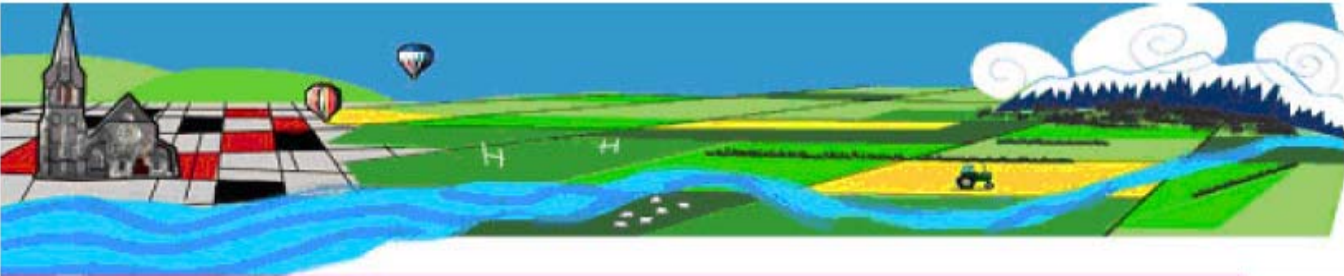


District Annual Plan 2007/2008



Canterbury District Health Board

Canterbury

District Health Board

Te Poari Hauora o Waitaha

DISTRICT ANNUAL PLAN

1 July 2007 – 30 June 2008

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TABLE OF CONTENTS

- 1 EXECUTIVE SUMMARY 1**
 - Statement from the Chairman and Chief Executive Officer 1
 - Approval Letter from the Minister of Health 3
- 2 INTRODUCTION 6**
 - 2.1 The Canterbury DHB - Who are we?6
 - 2.2 Our Vision and Values6
 - 2.3 Our Organisation Structure7
 - 2.4 About this District Annual Plan.....9
 - 2.5 Our Decision Making Principles9
 - 2.6 Collaboration, Partnerships and Community Participation10
- 3 OUR ENVIRONMENT 13**
 - 3.1 Overview of the Canterbury Population13
 - 3.2 Key Health Trends for Canterbury14
 - 3.3 Demand Pressures16
- 4 OUR STRATEGIC PRIORITIES AND DIRECTION 17**
 - 4.1 Our Core Directions and Health Gain Priorities17
 - 4.2 The Minister of Health’s Priorities and Expectations17
 - 4.3 Key Focus 2007/0818
- 5 ISSUES, ASSUMPTIONS AND RISKS 20**
 - 5.1 Key Risks and Mitigation Strategies20
 - 5.2 Assumptions Made in Developing this Plan.....20
 - 5.3 Funding Envelope 2007/0821
 - 5.4 Pressures on Expenditure.....21
 - 5.5 Allocation of Funds - Service Coverage 2007/0823
 - 5.6 Capability, Capacity, Productivity and Value for Money24
 - 5.7 Anticipated Service Changes 2007/08.....28
- 6 ADVANCING OUR STRATEGIC PRIORITIES 30**
 - 6.1 Our Core Directions30
 - 6.1.1 Improve the Health of Our Community 30
 - 6.1.2 Find Better Ways of Working 32
 - 6.1.3 Work Together 34
 - 6.1.4 Develop our Health Workforce 36
 - 6.1.5 Be a Leader in Health 38
 - 6.2 Our Health Gain Priorities40
 - 6.2.1 Child and Youth Health 40
 - 6.2.2 Health of Older People 44
 - 6.2.3 Maori Health - He Korowai Oranga 46
 - 6.2.4 Primary Health 49
 - 6.2.5 Disease Prevention and Management 51

6.3	Our Disease Priorities	55
6.3.1	Cancer	55
6.3.2	Cardiovascular Disease	57
6.3.3	Diabetes	58
6.3.4	Respiratory Disease	60
7	ADVANCING OTHER GOVERNMENT PRIORITIES	61
7.1.1	The NZ Disability Strategy	61
7.1.2	The NZ Mental Health Strategy	62
7.1.3	Infrastructure - The Health Information Strategy	65
7.1.4	Quality and Patient Safety	67
7.1.5	Elective Services, Orthopaedics and Cataracts	68
7.1.6	Family Violence	73
8	MEASURING SUCCESS	74
8.1	Monitoring and Reporting Our Performance	74
9	MANAGING FINANCIAL RESOURCES	76
9.1	Managing Within Our Operating Budget.....	76
9.2	Outyears Scenario	76
9.3	Asset Planning and Investment	77
9.3.1	Business Cases	77
9.3.2	Capital Expenditure	77
9.4	Debt and Equity.....	77
9.5	Efficiencies and Service Reconfigurations.....	77
9.6	Forecast Financial Statements - 2007/08 to 2009/10	78
9.6.1	Forecast Group Statement Financial Performance	78
9.6.2	Summary of Revenue and Expenses by Output Class	79
9.6.3	Forecast Group Statement Financial Position	80
9.6.4	Forecast Group Statement of Movement in Equity	80
9.6.5	Forecast Group Statement Cashflow	81
10	APPENDICES AND REFERENCES	82
10.1	Organisational Chart of the Canterbury DHB.....	83
10.2	Hospital and Specialist Services - Overview of Service Divisions.....	84
10.3	Glossary of Terms.....	85
10.4	Consolidated List of Indicators of DHB Performance	90
10.5	Diabetes Case Study – Value for Money	96

1 EXECUTIVE SUMMARY

Statement from the Chairman and Chief Executive Officer

We are pleased to present our District Annual Plan (DAP) for the 2007/08 financial year. This document reflects our continued commitment to promoting, enhancing and facilitating the health and wellbeing of the people of Canterbury.

In 2004 the Canterbury District Health Board (DHB) chose five Core Directions, five Strategic Health Gain Priorities and four Disease Priorities. These local strategic priorities are coupled with national and regional objectives and expectations to set our long-term direction and goals. The following DAP document outlines the activity we have planned in 2007/08 that will contribute to achieving the long-term objectives and goals that we have set.

Over the past year the Canterbury DHB has achieved some excellent outcomes and results against both national and regional expectations as well as local DHB priorities. These achievements provide an excellent foundation for making further progress in meeting national objectives and local priorities in 2007/08 and include:

- Implementing the 'Improving the Patient Journey' Programme and various patient flow projects aimed at reducing patient delay and duplication, improving access and utilisation of critical resource and improving continuums of patient care;
- Opening the new Diabetes and Home Dialysis Training Centre and completion of the Burwood Hospital (Stage 2) Re-development, delivered on time and within budget;
- Successful challenging of traditional health care roles and implementing nurse-led services and a dedicated night team;
- The securing of additional electives funding for the majority of elective services;
- The establishment of the Acute Medical Assessment Unit at Christchurch Hospital;
- Implementation of our *Healthy Ageing, Integrated Support* Strategy and completion of the trial of a geriatric assessment tool aiming to improve coordinated clinical assessment;
- A review of Acute Demand and After Hours Cover in Canterbury with the establishment of collaborative recommendations to address acute demand growth; and
- Successful implementation of the 'Fruit in Schools' Programme promoting healthy eating, physical activity, sun protection and smokefree environments.

In seeking to achieve both national and local objectives, our single largest challenge continues to be maintaining financial viability in a climate of increasing demand and public expectation. As in previous years 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. It will also depend on 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, other health service providers, our workforce and our community to find ways to overcome the issues and risks we face and will seek support for joint problem solving, prioritisation and for implementing necessary services 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 during this period 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 the Acute Demand and After Hours Cover Review 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 during the next year 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 Exercise* (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. A focus for the DHB in 2007/08 is improved planning and service development to better meet the needs of our population. We will be looking to establish a direction for future health service delivery in Canterbury through our Health Services Planning Programme. 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 year will be a challenging one 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 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.

Signatories



Syd Bradley
Chairman



Gordon Davies
Chief Executive

Approval Letter from the Minister of Health



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

9 JUL 2007

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

Dear Mr Bradley

Canterbury District Health Board: 2007/08 District Annual Plan

I am pleased to advise that I have signed Canterbury District Health Board's (CDHB) 2007/08 District Annual Plan (DAP) for three years, and that the Board has my full support for implementing this plan.

This year your Board and management have put tremendous effort into successfully managing what was a challenging 2006/07 plan. I can see from your 2007/08 plan that you intend to continue this effort. I am really appreciative of this.

Service Change and Reconfiguration

May I remind you that my approval of your DAP does not constitute approval of proposals for service changes or service reconfigurations. You will need to comply with the requirements of the Operational Policy Framework and advise the Ministry where any proposals may require my approval.

Health Targets

The introduction of the new Health Targets was designed to provide an increased focus on my continuing priorities. They provide the sector with a solid platform for measurable progress in the coming year. I am delighted with the emphasis that your Board plans to give to these priorities. I look forward to receiving updates from you as the year progresses.

Reducing Burden of Chronic Disease

Although variable across DHBs, many DAPs this year are showing an increasing commitment to health promotion and illness prevention strategies. Healthy Eating Healthy Action (HEHA) initiatives are developing well and the progress the sector plans on oral health and tobacco control is very pleasing. CDHB's extension of HEHA into a Healthy Eating Active Living (HEAL) plan for your local population is particularly interesting to me. Keep up the good work on establishing the cancer

control regional networks. The work you are doing on cancer services is so important because it impacts on the lives of so many New Zealanders.

Primary Care

This year I will be looking for the progress you signal in primary care. Primary Health Organisations (PHOs) are not new anymore. You should be expecting a solid contribution from them towards both your promotion and prevention strategies (especially for children and youth), and in their management and support of patients with chronic disease.

Primary care has a tremendous contribution to make to the management of elective services. I encourage you to continue to give full support to your General Practitioner (GP) liaisons so that we can achieve real improvement in the interface between primary and secondary services. I am looking forward to hearing of your progress on your integrated referral management gateway for patients. Consider reviewing your processes within both primary and secondary care where tremendous gains can still be made.

Electives

Meeting Elective Service Patient Flow Indicators (ESPI) remains an area of high priority. I do realise the challenges inherent in the management of elective services but will reiterate my message to you from last year. People have a right to know when they have been promised surgery that they will get it within a specified timeframe, or if they cannot be offered treatment what their options are. Could you as a Board, please ensure that you have mechanisms (such as "buffers" and robust internal reporting systems) in place to ensure that your ESPI compliance is maintained and that your commitment to additional volumes is achieved.

Achievement of increased elective volumes could be a tangible demonstration of productivity gains and a contribution to value for money strategies. Please frequently review your productivity levels as the year progresses.

Health of Older People

Your plans to advance the implementation of the Health of Older People strategy shows a strong commitment to this age group in your community. I am very pleased to see the work you plan on developing community based services and on supporting workforce enhancements.

Mental Health

I note that again you have taken up the opportunity of Blueprint funding. I am keen to see that you have in place mental health services, using this funding (and as much as possible of your previous mental health surpluses) as early as possible in the new year.

As a nation we still need to make more progress in building and broadening services to support people with mental health or addiction illnesses. This year I am expecting to see real improvements in services for children and young people.

Financial and Risk Management

I hardly need to remind you of the need to continue to manage your services within your allocated funding. I note the risks outlined in your DAP and the mitigation

strategies you have identified have my support. I expect robust financial performance and that you continue to keep the Ministry of Health (the Ministry) informed of emerging risks.

Capital

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

Monitoring Intervention Framework

I am pleased to note that CDHB has maintained the status of standard monitoring on the Monitoring and Intervention Framework (MIF). This is a reflection of your ongoing positive performance and is rewarded by the benefit of receiving early payment of your funding. I am confident that you will be working to retain your MIF status throughout 2007/08.

Inequalities

Lastly, but most importantly, there remains within our community population groups whose health and well being is significantly lagging behind the majority. I ask that you continue to focus on reducing inequalities.

In conclusion I know that as you enter this new year you and your Board will have in the front of your minds improving service quality, meeting fiscal imperatives and managing industrial challenges. All this in the context of impending Board elections. It is a tremendous contribution that you are making to the lives of New Zealanders. Thank you. Best wishes with the implementation of your 2007/08 DAP.

Could I ask that a copy of this letter is attached to the copy of your signed DAP held by the Board and to all copies of the DAP made available to the public.

Yours sincerely



Hon. Pete Hodgson
MINISTER OF HEALTH

2 INTRODUCTION

2.1 The Canterbury DHB - Who are we?

DHBs were established in January 2001, under the New Zealand Public Health and Disability Act 2000 (NZPHD Act)¹. There are twenty-one DHBs spread across the country and their prime responsibility is to work (within the funding allocated to them) to improve, promote and protect the health and independence of the population of their region.

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

- We *plan*, in consultation with stakeholders and our community, the strategic direction for health and disability services in the Canterbury region.
- We *fund* most of the health and disability services provided in Canterbury and hold more than 800 service contracts with health and disability service providers.
- We *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.
- We *promote* community health and well-being through population health programmes, 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 - 'ON AN AVERAGE DAY'

\$3 million is spent	197 people are admitted to a public hospital 12 admissions were potentially preventable	225 people are seen in ED 3067 people are seen in general practice	15 babies are born 0.9 have low birth weight 2 are born to teenage mothers	34 people are admitted for elective surgery 90% are satisfied with their care
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2.2 Our Vision and Values

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.

¹ The NZPHD Act can be found on the Ministry of Health website www.moh.govt.nz.

2.3 Our Organisation Structure

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

GOVERNANCE

The governance structure of DHBs is set out in the NZPHD Act (the Act which established DHBs). Each DHB has an eleven member Board, the members of which are responsible to the Minister of Health for the overall performance (or governance) of the DHB. Seven board members are elected by the DHB's community and four are appointed by the Minister of Health. The Board's role is to:

- Set long-term strategic direction, consistent with government objectives;
- Ensure compliance with the law, accountability requirements, relevant Crown expectations and the requirements of the NZPHD Act;
- Monitor the financial and non-financial performance of the DHB;
- Appoint the Chief Executive and maintain that employer relationship; and
- Maintain appropriate relationships with the Minister of Health, Parliament, Maori communities and the public (or population) of its region.

Each Board is required to have three Statutory Committees (comprised of a mix of both Board members and community representatives)²:

- *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.
- *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.

Our Board also has an additional sub-committee specific to the Canterbury DHB, the *Finance, Audit and Risk Committee (FARC)*, established to enhance the Board's governance function by providing advice on the financial operation of the DHB.

While the responsibility for DHB performance rests with the Board, it has a delegation policy, assigning operational and management matters to the Chief Executive Officer (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, Hospital and Specialist Services, Community and Public Health and Corporate Services divisions (refer to Appendix 1 for an Organisational Chart).

At this EMT level we also have 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).

PLANNING AND FUNDING HEALTH AND DISABILITY SERVICES

The Planning and Funding division of the DHB is 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.

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.

² In accordance with the NZPHD Act, meetings where the Board or any of its Statutory Committees make decisions are open to the public to attend as observers. Notice of the meetings is available on the DHB's website www.cdhb.govt.nz.

Service contracts are held with a wide range of health and disability service providers including a mix of private, religious, welfare, government and Non-Government Organisations (NGOs). The services contracted include primary care services (general practice and nursing services, community, pharmacy and laboratory services), mental health, public health, child health, oral health, family health and maternity services, services for older people, disability and rehabilitation services, residential support and rest home services, Maori and Pacific health services and hospital and specialist services.

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, promotes innovation, develops services to meet any identified gaps in service delivery and improves health outcomes for our community.

This 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 are:

- Determining the health and disability status and needs of our population;
- Planning, prioritising and operationalising national strategies in relation to those needs;
- Involving stakeholders and the community through consultation and participation;
- Funding health and disability services by undertaking service contracting; and
- Monitoring and evaluating service delivery, including audits, and accounting to the Ministry of Health (Ministry) for the DHB's performance.

PROVIDING HEALTH AND DISABILITY SERVICES

The Provider-arm of the Canterbury DHB is referred to as the Hospital and Specialist Service (HSS) division. This division provides inpatient and outpatient services, community services and day programmes, across its six service divisions (refer to Appendix 2 for an overview of the services provided by each division).

The level and variety of services provided by DHBs depends on their relative size, with some DHBs providing more specialist and tertiary level services than others. Because of the size of the Canterbury DHB our HSS division provides an extensive range of specialist secondary and tertiary level services.

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.

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 (PVS³)). However, the HSS division also has service contracts with external purchasers, such as the Accident Compensation Corporation (ACC), and also provides funded services as required by contracts with those external purchasers.

Our services are also provided to patients from outside the Canterbury region, coming from DHBs where more specialist services are not available. Those other DHBs are responsible for meeting the costs of the services provided to their patients by our HSS division; referred to as 'inter-district' services or Inter-District Flows (IDFs). These IDFs are closely monitored to ensure our ability to provide for our own resident population is not effected by the flow of patients from other regions.

SERVICE DIVISIONS WITHIN HSS

Medical and Surgical Services	Mental Health Services	Rural Health Services	Women's and Children's Services	Older Person's Health and Rehabilitation Services	Hospital Support and Laboratory Services
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³ 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.

2.4 About this District Annual Plan

The NZPHD Act sets out the statutory objectives, functions and responsibilities of a DHB and outlines how they will develop District Strategic Plans (DSPs) to describe their objectives and long-term goals. Our DSP, *A Healthier Canterbury: Directions 2010*, was developed in 2005 and outlines the strategic direction of health services in Canterbury for the period 2006-2010.

The DSP is aligned to the government's health and disability strategies and is influenced by the revenue available to the DHB and the specific health needs of the DHB's resident population. In 2004 we undertook a Health Needs Assessment (HNA) of our population and an extensive public consultation process to gather feedback from our community. The outcome of these processes was recognition of the specific local needs of Canterbury residents and the subsequent establishment of five Core Directions, five Strategic Health Gain Priorities and four Disease Priorities where we will place additional focus to better meet the needs of our resident population. We are committed to improving health outcomes in these selected priority areas as well as implementing national objectives that will improve the health status of our community.

CORE DIRECTIONS	HEALTH GAIN PRIORITIES	DISEASE PRIORITIES
Improve the Health and Wellbeing of our Community	Child and Youth Health	Cancer
Find Better Ways of Working	Older People's Health	Cardiovascular Disease
Work Together	Māori Health	Diabetes
Develop our Healthcare Workforce	Primary Health	Respiratory Disease
Be a Leader in Health	Disease Prevention/ Management	

All DHBs are also required to produce District Annual Plans (DAPs) and Statements of Intent (SOIs). These documents, in essence, detail how the DHB will achieve the long-term goals and objectives set in their DSPs. The DAPs are action focused and outline activity planned for the coming year that will assist the DHB not only to achieve its long-term goals but also to meet its immediate challenges and fulfil the expectations and requirements of the Minister of Health. The SOI is a high-level summary of the DAP and includes performance measures and targets for a three-year period.

Because the DAP is closely aligned to the DSP and SOI, it should be read in conjunction with those documents, all of which can be found on the DHB's website www.cdhb.govt.nz.

The DAP, which follows, is designed to show:

- Our intended activity and outputs for 2007/08 and how these relate to our DSP;
- The funding proposed for those intended activities and outputs;
- Our expected capital investment;
- Financial and non-financial performance forecasts; and
- How performance will be monitored, measured and reported.

2.5 Our Decision Making Principles

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 by the DHB, at what level they will be provided and what funding will be provided for those services.

DHBs must also note government strategies when making funding decisions, particularly: the NZ Health Strategy 2000, NZ Disability Strategy 2002 and the NZ Maori Health Strategy 2002⁴.

For those services for which there is a greater level of discretion the Canterbury DHB has developed a Prioritisation Framework, identifying a set of principles to assist in making choices and decisions about which services to fund/provide in the future and at what level.

⁴ These national strategies as with all national health strategies referred to in this document can be found on the Ministry's website www.moh.govt.nz.

The DHB is also guided in its decision making process by the Strategic Priorities established during the development of our DSP. When making decision on which health services to fund/provide the DHB's choice is also heavily influenced by the specific health needs of different groups within its population.

CANTERBURY DHB DECISION MAKING PRINCIPLES

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

2.6 Collaboration, Partnerships and Community Participation

While we have set out our long-term objectives and goals we realise that our vision will not be achieved through the DHB's efforts alone. By looking outside our organisation, establishing partnerships with other agencies and with other sectors, as well as with our community and consumers, the DHB can work to influence the determinants of health and enhance the continuum of care needed to achieve improved health outcomes.

We have inter-agency relationships with a wide range of government agencies including: the Ministry, the Mental Health Commission, Child, Youth and Family, Police, Housing NZ, the Ministries of Justice, Education and Social Development, ACC and the Department of Corrections.

We work collaboratively with the Christchurch City Council (CCC), Environment Canterbury and the five TLAs in the wider Canterbury area along with Canterbury schools, the NZ Diabetic and Cancer Societies, the Heart Foundation, the regional Sports Trust and many other NGOs in the Canterbury region. We also actively support a number of collaborative ventures including Healthy Christchurch, Push Play, the Healthy Heart Awards and the Canterbury Intersectoral Physical Activity and Nutrition Group (CIPANG) which endeavour to improve the health of our population.

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 (CPIT) and the Clinical Training Agency (CTA). This work supports the growth of the capability and capacity of 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 DHBNZ⁵ and participate in DHBNZ activities in areas including primary health, industrial relations, prioritisation tools, workforce development and information sharing.

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.

⁵ DHBNZ is the national representative body for all twenty-one DHBs.

The Canterbury DHB is also a 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. The purpose of SISSAL is to support DHBs to meet their objectives by providing health information, service planning and external audit functions as well as coordination and analytical support and some benchmarking of services.

Directions agreed in our key accountability documents and local health 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. In the past year a representative of Ngai Tahu has been invited to attend Board meetings as an observer⁶.

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 to have involvement in working parties.

A number of initiatives or policy changes a DHB proposes may warrant formal consultation. The NZPHD Act specifies DHB consultation in relation to developing or changing the DSP, changes to the DAP and the disposal of any Crown land. We would also expect to consult on any major reconfiguration of services and will identify any consultation needs in each instance and meet our obligations in this regard (including consulting with the Minister of Health).

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. We meet regularly with Manawhenua ki Whaitaha⁷, Maata Waka and several Pacific community groups to ensure Maori and Pacific input into the development of strategies, policy and initiatives to improve health care access and delivery and reduce inequalities in health status.

Over the 2006/07 year we have undertaken considerable consultation on a number of key strategies and plans including most notably: the development of frameworks for health services planning and the management of chronic conditions, the review of acute demand management and after hours cover, the development of a youth health position paper, the revision of our Maori Health Plan, the development of a model of delivery for community services for older people and a model of care for Ashburton and Kaikoura and a stakeholder forum on home based mental health services.

This consultation has involved stakeholders, staff and the public through a number of different processes including reference groups, hui and fonos, public and stakeholder meetings, staff focus groups and working groups. 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.

Pandemic and Emergency Planning

The Canterbury DHB continues to take part in emergency exercises, placing particular emphasis on institutional and public health readiness for emergencies and assisting community health providers in their preparedness. We participate in the South Island Regional Health Emergency Plan in conjunction with the Ministry, St John Ambulance and the other South Island DHBs. This Plan covers a multi-DHB response to any emergency.

We comply with all aspects of Ministry emergency planning requirements including training, planning, exercises and risk reduction. All DHB staff are orientated to Canterbury's hazard environment and a number of staff have attended NZ Qualifications Authority's Coordinated Incident Management System Training which is the benchmark for NZ emergency planning.

During the winter months we activate our Snow Plan to ensure that any disruption to patient care is minimized. Other important work is also underway regarding earthquake preparedness planning.

⁶ Although this member has no voting rights their contribution to discussions is valued input for the DHB's Board.

⁷ Manawhenua ki Waitaha is a representative group which comprises the seven Ngāi Tahu Rūnanga.

We also maintain our own major incident and emergency plans identifying how essential health services will continue to be delivered in the event of a national health-related emergency. Our pandemic planning is well advanced and is based on the scenario developed by the Ministry. Projects are being undertaken in conjunction with a wide range of health providers including primary and private providers, key community groups, other emergency services, civil defence emergency management groups, Maori community groups and neighbouring DHBs.

In 2007/08 our main emergency planning activity will be 'Exercise Cruickshank' a whole of government emergency exercise being led by the Ministry. We will coordinate the response of the health sector within the Canterbury region as well as providing expert support to Civil Defence and law enforcement agencies and leadership for the South Island response. The DHB will also have particular responsibility for managing 'border control' and for managing the 'cluster control' aspects of the exercise.

3 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 make⁸.

In September 2004 we completed our second comprehensive 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).

3.1 Overview of the Canterbury Population

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.

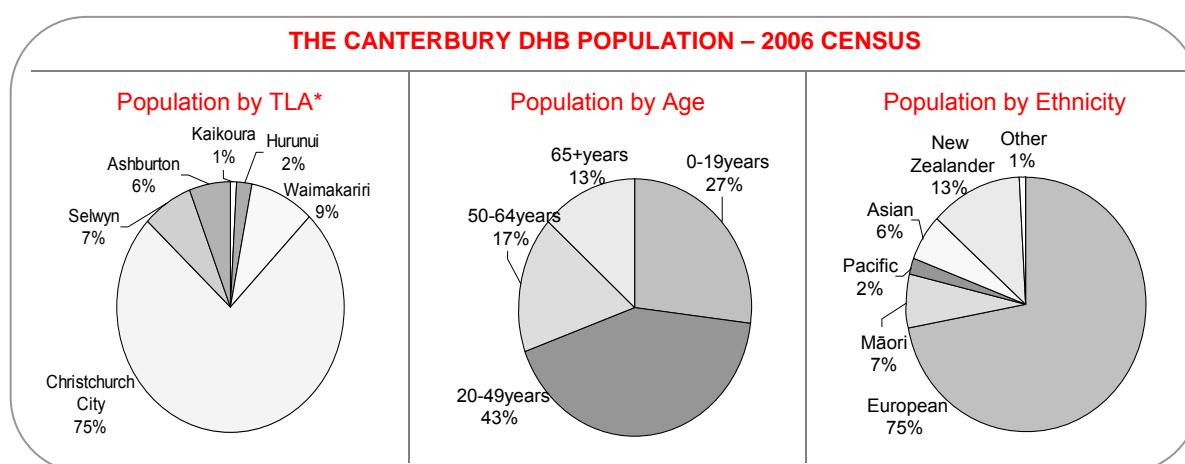
There has been some change in the ethnic mix in Canterbury over the past five years, with the latest 2006 figures showing Maori making up 7.2% of the Canterbury population, Asian people 6.1% and Pacific people 2.2%⁹. Most people identifying as Maori, Asian or Pacific live in Christchurch City.

In the 2001 census, Ngai Tahu was the largest identified iwi in Canterbury, followed by Nga Puhī and Ngāti 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.



⁸ Detailed analysis of the 2006 Census has yet to take place. Most figures 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.

⁹ Allows for double counting where individuals identify with more than one ethnic group.

While there are fewer older Maori and Pacific people in New Zealand, 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.

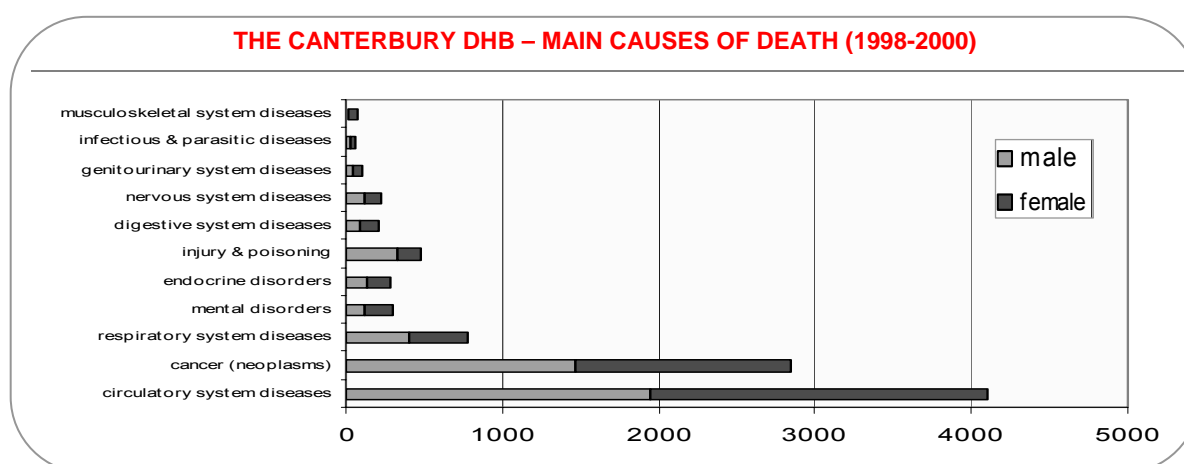
Poorer health status is linked with high degrees of deprivation and the 2001 Census showed Canterbury had around 80,000 people living in NZ Deprivation Deciles 8, 9 and 10 (the highest levels of deprivation). The percentage of Maori and Pacific people living in these areas was higher with 43% of Pacific 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.

