its subsidiaries. The subsidiaries are accounted for by adding together corresponding assets, liabilities, revenues and expenses on a line by line basis.

The interest in the associate companies has been reflected in the financial statements on an equity accounting basis that shows the share of surplus/deficit in the statement of financial performance and the share of post-acquisition increases/decreases in net assets in the statement of financial position.

All significant inter-company transactions are eliminated on consolidation.

D CHANGE IN ACCOUNTING POLICIES

There have been no changes from the accounting policy changes adopted in the previous financial period. All policies have been applied on a basis consistent with the previous period.