South Canterbury
District Health Board

The South Canterbury District Health Board

Statement of Performance Expectations

2014-2015

Enhancing the health and independence of the people of South Canterbury

www.scdhb.health.nz

1.0 INTRODUCTION

DHBs are expected to deliver against the national health sector outcomes: "*All New Zealanders lead longer, healthier and more independent lives*" and '*The health system is cost effective and supports a productive economy*' and to meet Government commitments to deliver '*better, sooner, more convenient health services*'.

Each District health Board (DHB) has a statutory responsibility to prepare a Statement of Performance Expectations under the Section 149c of the Crown Entities Act 2004, as amended by the Crown Entities Amendment Act 2013, providing financial accountability to Parliament and the public annually.

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

South Island DHBs have identified four collective outcomes where individual DHB performance will contribute to regional success - along with a core set of associated outcomes indicators, which will demonstrate whether they are making a positive change in the health of their populations. These are long-term outcome indicators (5-10 years in the life of the health system) and as such, the aim is for a measurable change in health status over time, rather than a fixed target. Detail relating to these long term indicators can be found in the South Canterbury District Health Board's Statement of Intent for 2014 – 2018.

Each of the South Island DHBs has also identified a set of associated medium-term (3-5 years) indicators of performance. Because change will be evident over a shorter period of time, these impact measures have been identified as the 'headline' or 'main' measures of performance and each DHB has set local targets in their Annual Plans to evaluate their performance during 2014 - 2015.

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

South Canterbury is pleased to produce its Statement of Performance Expectations for the 2014 – 2015 year and will report its performance against the measures contained in this document in its Annual Report for 2014.

Signatories

DATED THIS DAY OF 2014

(Made under sections 138, 139, 141, 144 and 146-149 of the Crown Entities Amendment Act 2013).

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Murray Cleverley
Chairman of the Board

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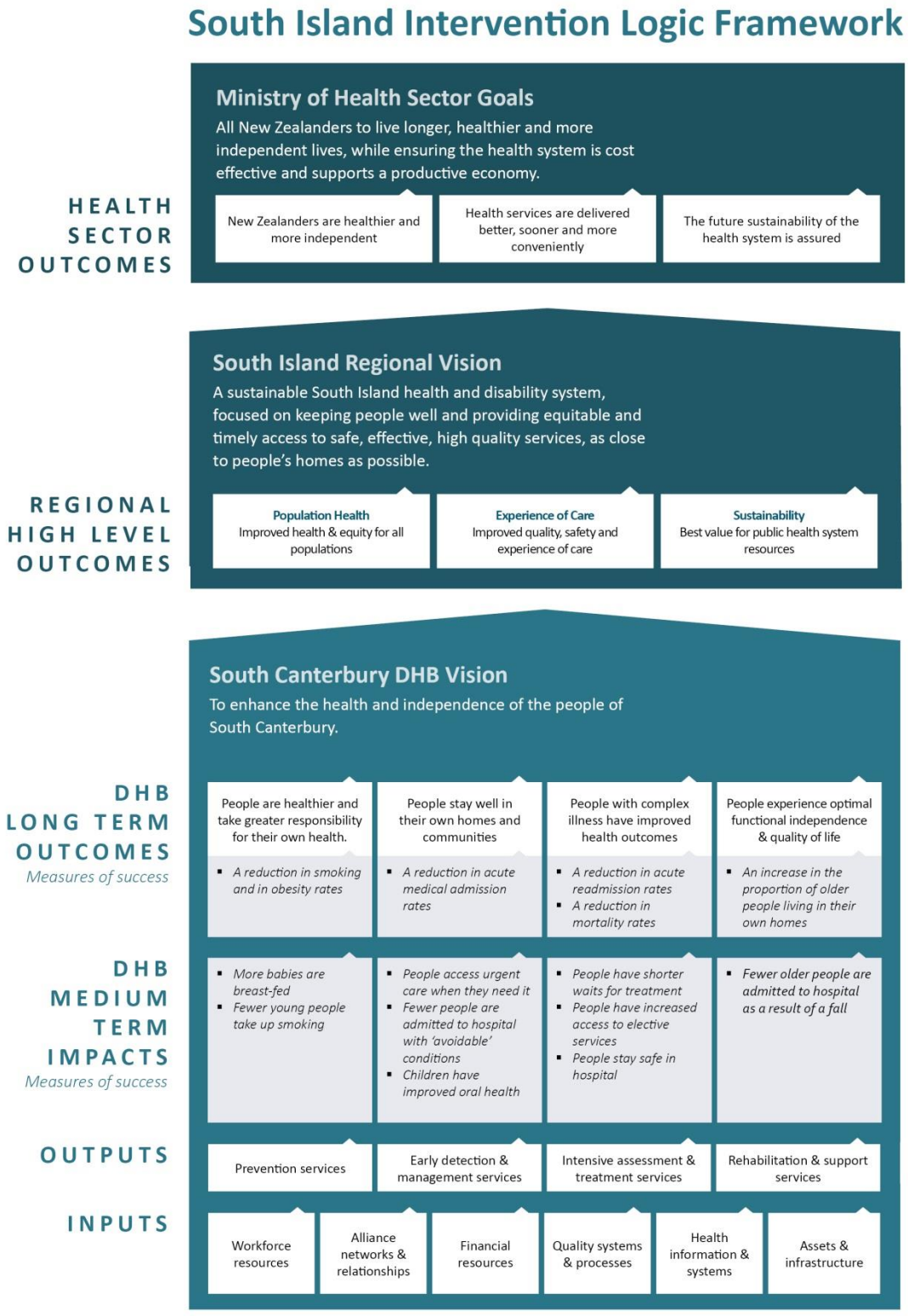
Ron Luxton
Deputy Chairman of the Board