3.2 Key Health Trends for Canterbury

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 our region. This understanding has assisted the Canterbury DHB in selecting our long-term Strategic Health Gain Priorities 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 health¹⁰. 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

¹⁰ The NZ Health Survey can be found on the Ministry website, www.moh.govt.nz.

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.

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 Strategic Priority; Child and Youth Health.

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 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 effect these ethnic groups. To add local focus we have included Maori Health and Child and Youth Health amongst our Strategic Priorities.

3.3 Demand Pressures

The Canterbury DHB, like most DHBs across the country, is facing an environment of increasing demand for its services. Our ageing and growing population and the increasing burden of chronic conditions are amongst factors which have contributed to this rising demand.

Christchurch Hospital Emergency Department (ED) visit volumes remained relatively static until 2004 when growth began to increase at around 5% a year; this equates to an additional 3,944 visits. Relative to the DHB's population, ED attendances have increased from 142 attendances per 1000 people to 150 attendances per 1000 people. The additional volumes over this period are primarily people under 30 years of age who make up nearly 64% of the growth observed over 2004/05.

In 2005/06 there were 64,000 discharges from our hospitals, 60,000 were Canterbury residents. The total number of discharges is also increasing over time as demand for our services grows. There are two types of hospital admissions: acute (or emergency) services for patients who are very ill and require immediate treatment and elective services for patients who have conditions that do not require immediate hospital treatment. The number of discharges for acute services has grown faster than growth in our population.

Over the coming year the DHB is undertaking a number of initiatives focused on reducing the demand for acute services and reducing unnecessary or 'avoidable' admissions to hospital, including implementing the recommendations of the Acute Demand and After Hours Cover Review and developing a framework for managing chronic conditions. However, these initiatives will take time to impact on the levels of demand and hence in the short term we are likely to continue to face increasing demand for hospital services.

The DHB will continue with its commitment to improving elective services management and implementing its Improving the Patient Journey Programme across all services in acute settings to reduce inpatient delay, increase the ability of our services to cope with growing demand and improve access to theatres and services by reducing process delays and improving our utilisation of critical resources (such as staff and beds).

4 OUR STRATEGIC PRIORITIES AND DIRECTION

4.1 Our Core Directions and Health Gain Priorities

As highlighted in Section 2.4, five Health Gain Priorities and four Disease Priorities have been identified for special attention or focus by the DHB. The selection of these Strategic Priorities was based on a HNA for the Canterbury region (completed in 2004), the directions of key government health strategies and on feedback received during public consultation on our DSP in 2005.

In addition to these Health Gain and Disease Priorities we also identified five Core Directions which will assist the DHB to build the foundations essential to addressing the challenges we face and ensuring we are able to meet our obligations and responsibilities and work towards our ultimate goal of promoting, enhancing and facilitating the health and well-being of our community.

CORE DIRECTIONS	HEALTH GAIN PRIORITIES	DISEASE PRIORITIES
Improve the Health and Wellbeing of our Community	Child and Youth Health	Cancer
Find Better Ways of Working	Older People's Health	Cardiovascular Disease
Work Together	Māori Health	Diabetes
Develop our Healthcare Workforce	Primary Health	Respiratory Disease
Be a Leader in Health	Disease Prevention/ Management	

The following section of this document (Section 5) outlines the goals and objectives the DHB has identified for each Core Direction, Health Gain Priority and Disease Priority and the actions we intend to undertake over the coming year to achieve the long-term vision set out in our DSP.

4.2 The Minister of Health's Priorities and Expectations

When determining the actions and activity required in 2007/08 to progress our Core Directions and identified Priorities we also consider the Minister of Health's national expectations and priorities, which are signalled as part of the Ministry's annual Planning Package delivered to all DHBs.

The Planning Package ensures that the Ministry and DHBs have agreed guidelines for accountability documents and, by clearly outlining annual expectations and priorities, provides parameters for DHB planning. The Package also ensures that the requirements of relevant legislation are met and, together with policy direction, helps to maintain national consistency across the sector.

For 2007/08 the Minister of Health has signalled expectations around substantial and measurable progress on national health strategies (focusing on quality and safety, innovation and further reductions in health inequalities).

The Minister is also looking to instil a 'Common Purpose' promoting partnerships and supportive relationships, both within and beyond the health system, and collaboration on common strategies and priorities.

The Minister of Health's specific Priorities for 2007/08 are:

- *Chronic Disease.* With emphasis on progressive implementation of the Healthy Eating Healthy Action (HEHA) Strategy, Cancer Control Strategy and the Tobacco Control Strategy. Focus is also on programmes which assist early diagnosis and management of conditions such as diabetes or depression;
- *Child and Youth Services.* Emphasis on progressing improvements in oral health services, child and youth mental health services and adolescent sexual health services. Continued development and implementation of the 'ready for school' health and wellness checks, free primary health care for under sixes, newborn hearing screening and early intervention;
- *Primary Health.* Emphasis on the maturation of PHOs - the development of new models of service, the involvement of a broader range of professionals, an improved primary/secondary interface and a focus on the population health lens;

- *The Health of Older People.* Emphasis on continued change in service delivery and the implementation of new assessment tools, new models of supportive care for those choosing to live longer at home and renewed attention on workforce training in the sector;
- *Infrastructure.* Emphasis on continued investment in improvements to the health information system and cooperation and coordination across the sector. Focus will also be placed on progressing the national Future Workforce Initiative; and
- *Value for Money.* While good gains continue to be made in cost effectiveness there will be further emphasis on opportunities to improve organisational efficiency and ensure value for money.

Ongoing Priorities:

- Progress the objectives of the NZ Disability Strategy;
- Progress the objectives of the NZ Mental Health and Addiction Action Plan;
- Reduce inequalities particularly for those groups with the poorest health (those of low socio-economic status and Maori and Pacific people) and those with disabilities;
- Improve the quality and safety of health and disability services;
- Improve elective services including progressing the Orthopaedic and Cataract Initiatives; and
- Collaborate across agencies to reduce family violence and implement the Ministry's Family Violence Intervention Guidelines.

Because of our consideration of national priorities in developing our local approach and our DSP a number of our Core Directions and identified Strategic Priorities are the same as those identified nationally by the Minister of Health and our direction is very much aligned with the 'Common Purpose' expected by the Minister.

Where the Minister's priorities for the coming year are additional to those priorities specifically identified by us, the action and activity we have planned to meet the Minister's expectations has been identified in Section 6 of this document.

4.3 Key Focus 2007/08

While managing their three roles in health (Governance, Planning and the Funding and the Provision of health and disability services), DHBs face a number of challenges. In our DSP we identified the Canterbury DHB's challenges as:

- Working with funding and financial pressures;
- Meeting increasing demand for services;
- Workforce capacity;
- Reducing inequalities;
- Improving access to health care;
- Reducing the impact of lifestyle diseases;
- Addressing the health issues of an ageing population;
- Focusing on effective and quality services;
- Managing community and staff expectations;
- Increasing productivity in the provider-arm (HSS);
- Working with other South Island DHBs; and
- Developing our infrastructure.

In the coming year we will continue to address the challenges we face that would otherwise hamper our long-term progress. Much of the activity under our Core Directions is planned to assist with addressing these barriers to success and over the past year work has already begun which will provide the foundations to enable the DHB to change its culture and practice and allow us to create opportunities to change the way we fund and deliver health services in Canterbury.

Our Board and CEO have identified and confirmed the key focus for the DHB over the coming year to provide us with the best opportunity to improve health outcomes for our population.

- Defining New Ways to Provide Services:
 - Health Services Planning;

- Integrated Care and the Management of Chronic Conditions; and
- Patient Centred Care and Improving the Patient Journey.
- Ensuring the Supportive Infrastructure to Make Changes:
 - Information Technology and the Interchange of Information;
 - Quality and Patient Safety; and
 - Future Workforce Development.
- Ensuring Change is Supported:
 - Relationships to Improve Environments;
 - Partnerships to Improve Service Delivery and Manage Demand;
 - Improved Productivity, Efficiency and Effectiveness; and
 - Community Engagement.

The table that follows summarises how the focus for 2007/08 will help us to address the challenges we face and progress change in our region. The table also demonstrates how our focus for 2007/08 relates to the long-term priorities and directions of the DHB.

FOCUS FOR 2007/08	CHALLENGE	DHB PRIORITY
Defining New Ways to Provide Services		
Develop a Health Service Plan	<ul style="list-style-type: none"> ▪ Working with funding and financial pressures ▪ Meeting increasing demand for services 	<ul style="list-style-type: none"> ▪ Finding Better Ways of Working
Develop a framework for managing chronic conditions	<ul style="list-style-type: none"> ▪ Reducing the impact of lifestyle diseases ▪ Addressing the needs of an ageing population 	<ul style="list-style-type: none"> ▪ Disease Prevention and Management
Continue to implement the Improve the Patient Journey Programme	<ul style="list-style-type: none"> ▪ Meeting increasing demand for services ▪ Focusing on effective and quality services ▪ Increasing productivity in the provider-arm 	<ul style="list-style-type: none"> ▪ Finding Better Ways of Working
Ensuring the Supportive Infrastructure to Make Changes		
Support the establishment of a Clinical Portal and the implementation of our Information Services Strategic Plan (SSP).	<ul style="list-style-type: none"> ▪ Focusing on effective and quality services ▪ Increasing productivity in the provider-arm ▪ Developing our infrastructure 	<ul style="list-style-type: none"> ▪ Being a Leader in Health
Continue the development and implementation of the DHB's Quality Strategic Plan.	<ul style="list-style-type: none"> ▪ Focusing on effective quality services ▪ Managing community and staff expectations 	<ul style="list-style-type: none"> ▪ Being a Leader in Health
Develop a strategic workforce vision and challenge traditional roles in health.	<ul style="list-style-type: none"> ▪ Workforce Capacity ▪ Increasing productivity in the provider-arm ▪ Focusing on effective quality services 	<ul style="list-style-type: none"> ▪ Working Together ▪ Developing our Health Workforce
Supporting Change		
Collaborate on implementing the HEHA Strategy to raise health awareness and reduce risk factors.	<ul style="list-style-type: none"> ▪ Reducing the impact of lifestyle diseases ▪ Reducing inequalities 	<ul style="list-style-type: none"> ▪ Disease Prevention and Management ▪ Child and Youth Health
Implement acute demand work streams with an emphasis on reducing Ambulatory Sensitive Admissions.	<ul style="list-style-type: none"> ▪ Meeting increasing demand for services ▪ Improving access to health care ▪ Reducing inequalities 	<ul style="list-style-type: none"> ▪ Improving the Health of our Community ▪ Primary Care
Improve resource utilisation focusing on freeing space and resource for elective services.	<ul style="list-style-type: none"> ▪ Increasing productivity in the HSS ▪ Meeting increasing demand for services ▪ Improving access to health care ▪ Managing community and staff expectations 	<ul style="list-style-type: none"> ▪ Improving the Health of our Community ▪ Finding Better Ways of Working
Support community provider development and community input into decision making.	<ul style="list-style-type: none"> ▪ Reducing Inequalities ▪ Managing community and staff expectations ▪ Improving access to health care 	<ul style="list-style-type: none"> ▪ Improving the Health of our Community ▪ Maori Health

5 ISSUES, ASSUMPTIONS AND RISKS

5.1 Key Risks and Mitigation Strategies

The complex nature of a DHB's activity and responsibilities exposes the organisation to a variety of risks. Broadly speaking, the DHB faces three types of risk: internal risks which can be managed directly by the DHB; risks to services run by contracted providers where the DHB must work with the providers to minimise risks; and external or environmental risks that are faced across the region or by the DHB sector as a whole. We can only manage these external risks by working jointly with the primary and community sectors, government agencies, other DHBs and with the Ministry.

The Canterbury DHB has adopted an organisation-wide approach to risk management and risk reporting, which deals with all potential areas of risks, including clinical, operational, financial and organisational for all services funded by the DHB. A comprehensive Risk Management process has been developed to identify and track the treatment of these risks.

Major risks are regularly reported to our management teams including: the Board's advisory committees (FARC and HAC), the DHB's Clinical Board, our CEO, EMT, HSS General Managers and quality teams.

The risk management system accords with the guidelines in the current Australian and NZ Standard: Risk Management AS/NA 4360:2004 and with our obligations under the Ministry's Operational Policy Framework.

Internal reviews and audits are undertaken across the DHB to provide assurance that the controls to mitigate and reduce risk are in place and are effective. Training and assistance is provided to ensure the risk identification and management process is consistent across the DHB and is of a high standard. We continue to enhance systems to manage both financial and non-financial service risks that we face.

When considering the achievement of our long-term goals and objectives the biggest risks facing the DHB going into 2007/08 relate to financial sustainability including increasing compliance costs, unforeseen price increases and wage increase expectations for the health sector and the increasing demand resulting from the growing burden of chronic conditions.

5.2 Assumptions Made in Developing this Plan

Given the significant challenges and risks we face as a DHB a number of planning and financial assumptions have been made in developing this Plan. These assumptions highlight the risks that are, in the main, outside of our control. If these assumption do not hold true this may limit the DHB's ability to improve the health of our community or may lead to adverse financial outcomes.

Assumptions have been made that the DHB operating environment will not change dramatically and that funding advice provided to the DHBs will hold true.

PLANNING AND FINANCIAL ASSUMPTIONS – <i>it is assumed that ...</i>	
Operating Environment	<ul style="list-style-type: none">- 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 Funding	<ul style="list-style-type: none">- Baseline and out-years funding will increase as per funding advice from the Ministry.- Any future changes to the Population Based Funding (PBF) formula will not impact adversely on future funding levels¹¹.- Demographic funding will be received in future years.
Demand for Services	<ul style="list-style-type: none">- 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.
Price Increases	<ul style="list-style-type: none">- Contracts with NGO providers will be settled (on average) within baseline Future Funding Track (FFT)¹² including any increases in demand for services.- The introduction of new drugs or technology will be within the technology adjuster funding provided to the DHB.

¹¹ PBF is the Ministry funding system - using a formula to allocate each DHB a fair share of the available resources.

	<ul style="list-style-type: none"> - 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%.
Inter-District Flows	<ul style="list-style-type: none"> - Net Inter-District Flow (IDF) revenue can be fully realised and IDF volumes will remain stable and not decline significantly. - Neighbouring DHBs will not alter referral patterns without adequate advance notification.
Efficiencies	<ul style="list-style-type: none"> - 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.
Elective Services	<ul style="list-style-type: none"> - The DHB will remain 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.
Compliance Costs	<ul style="list-style-type: none"> - 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. - Any impact of future asset revaluation under FRS-3¹³ will be cost neutral to the DHB.
Wage and Salary Costs	<ul style="list-style-type: none"> - Collective employment agreements will be settled within the baseline FFT increase, inclusive of automatic step movements and flow-on impact from previous year's employment settlements.
Capacity and Capability	<ul style="list-style-type: none"> - The DHB is able to recruit and retain staff in key clinical positions.
Gain on Assets	<ul style="list-style-type: none"> - Projected proceeds from approved sale of surplus assets can be realised as planned.
Pharmaceutical Expenditure	<ul style="list-style-type: none"> - 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.

5.3 Funding Envelope 2007/08

For the first time since the formation of DHBs population forecasts have been realigned to the latest Census figures, funds available to DHBs have been increased and the PBF formula has been revised. When we prepared our long-term vision and DSP in 2005 the Canterbury DHB was considered to be receiving more than its fair share of health funding (for its population) under the PBF formula. While we were to receive increases in funding for demographic changes, the level of this increase was to be reduced until our funding was in line with our population share.

The latest 2006 Census results and PBF review have resulted in the Canterbury DHB reaching funding equity under the PBF formula. What this means in funding terms is that in the future we will receive our full share of the funding increase for demographic funding for any increases in our population levels.

In 2007/08 the Canterbury DHB expects to receive \$952M in revenue through its Crown Funding Agreement and \$80M for provision of services to residents of other DHBs (IDFs).

In addition to this we expect to receive a further \$32M from separate contracts with the Crown in 2007/08 (for example \$7M for additional Elective Services, \$5.3M for the Orthopaedic and Cataract initiatives and \$420K for the implementation of the national HEHA Strategy) giving a total of \$1.064B to operate the DHB and fund services for Canterbury residents within the Canterbury region.

5.4 Pressures on Expenditure

While our return to equity reduces some pressure on the DHB in the future, the additional baseline funding provided for 2007/08 is expected to be absorbed by cost pressures as the baseline funding falls short of projected cost increases. Additionally, our population is predicted to increase by 1% over the coming year which will increase demand for existing services.

¹² FFT is the annual percentage price increase to DHBs from the Ministry.

¹³ FRS-3 is the Property, Plant and Equipment Accounting Standards

In seeking to achieve ongoing strategic 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, better, but more expensive interventions. DHBs also face key pressures to increase the volume of services funded and prices paid for those volumes and increasing expectations around wage and salary growth.

A number of these issues, or pressures, have been 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)¹⁴ and the Labour Cost Index (LCI)¹⁵.

Health sector non-wage costs tend to rise faster than 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 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 been increasing significantly and this trend will need to be contained in future periods. The effect otherwise will be the reduction in patient services in order to pay additional levels of wages.

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 eased by our equity position after the recent review of the PBF formula, when we compare the funding increases provided and the anticipated cost growth there still remains a clear cost gap which the DHB will need to address and manage.

AS A FUNDER WE WILL NEED TO:	AS A PROVIDER WE WILL NEED TO:
<p>Constrain the price growth to within baseline FFT.</p> <p>Re-allocate volumes between discretionary and non-discretionary services to manage demand driven growth, while providing incentives to providers to minimise/manage growth in demand.</p>	<p>Constrain the growth in the cost of service delivery to enable delivery of the desired mix of services within the available funding including managing the introduction of new treatment regimes and technologies.</p> <p>Collaborate with primary care and community based providers to manage demand for acute hospital services.</p>
KEY PRESSURES ON EXPENDITURE	
<ul style="list-style-type: none"> ▪ Labour Costs - cost of national settlements set through national processes of which we are only one player. Current and future employment agreements and in particular the compounding effect of annual "step" increases coupled with expectation of CPI based increases. ▪ Increasing Demand – cost of the increasing demand for services exceeding additional funding for population growth (demographic adjustment). ▪ NGO Expectations - pressure to meet wage growth pressures and cost growth. ▪ DSS Aged Care Services – with an ageing 	<ul style="list-style-type: none"> ▪ Employee Costs - job sizing, union expectations, locums and bureau costs, the real 'full costs of employment' including the costs of allowances and the costs of additional conditions of employment. ▪ Industrial Action - service delivery risks, inability to meet contract due to strike action and meeting the costs of contingency planning. ▪ Demand Higher than Budget Volumes - both volume driven due to changes in demographics and the increasing chronic disease burden. ▪ IDF - casemix higher than IDF and prices not adjusted to meet the costs. ▪ Treatment Costs and New Drugs - the impact of cancer drugs (increase demand and new drugs) has

¹⁴ 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.

¹⁵ 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.

<p>population there is an increase demand for long-term support services.</p>	<p>not been included in IDF charging/washup.</p> <ul style="list-style-type: none"> ▪ National Policy - potential impact of the Restraint Policy, Holidays Act, merger of Medsafe and TGA, Electrical Regulatory Compliance and Fire Compliance Upgrades; ▪ Clinical Training Costs - prices do not cover the total cost of training and do not take into account or keep pace with national collective award increases. ▪ ACC Changes - employer programme cost increases.
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5.5 Allocation of Funds - Service Coverage 2007/08

Together with contracting processes including the use of Request for Proposal (RFP) processes we work hard to treat our internal and external providers equitably. Within our available resources, the Canterbury DHB will:

- Facilitate timely and equitable access to appropriate health services, in accordance with Crown Funding Agreement requirements;
- Undertake service development to ensure that the health service outcomes, as outlined in the NZ Health Strategy, NZ Maori Health Strategy and the NZ Disability Strategy, are taken into consideration;
- Fund in 2007/08 a range of services similar to those funded in 2006/07;
- Ensure, where appropriate, that the Nationwide Service Framework is applied when entering into service agreements, including utilising nationally consistent service specifications and/or prices;
- Ensure that the service coverage requirements of the Operational Performance Framework and Service Coverage Schedule requirement are met;
- Ensure that ring-fenced mental health funding is spent funding mental health services (including alcohol and other drug services)¹⁶.

Maori Health Funding

Like all DHBs, we are working to foster the development of Maori capacity for meeting the health needs of Maori and reducing inequalities in access and outcomes. As with other DHBs, we provide Maori health and disability services via a mixture of explicit Maori health funding and through funding allocated to mainstream services. A Maori health expenditure stock-take, undertaken by the DHB, identified expenditure of \$9.4M through a combination of Maori community providers, mainstream community providers and our HSS division for the year ending June 2006.

Our Maori health expenditure target for the 2007/08 financial year is expected to be set at \$10.4M and forecast targets for 2008/09 and 2009/10 are \$10.7M and \$11.0M respectively. An outline of the proposed direction for Maori health in Canterbury is provided in Section 6.2.3.

Mental Health Blueprint

In 2007/08 the additional Blueprint Funding that we will receive is \$680,000. We intend to invest this funding in expanding a number of services which are outlined in Section 7.1.2.

Additional Electives Funding

The Canterbury DHB has been allocated an additional \$7M in 2007/08 for Elective Services and this funding will be devolved to appropriate HSS service divisions as part of the DHB's PVS negotiations whereby the Planning and Funding and HSS divisions determine the area of greatest need for our population, and where there is HSS capacity to increase volumes. These negotiations will determine where the additional electives funding will be allocated. Added to this the DHB has received \$5.3M for the continued implementation of its Orthopaedic and Cataract initiatives and this funding will be used to increase volumes in both service areas. An outline of the direction and activity in these areas is given in Section 7.1.5.

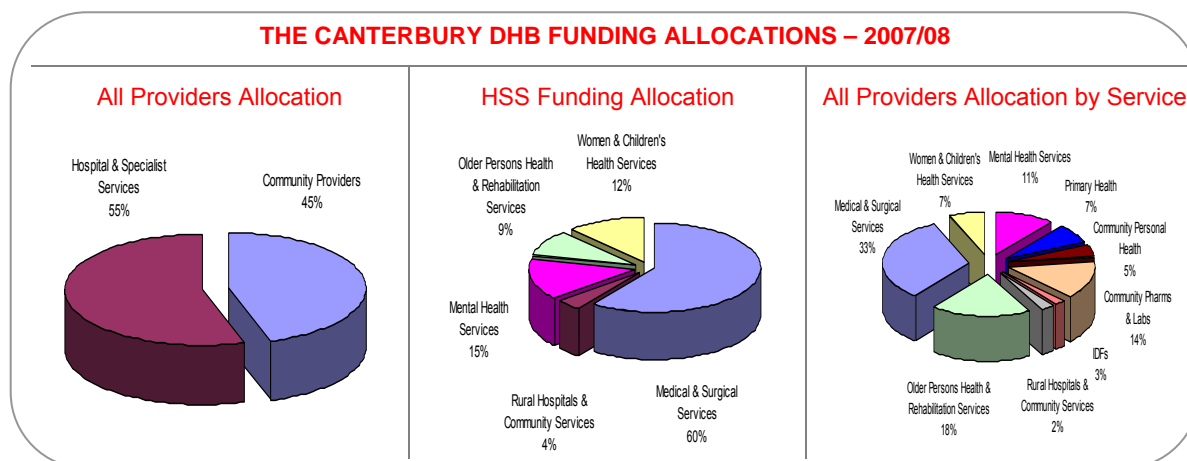
¹⁶ The Crown Funding Agreement, National Service Framework, Operational Policy Framework and Service Coverage Agreement are all accountability documents between the Ministry and DHB, under which DHBs operate.

HEHA Funding

In 2007/08 we have also been allocated \$420K specifically for the implementation of the national HEHA Strategy in the Canterbury region, an outline of the activity planned to drive this implementation is provided under our Health Gain Priority, Disease Prevention and Management, Section 6.2.5.

Current Funding Allocations

The following diagrams indicate how the Canterbury DHB's current funding is allocated:



5.6 Capability, Capacity, Productivity and Value for Money

The Canterbury DHB is committed to building health sector and workforce capability and capacity through provider relationships, cross-sector collaboration and leadership, 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.

However, with funding constraints and increasing demand, the need for service planning, service reconfiguration and the development of innovative models of care and 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 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 long-term illness and 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 framework which will directly support a Facilities/Site Master-Plan enabling the DHB to undertake any major facility redevelopment in an informed manner

and to reconfigure service delivery models to match 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, the setting and the location of future service delivery.

We also need to ensure that the investments we have made are returning value for money, that our operations are effective and efficient and that we are being as productive as possible.

As such the DHB remains committed to ensuring all services funded are evidence based, and to give priority to interventions that give the most benefit relative to the resources used. We will continue to focus on the reduction of inequalities in health care and support the development of new services in those areas where funding will produce changes in health status for our community.

As already discussed, where we have some discretion with regards to investment and funding the DHB has developed a Prioritisation Framework (refer Section 2.5). As we consider the allocation of funding the principles of this Framework assist in our decision making along with the Strategic Priorities identified in our DSP and through our HNA.

When considering the investments we have already made a variety of productivity measures and benchmarking are used to assess and promote service quality and efficiency and these will continue to be developed and applied in 2007/08. 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.

The DHB has an ongoing process to review its infrastructure costs and, where appropriate, initiatives are implemented to manage and/or reduce these costs. Efficiency initiatives over past years have resulted in our low administration component relative to the size of our organisation and have assisted in improving productivity. 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 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 and effectiveness in this manner in the coming year. While we work on longer-term initiatives, our priorities centre on maintaining service provision, ensuring equity of access to services and ensuring effectiveness while maintaining quality standards. We plan to undertake a number of programmes, initiatives and/or service reconfigurations in 2007/08 to improve our productivity and to ensure that our process and systems allow us to maximise outcome for investment and value for money. The initiatives to be undertaken include:

- Continued implementation of the Improving the Patient Journey Programme;
- 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;
- Ongoing HSS non-clinical support services reviews and consolidations;
- 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;
- Continued review and evaluation of HSS employee cost control processes, nursing workforce costs, treatment-related costs, the costs of new technology and review of leave management and roster activity;
- Development and implementation of a framework for managing chronic conditions.
- Implementation of the recommendations from the Community Laboratory Review;
- 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;
- Review provider contracts, both those with external providers and those with HSS to determine whether we are achieving the best outcomes possible for the public funding invested;
- 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;

- 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; and
- Implementation of any reviews, reconfigurations or initiatives arising from the completion of a Health Services Plan for the Canterbury DHB – matching best location and best provider to treatment and delivery.

In undertaking this work we will also be looking at the associated benefits, including improved service quality, adoption of best practice and long-term service sustainability. All initiatives to ensure and achieve value for money will have input from clinicians, where appropriate, to ensure patient safety and related issues are adequately considered and factored in the decision making process.

A considerable focus for our provider-arm centres on improving future capability and capacity to manage the increasing demand for health and disability services from our ageing community.

One of the more obvious areas has been in the development of sufficient facilities in which physically to provide both existing and new services including the development of a Diabetes Centre, the new Christchurch Women’s Hospital and Day Surgery Unit and Stage II of the Burwood Hospital Redevelopment. Development of a clinical portal will offer clinicians useful electronic ‘real time’ information and a de-facto electronic medical record to enable improved patient care.

Inevitably staffing resource is the most complex area to improve capability and capacity. We have embraced moves towards national and regional recruitment initiatives to fill positions where there are international shortages and have moved towards more cost effective and internet based recruitment models. Our approach to learning and development continues, with an extensive internal organisational development programme which encompasses the professional, organisational, leadership and cultural dimensions required of our staff.

The DHB has taken a progressive, innovative approach to examining how patients and clients are cared for in our system and the roles and relationships between different health professional groupings. It is clear that greater interdisciplinary learning and process review are vital to reduce the fragmented care that is provided in some situations. We are committed to progressing our Improve the Patient Journey Programme, to the development of a framework for managing chronic conditions to improve the integration of care and to the implementation of recommendations from the Review of Acute Demand and After Hours Cover.

The focus of capacity planning work within HSS over the next year will be linked to the DHB’s Health Services Planning Programme. The DHB is taking a constructive, transparent and collaborative approach to determining the health and disability needs of our future population and what that will mean in terms of service models, facilities and workforce. The development of business plans for our HSS divisions is an integral part of this planning with workforce plans sitting alongside this work.

The majority of the key actions and activity of HSS service divisions are covered off in this document under the DHB’s Strategic Priorities. However building capability and capacity within Women’s Health Services is not specified and actions to enhance services for women and children across the DHB will be a focus in the coming year. The DHB will raise national discussion around the underlying pressures and drivers of increasing demand on Neonatal Services. A number of reviews are also planned, along with the intended development of a Maternity Plan for the DHB.

Aim	Enhance Women’s and Children’s Health Services within HSS and across the DHB.
Sponsor	GM Women’s and Children’s Health GM Planning and Funding GM Community and Public Health
Actions	<p>Neonatal Services</p> <ul style="list-style-type: none"> ▪ Work to ensure a coordinated and sustainable neonatal transport service focusing on a multi-disciplinary team approach to maintaining training, rostering and data collection and undertake assessment of equipment and resources. ▪ Identify key positions within the HSS neonatal service required to maintain a robust nursing workforce and skills and training need to maintain those positions. ▪ Work with the Ministry on planning to achieve the first phase of the Newborn Hearing Screening Programme implementation. Support the national Implementation Advisory Group in the development of critical components of the national programme and, as funding allows, move to a state of readiness to implement the programme. <p>Gynaecology:</p>

	<ul style="list-style-type: none"> ▪ Respond to the changes to the Ministry agreement for provision of Cervical Screening Services with centralisation of the Cervical Screening Register in Wellington in 2007. ▪ Provide a HSS based Gynaecology GP Advice Service implementing patient referral criteria/proformas for specific gynaecological conditions for use by GPs and implement follow up plans for GP follow up intervention. ▪ Provide medical management treatment options for pregnancy loss, working with colleagues to embrace alternative treatment options, develop policy/procedures and provide education to Lead Maternity Carers (LMC) and GPs to ensure appropriate utilisation of the service. <p>Maternity:</p> <ul style="list-style-type: none"> ▪ Develop a Maternity Plan for the DHB. ▪ Scope the development of a Diabetes Midwifery Clinic to enhance care for women with diabetes in pregnancy and alleviate pressure on Obstetric and Physician clinics. ▪ Continue to implement Smokechange Pregnancy Services, with continued education and study days for staff¹⁷. ▪ Review Community Midwifery Services, analysing service coverage by independent providers, and if appropriate develop a proposal for change for consultation and implement any recommendations from that consultation. ▪ Maintain Baby Friendly Hospital Initiative (BFHI)¹⁸ accreditation, continuing education and study days and consult with Maori and other key community groups on breastfeeding policy. ▪ Implement a planned approach to the provision of caesarean sections where the procedure is clinically appropriate and to occur prior to the commencement of labour. Plan for procedures, scope staffing levels and implement an audit loop (reviewing the clinical threshold for caesarean section as a planned procedure). ▪ Working with the Ministry the Community and Public Health (CPH) division will identify data and resource requirements to implement the National Universal Routine Antenatal HIV Screening Programme in the community.
Outputs	<p>Neonatal Services</p> <ul style="list-style-type: none"> ▪ Staff skill levels and personnel required to provide a 24-hour 7 day-a-week neonatal transport services are maintained. Available equipment and resources are appraised. ▪ Identification of key positions assists the nursing workforce to develop skills to manage neonates with complex medical conditions. ▪ Planning for the implementation of the Newborn Hearing Screening Programme is supported and the DHB is in a state of readiness to implement the programme. <p>Gynaecology:</p> <ul style="list-style-type: none"> ▪ The change management process associated with the change to Cervical Screening Services are complete and a new infrastructure for service provision is implemented. ▪ The implementation of proforma use/follow up plans is complete and GPs are provided with comprehensive information for management plans, specialist knowledge and education. ▪ The number of surgical Dilation and Curettage (D&C) procedures are reduced. <p>Maternity:</p> <ul style="list-style-type: none"> ▪ A Maternity Plan for the DHB is approved and implementation is commenced. ▪ Continuity of care is provided for diabetic women. ▪ Women who smoke in pregnancy are referred to smoke change services. ▪ Community Midwifery Services are reviewed with recommendations underway. ▪ Baby Friendly Hospital Initiative (BFHI) accreditation is maintained. ▪ A planned approach to the provision of caesarean sections is developed and implemented. ▪ Using regional expertise from established programme, CPH will develop and seek Board approval for a plan to implement the HIV Antenatal Screening Programme which, within available funding, meets the standards for screening and includes development of data capture standards and systems for evaluation.

¹⁷ Smokechange is a Ministry funded smokefree pregnancy service providing an early intervention programme.

¹⁸ The BFHI is a Ministry initiative which focuses on the promotion of choice and provisions of support for all women in feeding their baby and ensuring that the choice is made from a position of knowledge, having been fully informed of the options and the benefits to the baby.

5.7 Anticipated Service Changes 2007/08

The past two years have been a period of development for the DHB, working under an updated DSP, and a number of service changes, reviews and efficiency initiatives have been scoped and developed over this time to improve capability, increase capacity and productivity and to introduce alternative service delivery models to improve effectiveness. Implementation is underway on a number of these initiatives, with activity continuing in the coming years, including:

- Implementing outcomes from the Child and Adolescent Family Mental Health Services Review;
- Implementing outcomes of the Model of Care in Adult General Mental Health Services Review;
- Implementing the re-provision of residential services for those with intellectual disability and psychiatric illness;
- Implementing the recommendations of the Review of Health Services in Ashburton;
- Implementing the recommendations from the Community Laboratory Review, including changes to funding mechanisms and demand management;
- Implementing the Improving the Patient Journey Programme and Patient Flow projects; and
- Implementing the outcomes of the *Healthy Ageing Integrated Support* Strategy for Older People.

Service Change in 2007/08

The increases in funding we will receive in the coming year will be insufficient to meet projected demand pressures and the increasing cost of service provision. Hence productivity gains will be key in meeting future demand whilst ensuring our continued financial viability.

We will still be looking to make efficiency gains by delivering the same service in more efficient ways. We will also be aiming to ensure value for money for our investment and evaluating possible service re-configurations (delivering the same outcomes through the delivery of services in different ways) that would provide a more effective or productive service for our community. These include those mentioned throughout this document, in the DHB's DSP and the following:

- Implementation of external ministerial or national reviews, initiatives or reconfigurations to ensure consistency across the sector, equity of access and improved health outcomes such as:
 - Implementation of national School and Community Dental Clinics Model of Care;
 - Review of the funding for laboratory tests by private specialists;
 - Continued implementation of the Cataract and Orthopaedic Initiatives;
 - Continued commitment to achieving compliance in all Elective Services Patient Flow Indicators (ESPIs) and implementation of additional elective services funding;
 - Implementation of the NZ Cancer Control Strategy, the national HEHA Strategy, Primary Care Strategy and Health of Older People Strategy; and
 - Implementation of national initiatives (as funding allows) such as screening services and Family Violence Guidelines; and
 - Ongoing review and allocation of Mental Health Blueprint Funding.
- Implementation of internal reviews, initiatives or re-configurations to improve capability, capacity, efficiency, quality and health outcomes, reflected throughout this document and including:
 - Implementation of the recommendations of the Review of Acute Demand and After Hours Cover and continued review of the interface between general practice and the ED to ensure patients are managed in the most appropriate setting;
 - Continued implementation of the Improve the Patient Journey Programme to review patient processes, reduce unnecessary waits and delays and to improve patient flows;
 - Continuation of the Health Services Planning Programme recommending reconfiguration of service delivery models to match the best location for the provision of treatment and care and informing the completion of a Facilities Master-Plan and Strategic Workforce Strategy;
 - Development and implementation of a framework for managing chronic conditions;
 - Continued review of staff and skill mix within services and consideration of alternative models of care to improve services delivery and the patient journey;
 - Continued implementation of our local health strategies including: our Youth Health Position Paper, *Healthy Ageing Integrated Support* Strategy, Maori Health Plan, Canterbury Heart Health Strategy, Mental Health and Addictions Strategy, Information Services Strategic Plan and our Quality Strategic Plan; and

- Continued review of support services processes to align to best practice including warehousing, distribution and purchasing processes.
- Long-term consideration of service and delivery models to achieve value for money, better target inequalities in health status and lead innovation in health services delivery and to ensure sustainability of service delivery:
 - Work to reduce the costs to our organisation on a national and regional level;
 - Consider service provision to allow hospitals to focus on emergency and serious illness;
 - Consider the clinical and financial sustainability of some rural and metropolitan services;
 - Identify least cost effective services and consider alternative models of care; and
 - Consider reductions in non-essential services to levels in line with other DHBs and establish service benchmarks with other DHBs to address national consistency and equity of access.

Some reviews will be implemented in 2007/08, while others will be in preparation for changes and developments in the 2008/09-year and beyond. Further detail with regard to operational efficiency and productivity initiatives is provided in our DSP and in previous DAP and SOI documents.

Service reconfigurations will involve consultation with hospital or community based service providers, to determine appropriate solutions that best meet the needs of our community. Where service reconfigurations are in the area of mental health the ringfence requirements will be maintained. Any DHB service reconfiguration processes will comply with the Operational Policy Framework.

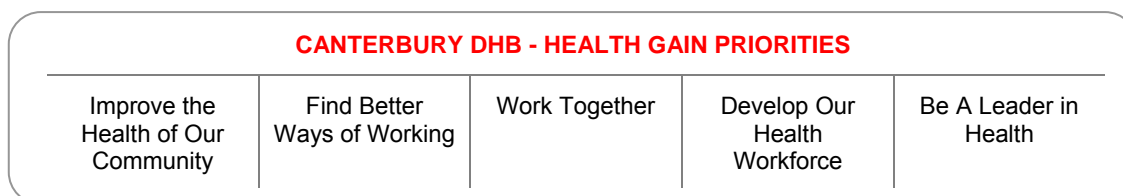
6 ADVANCING OUR STRATEGIC PRIORITIES

6.1 Our Core Directions

The pressure of financial and service demands has been highlighted earlier in this document and managing these demands will be central to achieving the long-term goals and objectives outlined in our DSP. Work has already begun on a number of projects and initiatives to address and alleviate the pressures we face, with significant work having already taken place in the past year, particularly around acute demand and electives services management and improving the patient journey.

The DHB will focus in 2007/08 on the way in which we deliver and evaluate services and will be aiming to do things better within available resources and to implement changes in models of care and delivery to enable these improvements. Health Services Planning - looking at the picture of health in our community and our community's future needs, will be central as we move forward and improve the way in which we deliver services. The DHB's HSS division is also working on the development of Business Plans for all its service divisions assisting in developing a clearer picture of future need, the impact of increasing demand and opportunities for integration of care.

The following section outlines the activity the DHB has planned under its Core Directions, looking primarily at address key challenges and building foundations to enable change.



6.1.1 Improve the Health of Our Community

Reducing disparities, addressing inequalities and improving access to health services is a focus for the Canterbury DHB and are expectations of the Minister of Health. We will aim not just to identify gaps through improved data collection, but to target resources towards high need and high-risk groups and to affect long-term changes in health status.

We are aware of the inter-relationships that exist between socio-economic status, education, employment, housing and health and will continue to work collaboratively to set goals and objectives for our community's health, to share data and research on health outcomes and to provide a healthy environment for our population.

One of the groups we work with, in an effort to build relationships with other organisations and develop a shared approach to the health of our community, is Healthy Christchurch¹⁹. This group began as an intersectoral initiative sponsored by the DHB, the CCC, Te Runanga O Ngai Tahu, He Oranga Pounamu, Pegasus Health, the Christchurch School of Medicine and the Ministry and now involves over 200 organisations who have signed the 'Healthy Christchurch Charter'. Its aims are:

- To forge a common vision for a healthy city.
- To foster healthy relationships between diverse agencies and sectors, from 'grassroots' groups to government agencies.
- To enable flexible, collaborative and prompt responses to emergent health issues.
- To ensure all policy incorporates a health perspective.

The initiative recognises that all sectors and groups have a role to play in creating a healthy city, whether their specific focus is recreation, employment, youth, transport or any other aspect of city life. Some of the projects to date include:

- Healthy Workplaces - developing a pilot programme for addressing workplace health issues, including stress, nutrition, relationships and employment law;

¹⁹ Information on Healthy Christchurch can be found at www.healthy.christchurch.org.nz

- Healthy Homes - aimed at promoting awareness of environmental issues and their potential financial and health impacts among the Christchurch population with sessions focused on energy, transport, waste, gardening, water and shopping;
- Oral Health - proposed to address the adverse oral health impacts of the decision not to fluoridate the Christchurch water supply. One achievement included every Christmas food parcel distributed through the Methodist Mission containing a toothbrush and fluoridated toothpaste for each child – this reached around 800 children across the city; and
- City Harvest - a citywide celebration of growing your own food and eating healthily linked to the central themes of good nutrition, gardening/ harvesting and celebration.

During 2007/08 we will be focusing on the following activity to improve environments for our population in an effort to reduce disparities and inequalities and will build further on the foundations already put in place in the past year:

Aim	Share responsibility for quality health outcomes.
Sponsor	General Manager (GM) Community and Public Health
Actions	<ul style="list-style-type: none"> ▪ Collaborate with external agencies, providers and community organisations to establish systems for collecting and analysing population based health data and establishing joint goals for improving health status of our community; ▪ Provide health promotion and public health training to improve the knowledge and skills of Canterbury organisations and their ability to implement a population health approach; ▪ Communicate health information to key stakeholders to improve dissemination of, access to or implementation of evidence for public health policy and practice; and ▪ Develop and distribute effective and efficient health education resources to support the development of innovate models of care and the reduction of inequalities.
Outputs	<ul style="list-style-type: none"> ▪ Effective information systems are developed and provided that support planning, delivery, evaluation and reporting of public health interventions. ▪ An increased focus on health determinants and addressing health inequalities is reflected in the Long Term Community Council Plans (LTCCP) of Canterbury Councils and in the DHB's strategic and accountability documents. ▪ Population health outcome indicators are identified and incorporated into DHB DSP and DAP documents and into LTCCPs.

As part of the development of our DSP and long-term direction in 2005, the DHB concluded that it would need to optimise capability and capacity in its HSS division to cope with increasing demand in the coming years (refer Section 5.6). In considering the unique challenges faced by our rural services, a Review of Rural Health Services and a Review of Ashburton Health Services were undertaken in 2005. A specific strategy was developed and the resulting, Ashburton Integrated Model of Care project was begun.

The work begun in Ashburton involves the establishment of closer relationships between our HSS Rural Health Services, Rural Canterbury PHO, and NGO providers who will work together to ensure patients have a 'seamless journey' through a well-coordinated health system.

The overriding principles for integrated care are:

- The patient and family/whanau are at the centre of decision making;
- Right care, right place, right time, right people;
- Working together to provide safe and improved health services and quality of care;
- Integrated and coordinated care across primary, secondary and tertiary services;
- Adaptability and flexibility of health services that are affordable;
- Clinical procedures and services supported by technology;
- An appropriately skilled and available workforce; and
- Flexible environment that supports medical and rehabilitation in-patient services, day surgery with short stays, outpatient and community-based services and long-term care for the elderly.

The Integrated Model of Care for Ashburton is being developed through six projects and project teams, all of which include advisors from the community, the DHB, and other key health service providers. Key successes over the past year have included:

- An increase in Day/Short Stay treatments and additional elective surgery completed in Ashburton;
- Changes to Medical Officer workforce based in Ashburton to allow for greater flexibility in service delivery to better meet the needs of the smaller rural area; and
- Implementation of Picture Archiving and Communication System, commissioning of a CT Scanner and establishment of a Urology Day Service to improve service delivery in the rural area.

Aim	Ensure rural services are accessible, sustainable and clinically viable.
Sponsor	GM, Rural Health Services (HSS)
Actions	<p>Continue to implement the Ashburton Integrated Model of Care, focusing on the development and implementation of the following projects:</p> <ul style="list-style-type: none"> ▪ Collaboration and Integration with Primary, Community and Public Health Services; ▪ Core Services and Specialist Led Services; ▪ Investing in Workforce Development; ▪ Health Information and Technology Systems; ▪ Health Promotion; and ▪ Site Redevelopment and Ancillary Services. <p>Implement the recommended actions from the Review of Rural Health Services (November 2005):</p> <ul style="list-style-type: none"> ▪ Continue accreditation of all Rural Health Service Hospitals; ▪ Provide ongoing support for Rural PHOs; and ▪ Develop a services plan for the Kaikoura region (as a pilot under Health Services Planning).
Outputs	<ul style="list-style-type: none"> ▪ Establishment of an after hours primary care service using the resources of Ashburton GPs and Ashburton Hospital Medical Officers and in conjunction with the recommendations from the Canterbury DHB's Review of Acute Demand and After Hours Cover. ▪ Expansion of Ashburton based GP Liaison role. ▪ Review of primary maternity services in Ashburton. ▪ Development of an action plan for Older People's Services and for the management of chronic conditions specifically for the Ashburton district. ▪ New or expanded visiting specialist services based at Ashburton Hospital. ▪ Increased number of day and short stay procedures performed at Ashburton Hospital. ▪ Development of a workforce profile and projections for Ashburton and an action plan for workforce development for all health workers in the Ashburton region. ▪ Health promotion programmes more integrated across all providers in the region. ▪ Facility plans in place, based on projected future health service needs and accredited facilities for safe and efficient patient care. ▪ Sustainable health services plan completed for the Kaikoura region.
Measure	<ul style="list-style-type: none"> ▪ Sustainable after-hours primary health care services in place. ▪ Sustainable maternity services in place along with services to meet the needs of older people. ▪ Increased access to specialist services in Ashburton, reducing the need for Ashburton residents to travel to Christchurch for treatment. ▪ Reduced length of stay. ▪ Sustainable medical workforce in place at Ashburton Hospital and in the Ashburton region. ▪ Health care facilities meet the needs of the population.

6.1.2 Find Better Ways of Working

If the DHB intends to ensure effective utilisation of resources and delivery of the best possible health outcomes within the funding allocated we need to ensure that health resources are protected, sustainable and supported long-term. A focus for the coming year is to progress planning for future health services through the development of health services models, the development of a framework for the management of chronic conditions and the development of integrated service models.

These developments will provide a strategic roadmap for changes in future funding models, the development of workforce strategies and the development of a Facilities Master-Plan. This will mean new thinking around the best way to provide care to our population, looking at the best location, the best service and the best provider. However this will enable us to ensure ongoing provision of health and disability services and to provide services which are better integrated and configured, and that operate seamlessly across geographical, professional and service boundaries.

As we continued our drive for a more consumer focused service our Improving the Patient Journey Programme, will assist us to develop more effective continuums of care, to build capability, capacity and to improve productivity – key streams of the Programme will be progressed over the coming year.

Aim	Work to ensure optimum use of resources and investment – Health Services Planning.
Sponsor	GM Planning and Funding
Actions	<p>The focus of the Health Services Planning Programme is to optimise the future use of capital within the DHB. Over the coming year work will be undertaken on the development of a Strategic Health Services Plan.</p> <p>Through a governance structure, including Steering Group and Project Team, models of care will be developed for focus areas in a phased roll-out following the completion of models in four pilot areas: Child Health, Respiratory Health, Eye Health and Rural Health (Kaikoura):</p> <ul style="list-style-type: none"> ▪ Phase One: Cardiovascular Health, Diabetes, Cancers, Women's Health; ▪ Phase Two: Musculoskeletal Health, Neurological, Older Person's Health; ▪ Phase Three: Consultancy Services, High Specialisation Services, Acute Services; and ▪ Phase Four: Mental Health, Rural Health. <p>Once models are complete a Health Services Plan will be produced, informing the development of:</p> <ul style="list-style-type: none"> ▪ Service (re)development within HSS and external provider services; ▪ A Strategic Workforce Development Plan; and ▪ A Facilities Masterplan for the DHB.
Outputs	<ul style="list-style-type: none"> ▪ Consumer Groups are established to ensure patient/consumer participation to enhance the planning of future health services. ▪ A Combined Data Set is developed to assist in understanding future demand for services, the development of models of care and ultimately the Strategic Health Services Plan. ▪ Models of Care are developed for selected focus areas. ▪ A DHB-wide Strategic Health Services Plan is developed.

Aim	<p>Continue the implementation of streams of the Improving the Patient Journey Programme:</p> <ul style="list-style-type: none"> ▪ Medical Patient Programme - Reduce inpatient delays, prevent admissions and increase the ability of the service to cope with growing demand and an aging population; ▪ Surgical Patient Programme - Improve access to theatre by reducing process delays and making improvements in utilisation of critical resources (staff and beds); ▪ Radiology Programme - Reduce patient delays to diagnostic results: and ▪ After Hours Model of Care Programme - Review how patient care is provided after-hours - establishing an integrated night service (2230-0800 hours).
Sponsor	Executive Director of Nursing Chief Medical Officer
Actions	<p>Medical Patient Programme</p> <ul style="list-style-type: none"> ▪ Establish a Medical Progressive Care Unit to accommodate patients that currently occupy the Intensive Care Unit or have higher nursing input on wards and speed up the flow of patients from the ED by placing these patients in a more appropriate setting. ▪ Develop a chronic care pathway for respiratory and cardiology patients, focused on assessing the most appropriate care setting for patients and identifying opportunities to improve care. ▪ Enhance management reporting tools and provide improved information to clinical leaders to enable service improvements.

	<p>Surgical Patient Programme</p> <ul style="list-style-type: none"> ▪ Further improve access to acute theatres – ideally patients wait no longer than 24 hours. ▪ Analyse the elective surgery ‘value stream’ from GP request to discharge back into community care. Improve the link between critical resources, such as radiology, beds and theatre. ▪ Review peri-operative processes to identify improvements in patient flows and utilisation of critical resources. Assess the implementation of peri-operative management tools to support improved processes. ▪ Identify opportunities to further utilise DHB theatre capacity, within funding allocations. ▪ Implement further reductions in bed-days for surgical patients through improved access to theatre and diagnostics. <p>Radiology Programme</p> <ul style="list-style-type: none"> ▪ Analyse patient demand, and identify priorities for accessing critical radiology resources. ▪ Assess radiology demand versus capacity and identify and implement process improvements to reduce patient delays. ▪ Implement improved resource management tools and additional MRI and CT scanners. <p>After Hours Model of Care Programme</p> <ul style="list-style-type: none"> ▪ Review the impact of the establishment of the Night Team Coordinator role. ▪ Re-audit the workload on the night shift comparing data with the 2006 audit and hold a stake holder workshop to identify issues/perspectives of the night shift processes and interactions. ▪ Establish a working group to use audit and workshop data to define the tasks and skill mix required of a night team.
Outputs	<p>Medical Patient Programme</p> <ul style="list-style-type: none"> ▪ Medical Progressive Care Unit is established. ▪ A joint care plan for chronically ill respiratory patients is commenced, in conjunction with community care providers. ▪ Key performance reports are instituted across the medical stream of the HSS Medical and Surgical division, helping reduce variation in patient processes. <p>Surgical Patient Programme</p> <ul style="list-style-type: none"> ▪ A holistic model/tool is developed to better understand surgical patient flow and constraints. ▪ Improved and standardised peri-operative processes are implemented. <p>Radiology Programme</p> <ul style="list-style-type: none"> ▪ A reduction in delays for patient diagnostic results to be received. <p>After Hours Model of Care Programme</p> <ul style="list-style-type: none"> ▪ A night team defined by required competencies and workload is established. ▪ Opportunities to improve the working lives of staff at night are identified. ▪ Improved quality of patient care with improved risk assessment, co-ordination and prioritisation of work to match patient needs.
Measure	<ul style="list-style-type: none"> ▪ Further reductions in the wait times for patients in the ED. ▪ Resourced bed-days remain static whilst absorbing growth in patient demand. ▪ Increased percentage of acute surgical patients getting to theatre within 24 hours. ▪ Acute surgical bed-days are reduced. ▪ Patient access to radiology within appropriateness guidelines is achieved. ▪ Time taken to report diagnostics is reduced. ▪ Correct after hours resource levels are identified. ▪ RMO run and night nurse evaluation of provision of patient care demonstrates staff satisfaction.

6.1.3 Work Together

We strongly believe that by looking outside of our organisation, establishing partnerships with other agencies and with other sectors, as well as with our community and consumers, the DHB can work to influence the determinates of health, improve the environment in which we live and enhance the continuum of care needed to achieve improved health outcomes.

We remain committed to working collaboratively with our own workforce and to encouraging work across professional and organisational boundaries to optimise the use of combined health resources and to challenge traditional roles to improve health outcomes for patients and consumers.

We will also work closely with the primary sector to address the challenges of increasing demand. In 2006/07 we undertook an Acute Demand and After Hour Cover Review and over the next year we will work in collaboration with primary, community and HSS services to implement the recommendations of that Review.

Aim	Enhance partnerships between our clinical workforce and management - considering the changing mix of skills required for future service provision and changing models of care.
Sponsor	Executive Director of Nursing Chief Medical Officer
Actions	<p>Encourage and support clinical staff working across sectors to enable rapid access to expert advice for the primary and community sector and to support the provision of services in the right place. Consider models to promote the following:</p> <ul style="list-style-type: none"> ▪ Clinical teams focused more on the patient – more ambulatory focus on service delivery that may require specialist oversight but the patient remains in the community; ▪ Hospital specialists working on more than one site – clinics located in the community; ▪ Specialist nurses more aligned to primary than secondary – from ‘out-reach to in-reach’; ▪ GPs with a speciality focus such as plastics or minor procedures clinics; and ▪ Development of specialist Allied Health roles – such as chronic care roles. <p>Continue to challenge the roles of health care workers and the models of services delivery for the benefit of patients, consumers and service users. Direct the focus onto competency rather than who has traditionally performed the tasks:</p> <ul style="list-style-type: none"> ▪ Nurse and Allied Health led services – treat and discharge in ED, front door physiotherapists and nurse led admissions. ▪ Extending the Registered Nurse and Allied Health roles – pharmacists integrated as part of the patient care team, continued support for the nurse practitioner and the development of advanced and specialist nursing and Allied Health roles. ▪ Develop the roles of Medical Officers and speciality focused GPs. ▪ Continue to develop and implement professional development and recognition programmes.
Outputs	<ul style="list-style-type: none"> ▪ Alternative models of care are identified for specific patient groups. ▪ An ‘Expert Patient’ Model is developed. ▪ The ‘Night Team’ is supported and extended to cover afternoon and weekend shifts.

Aim	Optimise access to primary, community, hospital and specialist health services in Canterbury.
Sponsor	GM, Planning and Funding
Actions	<p>Implement the recommendations of the Review of Acute Demand and After Hours Cover in the primary care sector, in collaboration with PHOs on the following work streams:</p> <ul style="list-style-type: none"> ▪ Work to provide Rapid Access to Expert Advice for general practice; ▪ Support a Telephone Advise Service for general practice; ▪ Develop and implement packages of care, Acute Community Nursing, Community Observation Services and Service Co-ordination Services to support the new direction; ▪ Develop and implement Rapid Diagnostic and Rapid Response services; ▪ Develop a Public Information and Education Programme to support the new direction; ▪ Improve the links with Aged Residential Care; and ▪ In consultation with stakeholders, implement the recommendations of the After Hours Direction Paper for the Canterbury region.
Outputs	<ul style="list-style-type: none"> ▪ After Hours Direction Paper implemented. ▪ Rapid Diagnostic Services in place. ▪ Supportive packages of care, Acute Community Nursing, Community Observation Services and Service Coordination Services in place.

<ul style="list-style-type: none"> ▪ Public Information and Education programme in place. ▪ Rapid Access to Expert Advise Service for General Practice in place.
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6.1.4 Develop our Health Workforce

Workforce development is central to the DHB's ability to provide effective quality services and meet the challenges of improving our community's health. We aim to make Canterbury a preferred district for health workers in NZ by supporting flexibility and innovation and providing leadership and skill development opportunities. In developing our DSP in 2005 we highlighted four key workforce goals:

- Encourage a flexible approach to reflect 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 and health-promoting environment to support and retain staff.

In aiming to achieve these goals there are a number of specific challenges around workforce; primarily that in order to sustain and deliver services long-term we need to take a coordinated approach to workforce. We must consider not just our own staff but the workforce of the health sector as a whole, this involves:

- Building a co-ordinated approach to workforce development at a local, regional and national level;
- Consideration of and response to our wider community workforce needs; and
- Implementation and sustainability of priority initiatives that provide an organisational work environment which fosters innovation and career development.

At the same time we must develop our own workforce and provide a safe and health promoting environment for our staff through safe handling programmes, membership of the ACC Partnership Programme and continued reduction in our injury costs.

As we near the conclusion of our 2006/07 DAP year, our key achievements to date include:

- Introduction of leadership and management development pilot activity specifically the Middle Management, Orientation to Management and Change Management Programmes;
- Progression of workforce information capacity and structure;
- DHB representation across local, regional and national workforce development initiatives;
- Secondary level attainment in the ACC Partnership Programme Audit;
- Successful delivery of the 12th Annual DHB Health and Safety Conference; and
- A continued decrease in our Lost Time Injury Frequency Rate (LTIFR).

The workforce we nurture must meet the capability and capacity needs of our community and our workforce development activities over the coming year will provide a framework to support management development, skills mapping, workforce redesign and participation in national workforce initiatives as we continue to support the national Future Workforce 2005/10 Strategy²⁰.