Figure 1: South Island Intervention Logic Diagram



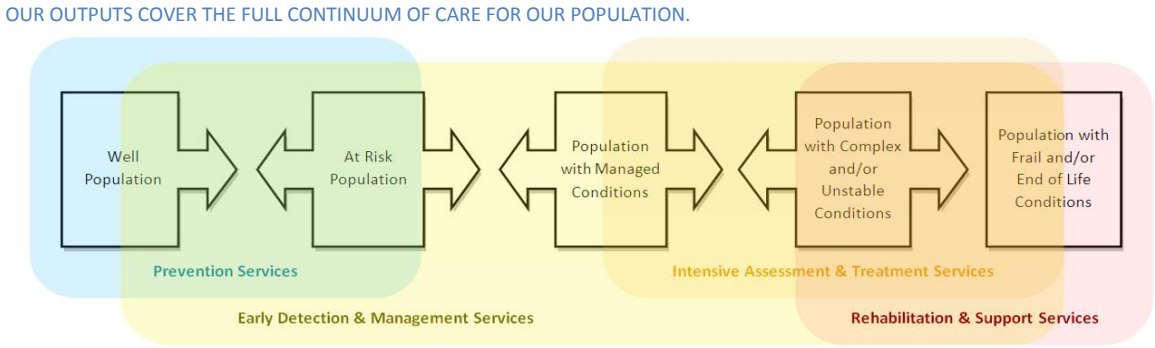
2.0 STATEMENT OF PERFORMANCE EXPECTATIONS

2.1 How will we measure our performance?

Over the long term, we aim to make positive changes in the health status of our population. As the major funder and provider of health and disability services in South Canterbury, the decisions we make about which services will be delivered have a significant impact on our population and, if coordinated and planned well, will improve the efficiency and effectiveness of the whole South Canterbury health system.

Understanding the dynamics of our population and the drivers of demand is fundamental when determining which services to fund for our population and at which level. Just as fundamental is our ability to assess whether the services we are purchasing and providing are making a measurable difference in the health and wellbeing of our population.

Figure 2: Scope of DHB operations – output classes against the continuum of care.



One of the functions of this document is to demonstrate how we will evaluate the effectiveness of the decisions we make on behalf of our population. Over the longer term we do this by measuring our performance against a set of desired outcomes which are outlined in our Statement of Intent 2014 – 2018 which should be read in conjunction with this document and highlighted in the intervention logic diagram contained in the introduction.

In the more immediate term, we evaluate our performance by providing a forecast of our planned outputs (what services we will fund and provide in the coming year). We then report actual performance against this forecast in our end of year Annual Report.[1]

In order to present a representative picture of performance, outputs have been grouped into four *'output classes'* ; Prevention Services; Early Detection and Management; Intensive Assessment and Treatment Services; and Rehabilitation and Support Services that are a logical fit with the stages of the continuum of care and are applicable to all DHBs.

Identifying a set of appropriate measures for each class is difficult. We cannot simply measure *'volumes'*. The number of services delivered or the number of people who receive a service is often less important than whether *'the right person'* or *'enough'* of the right people received the service, and whether the service was delivered *'at the right time'*.

In order to best demonstrate this we have chosen to present our forecast of service performance expectations using a mix of measures which focus on four key elements of performance:

- Quantity (V) – to demonstrate volumes of services delivered;
- Quality (Q) – to demonstrate safety, effectiveness and acceptability;
- Timeliness (T) – to demonstrate responsive access to services; and
- Coverage (C) – to demonstrate the scope and scale of services provided.

All of these help us to evaluate different aspects of our performance and against which we have set targets to demonstrate the standard expected.

[1] *SCDHB Annual Reports can be found at www.scdhb.health.nz*

The output measures chosen cover the activities with the potential to make the greatest contribution to the wellbeing of our population in the shorter term and to the health outcomes we are seeking over the longer term. They also cover areas where we are developing new services and expect to see a change in activity levels or settings in the coming year – and therefore reflect a reasonable picture of activity across the whole of the South Canterbury health system.

To ensure the quality of services provided, the DHB invests in programmes that are evidence-based or evidence-informed where research shows definite gains and positive outcomes such as Green Prescription, ABC smoking cessation, and InterRAI assessments. This provides the DHB with greater assurance that these are 'the right services', allowing us to focus on monitoring implementation and whether the right people have access at the right time and in the right place.