Aim	Future Workforce - Encourage a flexible approach to reflect the changing needs of our community.
Sponsor	Group Manager, Human Resources
Actions	<p>Identify the likely impacts of future models of care on the health workforce to enable strategic workforce planning and development.</p> <ul style="list-style-type: none"> ▪ Support and sustain a Workforce Steering Group to govern strategic workforce activity, in alignment with Health Services Planning and the CEO's Workforce Development Group; ▪ Participate in, and support, identified Yr 2 Future Workforce Projects, including Health Careers Branding and the Health Careers Framework; ▪ Support and contribute, as appropriate, to the six national Workforce Strategy Group initiatives; ▪ Support and contribute to the 2007/08 Employment Relations (ER) and Industrial Relations (IR) priorities and projects, at a local, regional and national level, including negotiations,

²⁰ The Future Workforce Strategy is available on the Ministry's website www.moh.govt.nz.

	contingency planning and risk mitigation activity; and <ul style="list-style-type: none"> Develop a DHB Workforce and Capability Strategy and seek executive level consideration.
Outputs	<ul style="list-style-type: none"> Increased coordination and strategic alignment of local priority workforce development activity. Participation in national Future Workforce Strategy and Strategy Group Yr 2 activities. Specialist participation, advice and coordination of local, regional and national ER/IR activities. Development of a local Workforce and Capability Strategy.

Aim	Capable Health Workforce - Develop a workforce providing the 'right skills' for the best health outcomes to ensure long-term capacity for service provision.
Sponsor	Group Manager, Human Resources
Actions	<p>Continue to work with education providers to develop programmes for a changing health environment and encourage enrolment, particularly amongst under represented groups:</p> <ul style="list-style-type: none"> Respond to opportunities and consider options for referring/engaging with local education providers in the alignment of curricula with our health sector workforce needs. <p>Improve workforce information and data collection to assist with workforce development and capacity planning and as appropriate:</p> <ul style="list-style-type: none"> Continue to support and participate in the HR Management System (HRMS) project and provide key support and liaison with the designated Project Change Manager; Support Health Workforce Information Programme (HWIP) by sourcing and providing workforce data, for the purposes of workforce forecasting, modelling and planning; and Support and participate in HWIP data quality improvement activity.
Outputs	<ul style="list-style-type: none"> Assistance and support provided as required to education providers, enabling the development of programme curricula that reflects the needs of our health workforce. Participation, advice and input from a Human Resources and workforce perspective to the HRMS project, contributing to a tailored system to meet our organisational needs. Support to HRMS Change Manager to ensure workforce, culture and people considerations are identified and effectively managed. Provision of required DHB data, as appropriate, to DHBNZ in support of HWIP.

Aim	Good Place to Work - Ensure Canterbury's health sector is a 'good place to work'.
Sponsor	Group Manager, Human Resources
Actions	<p>Provide leadership and career opportunities for our workforce and support career development:</p> <ul style="list-style-type: none"> Facilitate and reinforce the CEO's Workforce Development Initiatives, in particular Project 4: Leadership and Management Development Programme (under the Business Development Unit); Progress the Quality Health NZ Accreditation and Certification Human Resources Standard; Scope and prepare for consideration an organisational coaching and mentoring programme; Develop and deliver "Stage 2" identified activity from the Performance Review Project; and Identify priority improvement opportunities from the Succession Planning Discovery Report, scope and present for consideration.
Outputs	<ul style="list-style-type: none"> Facilitate from a workforce perspective the CEO's Workforce Development initiative, supporting achievement of programme objectives to reinforce the culture we expect to develop. Coaching and mentoring programme proposal developed and introduced for consideration. Stage 2 deliverables from the Performance Review Project such as tools, templates and guidelines tailored to professional groups developed and implemented. Succession Planning Scope prepared and introduced for consideration. Accreditation/certification status maintained through delivery of Human Resources Tactical Plan milestones.

Aim	Safe and Healthy Workforce - Create a safe and health-promoting environment to support and retain staff.
Sponsor	Group Manager, Human Resources
Actions	<p>Continue the ongoing progression of Health and Safety management practices and culture:</p> <ul style="list-style-type: none"> ▪ Develop and maintain a consistent Health and Safety management system and programme; ▪ Maintain membership of the ACC Partnership Programme; ▪ Maintain the Managing Health and Safety sections of the Quality Health NZ Safe Environment and Practice Accreditation and Certification Standards; ▪ Develop and implement a consistent Safe Handling Programme across the DHB that meets relevant competencies and guidelines; ▪ Progress the Occupational Health Programme to monitor staff health in relation to identified hazards they face at work; ▪ Develop and implement an annual healthy workplace and employee wellbeing programme; and ▪ Participate and support national initiatives arising from DHB Health and Safety forums.
Outputs	<ul style="list-style-type: none"> ▪ Annual Health and Safety Tactical Plan developed and implementation commenced and accreditation/certification maintained through delivery of Plan milestones. ▪ Participation, advice and input from a DHB perspective in scheduled national Health and Safety activities. ▪ ACC Partnership Programme audit completed and secondary level status maintained/enhanced. ▪ One hazard management system for the DHB implemented. ▪ Staff Health and Wellbeing Day hosted as part of the employee wellbeing programme, with identified aspects of the programme delivered in partnership with ACC injury prevention. ▪ Staff influenza campaign delivered. ▪ Enhanced occupation health pre-placement screening piloted in identified areas. ▪ Safe patient handling self-learning package and competencies for nurses proposals developed and presented to DHB Directors of Nursing for approval. ▪ Safe patient handling patient risk assessment tool proposal developed.

6.1.5 Be a Leader in Health

In order to enable change we need to provide leadership to our community and develop a stable infrastructure to support the improvements we plan to make. We will continue supporting expertise in health, encouraging innovation and promoting quality health care service delivery.

With challenges around the growing cost of new technology and the expectations of both patients and staff that the DHB will provide access to new treatments it is important that any new technology, drugs or treatments introduced are evidence based, clinically sustainable and cost effective. The DHB has supported the development of a Clinical Review Committee and Health Technology Assessment Committee to review the introduction of new technology and treatments. This support for clinical oversight and review of evidence will continue.

To assist in affecting changes in practice the DHB has begun the development of a Clinical Portal to provide integrated and timely information at the point of care. Clinically relevant information is currently stored in multiple systems which are not integrated. Our clinical staff move from patient to patient and need mobile, wireless access to patient data and information. Our approach to these two problems is to provide an integrated view of the available information through static and mobile wireless terminals. The Clinical Information System (CIS) is a portal which brings into one view the clinical information we already hold on patients and facilitates the entry of new data in an organised way.

Currently this system is being piloted in our HSS Ear, Nose and Throat services and once the pilot is complete and evaluated this will form the basis of a roll-out across HSS. This will be a focus for 2007/08 with future challenges being integrating the systems across the wider health sector.

Aim	Develop innovative models of care and delivery to meet community needs.
Sponsor	Chief Medical Officer
Actions	<p>Continue the development of the CIS as a platform for improved clinical systems, improve access to clinical patient information, provide point of care patient services and work on the provision of electronic patient records. Focusing the roll-out on integrating the following elements into the Portal:</p> <ul style="list-style-type: none"> ▪ Clinical Documents – discharge summaries, clinical letters and theatre records; ▪ Investigation Results – blood tests and imaging reports; and ▪ Patient Management System Data – admission records and outpatient appointments. <p>Facilitate the bringing together of total sets of laboratory results both hospital and community based and facilitate the integration of the CIS across the wider health sector.</p>
Outputs	Clinical documents, investigation results and patient management data integrated into the CIS.

Aim	Encourage innovation, development and research.
Sponsor	Chief Medical Officer
Actions	<ul style="list-style-type: none"> ▪ Support continuation and development of the Canterbury DHB Innovation Awards. ▪ Support Canterbury DHB projects as entrants in the National Innovation Awards. ▪ Develop a coordinated process to support and manage research projects conducted within the DHB's HSS divisions.
Outputs	<ul style="list-style-type: none"> ▪ Successful coordination of the DHB Innovation Awards. ▪ DHB Projects are supported to progress to National Innovation Awards. ▪ A framework is developed for coordinating research projects within DHB.

6.2 Our Health Gain Priorities

The Strategic Health Gain and Disease Priorities identified in our DSP are a mix of population, service and disease based approaches and they represent the areas where we believe there is potential to make improvements in the health status of our population and in the delivery or effectiveness of services.

The approach to making progress in all of these priority areas will be consistent, in particular:

- Working collaboratively with the primary and community sectors, with our community and with external organisations to ensure an integrated and patient centred approach to care and the development of robust chronic disease continuums;
- Promoting messages related to lifestyle choices, physical activity, nutrition, reducing obesity and smoking cessation; and
- Working with providers and community agencies to reduce inequalities in health status through increased access and uptake of services.

A number of our chosen Strategic Priorities are also a focus nationally and as such the DHB will be taking a 'Common Purpose' approach and is committed to implementing at a local level appropriate strategies and policy developed nationally. We will also be taking all opportunities to work regionally to improve the management of chronic conditions and reduce the burden of long-term illness.

CANTERBURY DHB - HEALTH GAIN PRIORITIES				
Child and Youth Health	Older People's Health	Māori Health	Primary Health	Disease Prevention and Management

6.2.1 Child and Youth Health

Child and Youth Health is a key Health Gain Priority for both the government and the Canterbury DHB. Keeping our young populations healthy provides them better opportunities for becoming healthy adults. We aim to improve outcomes for children and youth in Canterbury, particularly those with high needs, those at risk and those in environmentally disadvantaged situations. With an increasing percentage of our younger population being Maori and Pacific (groups with statistically lower health status) it is particularly important that we target inequalities to achieve overall improvements in the health status of these younger population groups.

Our Child Health and Disability Action Plan, *Mahere o te Hauora Tamariki me te Hauatanga*, is now in its third year of implementation. The focus continues to be on initiatives that meet the Plan's ten priorities for improving children's health: access to services, child health information, hearing, immunisation, injury prevention, mental health, nutrition and physical activity, oral health, parenting and smokefree environments.

In the past year particular success coming out of activity around the Action Plan has included:

- Successful implementation of the Fruit in Schools programme with ten schools from low socio-economic areas in Christchurch now taking part and promoting healthy eating, physical education, sun protections and smokefree environments;
- Completion of the Meningococcal B Vaccination Programme, with more than 86% of our eligible population receiving dose one of the vaccine and providing an opportunity to roll out the National Immunisation Register (NIR). The NIR will help us to measure the effectiveness of our immunisation strategies as we work towards raising our coverage to 95%; and
- Launch of the 'Smile for Life' oral health initiative aimed at combating the epidemic of tooth decay in our region. A mail drop to over 230,000 houses distributed an education pamphlet on the importance of a good diet and fluoride for healthy teeth.

Much of this work has involved working closely with external organisations with joint priorities such as the Ministry of Education, Sport and Recreation NZ (SPARC), the National Health Foundation, the Cancer Society, PHOs, Maori health providers and local government. This beneficial collaborative work will continue in 2007/08.

The DHB produced a Youth Health Position Paper in late 2006, outlining actions and initiatives that we will invest in to improve the health of young people in Canterbury. This direction was signed off by the Board in April 2007 and will involve extensive collaboration to achieve our goals and aims:

- To provide a safer, more supportive environment for young people – improving school based health services and access to primary care services;
- To show a measurable improvement in young people’s mental health – strengthening links with non-government agencies providing youth respite and community support services to improve accessibility and responsiveness. We will also focus on improved management of suicide prevention and services for young people with drug and alcohol problems; and
- To show measurable improvement in young people’s physical health – improving oral health, a reduction in sexually transmitted infections and unintentional pregnancies, lower rates of obesity and an emphasis on increased physical activity. Reducing smoking, alcohol consumption and illicit drug use is also a focus, as is improved management of young people’s chronic or complex medical conditions.

In addition to this work we have also signed two MoUs to formalise collaboration around youth health. We will work with the Collaborative for Research and Training in Youth Health and Development to create a centre to enhance the health and development of young people through research and education. We will also work with the University of Auckland and Paediatric Society of NZ to take part in the NZ Child and Youth Epidemiology Study, a three year project to provide high quality child and youth health information to the sector.

Increasingly, Christchurch is becoming a major paediatric centre with additional demand placed on our tertiary services to provide care for much of the South Island. Our challenge is to balance these needs against those of our local population. In the year ahead we will continue our collaborative focus and improve links with primary health care providers to encourage a team approach to the management of child and youth health.

Aim	Improve the interface with providers, stakeholders and external organisations to inform decision-making and shared direction and to collaborate to ensure child services are provided in an effective, equitable and timely manner.
Sponsor	GM, Planning and Funding GM, Women’s and Children’s (HSS)
Actions	<p>Complete a DHB-wide Immunisation Plan linking primary care, immunisation coordination, outreach service and NIR coordination providers to improve immunisation rates in Canterbury:</p> <ul style="list-style-type: none"> ▪ Integrate the NIR into ongoing work; ▪ Focus on outreach work to ensure ‘hard to reach’ children are immunised; ▪ Work with PHOs as part of the PHO Performance Management Programme on meeting targets for childhood immunisations; and ▪ Establish a DHB-wide governance group for immunisation. <p>Work collaboratively particularly around the priorities identified in our Child Health and Disability Action Plan focusing on the reduction of avoidable hospital admissions and on establishing the groundwork for good health, healthy eating and low risk living patterns.</p> <ul style="list-style-type: none"> ▪ Implement the Ministry’s ‘Ready for School’ programme in Canterbury. ▪ Work with PHOs to implement health promotion services targeted at children. ▪ Work with the Ministry on planning to achieve the first phase of the Newborn Hearing Screening Programme implementation. ▪ Support the HSS Women’s and Children’s division’s commitment to the BFHI, the division’s Breastfeeding Policy, and continuation of Smoke-free Pregnancy Services. <p>Continue to work with providers and stakeholders to invest in cultural training and ensure programme are culturally appropriate to improve access and uptake by Maori as a high-risk group.</p> <ul style="list-style-type: none"> ▪ Place emphasis on the provision of Tamariki Ora well child checks in Canterbury.
Outputs	<ul style="list-style-type: none"> ▪ A DHB-wide Immunisation Plan is developed focused on removal fragmentation of immunisation services and improving immunisation rates. Regular NIR newsletters are circulated and regular practice based audits are implemented. ▪ Tamariki Ora providers deliver according to WellChild Frameworks. ▪ BFHI accreditation is maintained.
Measure	<ul style="list-style-type: none"> ▪ An increase in the percentages of children fully immunised (POP 08).

	<ul style="list-style-type: none"> ▪ Increase in the rates of babies exclusively/fully breastfeed. ▪ Reduced Ambulatory Sensitive Admissions for children 0-4years (POP 09).
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Aim	Collaborate across sectors to ensure youth services are provided in an effective and equitable manner and meet the annual objectives as identified in the DHB's Youth Health Position Paper.
Sponsor	GM, Planning and Funding GM, Community and Public Health
Actions	<p>Implement the actions outlined in our Youth Health Position Paper aiming to improve access and responsiveness, reduce risk behaviour and improve long-term care and disease management for younger people.</p> <ul style="list-style-type: none"> ▪ Working with PHOs, develop and implement a specific health promotion programme for oral health targeted at high needs adolescents 'Adolescent Oral Health Promotion Project'. ▪ Work with PHOs to implement health promotion services targeted at youth, particularly around smoking, sexual health and obesity through their Health Promotion Plans. ▪ Establish screening and monitoring of Sexually Transmitted Infections (STIs). ▪ Support the implementation of the national HEHA Strategy in terms of Health Promoting Schools, increased activity levels and improved nutrition. ▪ Provide primary health nurse focused training programme for Public Health Nurses. ▪ Improve the links between providers of mental health services.
Outputs	<ul style="list-style-type: none"> ▪ Recommendations of the Youth Health Position Paper are implemented. ▪ A Health Promoter Workplan is completed for adolescent oral health promotion services. ▪ PHOs are funded to provide free sexual health services to people under 21. ▪ STI network developed and an out-reach programme established ▪ Public Health Nurses are support to complete appropriate training including: the Collaborative Trust HEADDS programme, the NZQA Family Planning course and the National Heart Foundation Stage 2, Smoking Cessation course. ▪ Mental Health NGOs and the HSS division better understand the role of each others services and develop a format to enable networking.
Measure	▪ Reduced Ambulatory Sensitive Admissions for children 0-4 years (POP 09).

Aim	Work to provide ongoing sustainability, child and youth health services in Canterbury, improving national consistency and providing leadership.
Sponsor	GM, Planning and Funding
Actions	<ul style="list-style-type: none"> ▪ Review the funding and overall spend for child and youth service in Canterbury looking particularly at Maori and Pacific services and evaluating our ability to address inequalities in health status, and set common priorities. ▪ Develop closer links with other South Island DHB funders to share knowledge and information and to ensure regional and national consistency in service access and delivery. ▪ Encourage greater provider accountability through improved understanding of guidelines and service development needs. Introduce longer agreement terms for provider contracts with integration of agreements where possible to improve long-term planning and streamline the contracting processes.
Outputs	<ul style="list-style-type: none"> ▪ Regular comparative analysis of agreements is undertaken by region and reported accordingly allowing for national benchmarking. ▪ An effective process is implemented to ensure quarterly monitoring returns are reviewed and updated so that any under-delivery or service need is quickly identified and effectively resolved.

Oral Health

One major undertaking in child and youth health this year is the implementation of the Ministry's Oral Health Reform. This reform includes a move away from the traditional school dental clinics to modern community oral health services with increased emphasis on prevention. The new model involves close collaboration with providers, PHOs and private dentists and will create a community focused service to address inequalities faced by Maori, Pacific, rural and low income groups.

The new model will also address workforce issues being faced by school and community dental services addressing professional and personal isolation issues and promoting more interactive and educative service roles.

Aim	Improve child and adolescent dental health services in Canterbury, promote good oral health practice and ensure long-term sustainability of dental services.
Sponsor	GM, Planning and Funding GM, Organisational Support and Development
Actions	<p>With approval from the Ministry - Implement the recommendations of the DHB's Business Case for Investment in Child and Adolescent Oral Health Services, approved by the Board, February 2007.</p> <ul style="list-style-type: none"> ▪ Reorientate oral health services to align with the DHB's identified health gain priorities: Child and Youth Health, Maori Health and Disease Prevention and Management: ▪ Increase the hours of oral health service to include school holidays and extended working days; ▪ Maximise the benefits to the community by locating mobile examination and treatment clinics to target at risk and high need population groups; ▪ Measure and report access to all services by Maori and non-Maori and set targets to reduce inequalities in oral health status. <p>Improve integration and configuration of services and apply a health promotion/disease prevention approach to service delivery.</p> <ul style="list-style-type: none"> ▪ Implement the Adolescent Oral Health Promotion Project working with PHOs to encourage youth to make the most of the free oral health services available to them. ▪ Ensure oral health messages are promoted along with other healthy lifestyle messages particularly as part of the HEHA Strategy; ▪ Promote awareness of the role and value of fluoridation in oral health; and ▪ Implement the pre-school early identification and presentation service. <p>Enhance clinical and management partnerships considering the changing mix of skills required for future service provision and the new model of care for community oral health services:</p> <ul style="list-style-type: none"> ▪ Foster collaboration and cooperation between dentist, dental therapists and dental assistants; ▪ Utilise support for shared service provision or employment such as the development of dental teams in rural communities; and ▪ Support the development of joint initiatives with dentists in specific services areas such as non-attending adolescents. <p>Encourage a flexible approach to reflect the changing needs of our community and support the development of an oral health workforce providing the 'right skills' for the best health outcomes and ensuring long-term capacity for service provision.</p> <ul style="list-style-type: none"> ▪ Nurture relationships with education providers to support recruitment and training; and ▪ Continue with the refresher course for dental therapists returning to work and respond to changes in working conditions to retain experienced staff. <p>Increase the level of community action amongst the health sector and intersectorial partners to improve the knowledge and skills base to implement a population health approach.</p> <ul style="list-style-type: none"> ▪ Increase parent/whanau participation in the oral health care of children and adolescence; and ▪ Consult with stakeholders to ensure the project addresses main issues and concerns.
Outputs	<p>Implement Stage 1 of the Investment in Child and Adolescent Oral Health Services Business Case:</p> <ul style="list-style-type: none"> ▪ A DHB Project Steering Group is established to oversee the project and a Facilities Project Manager is appointed and responsible to the construction of facilities (fixed and mobile) and liaison with site owners; ▪ A plan is developed to manage service delivery models during transition with a set of key messages for staff so that they can champion and communicate the service vision during the transition process and keep all staff and schools informed; ▪ A system is developed to support monitoring, reviewing and updating the service plan and making evidence based changes; ▪ A process is developed to track and monitor the uptake of service to ensure high risk children continue to receive regular oral health care; and ▪ Construction of the first community facilities is completed by the end of the 2008 calendar year with purchase of mobile units to support each clinic.

Measure	<ul style="list-style-type: none"> ▪ Regular monitoring and reporting of population health indicators for oral health. ▪ Demonstrated increase in adolescent oral health utilisation (POP 11). ▪ A reduction in the incidence of dental disease amongst children and adolescences and a decrease in the inequalities between population groups (POP 04 and POP 05).
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6.2.2 Health of Older People

Canterbury is faced with the challenges of an ageing population with estimates that by 2021 nearly 20% of our population will be over 65. People in older age groups, particularly those over 75 and in the last year of their life, consume significant health resources and we must plan ahead to meet our populations future needs. Again this Strategic Priority chosen by the DHB is also one signalled by government and identified by the Minister of Health as a Priority for 2007/08.

In 2002 the Ministry's national Health of Older People (HOP) Strategy was released and subsequent to this (February 2006) the DHB developed a comprehensive health strategy for older people, *Healthy Aging, Integrated Support*. This Strategy provides us with the platform to implement the national HOP Strategy at a local level and the focus and aims of our Strategy are in line with the direction of national work. Our HSS Older Person's Health Service have developed a 'Directions 2006-2010' document, providing specific direction for the HSS in implementing the changes outlined in the DHB's *Healthy Aging Integrated Support Strategy*.

Implementation of the local Strategy has already resulted in the following achievements:

- 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 map of service location, type and demographics, which will help to improve planning for additional older person's services;
- Development of a database which identifies entry, exit and length of stay trends in residential care and that will assist with future capacity planning;
- A joint initiative with the Nurse Maude Association and Healthcare NZ to improve access to complex wound care for subsidised residents in aged residential care. This two year project is a first in NZ will also focus on mentoring registered nurses and promote improved wound management (less pressure ulcers and other complex wounds) and therefore fewer admissions to secondary care;
- Completion of the two year trial of the geriatric assessment tool, International Resident Assessment Instrument (InterRAI) (Minimum Data Set Home Care Version) with approval for wider use of the tool within our HSS Older People's Health Service. This tool aims to improve coordinated clinical assessment by avoiding duplication and using one integrated plan for each patient. The information captured will also provide insight into the health needs of our ageing population;
- Introduction of a HEHA Nutrition Initiative resulting in additional funding from the Ministry to continue the work. Working with Partnership Health PHO, several nutrition pamphlets and a recipe book were developed for specifically for older people and made free to those living independently and at risk of poor nutrition. Over 1000 initial copies were distributed and a reprint of the recipe book has been undertaken;
- Utilisation of Blueprint funding for re-establishing a Psychiatric Service for the Elderly Memory Assessment Clinic;
- Continuation of the 'Stay on Your Feet' fall prevention programme. Funding has enabled the employment of a Programme Coordinator and further roll-out of the programme;
- 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 *Te Huanui*, our Maori Health Plan for Older People and the employment of a dedicated Maori Health Worker.

Our priority for 2007/08 is the continued implementation of both our local Strategy and the national HOP Strategy. We will focus on continuing to support older people in the community and away from institutional care through flexible packages of care and the development of new care coordination and case management models. We anticipate completion of the review of the Needs Assessment

Service Coordination Service (NASC) model in early 2007 and implementation of the outcome of this review in 2007/08.

We will continue to increase community based services, with the introduction of Community Support Worker roles and an increase in stand alone day support facilities. We will also collaborate with primary and community providers to develop integrated continuums of care for older people and will continue the focus on a smooth transition between services and a restorative/rehabilitation approach.

We will continue to work on positive relationships with providers, particularly around capacity and capability issues, quality improvement, workforce development and fair employment practices. Improved management of elective services and increasing access to orthopaedic and cataract surgery will also benefit older people (see Section 7.1.5) and we are also positive about the direction and input being received from the Elder Care Canterbury reference group established in 2006. This group will be a key consultation group for the continued implementation of our Strategy.

Aim	Ensure effective primary and population health services reaching those most in need.
Sponsor	GM, Planning and Funding GM, Older Person's Health (HSS) GM, Community and Public Health
Actions	<ul style="list-style-type: none"> ▪ Work with primary and community providers to target illness prevention, early intervention and effective treatment and interface on shared priorities and goals. Focus on increased screening by nurse led clinics, falls prevention, influenza vaccinations, oral health for older people and continuation of nutrition initiatives for older people – particularly those most at risk. ▪ Ensure primary care is accessible and effective focusing particularly around access to services, enrolments in PHOs and assisting PHOs to reach those most in need by promoting Care Plus to those over 65. Consider the use of the InterRAI assessment tool in primary and community settings and further develop the Medicines Use Review with an older person's focus. ▪ Work with Housing New Zealand and the CCC sharing goals for addressing the determinants of health for older people and the working with the CCC on a strategy of older people around neighbourhood groups and community services.
Outputs	<ul style="list-style-type: none"> ▪ The joint CCC and DHB Winter Warmth initiative is continued. ▪ Increased numbers are enrolled in the 'Stay on Your Feet' falls prevention programme.
Measure	<ul style="list-style-type: none"> ▪ Influenza Immunisation Rates for over 65s in Canterbury remain high. ▪ PHO enrolments of those over 65 remain high with improvement in the number of older Maori enrolled and those 65+ accessing Care Plus services. ▪ Reduced Ambulatory Sensitive Admissions for older people (POP 09).

Aim	Address barriers to accessing services and improve service coordination.
Sponsor	GM, Planning and Funding GM, Older Person's Health (HSS)
Actions	<ul style="list-style-type: none"> ▪ Continue the roll-out of the InterRAI assessment tool to improve identification of service requirements and implement the outcomes of the review on the NASC model, working particularly with those most at risk. ▪ Implement an improved model of care for specialist community based services – the CARE Team Model²¹. Focus on the rehabilitative component of the CARE model and support national workforce initiatives for home based care and specialist support for GP and primary services. ▪ Enhance discharge planning via improved inter-disciplinary team models in in-patient settings. ▪ Scope the provision of a seven day a week allied health community and in-patient service. ▪ Use the Map of Canterbury Services (developed in the past year) to focus on allocation vs utilisation, evaluate bed availability for respite and the use of booking systems and evaluate the impact of increased day support and activity based services.
Outputs	<ul style="list-style-type: none"> ▪ Older Person's Health Assessors and other disciplines have been trained to use the InterRAI Home Care Assessment tool. ▪ Implementation of a Community Support Worker Role to promote intermediate care models. ▪ The HSS Community Stroke Service pilot is implemented as part of the wider community

²¹ The CARE Team Model – Coordinates, Assesses and Rehabilitates the Elderly.

	<p>services configuration providing stroke patients with access to the full continuum of care (acute, rehabilitation and community service provision).</p> <ul style="list-style-type: none"> ▪ Scope is completed for the seven day a week service for allied health provision.
Measure	<ul style="list-style-type: none"> ▪ InteRAI and NASC results show improvement in service identification vs service delivery.

Aim	Improve the responsiveness of health and disability services for older people and the coordination between community services.
Sponsor	GM, Planning and Funding GM, Older Person's Health (HSS) GM, Community and Public Health
Actions	<ul style="list-style-type: none"> ▪ Improve the Patient Journey for older people promoting best practice guidelines and awareness of older people's culture with a particular focus on outpatient services. ▪ Improve and develop the cultural awareness within Older Person's Health Services with regular hui and fono and participation of Maori in older person's health services.
Outputs	<ul style="list-style-type: none"> ▪ There is Maori representation on the Elder Care Reference Group. ▪ The Older Person's Health Service Maori Health Action Plan <i>Te Huanui</i> is implemented to enhance responsiveness of HSS services.

Aim	Work to ensure that Home Support Services are effective and efficient and that there is a collaborative approach to service provision through improved coordination of services.
Sponsor	GM, Planning and Funding GM, Older Person's Health (HSS)
Actions	<ul style="list-style-type: none"> ▪ Continue to work with providers to develop strategies to assist in the retention and recruitment of carers to ensure a workforce that is flexible and available to provide the services required. ▪ Implement the recommendations of the review of the roll of District Nursing Services in Canterbury working with individual providers to enhance the services provided and implement regular key stakeholder forums to support collaborative service improvement. ▪ Scope the development of a Home Based Support Services Restorative Model of Care, looking at moving away from tasks focused on illness to a wellness prospective.
Outputs	<ul style="list-style-type: none"> ▪ Develop an HSS workforce plan to address the ageing and part-time workforce issues and collate robust data on the current status of our workforce - link into the work being done nationally around workforce recruitment. ▪ Implement Key Stakeholder Forums on District Nursing. ▪ Establish a working party to scope a Restorative Service Model and complete a Request For Proposal (RPF) process to establish provider/s to commence a pilot project.

6.2.3 Maori Health - He Korowai Oranga

Although progress has been made, Maori Health remains an identified priority both locally and nationally. In line with national trends, Canterbury's Maori population has on average a poorer health status than other groups in the region. Maori are twice as likely to develop diabetes, have a shorter life expectancy and are over-represented in measures such as, injuries and heart disease.

A number of strategies are in place to address these disparities in health status and we continue to work closely in partnership with the Maori community and Maori health providers to make continued improvements in Maori health provision with the aim of reducing present inequalities.

We have a regular meeting schedule with Ngai Tahu, as Manawhenua of the district, through Manawhenua ki Waitaha and a representative of Ngai Tahu has been invited to sit as an observer at the Board table. 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. The outcomes of these meetings feed directly into our planning processes to ensure Maori participation in planning the long-term direction for Maori health in Canterbury.

We are also pleased to have welcomed a new Kaumatua to the DHB who actively participates in the Te Kahui Taumata group, along with our Taua and Executive Director of Maori and Pacific Health, providing expert advice directly to our CEO.

Over the past year progress has been made in implementing projects that support our Maori Health Plan, *Whakamahere Hauora Maori ki Waitaha*. The Plan, developed in 2002 and currently being revised, recognises our Treaty of Waitangi obligations within the framework of the NZPHD Act and is consistent with the directions outlined in the national Maori Health Plan, *He Korowai Oranga*.

A number of achievements have been made in implementing the direction set out in our Maori Health Plan over the past year:

- 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;
- Collaboration with local Maori groups to implement a smoke-free marae campaign with several local marae now having designated smoking areas and one becoming smoke-free; and
- Development by Te Korowai Hinengaro Oranga ki Waitaha (a joint Canterbury mental health provider network), of two programmes:
 - An orientation programme to coordinate and integrate Maori mental health services by providing a comprehensive introduction to the Maori mental health provider community in Canterbury and fostering collaboration between the different providers; and
 - A training programme offering governance training to the provider network covering topics from self analysis and strategic planning to financial management. This programme is funded through the DHB, by the Ministry's Maori Provider Development Scheme (MPDS) and will assist providers to provide input into strategic planning.

We continue to work on capacity and capability issues through Te Herenga Hauora o te Waka a Maui (the South Island Maori Managers Network), 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, the results of which are being discussed with the Ministry with recommendation expected to be released for implementation in 2007/08.

We have also set expenditure targets for all Maori health services and service-related initiatives in 2006/07 and have established a monitoring programme that we will implement in the coming year. The focus for 2007/08 centres on the implementation of our revised Maori Health Plan and around progression of collaborative projects and initiatives put in place over the past year.

The revised Maori Health Plan was taken to the Board for approval and it has been decided that the Plan will be taken out for further consultation and key stakeholders within the Maori community have been asked to participate in a final review of the Plan. Three consultation hui were held in early 2007 to finalise the Plan which will be re-presented for final approval to the Board.

Aim	Implement the revised Canterbury DHB Maori Health Plan (once approved).
Sponsor	Executive Director Maori and Pacific Health GM, Planning and Funding
Actions	<ul style="list-style-type: none"> ▪ Maintain relative investment in Maori health, implement expenditure targets for all Maori health services and service-related initiatives and a monitoring framework that meets internal and external accountabilities for the community and the DHB. ▪ Review Maori health policy and quality frameworks, within the DHB and its community providers and support Maori providers' participation in quality improvement programmes. ▪ Continue support for Maori provider capacity and capability through the MPDS. Reinforce key

	<p>messages: Quality, Sustainability, Collaboration and Cooperation and evaluate the impact of that scheme.</p> <ul style="list-style-type: none"> ▪ Progress the Ethnicity Data Collection Project to ensure that all DHB sites collect ethnicity data and introduce processes and systems to analyse that data to determine and formalise access levels and access issues for Maori. ▪ Implement the Maori Mental Health National Strategic Framework, <i>Te Puawaitanga</i>, and other mental health frameworks, as well as continued implementation of Mental Health Blueprint and the Mental Health Workforce Development Plan, <i>Tuutahitia te Wero</i>. ▪ Continue collaboration around national and local strategies that promote health in areas of priority for Maori such as healthy nutrition and increased physical activity (HEHA and HEAL). ▪ Scope and implement innovative service delivery initiatives in Maori health provision.
Outputs	<ul style="list-style-type: none"> ▪ The revised Maori Health Plan is endorsed. ▪ A Monitoring Framework is implemented. ▪ Maori Health Policy and Quality Framework are reviewed. ▪ The MPDS is reviewed and innovative service delivery initiatives for Maori are implemented.
Measure	<ul style="list-style-type: none"> ▪ Demonstrated improvement in the DHB's inpatient Ethnicity Data Collection. ▪ Demonstrated improvements in the pathways of care focused on improving outcomes and reducing inequalities for Maori (HKO 03). ▪ Actual expenditure on Maori Health is reported (HKO 04).

Aim	Ensuring a coordinated, population based, community approach to reducing disparities and fostering Maori community participation at all levels throughout the DHB.
Sponsor	Executive Director Maori and Pacific Health GM Community and Public Health
Actions	<ul style="list-style-type: none"> ▪ Ensure Maori input into key DHB strategies, PHO process and other integration initiatives particularly in key areas for Maori such as Child Health, Diabetes, and Cardiovascular Disease and focus on pathways of care that will lead to better outcomes for Maori. ▪ Continue to enact, in consultation with Maori, appropriate processes to engage with the Maori community and Maori providers. Formalise the relationship that exists with Ngai Tahu and Manawhenua ki Waitaha through the development of a formal relationship agreement. ▪ Continue regular Maori community consultation hui and participate in intersectoral Maori networking forums and initiatives that positively affect Whanau Ora. ▪ Identify and support Maori-led community development in priority areas. ▪ Continue current involvement in the activities of groups such as: Christchurch Social Policy Integration Network, the Housing Network and Strengthening Families and foster relationships with Te Puni Kokiri and the Ministries of Education and Social Development to address environmental disparities that effect health status. ▪ Improve Maori health status by promoting smokefree lifestyles, as articulated in Auahi Kore initiatives and the Aukati Kai Paipa programme.
Outputs	<ul style="list-style-type: none"> ▪ A formal relationship agreement is in place between the DHB and local iwi. ▪ At least two key milestones from the Maori Health Plan have been achieved in 2007/08.
Measure	<ul style="list-style-type: none"> ▪ An increase in the number of PHOs with Maori Health Plans agreed to by the DHB (HKO 01).

Aim	Further develop the Maori health and disability workforce and work to improve the cultural responsiveness of Canterbury health services.
Sponsor	Executive Director Maori and Pacific Health Group Manager, Human Resources
Actions	<ul style="list-style-type: none"> ▪ Complete the DHB's Maori Workforce Development Plan. The main aim is Whanau Ora with the key focus being the implementation of He Korowai Oranga. ▪ Implement cultural development training for staff, establishing a cultural training programme for contract managers and ensure Board members are also offered training. ▪ Support a trainer position in the DHB's Maori Health Team to develop workforce initiatives, provide cultural training and to develop Tikanga practice guidelines for service delivery. ▪ Collate Maori health workforce data to identify baseline and project areas and develop a

	<p>workplan to implement a strategic directional plan for Maori health workforce needs.</p> <ul style="list-style-type: none"> ▪ Continue to work with HSS to promote Maori health knowledge and training for non-Maori staff. ▪ Continue to work with the education sector to promote Maori health careers and to support the Te Waiparanu Recruitment Specialist Project to promote health careers to Maori students.
Outputs	<ul style="list-style-type: none"> ▪ Implementation of the DHB's Maori Health Workforce Plan is underway. ▪ A workplan of cultural training programme is development. ▪ Board members received Maori cultural training assisting them to understand how Maori views and values can impact on their governance role. ▪ Tikanga Best Practice Guidelines for staff are distributed.
Measure	<ul style="list-style-type: none"> ▪ Demonstrative improvement in the DHB's recording and monitoring of staff ethnicity (HKO 02). ▪ All Board members receive cultural training (HKO 01)

6.2.4 Primary Health

Primary care is often the first point of contact with the health sector and reducing barriers to access helps people to stay well and avoid hospital admission. Statistics show us that costs may be a significant barrier for some people; hospitalisation rates for people on lower incomes are higher than the Canterbury average.

Since 2002 major changes have been made to the way primary health care is funded and delivered in NZ. As part of the Ministry's national Primary Care Strategy, PHOs have been created to help deliver primary care services to communities. PHOs are seen as the key vehicles in achieving improvements in primary health outcomes and reductions in inequalities.

Canterbury has five PHOs that encompass the region and we have developed a close working relationship with those PHOs²². Together we have achieved a number of successes in implementing the Primary Care Strategy over the past year:

- PHO enrolments cover 98% of the Canterbury population, with all PHOs providing Care Plus;
- The implementation of several 'Services to Improve Access' programmes including: longer GP consultations, school health clinics, community nursing services;
- Collaboration on health promotion programmes including smoking cessation, youth oral health, physical activity and nutrition programmes. Successful implementation of the Meningococcal B vaccination campaign was a significant collaborative effort between the DHB and PHOs along with the development of a nutritional cookbook for older people. Health promotion funding has also enable initiatives such as the funding of a Pacific Worker in Ashburton (by the Rural Community PHO) focused on chronic conditions;
- Streamlining of primary care service funding to ensure limited funding is targeted at key health priority areas. This includes our commitment to fund all primary care through PHOs;
- Continued development of audit process for PHOs to enhance better ways of working. All PHOs in Canterbury are now enrolled in the PHO Performance Management Programme enabling the DHB to monitor their performance in line with key indicators;
- A review of Acute Demand and After Hours Cover in Canterbury in collaboration with PHOs and GPs, resulting in the development of the Canterbury DHB After Hours Discussion Paper; and
- The DHB has also made available additional resources to increase Pacific community nursing services in Canterbury. District Nursing Organisations and PHOs will be able to utilise the expertise of this nursing position to help reduce inequalities faced by Pacific People particularly around chronic conditions management;
- The development of the Canterbury DHB Primary Mental Health Positioning Paper and continued implementation of Mental Health Demonstration Models within primary care.

A priority not only for us but also for government; we will continue to support the ongoing implementation of the Primary Care Strategy and will aim to enhance the our population's health by improving access to primary care and public health programmes designed to meet local needs and to reduce inequalities in access and in health status.

We support the priorities of the joint DHB/Ministry Implementation Work Programme signed off in mid 2006 and will emphasis the following priorities in 2007/08:²³

²² *The Canterbury Community, Rural Canterbury, Hurunui Kaikoura, Partnership Health and Christchurch PHOs.*

- PHOs and DHBs working more closely together;
- PHOs involved in DHB planning, particularly primary/secondary interface and shared targets;
- Development and consolidation of primary health capacity and expertise;
- Rapid development of population health and a focus on chronic conditions; and
- Improved governance and the involvement of communities in PHO governance.

The DHB's representatives regularly attend PHO Board meetings to provide support and direction in PHO development and strategy. The DHB will continue to support any necessary changes to the PHO agreement and will utilise the Ministry Toolkits to support change regarding PHO governance. Attendance at these PHO Board meetings has shown that the Maori and Pacific representatives within PHOs in Canterbury have key input into PHO decision making and setting direction. To further assist these PHO Board members the DHB is considering facilitating meetings between these PHO representatives and the DHB's Executive Director of Maori and Pacific Health.

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 we:

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

This work will continue in 2007/08 with emphasis on the effective management of demand, the collaborative development of disease management tools such as disease registers and on integrated care continuums for chronic disease and the management of long-term illness.

Aim	Streamline primary care services and work with the sector to reduce the number of avoidable admissions to hospital.
Sponsor	GM, Planning and Funding
Actions	<p>Continue to work with PHOs to implement the Primary Care Strategy; focusing on reducing inequalities and providing support for GPs to allow them to manage the care of their enrolled populations by:</p> <ul style="list-style-type: none"> ▪ Continuing to reduce economic barriers and inequalities to access in primary care by implementing reduced subsidies for 25-44 year olds and supporting any change in government policy regarding free health care for under six year olds; ▪ Continue to implementation of a variety of new PHO services including mental health workers, child health liaison workers and chronic care programmes; ▪ Complete the DHB and Canterbury PHO After Hours Cover Discussion Paper and implement the recommendations of this paper to ensure our population has 24-hour access to services; ▪ Complete a DHB-wide Immunisation Plan linking primary care, immunisation coordination, outreach service and NIR coordination providers to reduce fragmentation of immunisation services and improve immunisation rates in Canterbury. Work with PHOs as part of the PHO Performance Management Programme on meeting targets for childhood immunisations. ▪ Work with the PHOs to determine their role in the areas of pharmacy, laboratory and personal health services.
Outputs	<ul style="list-style-type: none"> ▪ Agreement is reached with PHOs to reduce co-payments for the 25-44 year age group. ▪ New PHO services are implemented with a particular focus on high need groups. ▪ The recommendations of the After Hours Cover Discussion Paper are implemented. ▪ A DHB-wide Immunisation Plan is developed regular NIR newsletters are circulated and regular practice based audits are implemented.
Measure	<ul style="list-style-type: none"> ▪ An increase in the percentages of children fully immunised (POP 08). ▪ Reduced Ambulatory Sensitive Admissions (POP 09).

²³ Information on the programme can be found at www.moh.govt.nz/primaryhealthcare.

	<ul style="list-style-type: none"> ▪ An increase in the rate of GP consultations per high need person (SER 01) ▪ An increase in the number enrolled in PHO Care Plus services (SER 02).
Aim	Ensure equitable access to Laboratory and Pharmacy Services in Canterbury.
Sponsor	GM, Planning and Funding
Actions	<p>Laboratory Services</p> <ul style="list-style-type: none"> ▪ Continue to implement the recommendations of the Review of Community Laboratory Services; ▪ Continue to contract in a way that ensures consumer choice and access to multiple collection facilities; ▪ Promote access to phlebotomy services for high needs populations; and ▪ Work with the Laboratory Reference Group to ensure the community is informed of pathology-related issues and initiatives within Canterbury. <p>Pharmacy Services</p> <ul style="list-style-type: none"> ▪ Implement Medicine Use Review Services across Canterbury with the aim of improving the management and safe use of pharmaceuticals in the community; ▪ Implement the dispensing of Clozapine by Community Pharmacy; and ▪ Continue to work with Pharmacies to investigate their role within the primary care sector and PHO environment.
Outputs	<p>Laboratory Services</p> <ul style="list-style-type: none"> ▪ A review of phlebotomy services and collection facilities is undertaken. ▪ A Strategy regarding the sharing of Laboratory results is developed. <p>Pharmacy Services</p> <ul style="list-style-type: none"> ▪ Medicines Use Review services are implemented. ▪ Dispensing of Clozapine is devolved to Community Pharmacy. ▪ Working with the Pharmacy Reference Group a 'New Services' pilot is implemented.
Measure	An increase in the number of government subsidised community pharmaceutical items dispensed by pharmacies and an increase in the number of tests carried out by community laboratories – submitted with valid NHI numbers (SER 03).

6.2.5 Disease Prevention and Management

Disease Prevention and Management is a key Health Gain Priority for the DHB and is closely aligned with the Minister of Health's priority *Chronic Disease Management*. Our four Disease Priorities, Cancer, Cardiovascular, Diabetes and Respiratory Disease, are all strongly influenced by lifestyle choices and risk behaviours.

Smoking contributes to a number of preventable illnesses resulting in a large burden of disease and is currently the single major cause of preventable death in NZ. However inactivity, poor nutrition and rapidly rising obesity rates are beginning to rival tobacco as the leading cause of preventable disease. All give rise to the disease priorities we have identified along with poor psychosocial outcomes and reduced life expectancy.

Current trends indicate that by 2011, 29% of our adult population will be obese. This has significant implications for rates of cardiovascular disease, diabetes, respiratory disease and some cancers. A complex range of environmental influences affect the lifestyle choices of our community and hence, we believe, a comprehensive multi-sector approach is needed to promote change and influence improvement in the health of our community.

In 2005/06 the Healthy Eating, Active Living (HEAL) Action Plan was developed which provides a platform for the DHB's newly appointed HEHA Development Manager to implement the national HEHA Strategy at a local level. The implementation of HEHA and HEAL have already contributed to a number of collaborative successes within the Canterbury District:

- Development of workshops on nutrition and physical activity for Pacific people working with schools and language nests and providing workshops in community halls. These workshops, run by Tagata Atumotu, Matua Pasifika and Pacific Trust Canterbury, are proving very popular with the Pacific community and a programme focused on reducing the number of young Pacific smokers is also planned;

- Implementation of Health Promoting Schools initiative which is the framework for health promotion in schools, delivered by our Community and Public Health division and focused on priority schools in the region (based on deprivation, ethnicity and other indicators of need);
- Introduction of our Health Promotion in Schools Grant. This Grant enables schools to develop initiatives around smokefree, nutrition, physical activity and mental health and well-being and we provide not only funding but also professional development assistance. We anticipate the uptake of this Grant will promote shared goals and emphasis consistent good health messages;
- Development of Appetite for Life, a six-week programme for women who are motivated to make lifestyle changes. The programme addresses physical activity issues, key nutrition issues and social and environmental influences on food choices and is designed to be delivered in a primary health care setting by a trained facilitator;
- Support for Community Action to Improve Nutrition Capacity (CATINC). This is a joint project involving funding between the DHB and PHOs with Partnership Health PHO as the lead agency. The project is focusing on workforce development (particularly in primary care) and building nutrition capacity in priority communities;
- Continued support of the Canterbury Active Communities (CAC) Project. A project which focuses on developing tools and systems for providers to encourage people to be more active, more often. This project received funding from SPARC along with a number of key stakeholders and was supported in its application by CIPANG (Canterbury Intersectoral Physical Activity and Nutrition Group). The DHB provides a governance role in the development of this project as well as funding for the evaluation tools; and
- We have also been able to collaborate on and support a number of community based initiatives to promote health and wellbeing including: research by the Canterbury West Coast Sports Trust and Partnership Health PHO into inactivity by young women 15-18, the Cancer Society's SunSmart School Programme and the Health Foundation's School Food Awards Programme.

As we move into 2007/08 the DHB is committed to its role as a leader in the implementation of the national HEHA Strategy and will ensure that there are good lines of communication between key stakeholders and providers and an appropriate governance structure in place to support this work.

The DHB will seek to build on existing services, strengthen foundations and ensure a collaborative and intersectoral approach to the implementation of the HEHA Strategy at a local level. The DHB is currently completing a Ministry Approved Plan (MAP) for implementation of the Strategy which will ensure that the DHB is committed to the implementation of the HEHA Strategy and its outcomes.

The DHB is emphasising collaborative involvement in developing the MAP and has already engaged with a range of stakeholders, providers and local community including Maori and Pacific providers to seek their input into the local direction for implementing the national HEHA Strategy.

The DHB will also continue its commitment to supporting smokefree environments and supporting smoking cessation programmes. Our focus on smoking cessation is highlighted through this document and our activity will support the achievement of health sector targets: to increase the prevalence of 'never smokers' amongst 14 and 15 years olds and the proportion of smokefree homes with one or more smokers and one or more children. This focus will also assist the DHB in addressing a major risk factor associated with our four Disease Priorities.

Also of particular note in 2006/07 was the beginning of the development of a framework for the management of chronic conditions. This framework will look at the continuum of care from 'wellness' at one end to 'unwellness' at the other and work to place the patient at the centre of the health continuum. The expected outcomes are early detection and intervention, continuity and coordination of care and improved information exchange and workforce alignment. The work will heavily influence the activity in each of our four Disease Priority areas in coming years.

Aim	Continued implement the HEHA Strategy and HEAL Action Plan - assisting our community to make healthy choices through supportive environments and a commitment to common goals for improved health and wellbeing.
Sponsor	GM, Planning and Funding GM, Community and Public Health
Actions	Work collaboratively with providers, sectors and agencies (including PHOs, TLAs, NGOs, education sector, local/regional government and Maori and Pacific providers) to promote a population-based approach to HEHA across the continuum of care with a particular focus on education, prevention, and early intervention. <ul style="list-style-type: none"> ▪ Foster and build policies and initiatives that meet HEHA's goals by working in partnership with

	<p>other sectors. Assist this process by developing environments that support healthy choices. Focus particularly on supporting intersectoral agencies to <i>Walk the Talk</i>, encouraging Active Transport and creating a Healthy Hospital environment including Baby Friendly Hospitals.</p> <ul style="list-style-type: none"> ▪ Foster initiatives that promote health in a range of key settings and communities. Work with the education sector to improve access to healthy food in schools and Early Childhood Centres through accessing the Ministry's Nutrition Fund, particularly those lower decile schools with the highest levels of need. Encourage work on the Under Fives Healthy Heart initiative with the National Heart Foundation and Sport Canterbury's Active Movement to promote healthy eating and physical activity in early childhood centres and Maori education centres. <p>Work with individuals, families/whanau to promote healthy weight, healthy eating and active living.</p> <ul style="list-style-type: none"> ▪ Foster systems and services to achieve and maintain healthy weight, healthy eating and active living for children and youth and their families. Focus on both population strategies to prevent the rise in obesity but also on services to met the needs of those children who are already overweight and obese. Support the HSS Paediatric Department's Healthy Families Project and the PHO/Sport Canterbury Green Prescription Active Families Model and the BFHI - promoting breast feeding in our hospitals. ▪ Foster systems and services to achieve and maintain healthy weight, healthy eating and active living for adults. Focus on cardiovascular disease, cancer and type II diabetes, and older adults at risk of malnutrition. Support initiatives which promote these messages such as Stay on Your Feet, Well Elderly and Baby Friendly community projects. <p>Build foundations to ensure the success of the HEHA Strategy focusing on capacity and workforce development, monitoring, evaluation and communication.</p> <ul style="list-style-type: none"> ▪ Communicate clear, consistent and effective messages that promote healthy weight, healthy eating and active living. Assist this by distributing health information relating to wellbeing issues through intersectoral partners. ▪ Build a skilled and knowledgeable workforce to support the promotion of healthy weight, healthy eating and active living in the Canterbury region. Support training for staff and providers particularly those working with at risk or high needs groups and support community based education programmes aimed at increasing knowledge of nutrition and physical activity. ▪ Monitor and evaluate initiatives developed through HEHA.
Outputs	<ul style="list-style-type: none"> ▪ An effective intersectoral approach to the implementation of the national HEHA Strategy is coordinated locally. ▪ Completion of a MAP to assist in the implementation of the HEHA Strategy.
Measure	<ul style="list-style-type: none"> ▪ Evidence of partnership and joint projects with intersectoral agencies. ▪ An increase in the number of adults (15+ in the Canterbury region) consuming at least three servings of vegetables and at least two servings of fruit per day. ▪ An increase in the proportion of infants exclusively and fully breastfed. ▪ An increase in the physical activity levels of the population in the Canterbury region.

Aim	Implement a framework for managing chronic conditions to enable better outcomes for people with chronic illness – supporting inter-sector collaboration that leads to effective development of integrated continuums of care.
Sponsor	GM, Planning and Funding
Actions	<p>Implement a strategic framework that will enable a move from a diagnosis-centred acute episodic treatment model of care, to a person-centred, managed care model that can be applied across the community-primary-specialist continuum of care for people with chronic conditions. This framework will be used to reconfigure services for people with chronic conditions to services that:</p> <p><i>Are person-centred rather than provider/location-centred</i></p> <ul style="list-style-type: none"> ▪ Services are built around the needs of service users, their family/whanau, carers and supports. ▪ Services will be delivered as close to the users' own environment and supports as possible. ▪ The model of service delivery and physical environment will allow or encourage staff to deliver care in a culturally sensitive and patient focused manner. Flexibility is inherent to allow for as much future-proofing as possible. <p><i>Encompass the sector-wide continuum of care</i></p> <ul style="list-style-type: none"> ▪ Service plans will be developed that span the continuum of care and promote collaboration and integration of service delivery that transcends current primary, secondary, tertiary boundaries. ▪ Service plans will support teamwork and collaboration between specialist, community and rural

	<p>services and will cover the continuum of care including health promotion, primary prevention, early intervention and treatment - that is, the plans will not be facility based.</p> <p>Are consistent</p> <ul style="list-style-type: none"> ▪ Service plans will be aligned to national and district policies and strategies. ▪ Service plans will use the Primary and Community Framework as developed by the DHB. <p>Are evidence-based</p> <ul style="list-style-type: none"> ▪ Service plans will be developed consistently with best practice/evidence-based approaches. ▪ Service plans will ensure quality, comprehensive health care services with a population health focus that aim to improve outcomes by understanding and responding to community needs. <p>Are appropriately prioritised</p> <ul style="list-style-type: none"> ▪ Service plans will recognise the need to optimise the use of finite resources within a context of increasing demand. ▪ Service plans will be evaluated and decisions made about which services will be delivered at what level within a clinical service area and how they may be delivered. The decision will be made using the DHB's established decision-making principles: Effectiveness, Cost, Equity, Maori Health and Acceptability (Section 2.5).
Outputs	<p>Service plans, consistent with the framework for managing chronic conditions, are implemented for the following priority conditions:</p> <ul style="list-style-type: none"> ▪ Respiratory Disease; ▪ Cardiovascular Disease; ▪ Diabetes; and ▪ Depression.
Measure	<ul style="list-style-type: none"> ▪ Evidence of a person-centred integrated continuum of care for people with chronic conditions. ▪ Improved baseline data regarding patients, and health provider performance. ▪ Improved sharing of information between health professionals regarding patient management. ▪ Improved knowledge and self management skills for patients and their families /carers. ▪ Increased population screening for chronic conditions. ▪ Decreased ambulatory sensitive admissions (POP 09). ▪ Decreased ED presentations.

6.3 Our Disease Priorities

CANTERBURY DHB - HEALTH GAIN PRIORITIES			
Cancer	Cardiovascular Disease	Diabetes	Respiratory Disease

6.3.1 Cancer

When all forms of Cancer are grouped together it is the second largest cause of death and a major cause of hospitalisation in Canterbury. Our rates of cancer will rise over the coming year as our region's population ages, however due to improved treatment and early diagnosis the risk of dying from cancer has not increased. This change presents other challenges for us in terms of the increasing costs of cancer treatment, home based support services, palliative care and long-term chronic treatment related conditions faced by survivors of cancer.

We have begun work, with other South Island DHBs, on implementing the Ministry's national Cancer Control Strategy and Action Plan at a regional level²⁴. This Strategy is the first phase in the development and implementation of a comprehensive and coordinated approach to reducing the burden of cancer through prevention, screening and early detection, diagnosis and treatment, support and rehabilitation, palliative care, data collection and research. A number of initiatives are already underway as part of the implementation of this national Strategy:

- Establishment of a South Island Regional Cancer Network whose steering group, made up of experts in the delivery of cancer services, will help advise on regional initiatives to meet the national Strategy's objectives;
- The launch of the Late Effects Assessment Programme (LEAP) and clinic for children and adolescents with cancer. More than 80% of young people with cancer survive and as they transition into adulthood many have chronic treatment related conditions needing long-term care. The clinic has been established to help monitor and support children and adolescents who have completed active cancer therapy;
- Funding for the Oncology Service's Radiation Therapist New Graduate Integration Programme designed to enhance the practical skills of graduates enabling them to integrate more easily without putting additional pressure on the clinical oncology team. This six month pilot enabled the Service to employ two additional graduates.

As highlighted in Section 6.2.5 (*Disease Prevention/Management*) we work very closely with community providers to promote health initiatives that reduce cancer rates, such as improving nutrition, promoting smoke-free lifestyles and increasing physical activity. In the past this has also included health education initiatives such as the launch of the Cancer Society's Colossal Colon to help educate the public on the importance of a healthy lifestyle in preventing bowel cancer.

Our primarily focus over the coming year will be working towards the goals and objectives of the national Cancer Control Strategy and meeting the priorities outlined in the Action Plan. We will be looking to maximise shared learning and provide the opportunity for consistency across regions. Treatment availability and cost are continuing challenges and together with community providers and agencies we will also be looking at ways to improve patient flow from diagnosis through treatment to cure or palliative care.

Aim	Work with other South Island DHBs to identify options for improved collaboration in delivering cancer treatment services and to progress the NZ Cancer Control Strategy and Action Plan.
Sponsor	GM, Planning and Funding GM, Medical and Surgical Division (HSS)
Actions	<ul style="list-style-type: none"> ▪ Promote a population-based approach to improving screening and awareness of risk activity and disease prevention activity across the DHB's four Disease Priorities particularly: primary intervention, QUIT programmes, smokefree policy and support for HEHA and HEAL projects. ▪ Assist our community to make healthy choices through supportive physical, social, economic and policy environments and commitment to improved health and wellbeing. Working with TLAs, Maori and Pacific community groups and community agencies on the development of policy, distribution of health information, and social initiatives to reduce risk behaviours.

²⁴ The NZ Cancer Control Strategy and Action Plan is available on the Ministry's website www.moh.govt.nz.

	<ul style="list-style-type: none"> ▪ Streamline primary health care services and work with the sector to reduce the number of avoidable admission to hospital and to promote population health and risk reduction. ▪ Further develop the Maori health and disability workforce to work to improve the cultural responsiveness of our cancer and palliative care services. ▪ Support the South Island Regional Cancer Control Network work to develop a regional approach to Cancer Control and reduction in inequalities in access and health status. ▪ Continue to support the development of service standards and multi-disciplinary teams to ensure effective diagnosis and treatment of cancer – through treatment advisory groups and tumour boards. ▪ Work through the Improving the Patient Journey Programme to reduce patient delays to diagnostic results and to achieve national targets for radiation treatment waiting times. ▪ Support innovation, development and research to encourage change in practice, increased screening and improved service delivery. ▪ Support the Late Effects Assessment Programme (LEAP) targeting paediatric patients who are assessed as being no longer at risk of disease relapse. ▪ Continue to work with providers to ensure opportunities are maximised to reduce inequalities for Maori and Pacific people.
Outputs	<ul style="list-style-type: none"> ▪ Continued development of a regional approach to Cancer Control led by SISSAL with recommendations for future alignment of DHB and regional cancer services. ▪ Produce a DHB Implementation Plan to demonstrate local implementation of the national Cancer Control Strategy. ▪ Analyse patient demand and identify priorities for accessing critical radiology resources and identify and enactment process improvements to reduce patient delays. ▪ Evaluation of the effectiveness of the LEAP programme with recommendation for future direction. ▪ Providers are encouraged to submit applications to the Ministry for Rural Oncology and Maori and Pacific Screening Services. ▪ Support is provided to Maori provider currently providing a Ministry funded screening programme and work with the provider to reduce any gaps that may become apparent through the implementation of this programme.
Measure	<ul style="list-style-type: none"> ▪ A reduction in delays for patient diagnostic results is achieved. ▪ Radiation Treatment Targets are met (POP 10).

Aim	Work with palliative care providers to ensure equity of access for rural and urban service users.
Sponsor	GM, Planning and Funding
Actions	<ul style="list-style-type: none"> ▪ Establish a community Palliative Medicine Specialist position in Canterbury. Investigate opportunities for residential care facility consultations for palliative care; home/community based consultations; and community registrar supervision in palliative medicine. ▪ Continue the SupportCare funding programme. Review the role and function of Needs Assessment Service Coordination (NASC) role in SupportCare Services. ▪ Develop a multi-disciplinary focused Palliative Care Service including hospice services, care coordinators, social workers, allied health and bereavement services. ▪ Continue to work with providers to ensure opportunities are maximised to reduce inequalities for Maori and Pacific people. The DHB's recently agreed Palliative Care agreement will see additional resources available for the Canterbury community and this will be enhanced by initiatives such as a recent provider initiative employing a Maori support worker to enhance Maori access to information around Palliative Care Services.
Outputs	<ul style="list-style-type: none"> ▪ Employment of a Community Palliative Medicine Specialist. ▪ Review of SupportCare NASC undertaken and recommendations of the Review implemented. ▪ A new Palliative Care Agreement is implemented to support a multi-disciplinary focused Palliative Care Service. ▪ Support is provided to providers to address inequalities in access for Maori and Pacific people.

6.3.2 Cardiovascular Disease

Cardiovascular Disease (CVD) includes coronary heart disease, other disease of the heart and circulation and stroke. It is the main cause of death in Canterbury and the incidence of CVD is likely to increase as our population ages, is usually linked with diabetes and is strongly influenced by lifestyle choice. Maori and Pacific have higher rates of CVD than other ethnicities.

Over the past year we have worked collaboratively to make gains in CVD and have entered into an agreement with the National Health Foundation, Partnership Health PHO and Pegasus Health to undertake a home based Heart Guide Aotearoa Programme to support rehabilitation following heart attacks. The training programme was introduced in 2006/07 and it is anticipated that the programme will commence in 2007/08.

Other recent successes will provide a good foundation for change and improvement over 2007/08:

- A health promoter is working with early childhood centres to encourage nutritionally health and physically active environments for children to establish a foundation for healthy lifestyles. Thirty-five centres have achieved the Heart Foundation's Healthy Heart Award; and
- A primary care based CVD risk assessment project was completed in Rangiora concluding that while practice had high levels of recording information on age, smoking, cholesterol and blood pressure their current practice for screening for CVD risk factors varied greatly. The assessment also highlighted the need for additional information technology support for general practice.

A plan for minimising the effects of CVD on our population was approved by our Board in 2004. This Plan, *Canterbury Heart Health Strategy*, highlighted the importance of population-based strategies for reducing the impact and incidence of CVD and the importance of improving rehabilitation and community treatment after acute heart events. Implementation of the recommendations of this Plan will continue to direct our focus over the next year.

Challenges include curbing and stabilising childhood obesity rates through community, school and early childhood centre programmes. We also intend to increase the numbers of partnerships, collaborations and alliances across the health sector in order to develop future initiatives to reduce the risk of heart disease and to ensure long-term capacity and capability in manage demand.

Aim	Implement the actions associated with the <i>Canterbury Heart Health Strategy</i> , covering the continuum from health promotion, disease prevention, treatment, rehabilitation and palliative care.
Sponsor	GM, Planning and Funding GM, Community and Public Health GM, Medical and Surgical (HSS)
Actions	<ul style="list-style-type: none"> ▪ Continue the DHB's collaborative health promotion approach to reducing the incidence and impact of CVD including supporting initiatives of community agencies and organisations and working with key stakeholders to promote messages related to physical activity, nutrition, weight reduction and smoking cessation. ▪ Implement the national HEHA strategy and local HEAL Action Plan. ▪ Support strategies to target heart health in Maori and Pacific communities to reduce health inequalities particularly through primary and community sector activity. Work to ensure services are culturally appropriate and work with Maori and Pacific communities to support prevention, early detection, and service uptake. ▪ Continue to work with primary care and hospital services to ensure and integrated approach to patient care and support the development of chronic disease management continuums. ▪ Continue to review specific interventions to meet indicator targets for cardiac surgery and angioplasty and (through the Improving the Patient Journey Programme) develop a chronic care pathway for cardiology patients, focused on assessing the most appropriate care setting for patients and identifying opportunities to improve care. ▪ Continue to support the Heart Guide Aotearoa Programme to support rehabilitation.
Outputs	<ul style="list-style-type: none"> ▪ A HEHA co-ordinator is in place to ensure implementation of the national HEHA Strategy. ▪ The chronic care pathway is developed. ▪ The Health Guide Aotearoa Programme commences.
Measure	<ul style="list-style-type: none"> ▪ An increase in the number of people who have suffered Acute Coronary Syndrome who attend a cardiac rehabilitation outpatient programme (POP 02). ▪ An increase in the number of people who have suffered a stroke event, who have been admitted to organised stroke services (POP 03).

6.3.3 Diabetes

Diabetes is estimated to cause around 1,200 deaths per year in NZ and managing diabetic complications (such as heart disease, blindness and kidney failure) is a significant burden for the country's health system. Type II diabetes, most frequently diagnosed in adults, is now more common in Canterbury's children and youth. While Type I diabetes continues to be priority for us, it is this increase in Type II diabetes, linked to poor nutrition and smoking, that is of greatest concern.

We work closely with community and primary care providers to progress a coordinated community approach to diabetes, to ensure equitable access to services and to promote timely intervention. Annual diabetes checks are undertaken by GPs and this service has been boosted by an increase in funding in 2006/07 to support PHOs to contribute to the overall direction of diabetes work in Canterbury.

One of our largest PHOs has developed a diabetes direction paper which outlines their objectives with regard to diabetes: to reduce the incidence of diabetes through prevention and health promotion strategies; to ensure effective screening and early diagnosis to reduce the impact of diabetes: to improve the quality of life for those with diabetes and their family/whanau through support and self-management; to ensure effective multidisciplinary treatment to enhance the quality of life and lastly; to improve the integration of diabetes services through planning, innovation and workforce development. These objectives strongly support the direction the DHB has chosen for diabetes, as set out in our DSP.

Success in 2006/07 centred on population-based interventions to promote healthy eating and increase physical activity and on implementation of initiatives to support our objectives and direction around increasing diabetes screening and improving self-management; these have included:

- A revised impaired blood glucose programme for those newly diagnosed with impaired blood glucose and the development of a community podiatry programme;
- The use of CarePlus to improve access to primary care services and PHO Maori Health and Health Promotion Plans which support the DHB's diabetes direction;
- Collaboration with the Christchurch Methodist Mission on the Healthy Lifestyle project helping food bank users to gain knowledge and skills to improve their own health. The Mission also improved the nutritional content of food parcels and the food and beverages offered to the public;
- Support for an opportunistic diabetes check programme by the Rural Canterbury PHO for the freezing workers in Ashburton where there is a high proportion of Maori and Pacific staff.
- Implementation of a Healthy Eating Policy for the DHB covering vending content of vending machines on DHB sites and the menus of DHB cafeterias.
- Completion of a purpose-built Diabetes and Home Dialysis Training Centre bringing together for the first time under one roof the DHB's Diabetes Services, Diabetes Life Education and Diabetes Christchurch (the local branch of Diabetes NZ). The building offers space for new treatment and assessment rooms, meeting rooms, diabetes administration and research and a Home Dialysis Training Centre.

The work that falls out of this direction happens in collaboration with the Local Diabetes Team whose membership includes a representative group of health professionals, community providers and consumer representatives with a vested interest in improve diabetes services.

This collaboration and shared direction will be important in making changes in diabetes service models and in improving diabetes health outcomes. The funding applied to diabetes prevention and services in 2007/08 is intended to impact on service outcomes, outputs and quality in a number of ways. We will continue to review diabetes services in Canterbury evaluating progress and achievements and focus on gains in this area. It is important to us to ensure accurate and robust monitoring of diabetes screening to enable a full picture of the current situation in Canterbury and to allow us to track and evaluate the success of interventions and initiatives.

In 2007 we expect to see more people diagnosed with diabetes as a result of a focus on opportunistic screening programmes, targeted to our Maori and Pacific communities. This work follows on from a local audit of diabetes case detection showing an increase in overall screening rates but a relatively small increase in screening of Maori and Pacific patients. A lifestyle programme will also be launched that aims to support people with diabetes with their ongoing management of diabetes and we anticipate an increase in overall numbers of people having annual diabetes checks.

The opportunistic screening and lifestyle programmes and the introduction of a community podiatry programme will see increased investment in diabetes in 2007/08.

Aim	Coordination of Diabetes services within the community to improve access and intervention.
Sponsor	GM, Planning and Funding GM, Community and Public Health
Actions	<p>Continue to work in collaboration with PHOs, local agencies and organisations to raise diabetes awareness and to progress shared goals and direction.</p> <ul style="list-style-type: none"> ▪ Support the implementation of both HEHA and HEAL to improve lifestyles and reduce risk behaviours. ▪ Support PHOs to provide health promotion in physical activity, nutrition and smoking cessation and to increase diabetes awareness amongst their enrolled populations. ▪ Continue to support initiatives and programmes that encourage prevention, early intervention and ongoing uptake of services by Maori and Pacific groups at high-risk of diabetes. ▪ Support an increase in the number of people with diabetes receiving annual checks and the number of diabetics managing their diabetes with adequate glycaemic control. ▪ Scope and develop an opportunistic screening programme in the community to increase diagnosis of diabetes in the Canterbury community. Target the programme at Maori and Pacific groups and low incomes families where the risk of diabetes is higher. ▪ Progress a coordinated approach to access to retinal screening and increase the rates of screening in Canterbury. ▪ Work to ensure all annual review data is collected for regional/national databases and improve the process for collecting and reviewing this information. ▪ Develop a diabetes lifestyle programme for people newly diagnosed with diabetes to provide self-management skills. ▪ Work with community podiatry services on providing access to foot care assessments and treatments for those with uncomplicated high risk feet and on providing education on foot care. ▪ Undertake a self-evaluation of the planning and funding of diabetes services in Canterbury to assess effectiveness of services over time and value for money and improve the setting of targets for achievement in out-years.
Outputs	<ul style="list-style-type: none"> ▪ An improved process for collecting diabetes screening and management data is established. ▪ A working party is established (involving PHOs and other key stakeholders) to agree on the direction of the opportunistic diabetes screening programme. Alongside the development of the screening programme, information technology query building is developed to help identify at-risk populations. ▪ A working party is established to determine the scope of the diabetes lifestyle programme and undertake an RFP process to determine provider(s) for this programme. ▪ Community podiatry clinics are established. ▪ A self-evaluation of diabetes services in Canterbury is complete.
Measure	<ul style="list-style-type: none"> ▪ An increase in the numbers on the diabetes register who received their annual check (POP 01). ▪ An increase in the numbers on the diabetes register that have had retinal screening in the last two years (POP 01). ▪ An increase in the numbers on the diabetes register that have good diabetes control (an HBA1c of equal to or less than 8%) (POP 01).

Value for Money

A part of the Ministry's priorities for 2007/08, DHBs are required to focus on Diabetes as a means of determining the extent to which Value for Money is being obtained through the pursuit of efficiency, productivity and innovation. To meet this expectation and to confirm its commitment to continuous improvement the Canterbury DHB will undertake a self-evaluation of the planning and funding of diabetes services based on the Diabetes Scorecard developed by PriceWaterHouseCoopers.

This evaluation will assist us to gauge our progress over time in providing diabetes related service and indicate how effective those services are in reducing the burden of diabetes. This evaluation will also assist the DHB in the setting of targets for out-years by determining the effectiveness and value of services and the best use of diabetes funding. Refer to Appendix 5 for the Diabetes Scorecard.

6.3.4 Respiratory Disease

Chronic respiratory diseases, particularly asthma and smoking related diseases such as Chronic Obstructive Pulmonary Disease (COPD) and emphysema, represent a significant public health problem. Nationally, asthma hospitalisations are higher for Maori than non-Maori despite asthma prevalence being similar in Maori and non-Maori children. Improved asthma self-management has been shown to significantly reduce hospital admissions.

Having identified Respiratory Disease as one of our four disease priorities we have, as an initial step, conducted a review of work currently being undertaken to meet the community's needs under this priority and identified some positive work being done in the region:

- Collaboration with Maori health teams and Hauora Matauraka and primary care providers on promoting smokefree environments and smoking cessation.
- Working with the CCC and other TLAs in Canterbury on a Health Housing Project looking for collaborative solutions to help improve air quality and create warm, dry homes for the elderly, the very young and low income groups. A research project is also underway to monitor 100 homes where there is a child diagnosed with asthma; and
- Provision of specific services to improve the management of respiratory disease such as: outreach services, diagnostic testing, pulmonary rehabilitation classes, a sleep laboratory and the South Islands only bronchoscopy services.

In the coming year we will work to formalise a direction to help manage respiratory disease in Canterbury and further develop collaborative relationships to reduce risk factors, improve screening and early intervention levels and self management of respiratory diseases and to promote rehabilitation and continuums of care for chronic conditions.

Work being done on the development of a framework for the management of chronic conditions and the development of service models as part of our Health Services Planning project will lead the direction for respiratory disease action over the coming year.

Aim	Work collaboratively to address risk activity that impacts on respiratory disease, to provide appropriate and timely treatment and work to improve the quality of life for those with chronic respiratory disease.
Sponsor	GM, Community and Public Health GM, Planning and Funding
Actions	<ul style="list-style-type: none"> ▪ Support the development of a framework for the management of chronic conditions and the development of a Health Services Plan to ensure that respiratory disease continuums of care are considered and developed. ▪ Through the Improving the Patient Journey Programme, develop a chronic care pathway for respiratory patients, focused on assessing the most appropriate care setting for patients and identifying opportunities to improve care. ▪ Continue to work on reducing exposure to second-hand smoke and the uptake of smoking by strengthening smoke-free promotion and support smoking cessation programmes. ▪ Continue to work collaboratively with external agencies and organisations to reduce admissions with influenza and asthma – contribute to joint projects such as the Warm Homes Project to ensure adequate home heating for older people to keep them healthy in their own homes. ▪ Work collaboratively on influenza immunisation planning and awareness. ▪ Support Maori and Pacific initiatives to reduce asthma admissions in children. ▪ Improve the self management of respiratory disease through enhanced provision of education and support to patients, families/whanau and caregivers.
Outputs	<ul style="list-style-type: none"> ▪ Service plans, consistent with the framework for managing chronic conditions are developed for respiratory disease as an identified priority condition under the Health Service Planning Programme. ▪ A joint care plan for chronically ill respiratory patients is commenced through the Improving the Patient Journey Programme. ▪ HSS sites remain smokefree and smoking cessation support is offered through HSS divisions. ▪ Canterbury retains a high level of update of influenza vaccinations.
Measure	Risk Reduction – Smoking rates in Canterbury decrease across population and age groups.

7 ADVANCING OTHER GOVERNMENT PRIORITIES

As a DHB we have a number of non-negotiable obligations and responsibilities under key national health strategies, the NZPHD Act, the Treaty of Waitangi, Crown Funding Agreement and as part of the Minister of Health's yearly and ongoing expectations and priorities. The following section addresses the specific expectations that fall outside our DSP priorities but never-the-less reflect ongoing work in our region.

7.1.1 The NZ Disability Strategy

The Canterbury DHB has a current Disability Strategy Action Plan 2004/2007 (*Action Plan for Disability*). This Plan 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 also offered us an opportunity to upgrade service delivery in terms of the needs of people with disabilities through implementation of the DHB Accessibility Plan.

The DHB's HSS Rehabilitation Services are located at Burwood Hospital and include: the Burwood spinal unit, musculoskeletal services, brain injury rehabilitation services, pain management services and orthopaedic rehabilitation. The Burwood Spinal Unit is one of only two such units in the country and treats 60% of NZ's spinal injury patients. The Spinal Unit is also involved in leading international research to help spinal patients rehabilitate and adjust.

A key success for our Rehabilitation Service over the past year has been the implementation of a Circuit Training Programme. The aim of this programme is to reduce physiotherapy outpatient waiting times and improve the efficiency of delivery without increasing therapist case loads. The programme also includes increasing participant satisfaction, improving reporting and auditing and improving therapist satisfaction and morale - therefore assisting with effecting 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 patients needs. We will aim to continue to improve service delivery over the coming year.

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:

Aim	Progress the objectives of the NZ Disability Strategy through implementation of the DHB's Disability Action Plan – address, maintain or promote physical and non-physical accessibility issues.
Sponsor	GM, Older Person's Health and Rehabilitation (HSS)
Actions	<p>Ensure that the health concerns and needs of people with disabilities are known at a service and planning level:</p> <ul style="list-style-type: none"> ▪ Collect through patient admission data information on a patient's disability, including type of disability, severity, particular needs and any other information the patient deems relevant; ▪ Continue to survey patients, as part of the monthly consumer satisfaction surveys to assist in determining what consumers of health services want in order to improve their experience; and ▪ Ensure the DSAC workplan is informed on progress against the Disability Strategy Action Plan. <p>Work to reduce inequalities of access to health services for people with disabilities:</p> <ul style="list-style-type: none"> ▪ Implement actions from the DHB's Maori Disability Strategy Development Project to help meet disability needs of Maori with disabilities; ▪ Continue to ensure all site redevelopment conforms to current standards of accessibility through adherence to the DHB's Accessibility Plan;

	<ul style="list-style-type: none"> ▪ Continue to provide 24-hour interpreter services, including those for Deaf people, in all major hospitals and comply with the requirements of the NZ Sign language Bill when enacted into law and as funding allows. <p>Enhance HSS Specialist Rehabilitation Services:</p> <ul style="list-style-type: none"> ▪ Develop Strategic Business Plans that support rehabilitation in the patient journey for Spinal Services, Brain Injury Services and Pain Management Services. ▪ Work with the DHB's Business Support and Site Redevelopment Divisions to progress the redevelopment of Burwood Hospital to improve delivery of rehabilitation services on this site. ▪ Identify areas of challenge with regard to workforce and develop sustainable workforce plans to meet ongoing staffing requirements in those areas. <p>Work collaboratively with other organisations and agencies in Canterbury to eliminate barriers that people with disability face in their daily lives and ensure equitable access to our services:</p> <ul style="list-style-type: none"> ▪ Continue to work through Healthy Christchurch and other similar joint ventures to highlight health and disability issues for our population. ▪ Maintain links to assist people with disabilities to return to the community including liaison with ACC, Lifelinks, domiciliary care and equipment access.
Outputs	<ul style="list-style-type: none"> ▪ Strategic Business Plans are developed for the DHB's Specialist Rehabilitation Services. ▪ A review of Stage II of the Burwood Redevelopment is undertaken and a framework is developed for the Business Case for Stage III. ▪ Workforce Plans are developed for HSS Rehabilitation Services to support service demands going forward.

7.1.2 The NZ Mental Health Strategy

Completion of the DHB's Mental Health and Addictions Strategy in 2004 provided a local framework for managing access to, and delivery of, a 'System of Care' model based on advancing recovery for people with serious mental illness. This marked a shift away from tertiary and secondary services towards community-based care with increased collaboration between providers, service users and their families/whanau.

Our local Mental Health and Addictions Strategy is consistent and complimentary to existing work at national and regional levels. Over the last two years \$4.4M additional funding has been invested in the mental health sector. The majority of this additional funding has gone to the NGO sector and has greatly expanded the range of community-based 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 service users.

The DHB is aware that these 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 the national Mental Health Strategy, *Te Tahuu Improving Mental Health*, and associated Implementation Plan, *Te Kokiri* and our own Mental Health and Addictions Strategy.

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

- Bottlenecks have been pin-pointed within our Specialist (HSS) Mental Health Services 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;
- Our HSS Child, Adolescent and Family Services are also adopting a single point of entry model as part of wider changes to the units overall structure;
- Investment has been made in Peer Support Services which has led to the development of a Canterbury Warmline (telephone support service) and a Strengths Based Peer Support Service;
- An additional six Community Support Worker FTEs have been funded, two of which are dedicated to rural areas in a unique demonstration service;
- An additional Family Peer Support Worker has been funded in the Alcohol and Other Drug sector;
- Three clinical FTEs were funded to deliver GP Liaison services in the primary care sector.

- The District Nursing Medication Service (a 2005/06 demonstration service) has been expanded;
- Additional funding has been received from the Ministry for methadone services funding a clinical FTE to support GP Liaison and a project worker;
- Additional one-off funding was provided by the Ministry for a Canterbury mental health website, mental health workforce development and education and support for specialist staff;
- The Consult Liaison Function delivered through our HSS Mental Health Services to support NGO providers and the primary care sector has been expanded;
- A joint initiative was undertaken with the CCC to identify service gaps and partnership opportunities between specialist mental health services and tenants of CCC Social Housing;
- A 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 Kaupapa Maori scoping project was completed to identify the level of need and potential models for service delivery in Canterbury;
- A NGO Mental Health Workforce Development Plan is currently being completed to identify workforce priorities, develop a training calendar and scope an NGO supervision brokerage service; and
- A key stakeholder forum on the development of a Home Based Treatment Approach was undertaken, which provides important background work for a project to explore, develop and improve our mental health system's acute response. This will be a HSS led initiative in partnership with NGOs and primary care and will be jointly sponsored by the Planning and Funding and HSS divisions.

Blueprint Funding

The 'Blueprint for Mental Health Services in NZ' is a government planning framework that identifies the services necessary for an effective mental health system and determines the types and levels of service that DHBs are expected to provide. The proportion of funding that DHBs receive for mental health and addiction services is tagged or 'ringfenced' specifically for those services, to ensure access for the 3% of the DHB's resident population (those considered most in need). The Canterbury DHB is currently resourced at 76% of Blueprint, and access levels reflect this.

Child and youth mental health access rates in Canterbury are slightly under Ministry expectations. This is partly because additional resources (7 FTE in 2005/06) invested in both Pacific and Maori child and youth community support worker services are strongly linked into primary care and therefore not captured in HSS reporting against population access targets. Access rates are expected to increase, for both Child and Youth and Adult Mental Health Services, through the implementation of a Single Point of Entry (using the UK Choice and Partnership Approach) and the increase in Consult Liaison Services as described below.

In 2007/08 the additional Blueprint Funding that we will receive is \$680,000 and we intend to invest this funding in the following new services:

- Community Support Workers (MHCR09.2) - funding for six additional FTEs to address the growth in demand for these services;
- Alcohol and Other Drug Services (MHCS01B) – funding for an additional 0.5 FTE Consultant Psychiatrist in Alcohol and Other Drug Services; and
- Mental Health Workforce Development (MHWD01) – funding of \$40,000 to support the implementation of the NGO Mental Health Workforce Development Plan and Training Calendar.

As in 2006/07 some providers of mental health services raise financial pressure as an issue citing pay equity demands as a flow on effect of the nurses' salary agreement, difficulties with recruitment and retention in a highly competitive environment and infrastructure/technology issues. In order to respond to these issues we will continue to examine the 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. We are continuing to address funding equity issues within the Canterbury mental health sector, utilising FFT to do this. Although this has caused some frustration for providers that have been relatively well funded in recent years, it has provided the sector with a more equitable funding base.

We will also continue to pursue the goals of Te Puawaitanga²⁵ and progress cultural responsiveness of mainstream mental health services and the development of the Kaupapa Maori Mental Health Sector. We contract with an NGO provider to support and lead Kaupapa Maori Mental Health Workforce Development in partnership with our Planning and Funding division. This provider facilitates the Kaupapa Maori Mental Health Provider Forum, supports providers with policy and procedure development, delivers identified training packages, and undertakes specific project work.

Priority Actions from the national Mental Health Strategy Te Tahuu

In considering the ten challenges of the national Mental Health Strategy and implementation plan (*Te Tahuu* and *Te Kokiri*) the DHB has undertaken a mapping project leading to the development of a draft local Strategic Framework that is currently with our mental health sector for consultation. This Strategic Framework aligns the ten challenges with the strategic objectives of the DHB as defined in our DSP, SOI and with our local Mental Health and Addictions Plan. It suggests priorities for action for the next three years and feedback from the sector will help to influence our future direction.

Primary Mental Health Care

In 2006/07 two PHOs were contracted to deliver a GP Liaison Service across Canterbury (3 clinical FTEs MHCS06A). The GP Liaison Service supports GPs (rural and urban) in their treatment of people with serious mental illness, who meet the criteria for specialist services but whose needs are able to be met in the primary care sector.

In 2007/08 we are putting another three clinical FTEs into HSS Mental Health Services to build up the consult liaison function, to better support the primary care and NGO sector.

Eating Disorders

The Canterbury DHB is the funder and provider of the regional specialist Eating Disorder Service. The South Island DHBs are currently participating in a regional specialist services project. The purpose of which is to establish criteria for determining which services should be regional and resolve issues related to access to regional services.

Aim	Improve and support flexibility and responsiveness in mental health services.
Sponsor	GM, Planning and Funding GM, Mental Health Services (HSS)
Actions	<ul style="list-style-type: none"> ▪ Complete the Mapping Project for Canterbury's mental health services producing a Strategic Framework which links DHB accountability documents and direction with national policy requirements and local sector initiatives to better inform future funding and planning decisions. ▪ Reprovision Dual Diagnosis (Intellectual Disability and Mental illness) Residential Services to the NGO sector and increase specialist outpatient services in HSS Mental Health Services. ▪ Formalise provider specifics that reflect actual service purchased. ▪ Set target volumes of service users supported within contracts. ▪ Finalise the development of the Mental Health Information Database to bring together contract and activity information for sector analysis and to improve relationships with providers based on strong information flow. ▪ Encourage NGO providers to use the information available to develop provider specifics that reflect actual service purchased for negotiation with the DHB. ▪ Challenge under-delivery of contract and performance targets by NGO and HSS providers. ▪ Implement Single Point of Entry to reduce barriers to access and duplication of triage systems. ▪ Complete a project to review the Mental Health Service's system of acute response and reconfigure inpatient (acute and rehabilitation) resources (if required) to support improved and increased service and treatment options for service users. ▪ HSS Mental Health Services and Planning and Funding divisions work collaboratively with the wider sector to take opportunities to the maximise utilisation and flow through of rehabilitation beds - including reviewing and changing models of service delivery and contract arrangements.
Outputs	<ul style="list-style-type: none"> ▪ A Strategic Framework for mental health services is completed, in consultation with the sector. ▪ Mental Health Information Database is developed. ▪ HSS Mental Health Services exit provision of Dual Diagnosis Residential Services and smooth

²⁵ *Te Puawaitanga is the Māori Mental Health National Strategic Framework developed by the Ministry in 2002.*

	<p>transition to NGO sector enabled.</p> <ul style="list-style-type: none"> ▪ Single Point of Entry is introduced within HSS Mental Health Services reducing duplication and improvement responsiveness with consistent information available to referrers. ▪ Our Mental Health Services' system of acute response is reviewed and recommendations are implemented. ▪ Collaborative review of Rehabilitation Services.
Measure	Improved Access to HSS Mental Health Services (POP 06).

Aim	Support cohesiveness and collaboration between mental health providers and stakeholders.
Sponsor	GM, Planning and Funding GM, Mental Health Services (HSS)
Actions	<ul style="list-style-type: none"> ▪ Support the roll-out of Mental Health Information National Collection (MHINC) and Mental Health Standard Measures of Assessment and Recovery (MHSMART) and commit to national Key Performance Indicators. ▪ Encourage responsiveness by NGO and HSS providers to the reporting requirements of South Island DHBs with regard to activity and process regarding regional services. ▪ Encourage innovation through working together. Encourage providers to trial multi-agency intake teams for like services (such as mainstream residential and community support worker services and the national 'Knowing the People Project' engaging and support service users with enduring mental illness. ▪ Collaborate with GPs and PHOs to support mental health service development in the primary care sector.
Outputs	<ul style="list-style-type: none"> ▪ Regular forums for communication and consultation with the mental health sector and internal stakeholders held. ▪ South Island activity reports for regional services completed on a quarterly basis. ▪ Knowing the People Project piloted at the Hereford Centre with the recovery model well embedded in care and service users engaged to improve physical health status through primary care.
Measure	An increase in the number of long-term clients (with enduring mental illness) with up-to-date crisis prevention plans (QUA 02).

7.1.3 Infrastructure - The Health Information Strategy

DHB Chairs and CEOs have established 'Information' as a collective strategic priority for DHBs; taking 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 'roadmaps' for each action zones. A regional view is expected to be presented for endorsement by the national CEO group in early 2007 which will assist us in our continued implementation of the HIS-NZ.

Alongside our commitment to the implementation of HIS-NZ we have also established an Information Services Strategic Plan (ISSP) and, through the implementation of both these strategic documents, significant changes have been made to our Information Services infrastructure and some key projects and initiatives have begun:

- Formation of a South Island Secure Health Data Network (action zone 1) providing the network infrastructure for agencies to share information. The network conceived and administered by us, 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) (action zone 3) this local index will allow us to link to the national HPI numbers once they are assigned;
- Implementation of Electronic Discharge Summaries (action zone 6) 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) (action zone 9) looking at the coding of outpatient visits. We were one of the first DHBs to provide data for stage 1 of this project;

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 clinical portal continues along with development of a Single Patient Administration System and we aim to complete a business plan for implementing the system in the coming year.

The next twelve months also brings a couple of key challenges for our information services:

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.

HIS-NZ - We will also be demonstrating our commitment to the HIS-NZ through continued implementation of the action zones within the Strategy moving on to the second stage of NNPAAC and concentrating on data quality (action zone 2) in 2007/08.

Aim	Continued implementation of the DHB's ISSP and delivery of a robust infrastructure framework.
Sponsor	GM, Organisational Support and Development
Actions	<ul style="list-style-type: none"> ▪ Further develop infrastructure programme procedures and systems. ▪ Continue the roll-out of the Clinical Information System Portal. ▪ Progress the upgrade of HR Payroll (HRIS) and Rostering systems. ▪ Move significantly towards selecting a new Patient Administration System. ▪ Support national initiatives that are not on Action Zones including the Project for the Integration of Mental Health Data (PRIMHED) Project.
Outputs	<ul style="list-style-type: none"> ▪ The DHB's ISSP is reviewed and updated to meet stakeholder expectations. ▪ System monitoring is expanded to the DHB's new systems. ▪ Clinical Information System Portal is rolled out to Hospitals. ▪ HRIS and Rostering Systems are implemented and supported. ▪ A new Patient Management System is evaluated and a case for the Regional Capex Committee is prepared for Ministry approval. ▪ The Project for the Integration of Mental Health Data is supported.

Aim	Actively participate in HIS-NZ, progress collaborative work to improve the stability and capability of Health Information Systems.
Sponsor	GM, Organisational Support and Development
Actions	<ul style="list-style-type: none"> ▪ Work with South Island DHBs to integrate the South Island Network with the new National Network as the National Network becomes available (Action Zone 1 - National Network). ▪ Actively participate in NHI promotion and work on the continuous improvement of data quality (Action Zone 2 - NHI Promotion). ▪ Integrate local HPI with the National system as the National system becomes available (Action Zone 3 - HPI Implementation). ▪ Progress resolving concerns re privacy around a regional repository of laboratory results (Action Zone 5 - E-Labs). ▪ Continue the rollout of electronic discharge summaries to all Canterbury DHB hospitals (Action Zone 6 - Discharge Summaries). ▪ Work with the Planning and Funding division to identify suitable plans for the implementation of systems that support chronic disease management (Action Zone 7 - Disease Management). ▪ Continue involvement in the development of Health Information Standards for forms server (Action Zone 8 - Electronic Referrals). ▪ Implement compliance changes as required by the Ministry (Action Zone 9 - National

	Outpatient collection).
Outputs	<ul style="list-style-type: none"> ▪ South Island Network is integrated with the new National Network. ▪ The DHB is represented on the NHI National Committee. ▪ The local HPI is integrated with the national system as it becomes available. ▪ Resolution of privacy concerns around community and hospital results available in one system are resolved. ▪ Electronic discharge summaries can be sent by all DHB hospitals. ▪ The DHB has input into the development of a forms server standard. ▪ Required outpatient compliance changes are implemented.

Aim	Drive to improve data quality throughout the organisation
Sponsor	GM, Organisational Support and Development
Actions	Implement a programme to highlight the importance of data quality.
Outputs	<ul style="list-style-type: none"> ▪ All training courses provided by DHB's Information Services Group will include a section that: <ul style="list-style-type: none"> - Highlights the importance of correctly identifying patients NHI; - Highlights the importance of correctly identifying clinical caregivers (HPI); and - Highlights the importance of quality data not just for clinical purposes but also highlighting that it is key to the planning and funding of services. ▪ All data quality reports from NZHIS will be routed to appropriate management for action. ▪ A Clinical Coding Audit will be carried out by external auditors.
Measure	An improvement in the quality of data provided to National Collections Systems (QUA 03).

7.1.4 Quality and Patient Safety

We have a strong commitment to the provision of high quality health care services and strive 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. Supported by our Corporate Quality and Risk Team the Council's primary goal is to provide leadership in improving quality and patient safety.

To advance this goal we have developed a Quality Strategic Plan which provides the Council with a framework that promotes leadership as the underlying driver of quality improvement and quality improvement as a continuum.

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. These are: 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.

The Council monitors progress on the goals set out in the Plan and there have been a number of key successes over the past year:

- The development and promotion of key quality and patient safety policies including the Culture of Patient Safety, No Blame Incident/Accident Reporting and Open Disclosure Policy.
- The beginning of an Incident Management Software selection project to select a standardised incident management software system for our HSS with the view of offering this system to external community providers in the future. 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;
- The continued development of the DHB's Quality and Innovation Awards Programme which has seen a total of 71 projects having been entered in the annual awards and many going on to enjoy national and international success. By encouraging staff and external provider organisations to record their quality improvements and innovations we have also fostered the sharing of

information both internally and externally. Roadshows have also been run to facilitate the sharing and learning gained from the applicants project activities;

- 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 reports are being developed and work is continuing on indicators for Respiratory Disease and Cancer;
- 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 initiatives that will assist us to achieve the goals and objectives contained within that Plan. The area of indicator development and reporting remains a priority.

Aim	Continue to implement the Canterbury DHB's Quality Strategic Plan – reviewing and realigning the Quality Strategic Plan with the DSP for 2006-2010 and the IQ Action Plan for 2007-2010.
Sponsor	Executive Director of Nursing Chief Medical Officer
Actions	<ul style="list-style-type: none"> ▪ The new Quality Strategic Plan and Quality and Patient Safety Council's workplan is implemented with cohesive quality and risk management structures in place across the DHB. ▪ Continue to develop quality and patient safety policies. ▪ Hold the DHB Quality and Innovation Awards annually and continue to review and develop the awards programme. ▪ Progress the work on developing a set of quality indicators and implementing regular reporting to the Board. ▪ Select and implement a new incident management software system for the HSS with a view to offering this system to our community based providers in the future. ▪ Implementation of the Intensive Care Outreach and Follow-up Service at Christchurch Hospital. ▪ Continue to develop and implement the Improving the Patient Journey programme. ▪ Continue to build capacity at all levels to enable consumers to be more effective partners in the care process.
Outputs	<ul style="list-style-type: none"> ▪ An education programme for staff on the key patient safety policies is developed. ▪ A new component to the current Quality and Innovation Awards programme is piloted. ▪ The needs of HSS and community based providers with regards to a new incident management software system are considered. The tender process is overseen and evaluated by the Council and the software option that best suits our requirements is selected. ▪ A review of the serious falls (over the two year period July 2004–June 2006) is conducted. ▪ The DHB works with national Quality and Risk Managers on the development and implementation of a standardised incident dataset to facilitate a consistent approach to the management of incidents nationally. ▪ A senior nursing position (Clinical Nurse Specialist) is established to further extend the intensive care outreach service at Christchurch Hospital. ▪ Key Performance Indicators related to the effectiveness of the Intensive Care Outreach Service are developed along with a regular audit plan. ▪ A Consumer Council is established to provide the DHB with patient/consumer advice about health priorities, to ensure that community stakeholder views are properly considered and to encourage effective community participation in all aspects of health service provision.
Measure	New incident management software system software is implemented across the HSS.

7.1.5 Elective Services, Orthopaedics and Cataracts

Managing demand for elective services is a primary focus for the DHB and a high priority nationally for the Minister of Health. The DHB's Elective Services Steering Committee continues to monitor

compliance against national Elective Services Performance Indicators (ESPIs) which are reported regularly to the Ministry. The key objectives with regard to elective services are to:

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

We are also committed to implementing government initiatives around electives in particular areas with national projects currently underway in both Orthopaedic and Cataract services. Over the past year we have made a number of significant achievements:

Elective Services:

- 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 matching of promises to capacity;
- Weekly ESPI patient and service level monitoring reports have been implemented to ensure patients are selected based on their assigned priority. This audit process applies to all surgical services.
- The Improving the Patient Journey initiatives delivered improvements in theatre utilisation and resource allocation that reduced the impact of trauma overload on elective volume delivery; and
- The Orthopaedic Continuous Quality Improvement (CQI) initiative delivered increased utilisation of resourced theatres, and reduced reliance on RMOs through Nurse Led activity.

During the process of achieving ESPI compliance 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. This group governs the activities of the Transactional (Compliance) and Transformational Groups. 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.

Orthopaedic Initiative:

- Initiative volume target and ESPI compliance achieved with the access threshold for orthopaedic surgery lowered to 90 points;
- Increased capacity has been commissioned at Burwood Hospital as part of the Stage II Redevelopment;
- A GP Liaison role has been appointed to coordinate central referral management with PHOs and department policy has been introduced to ensure all referrals follow an agreed pathway;
- A Physiotherapy Scoring Trial has been completed for all hip and knee referrals with confirmation that the tool improves the ability to delineate patient need and ability to benefit;
- A nurse-led model for pre-admission was introduced resulting in reduced reliance on RMOs;
- A patient 'Road Map' has been designed for patient (by patients);
- There has been a 40% increase in resourced theatre utilisation and the Acute Trauma Review has been completed resulting in recommendations to reduce the impact of trauma on elective surgery productivity; and

- An Orthopaedic Primary Hip and Knee Prioritisation Audit was completed where prioritisation outcomes for both public and private referred patients were compared using two different tools (the national tool and a local physio screening tool). The results were then evaluated by a combined DHB/PHO panel which evidenced that the local physio tool provided much improved ability to delineate need and ability to benefit. As a result a decision has been made to implement the physio screening tool for all primary hip and knee patients. Regular ongoing audit will be undertaken including inter-reliability across assessors also being monitored.

Cataract Initiative:

- Volume delivery target exceeded and ESPI compliance achieved with the access threshold for cataract surgery lowered to 25 points;
- Health Services Planning completed for Ophthalmology with the objective of identifying future objectives and challenges for the service;
- Cataract scores can now be applied by GPs, Optometrists and Ophthalmologists;
- 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;
- Initiative 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; and
- New equipment has been introduced to streamline the flow of patients through the pre-admission clinic achieving a reduction in wait-time of ten minutes per patient.

In the coming year we will continue our commitment to the priorities for Elective Services:

Aim	Progress and implement frameworks to achieve sustainable Elective Services management.
Sponsor	GM, Medical and Surgical (HSS) GM, Women's and Children's Health (HSS)
Actions	<p>Implement DAP commitments via the Elective Services Accountability Framework - devolve the objectives, policy, procedure and responsibilities through HSS annual performance management programme.</p> <p>Implement a Monitoring and Reporting Framework - support understanding and compliance at all levels. Meet operational needs and enable early response to fluctuations in demand, changes in referral patterns, capacity and resources:</p> <ul style="list-style-type: none"> ▪ Transaction group will monitor ESPI compliance and take early action to correct any changes required to remain compliant; ▪ Weekly reports available to all services; ▪ Elective Services Manager to be appointed as the key contact for Electives activity; and ▪ Threshold Models to be developed and reporting tools enhanced by the appointment of a dedicated Elective Services Analyst for the DHB. <p>Improve Referral Gateway Management - ensure every service has a single point of entry and that each referral follows an agreed pathway, so that promises made to patients are able to be delivered:</p> <ul style="list-style-type: none"> ▪ Develop new initiatives to increase access for referrals. <p>Capacity Planning and Threshold Modelling - provide the services with the tools to more closely match their promises to patients with their ability to treat them, within the six month timeframe.</p> <p>Improving Prioritisation Practice - focus on aligning priority and treatment decisions. Provide improved tools and reporting at a clinician level, to inform fair and equitable decision making.</p> <p>Increasing Efficiency and Utilisation of Current Resources - Roll out the successful Elective Orthopaedic Nurse Led Admission and Pre Admission models as standards across the DHB, thereby reducing the reliance on RMOs and Specialists:</p> <ul style="list-style-type: none"> ▪ Introduce virtual clinics in Gynaecology that enable access to Consultant advice for GPs, to avoid unnecessary referrals; and ▪ Continue monitoring "did not attend" rates to reduce wastage of clinical time. <p>Improve Data Integrity - improvement programme to ensure accuracy of ESPI data:</p> <ul style="list-style-type: none"> ▪ Undertake Six monthly audits of booking systems; and

	<ul style="list-style-type: none"> ▪ Ensure ongoing training of staff with booking system processes. <p>Shared DHB/PHO approach to Electives Management - work alongside the PHOs to develop centralised systems of referral monitoring and management that will better inform funding decisions and enable GPs to be clinically up skilled in specific areas:</p> <ul style="list-style-type: none"> ▪ Continue to work with primary sector to develop alternative options in the community; and ▪ Continue to improve primary providers access to diagnostics.
Outputs	<ul style="list-style-type: none"> ▪ ESPI compliance maintained. ▪ Tools established to measure production and demand. ▪ Booking systems audits undertaken and completed. ▪ “Did not attend” rates being measured. ▪ Development of a reporting framework overseen.
Measure	The DHB demonstrates continuous quality improvement and achievement of ESPIs (SER 04).

Aim	Implement systems to improve access to elective surgery across all population groups
Sponsor	GM, Medical and Surgical (HSS)
Actions	<p>Implement the Theatre Module of the Improving the Patient Journey Programme:</p> <ul style="list-style-type: none"> ▪ Increased number of acute theatre session to minimise impact on elective throughput; ▪ Increase the utilisation of preadmission clinics and identify patients suitable for 23hr pathway; ▪ Addressing staffing models in theatre; ▪ Measuring time of admission to time to theatre; ▪ Introduce 23hr pathway for selected procedures with nurse led discharges; ▪ Continue to increase day surgery percentages and day of surgery admission percentages; ▪ Increase number of anaesthetic technicians in training; and ▪ Continue to monitor recruitment and retention of skilled theatre staff.
Outputs	<ul style="list-style-type: none"> ▪ There is an increase in the number of acute theatres available. ▪ Theatre Scheduled Sessions are allocated in line with contracted volumes. ▪ Preadmission procedures for all specialties are implemented to increase day of surgery admission and day surgery. ▪ Alternative staff rosters and shifts allocated, where applicable, to maximise theatre availability.

Aim	Achieve consistent prioritisation for patients in all services with a focus on the link between assignment of priority and treatment decisions by clinicians.
Sponsor	GM, Medical and Surgical (HSS)
Actions	<ul style="list-style-type: none"> ▪ Work with surgeons to further delineate patient need and ability to benefit. ▪ Increase the elective surgery throughput with increase in funding. ▪ Identify opportunities for developing a local score tool, where there is no national tool. ▪ Working with primary sector to identify areas of unmet demand. ▪ Transformation group will identify new ways of working including community initiatives.
Outputs	<ul style="list-style-type: none"> ▪ The number of elective theatre sessions is increased. ▪ All areas to have a prioritisation tool in place. ▪ Projects are identified which implement new ways of working.

Aim	Progress and implement the national Orthopaedic initiative within the Canterbury DHB.
Sponsor	GM, Older Persons Health and Rehabilitation (HSS)
Actions	<p>Orthopaedic Volume Delivery:</p> <ul style="list-style-type: none"> ▪ Meet the target intervention rate and develop a plan to sustain this rate; ▪ Ensure additional public sector capacity is maximised; and

	<ul style="list-style-type: none"> ▪ Secure approval to proceed with Stage III Burwood Redevelopment. <p>ESPI Compliance:</p> <ul style="list-style-type: none"> ▪ Maintain ESPI compliance for Orthopaedics; and ▪ Apply the principles of the DHB's Elective Services Accountability Framework to the Orthopaedic Service. <p>Clinical Prioritisation of Patients:</p> <ul style="list-style-type: none"> ▪ Register the Physiotherapy Score Tool as the local tool for all hip and knee replacement patients; and ▪ Achieve consistent prioritisation for non-joint patients with a focus on the link between assignment of priority and treatment decision by clinicians. <p>CQI Productivity and Efficiency Initiatives:</p> <ul style="list-style-type: none"> ▪ Continue the programme to streamline the elective Orthopaedic Patient Journey and ensure an efficient model of care in the new facility.
Outputs	<ul style="list-style-type: none"> ▪ Health Services (Facilities) Planning findings are used to scope public sector capacity requirements and to develop a business case for Stage III Redevelopment at Burwood. ▪ A medium term workforce plan is developed to maximise available electives funding and support new capacity for Orthopaedics in 2008 and beyond. ▪ Roles and responsibilities for maintaining ESPI compliance within Orthopaedics are defined. ▪ Matching priority given to a patient with the order in which patients are treated (at an individual clinician level) becomes an integrated function within the service. ▪ Work continues with surgeons to further delineate patient need and ability to benefit into sub specialty areas, e.g. spine, hand etc. <p>Streamlining Programmes</p> <ul style="list-style-type: none"> ▪ An Orthopaedic DHB/PHO Focus Group is established to improve the understanding of access levels and to develop alternative patient pathways. ▪ An Orthopaedic Theatre Staffing Model is developed with a focus to reduce FTE requirements. ▪ A Consumer Reference Group is established to provide advice on standard messages for patients across the patient continuum. ▪ Outpatient patient flow and staffing schedule is redesigned to reduce patient wait times in clinic.
Measure	<ul style="list-style-type: none"> ▪ A increase in theatre capacity commissioned at Burwood Hospital. ▪ A Single Referral gateway is maintained and enhanced, in conjunction with PHOs. ▪ The matching of promises to capacity for both outpatient and inpatient treatment improves. ▪ Patient wait times in clinics are further reduced.

Aim	Progress and implement the national Cataract Initiative within the Canterbury DHB.
Sponsor	GM, Medical and Surgical (HSS)
Actions	<p>Cataract Volume Delivery:</p> <ul style="list-style-type: none"> ▪ Meet the target intervention rate and develop a plan to sustain that rate; and ▪ Progress the Health Services Plan recommendations for Ophthalmology. <p>ESPI Compliance:</p> <ul style="list-style-type: none"> ▪ Apply the DHB's Elective Services Accountability Framework principles to Ophthalmology. <p>Clinical Prioritisation of Patients:</p> <ul style="list-style-type: none"> ▪ Evidence consistent prioritisation for patients with a focus on the link between assignment of priority and treatment decisions by clinicians. <p>CQI Productivity and Efficiency Initiatives:</p> <ul style="list-style-type: none"> ▪ Focus on streamlining the Cataract patient Journey from referral to discharge; and ▪ Improve capacity within current resources by introducing Nurse Led Preadmission support by the Anaesthetic Service.
Outputs	<ul style="list-style-type: none"> ▪ Interim solutions to current capacity issues are facilitated, while concurrently developing longer term plans for increasing public sector capacity. ▪ Roles and responsibilities for maintaining ESPI compliance within Ophthalmology are defined.

	<ul style="list-style-type: none"> ▪ All referring clinicians are provided with regular information showing scoring patterns. ▪ The links between priority and treatment decision are monitored. ▪ Nurse led initiatives are further developed, under the governance of the ‘Improving the Patient Journey” Nurse Led Pre Admission Framework.
Measure	<ul style="list-style-type: none"> ▪ Detailed scoping and business case for future facility requirements are completed. ▪ Promises continue to be matched to capacity.

7.1.6 Family Violence

Reducing family violence is one of the thirteen health objectives of the NZ Health Strategy. It is a priority of the Minister of Health and is identified in the DHB’s Child Health and Disability Action Plan.

In 1998 the Ministry introduced its national Family Violence Guidelines for Health Sector Providers and national Family Violence Implementation Guidelines in 2002. There are seven principles outlined in the guidelines:

- Health sector providers will develop family violence protocols, procedures and policies to ensure best practice;
- Family violence protocols will be consistent with legislation;
- Health and disability service providers will be appropriately trained to respond to family violence;
- Effective and comprehensive community and hospital based services will be available to family violence victims and abusers;
- The sector will provide a coordinated, culturally effective response to family violence;
- Health and disability services will provide a timely, quality response to family violence; and
- Public health action on preventing and reducing the prevalence of family violence and abuse will be strengthened.

In response to various government reports, past guidelines and good clinical practice the Canterbury DHB already has a number of processes in place within our HSS, particularly in paediatric services, ED and mental health services. Work in line with the national guidelines has also taken place including a early stock-take of the status of Family Violence Guideline Implementation completed in 2001 and some uptake of the Ministry’s ‘train the trainer’ training for a number of HSS paediatric, women’s health, ED and sexual health staff.

However, primarily due to funding limitations, the DHB has taken an evolutionary approach to implementing the Guidelines. Over the coming years we will be establishing a more focused approach this work and the following outlines the beginning of that approach:

Aim	Work to implement the Ministry’s Family Violence Guidelines
Sponsor	Chief Medical Officer
Actions	<ul style="list-style-type: none"> ▪ Identify a Sponsor to lead implementation of the national Family Violence Guidelines. ▪ Consolidate the work completed to date and evaluate opportunities to apply this knowledge across the organisation. ▪ Fast track the development of a DHB Policy on implementing the Family Violence Guidelines across the organisation and external provider networks. ▪ Establish interim process requirements within targeted areas: Paediatrics, Child Health, ED, Sexual Health, Women’s Health and Older Person’s Health. ▪ Identify data and resource requirements to implement the Guidelines (including determining FTE allocations). ▪ Identify public health action already underway and evaluate opportunities to consolidate and support this work in alignment with the principles of the Ministry’s Guidelines. ▪ Seek approval for the DHB Policy and begin implementation.
Outputs	<ul style="list-style-type: none"> ▪ Updated stock take report on the current status of Family Violence protocols across the DHB. ▪ Interim Process requirements developed and implemented in targeted areas. ▪ DHB policy on implementing the national Family Violence Guidelines approved with implementation plan and resource requirements identified.

8 MEASURING SUCCESS

DHBs are expected and required to monitor and report on their performance. The Canterbury DHB meets its obligations in this regard through a number of internal and external reporting methods and structures including:

- Internal reporting on a mix of financial and non-financial performance indicators to the CEO, EMT and General Managers, Quality and Patient Safety Council, Clinical Board and our Board and Statutory Committees;
- Public reporting at our Board and Statutory Committee meetings against a mix of financial and non-financial performance indicators – including the performance goals and targets set in our DSP, SOI and DAP and yearly publishing of our Annual Report which includes an audited report against the performance targets set in our SOI document;
- Active monitoring and assessment of the quality of services provided by our HSS division and external providers; via service agreements. Monitoring includes reporting adverse incidents, routine quality audits, consumer surveys, service reviews and issues-based audits; and
- Existing reporting requirements under service contracts with the Ministry and information requirements contained in the Crown Funding Agreement and Operational Policy Framework such as:
 - Monthly financial reporting to the Ministry's DHB Funding and Performance Directorate;
 - Submitting of ad-hoc service or disease specific reports to the Ministry, such as data relating to elective surgical services and waiting times; and
 - Quarterly performance reporting against national accountability indicators of non-financial performance, Indicators of DHB Performance (IDPs) and national Balanced Scorecard Indicators.

8.1 Monitoring and Reporting Our Performance

The Ministry has established a number of accountability indicators to focus DHBs on priority health objectives, monitor activity, compare DHB performance, and to hold DHBs accountable. Progress toward achieving the targets set for these indicators is reported as part of our quarterly performance reports to the Ministry. Attached to this document (Appendix 4) are the Canterbury DHB's IDPs, primarily focusing on DHB activity in accountability priority areas.

While the IDPs reflect the accountability that we have for improving the health status of our population there are indicators where our ability to influence the outcome is not through direct funding but through influencing other funders or providers and in some cases influencing our community. This differential is reflected by the use of both quantitative and qualitative IDPs where the actions taken by the DHB to influence the direction of performance in relation to some targets is of as much importance as the match between actual performance and the indicator itself.

For each of the quantitative IDPs used, targets have been set for the 2007/08 year. These targets have been based on expectations expressed by the Ministry, the latest national data and the latest Canterbury DHB specific data.

This year the Minister of Health has also introduced national health indicators or 'core health targets' aligned with national priorities. It is anticipated that the development of these national core health targets will increasingly be used to drive performance improvement in the sector, incorporating shared learning and collaboration. The core health targets follow, accompanied by the local targets we have set.

We have endeavoured throughout this document to demonstrate the links between our activity and outcomes measures or targets against which we can evaluate our progress. In developing a set of indicators for our DSP and for our SOI we have used the base indicators used by the Ministry with the addition of indicators specifically relevant to the Canterbury DHB. In this way we can measure our ongoing performance against the sector as a whole.

9 MANAGING FINANCIAL RESOURCES

9.1 Managing Within Our Operating 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 Holiday's 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. The risks associated with these assumptions are set out in Section 5.

9.2 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 as identified in Section 5. 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:

	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	-	-	-

9.3 Asset Planning and Investment

9.3.1 Business Cases

With the need to operate within available funding, service reconfigurations and facility realignments are likely to take place and service reductions may need to be included to ensure breakeven in the outyears. The Canterbury DHB will also review continued ownership of subsidiary and associate companies as appropriate legal structures. The Minister of Health's approval will be obtained in accordance with government guidelines.

The Canterbury DHB has submitted a business case for the building of a Physical Containment Level 3 Laboratory based on a request from the Ministry. In addition, as part of the Ministry's national Oral Health Strategy, we will be submitting a business case requesting an equity injection of \$18.835M and annual operating costs of \$4.555M to improve oral health services in Canterbury for children and adolescents. As these business cases have not been approved, their financial impact has not been included in our forecast.

Business cases relating to information technology and other significant capital projects will include Regional Capital Committee, Ministry and National Capital Committee review and endorsement, where appropriate. Business cases that will be presented in 2007/08 include the replacement of the outdated legacy rostering, payroll, and human resources information system.

9.3.2 Capital Expenditure

The estimated capital expenditure budget for 2007/08 is \$30M and will be primarily 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 referred to previously, 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.

9.4 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.

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 9.83times
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 9.3.2.

9.5 Efficiencies and Service Reconfigurations

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

- Improve chronic conditions and acute demand management and reduce 'avoidable' admissions;

- Improve HSS employee cost control processes, leave management and roster activity and ;
- Continue to implement the Improving the Patient Journey Programme;
- Implement the recommendations of the community laboratory services review;
- Achieve procurement/usage savings on clinical and non-clinical consumables; and
- Improve collaborative arrangements with external providers on elective services delivery.

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

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.

9.6 Forecast Financial Statements - 2007/08 to 2009/10

The accounting policies adopted are consistent with those in the prior year. A full statement of accounting policies is an appendix to the DHB's 2007/10 SOI.

9.6.1 Forecast Group Statement 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	1,023,642	1,110,839	1,156,471	1,177,086	1,206,417
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	953,397	1,039,305	1,078,437	1,097,052	1,124,383
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	(67,384)	(74,034)	(78,034)	(80,034)	(82,034)
Net Operating Results	2,861	(2,500)	0	0	0

9.6.2 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)	-	-	-

9.6.3 Forecast Group Statement 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	480,500	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	(78,850)	(87,850)	(87,850)	(87,850)	(87,850)
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

9.6.4 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

9.6.5 Forecast Group Statement 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	963,919	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	481,946
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	-	-	-
	963,738	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

10 APPENDICES AND REFERENCES

The Canterbury DHB has developed key documents that have been referenced throughout this DAP. These documents can be accessed via the DHB website, www.cdhb.govt.nz, or by contacting the DHB's Planning and Funding Division on (03) 364 4160.

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

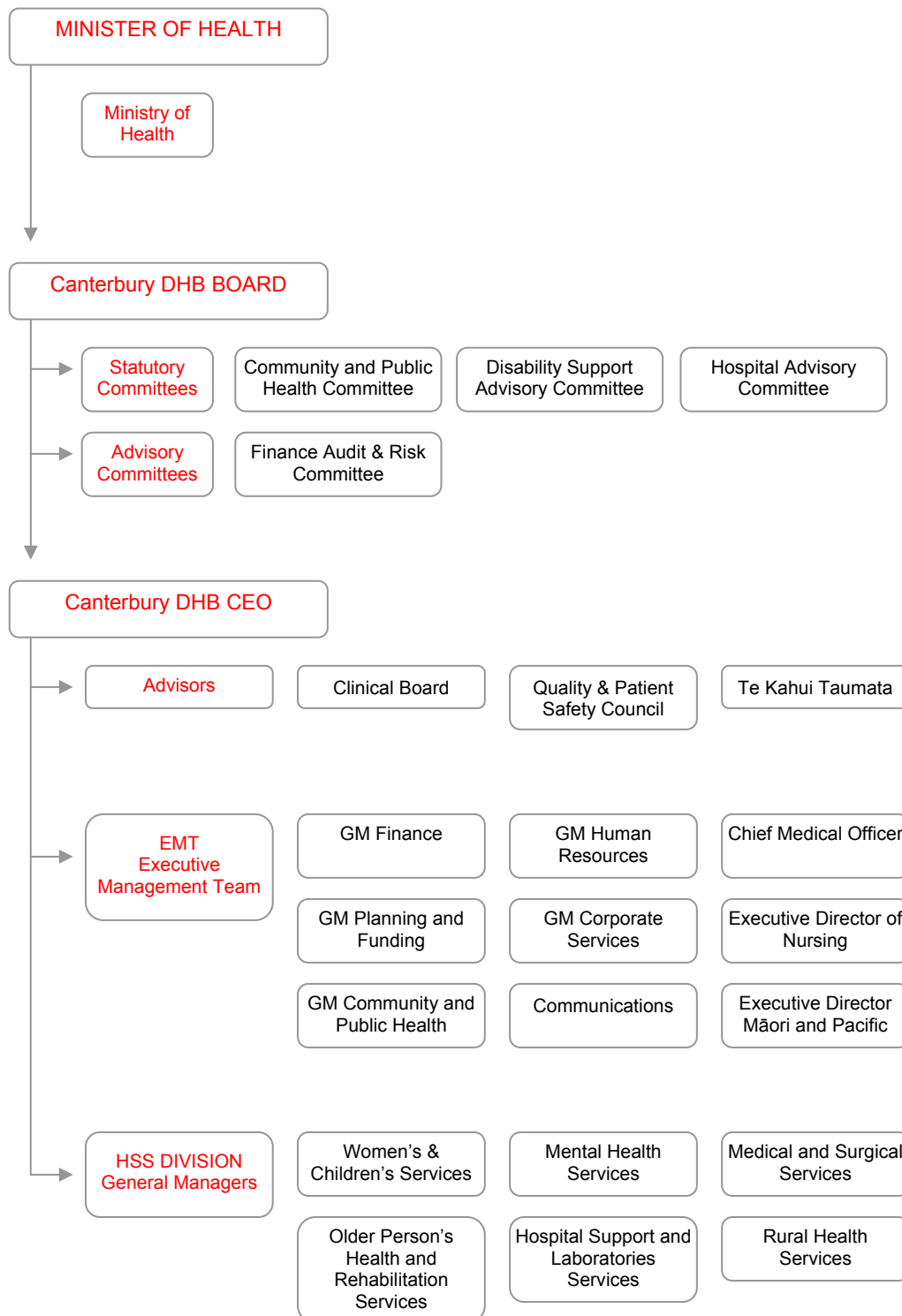
All Ministry documents referenced in this SOI are available on the Ministry's website (www.moh.govt.nz).

Appendices

- Appendix 1. Organisational Chart of the Canterbury DHB.
- Appendix 2. Hospital and Specialist Service Division - Overview of Services.
- Appendix 3. Glossary of Terms.
- Appendix 4. Consolidated List of Indicators of DHB Performance.
- Appendix 5. Diabetes Case Study Value for Money.

Appendix 1.

10.1 Organisational Chart of the Canterbury DHB



Appendix 2.

10.2 Hospital and Specialist Services - Overview of Service Divisions

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 around 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.

10.3 Glossary of Terms

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
	Credentiailling	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. Credentiailling 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 District 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 DSP document identifies 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	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	Key Performance Indicators 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 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.

10.4 Consolidated List of Indicators of DHB Performance

Our IDPs for 2007/08 follow and are in addition to a wider set used by the Ministry within its accountability arrangements with DHBs. These arrangements, as a package, ensure there is public accountability for DHB spending.

IDP CODE	MEASURE AND CANTERBURY DHB TARGETS	REPORTING PERIOD	CDHB PRIORITY
HKO-01 Local Iwi/Maori are engaged and participate in DHB decision-making and the development of strategies and plans for Maori health gain	<ol style="list-style-type: none"> 1. Percentage of PHOs with Maori Health Plans (MHP) agreed to by the DHB Target – 100% 2. Percentage of DHB members that having Treaty of Waitangi training Target – 100% 3. Report on achievements against the Memorandum of Understanding (MoU) between a DHB and its local Iwi/Maori relationship partner, and describe other initiatives achieved that are an outcome of engagement between the parties. Provide a copy of the MoU. 4. Report on how (mechanisms/frequency of engagement) local Iwi/Maori are supported by the DHB to participate in the development and implementation of the strategic agenda, service delivery planning, development, monitoring, and evaluation (include a section on PHOs). 5. Report on how MHPs are being implemented by PHOs and monitored by the DHB (include the names of the PHOs with MHPs) OR for newly established PHOs, a report on progress in the development of MHPs (include the names of these PHOs). 6. Describe when Treaty of Waitangi training (including facilitated by the MoH) has, or will, take place for Board members. 7. Identify at least two key milestones from your MHP to be achieved in 2007/08. For reporting in Q2, provide a progress report on the milestones, and for reporting in Q4, provide a report against achievement of those milestones. 	Six-monthly in the second and fourth quarter.	Maori Health
HKO-02 Development of Maori health workforce and Maori health providers	<p>Report the number of (i) management (ii) clinical (iii) administrative and (iv) other FTEs held by Maori out of the total numbers of (i) management, (ii) clinical, (iii) administrative and (iv) other FTEs in the DHB respectively. Target - The number of Maori people employed by the CDHB moves closer to the % of Maori people in the Canterbury population.</p> <p>Provide a copy of the DHB Maori Health Workforce Plan (or regional Maori Workforce Plan), or timeframe for completion.</p> <p>Report on achievements based on key deliverables in the DHB (or Regional) Maori Workforce Plan, or if the Plan is being developed, describe at least two key DHB Maori health workforce initiatives that the DHB has achieved.</p>	Six-monthly in the second and fourth quarters	Maori Health
HKO-03 Improving mainstream effectiveness	<p>A report describing the reviews of pathways of care that have been undertaken in the last 12 months that focused on improving Health outcomes and reducing health inequalities for Maori. Report on an example(s) of actions taken to address issues identified in the reviews.</p>	Six monthly, in the second and fourth quarters	Maori Health
HKO-04 DHBs will set targets to increase funding for Maori Health and disability initiatives	<p>Report actual expenditure on Maori Health Providers by GL code.</p> <p>Report actual expenditure for Specific Maori Services provided within mainstream services targeted to improving Maori health by Purchase Unit (PU).</p> <p>Report total actual expenditure for Iwi/Maori-led PHOs.</p> <p>Report actual expenditure for mainstream PHO services targeted at improving Maori health.</p>	Annual reports to the MoH in quarter four (not part of the monthly financial reporting template).	Maori Health
PAC-01 Pacific peoples	<p>Percentage of DHB strategies and plans on which Pacific communities or representatives were consulted. Target - 50%</p>	Six monthly in the second and fourth	Improving the Health of Our Community

are engaged and participate in DHB decision-making and the development of strategies and plans for Pacific health gain	<p>Percentage of DHB working groups and steering groups that included representation from Pacific communities. Target - 50%</p> <p>Report the number of (i) management (ii) clinical (iii) administrative and (iv) other FTEs held by Pacific peoples out of the total numbers of (i) management (ii) clinical (iii) administrative and (iv) other FTEs respectively in the DHB. Target - The number of Pacific people employed by the CDHB moves closer to the % of Pacific people in the population serviced by the DHB.</p> <p>Provide a report describing how Pacific peoples have been involved in the development of strategic planning at different levels (eg, steering group, consultation fono, service delivery by Pacific health service providers, or Pacific DHB staff members).</p>	quarter.	
POP-01 Diabetes – supportive environments.	Report on the number and type of agencies, organisations, and providers that have an influence on the environment, and the type of programmes and initiatives that are planned or underway, together with any evaluations and monitoring of implementation (for improving nutrition, physical activity and reducing obesity).	Annually in the third quarter.	Disease Prevention Management
POP-01 Diabetes follow-up	The number of unique individuals with type I or type II diabetes on a diabetes register, whose date of their free annual check is during the reporting period (broken down into Maori, Pacific, and Other ethnic groups) as a % of the expected number of unique individuals to have type I or type II diabetes, as at the end of the reporting period. Target – Maori >42%, Pacific >81%, Other >64%, Total >64%	Annually in the third quarter.	Diabetes
POP-01 Diabetes – Diabetic Retinopathy Screening	The number of people with type I or type II diabetes on the register that have had retinal screening or an ophthalmologist examination in the last two years, and the date of the free annual check is during the reporting period (broken down into Maori, Pacific, and Other ethnic groups) as a % of the total number of people with type I or type II diabetes on the register whose date of their free annual check is during the reporting period. Target – Maori 54%, Pacific 57%, Other 61%, Total 60%	Annually in the third quarter.	Diabetes
POP-01 Diabetes – Diabetes Management	The number of people with type I or type II diabetes on a diabetes register that had an HBA1c of equal to or less than 8% at their free annual check during the reporting period (broken down into Maori, Pacific, and Other ethnic groups) as a percentage of the total number of people with type I or type II diabetes on the diabetes register whose date of their free annual check is during the reporting period. Target – Maori 70%, Pacific 53%, Other 79%, Total 78%	Annually in the third quarter.	Diabetes
POP-02 Cardiovascular disease - Risk recognition	The number of people in each target group who have had their five-year absolute CVD risk recorded in the last five years as a % of the total number of people in each target group. Target groups: Maori/Pacific & Indian subcontinent men >35 years, women >45 years of age NZ European & other men >45 years of age, women >55 years of age. Target – The DHB is not currently able to measure this indicator through PHO Performance Monitoring.	Annually in the third quarter.	Cardiovascular Disease
POP-02 CVD Risk Management Statins	The number persons where CVD risk is greater than or equal to 15% where statins have been prescribed in the past year (broken down into Maori, Pacific, and Other ethnic groups) as a % of the total number of persons where CVD risk is greater to or equal to 15 %. Target – The DHB is not currently able to measure this indicator through PHO Performance Monitoring.	Annually in the third quarter.	Cardiovascular Disease
POP-02 Cardiovascular Rehabilitation Programme	The number of people who have suffered Acute Coronary Syndrome who attend a cardiac rehabilitation outpatient programme (broken down into Maori, Pacific, and Other ethnic groups) as a % of the total number of people who have suffered Acute Coronary Syndrome who were admitted and discharged from hospital. Target – The DHB's target to establish a baseline and target for this indicator.	Annually in the third quarter.	Cardiovascular Disease
POP-03 Stroke Organised	The number of people who have suffered a stroke event, who have been admitted to organised stroke services and remain there for their entire hospital stay (broken down into Maori, Pacific, and Other ethnic groups) as a % of the total number of people who have suffered a stroke event .	Annually in the third quarter.	Cardiovascular Disease

Stroke Services	Target – The DHB’s target to establish a baseline and target for this indicator.		
POP-04 Oral health - Mean DMFT score at year eight	The total number of permanent teeth of Year eight children, Decayed, Missing (due to caries), or Filled at the commencement of dental care, at the last dental examination, before the child leaves the DHB SDS against the total number of children, who have been examined in the Year eight group, in that year. The data must be broken down by: ethnic group, fluoridation status (of school area the child attends) and mean components of DMF index. Target - Maori Pacific Other Total 2.30-2.82 2.30-2.82 1.46 1.6	Annually in quarter three for the period 1 January to 31 December 2007.	Child and Youth Health
POP-05 Oral health - Percentage of children caries free at age five years	The total number of caries free children at the first examination after the child has turned five years, but before their sixth birthday, examined by the DHB SDS against the total number of children who have been examined in the age five group, in the year to which the reporting relates. The data must be broken down by: ethnic group, fluoridation status (of school area the child attends) and mean components of DMF index. Target - Maori Pacific Other Total 19-39% 16-36% 60% 51%	Annually in quarter three for the period 1 January to 31 December 2007.	Child and Youth Health
POP-06 Improving the health status of people with severe mental illness	The average number of people domiciled in the DHB region, seen per year rolling every three months being reported (the period is lagged by three months) against the projected population of the DHB region: The data must be broken down by age and ethnicity for the following groupings: child and youth aged 0-19, adults aged 20-64, people aged 65+. Target - Maori Other Total 0-19 2 2 2 20-64 2.5 2.5 2.5 65+ - (no targets as service historically funded by DSS)	Quarterly for the period to end of previous quarter.	Mental Health
POP-07 Alcohol and other drug service waiting times	DHBs will report their longest waiting time, in days, for each service type for one month prior to the reporting period. Waiting times are measured from the time of referral for treatment to the date the client is admitted to treatment, following assessment. Whilst assessment and motivational or pre-modality interventions may be therapeutic, they are not considered to be treatment. If a client is engaged in these processes, they are considered to be still waiting for treatment.	Measured, for one month, every three months. Reports due: Every quarter.	Mental Health
POP-08 Progress towards 95% of two year olds fully immunised	1. DHBs should provide qualitative information about the DHB strategies to progress towards the national immunisation target, including information on improving Maori and Pacific childhood immunisation coverage rates. A) DHB NIR Enrolled Populations 2. Number of newborns born and enrolled during the reporting period as a % of the number of children born during the same period. Target - 95% 3. Number of newborns born during reporting period of each ethnicity as a % of the number of children born and enrolled during reporting period of each ethnicity. Target – Ethnicity not currently reliably identified 4. Number of newborns born and enrolled during reporting period of each level of deprivation as a % of the number of children born during reporting period of each level of deprivation. Target – Deprivation not currently reliably identified 5. Number of children on the NIR less than two years of age with an ‘Opt-Off’ status as at the report date as a % of the number of children less than two years of age on the NIR as at that date. Target – 2% B) Progress towards the health target of 95% of two year olds fully immunised NIR Immunisation coverage at 6, 12, 18 and 24 months of age - for each of these reporting periods, coverage will be reported for each of the following	The indicator will be measured quarterly and annually.	Child and Youth Health

	<p>birth cohorts: those who turned 6mths, 12mths, 18mths and 24mths of age during report period.</p> <p>6. Number of children on the NIR up-to-date with immunisation on the day they turned (6, 12, 18, 24 months) during the reporting period as a % of the total number of children on the NIR who turned a specified age during the period. Target – 6&12 months 88-92%, 18&24 months 85-88%</p> <p>7. Number of children on NIR of each ethnicity up to date with immunisation on the day they turned (6, 12, 18, 24 months) during the reporting period as a % of the number of children on NIR of each ethnicity who turned that age during the period. Target – Ethnicity not currently reliably identified</p> <p>8. Number of children on NIR at each deprivation level up-to-date with immunisation on the day they turned (6, 12, 18, 24 months) during the reporting period as a % of the number of children on the NIR of each level of deprivation who turned that age during the reporting period. Target – Deprivation not currently reliably identified</p> <p>9. Number of children on the NIR up-to-date with MMR immunisation on the day they turned 18 months during the reporting period as a % of the number of children on the NIR who turned 18 months during the reporting period. Target – 85-88%</p>																		
<p>POP-09</p> <p>Reduce ambulatory sensitive admissions</p>	<p>The observed number of hospital discharges, considered being ambulatory sensitive, as they result from diseases and conditions sensitive to prophylactic or therapeutic interventions deliverable through primary care and are, therefore, avoidable as a ratio of the expected (ethnic level) number of ambulatory sensitive hospital admission as derived from national intervention levels.</p> <p>Targets must be presented in the following age bands: <5, 45-64, 0-74. Target – Observed to Expected (ethnic level) Ratio</p> <table border="1"> <thead> <tr> <th>Ethnicity</th> <th>0-4years</th> <th>45-64years</th> <th>0-74years</th> </tr> </thead> <tbody> <tr> <td>Maori</td> <td>≤1</td> <td><1</td> <td><1</td> </tr> <tr> <td>Pacific</td> <td>≤1</td> <td>≤1</td> <td>≤1</td> </tr> <tr> <td>Other</td> <td>≤1.312</td> <td>≤1</td> <td>≤1.071</td> </tr> </tbody> </table> <p>Note: Measured at 99% confidence level. 0-4yrs: Remaining at or below national level for Maori & Pacific and reducing to 31.2% above the national average for Other. 45-64yrs: Remaining below national level for Maori, and at or below national level for Pacific and Other. 0-74yrs: Remaining below national level for Maori, remaining at or below national level for Pacific and reducing to 7.1% above the national average for Other.</p>	Ethnicity	0-4years	45-64years	0-74years	Maori	≤1	<1	<1	Pacific	≤1	≤1	≤1	Other	≤1.312	≤1	≤1.071	<p>Six-monthly in the second and fourth quarters. Results based on most complete previous 12 months' data</p>	<p>Primary Care</p>
Ethnicity	0-4years	45-64years	0-74years																
Maori	≤1	<1	<1																
Pacific	≤1	≤1	≤1																
Other	≤1.312	≤1	≤1.071																
<p>POP-10</p> <p>Reduced radiation oncology and chemotherapy treatment waiting times</p>	<p>M1 - Monthly templates that measure the interval between the patient's referral from a medical practitioner to the oncology department, and the beginning of radiation/chemotherapy treatment, are supplied on time and complete from each DHB (or from cancer centre for contributing DHBs as agreed). (Including information by DHB of domicile and ethnicity.)</p> <p>M2 - A report updating on progress towards ensuring all patients receive oncology megavoltage radiation treatment, and chemotherapy treatment, according to nationally agreed standards. This report is to be agreed with all the peripheral DHBs whose populations have used the service during the quarter.</p> <p>In Q4 include information that demonstrates the centre has undertaken a data audit of waiting time data, and is satisfied high quality data is being provided. Target - No patients wait more than 8 weeks for Radiation Therapy.</p>	<p>M 1— Monthly. M 2— Quarterly.</p>	<p>Cancer</p>																
<p>POP-11</p> <p>Oral Health – Utilisation of DHB funded dental services by adolescents</p>	<p>The total number of completions and non-completions under the Combined Dental Agreement for adolescent patients plus additional adolescent examinations with other DHB funded dental services (eg SDS, Maori Health providers and other contracted providers) as a % of the cohort (provided by the MoH). Broken down by ethnic group (Maori, Pacific, Other). Target – 74.2%.</p>	<p>Annually in quarter three for the period 1 January to 31 December 2006.</p>	<p>Child and Youth Health</p>																

Risk Reduction – Smoking	The number of enrolled persons aged over 14 years with smoking status on record (by Maori, Pacific, and Other) as a % of the total number of enrolled persons over 14. Target – The DHB is not currently able to measure this indicator through PHO Performance Monitoring.	Annually in the third quarter.	Disease Prevention Management
QUA 02 Improving results for People with enduring severe mental illness	Report the number of adults (20–64 years) with enduring serious mental illness (two years or more in treatment since first contact with any mental health service (in treatment = at least one provider arm contact every three months for two years or more.) Report the number of long-term clients with up to date crisis prevention plans (NMHSS criteria 16.4), and describe how this is assured. Target - 95% of long-term clients have up to date plans. Number (and %) of long-term clients in full-time work (>30 hrs). Number (and %) of long-term clients with no paid work. Number (and %) of long-term clients undertaking education. Target – The DHB currently only records this information for a specific groups of clients participating in the Knowing the People Project.	Annual in 2nd quarter.	Mental Health
QUA-01 Quality Systems	The DHB provider arm demonstrates an organisational wide commitment to quality improvement and effective clinical audit by reporting a list of key quality improvement and clinical audit initiatives and results aligned to the Goals in <i>Improving Quality (IQ): A Systems Approach for the NZ Health and Disability Sector (2003)</i> . Using the reporting template provided by the MoH describe improvement initiatives and the effectiveness of those initiatives – in the following categories: 1. There are more effective service outcomes for Maori by acknowledging the special relationship between Maori and the Crown under the Treaty of Waitangi, and applying the principles of participation, partnership and protection. 2. There is a shared vision towards safe and quality care that is engendered through committed leadership at all levels, which supports constant maintenance and improvement in service quality, and takes into account Maori aspirations and priorities. 3. People are encouraged and supported to participate in the planning, delivery, and assessment of health and disability services and programmes, including active participation of Maori. 4. There is widespread awareness, understanding, and commitment to a quality improvement culture at all levels of the organisation. 5. There is evolutionary redesign of systems of care to support delivery of quality services. 6. Unexpected adverse outcomes are managed in an open and supportive manner that builds trust and confidence in the organisation, and is fair to all participants. 7. There is effective, open communication, co-ordination and integration of service activity recognising the value of teamwork. 8. There is a supportive and motivating environment that provides the workforce with appropriate tools, including cultural competency tools, for continuous learning and ongoing improvement in planning, delivery and assessment of health and disability services. 9. Useful knowledge and information, including Maori satisfaction information and clinical evidence, is readily available and shared to support a quality-conscious culture. 10. Regulatory protections that assure safe care are in place to support people and service providers. 11. There are more effective service outcomes for Pacific people, to address the current situation where Pacific peoples have generally worse health than that of the total population.	Annual in the third quarter.	Quality and Patient Safety
QUA-03 Improving the quality of data provided to National Collections	1. National Health Index (NHI) duplications – The number of NHI duplicates that require merging by NZHIS per DHB per quarter and a % of the total number of NHI records created per DHB per quarter. 2. Non-specific NHI Ethnicity – The total number of NHI records created with ethnicity status of 'Not Stated' or 'Other' per DHB per quarter as a % of the total number of NHI records created per DHB per quarter.	NZHIS will report to DHBs on the outlined measures quarterly	Infrastructure

Systems (NCS)	<p>3. Standard versus specific descriptors in the National Minimum Data Set (NMDS) – The number of versions of text descriptor per code per DHB as a % of the total number of codes per DHB.</p> <p>4. Error Diagnostic Related Group (DRG) – The number of discharge events with an error DRG as a % of the total number of NMDS events for patient discharges per DHB per quarter.</p> <p>5. The number of MHINC records able to be successfully loaded into the MHINC per DHB per quarter as a % of the total number of MHINC records submitted to NZHIS per DHB per quarter.</p>		
RIS-01 Service Coverage	A report providing information on progress achieved during the quarter towards resolution of gaps in service coverage identified in the DAP, and not approved as long term exceptions, and any other gaps in service coverage identified by the DHB or Ministry through: analysis of explanatory indicators, media reporting, risk reporting, formal audit outcomes, complaints mechanisms and sector intelligence.	Quarterly.	Better Ways of Working
SER-01 Accessible appropriate services	The age-standardised rate of General Practitioner consultations per high need person to the age-standardised rate of General Practitioner consultations per non-high need person. Target – 1.2 to 1	Quarterly.	Primary Care
SER-02 Care Plus Enrolled Population	The number of each PHOs Care Plus enrolled population (broken down into Maori, Pacific peoples, and Other ethnic groups) as a % of each PHOs expected Care Plus enrolled population. Target – 80%	PHOs report Care Plus data quarterly.	Primary Care
SER-03 The proportion of laboratory test and pharmaceutical transactions with a valid National Health Index	<p>Pharmaceuticals: the number of government subsidised community pharmaceutical items dispensed by pharmacies in the DHB district with a valid NHI submitted as a % of the total number of government subsidised community pharmaceutical items dispensed by pharmacies in the DHB district. Target – 95%</p> <p>Laboratory tests: The number of tests carried out by community laboratories in the DHB district with a valid NHI submitted. As a % of the total number of tests carried out by community laboratories in the DHB district. Target – 95%</p>	Quarterly.	Primary Care
SER-04 Continuous Quality Improvement and Improving Elective Services	<p>Standardised Discharge Ratios (SDR) for 11 elective procedures as published on the Ministry website each quarter (excluding hip and knee replacements, and cataracts covered by separate initiatives). Target – SDRs of 0.95 or above for the 11 procedures.</p> <p>A report demonstrating for any SDR that is more than 5% below the national average of one, i.e. a rate of less than 0.95, what analysis the DHB has done to review the appropriateness of its rate OR the reason that the DHB considers the rate to be appropriate for its population, or an action plan as to how it will address its relative under delivery of that procedure.</p>	Six-monthly, based on second and fourth quarter results.	Elective Services
SER-07 Low or reduced cost access to first level primary care services	<p>Report the number of fee increases that are above the annual statement of a reasonable standard GP fee increase that have been referred to a regional fee review committee and the number of practices who comply with the recommendations of the regional fee review committee, and in all cases where practices fail to comply the DHB applies appropriate sanctions. Target - 100%.</p> <p>The number of PHO practices ensure public access to local information on the fees PHO practices are charging patients. Target - 100%.</p> <p>The number of PHO practices that demonstrate that all increased subsidies translate into low or reduced cost access for eligible patients as a % of the number of PHO practices in a DHB region. Target - 100%.</p>	Quarterly.	Primary Care

10.5 Diabetes Case Study – Value for Money

DRAFT SCORECARD

CONSUMER/DHB POPULATION					FINANCIAL
Diabetes Case Detection²⁷					Diabetes Education, Detection and Management <i>Primary Care</i> Annual Reviews \$480,000 Community Nursing \$89,760 Mobile Nursing \$146,000 Local Diabetes Team Support \$30,600 <i>Secondary Care</i> First Specialist Assessments \$228,690 Follow-Up Assessments \$606,034 Education and Management \$563,534 Diabetes Support (high risk type 1) \$18,403 Maori Diabetes Programme \$50,278 Nurse Clinics \$1,044,415
	2003	2004	2005	2006	
Maori			24%	32%	
Pacific			51%	82%	
Other			52%	61%	
Total	53%	53%	49%	59%	
Diabetes Case Management²⁸					
Maori	58%	60%	66%	70%	
Pacific	51%	48%	48%	52%	
Other	75%	76%	79%	78%	
Total	74%	74%	78%	77%	
Diabetes Retinal Screening²⁹					
Maori	72%	41%	57%	44%	
Pacific	30%	37%	74%	47%	
Other	45%	48%	73%	56%	
Total	45%	48%	72%	55%	
INTERNAL PROCESSES					LEARNING/INNOVATION
Total Annual Reviews (2005)			6052		<ul style="list-style-type: none"> ▪ Support the implementation of HEHA and HEAL to improve lifestyles and reduce risk behaviours. ▪ Support the development of a DHB Health Service Plan and a framework for the management of chronic conditions ▪ Support PHOs to provide health promotion in physical activity, nutrition and smoking cessation and to increase diabetes awareness amongst their enrolled populations. ▪ Scope and develop an opportunistic screening programme in the community to increase diagnosis of diabetes and target the programme at high risk groups. ▪ Ensure annual review data is collected for regional/national databases and improve the process for collecting/reviewing this information. ▪ Develop a Diabetes Lifestyle Programme for people newly diagnosed with diabetes to provide self-management skills. ▪ Work with community podiatry services on providing access to foot care assessments and treatments for those with uncomplicated high risk feet and providing education on foot care. ▪ Undertake a review of diabetes services in Canterbury to assess effectiveness of services over time and improve the setting of targets for achievement in out-years.
Total HBA1c <=8 (2005)			1378 (78%)		
Inpatients admitted with a diabetes code in primary or secondary diagnosis.					
			2005/06		
Rate of admissions due to short-term diabetes complications per 1000 population (aged 19+).			0.24		
Rate of lower extremity amputations due to diabetes complications per 1000 population (aged 19+).			0.23		
End Stage Renal Failure due to complications of diabetes.			TBC		

²⁷ Case Detection – % of people who have an annual review of the total expected number of diabetics in the population according to the Ministry's Diabetes Model.

²⁸ Case Management – % who have an annual review who have good diabetes management (i.e. an HBA1c <= 8).

²⁹ Retinal Screening – % who have had an annual review and who have had retinal screening in the last two years.