Setting targets

Wherever possible, we have included baseline data to support evaluation of our performance at the end of the year, and the most recently published national averages to give context in terms of what we are trying to achieve.

In setting performance targets, we have considered the changing demographics of our population, increasing demand for health services and the assumption that funding will be limited. Targets tend to reflect the objective of maintaining performance levels against increasing demand growth by reducing waiting times and delays in treatment to demonstrate increased productivity and capacity.

Targets that demonstrate growth in service activity or the establishment of new services tend to be based in primary and community settings (closer to people's own homes) and are set against programmes that will support people to stay well and reduce demand for hospital and residential care.

Our targets also reflect our commitment to reducing inequalities between population groups, and hence some measures appropriately reflect a specific focus on high needs groups.

Some selected measures are new and as such have no baseline data. A number of the output measures also relate to South Canterbury specific services for which there is no national comparison or national average available. It is also important to note a significant proportion of the services funded/provided by the DHB are driven by demand. Estimated service volumes have been provided to give the reader context in terms of the use of resource and capacity across the South Canterbury system, however these estimated volumes are not seen as targets and are not set as such. They are provided for information to give context to the picture of performance. Some data is provided to the DHB by external parties and is provided by calendar and not financial year, where this occurs this has been noted.

Where does the money go?

The table at Page 24 provides a summary of the 2014/15 budgeted financial expectations by output class.

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

Output Class

2.2 Prevention Services

Output class description

Preventative health services promote and protect the health of the whole population, or identifiable sub-populations, and address individual behaviours by targeting population-wide changes to physical and social environments that engage, influence and support people to make healthier choices. These services include education programmes and services to raise awareness of risk behaviours and healthy choices, the use of legislation and policy to protect the public from toxic environmental risks and communicable diseases, and individual health protection services such as immunisation and screening programmes that support early intervention to modify lifestyles and maintain good health.

These services are the domain of many organisations across the region including: the Ministry of Health; Community and Public Health (the public health unit of Canterbury DHB which provides services for the South Canterbury region); primary care and general practice; a significant array of private and non-government organisations; and local and regional government. Services are provided with a mix of public and private funding.

Why is this output class significant for the DHB?

By improving environments and raising awareness, these services support people to make healthier choices, reducing the major risk factors that contribute to long-term conditions and delaying or reducing the impact of these conditions. Services are often designed to disseminate consistent messages to large numbers of people and can be cost-effective. High need and at-risk population groups are also more likely to engage in risky behaviours and to live in environments less conducive to making healthier choices. Prevention services are therefore also our foremost opportunity to target improvements in the health of high need populations and to reduce inequalities in health status and health outcomes.

Successful provision of these services will reduce risk factors such as smoking and improve positive behaviours such as breastfeeding, healthier diets and regular exercise – which will improve the overall health and wellbeing of our population. The effect of these outputs is demonstrated in the following medium term impacts.

IMPACT MEASURES MEDIUM TERM (3-5 YRS)

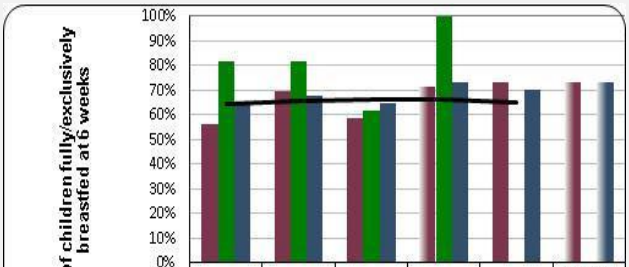
Over the next three years, we seek to make a positive impact on the health and wellbeing of the South Canterbury population and contribute to achieving the longer-term outcomes we seek. The following headlines indicators will be used to evaluate the effectiveness and quality of the services the DHB funds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

More babies are breastfed.

- *Breastfeeding helps lay the foundations for a healthy life, contributing positively to infant health and wellbeing and potentially reducing the likelihood of obesity later in life. Breastfeeding also contributes to the wider wellbeing of mothers.*
- *Although breastfeeding is natural, it sometimes doesn't come naturally, so it's important that mothers have access to appropriate support and advice.*
- *An increase in breastfeeding rates is seen as a proxy measure of successful health promotion and engagement, access to support services and a change in social and environmental factors that influence behaviour and support healthier lifestyles.*

Data sourced from Plunket via the Ministry of Health.[2]

The percentage of babies fully/exclusively breastfed at 6 weeks.



	2008	2009	2010	2011	2012/13	2014/15 Target
Māori - 6 Weeks	56.1%	69.5%	58.6%	71.0%	73.0%	73%
Pacific - 6 Weeks	81.8%	81.8%	61.5%	100.0%	NA	N/A
Total - 6 Weeks	63.8%	67.7%	64.8%	73.0%	70.0%	73%
National Average	64.0%	65.5%	66.0%	66.0%	65.0%	

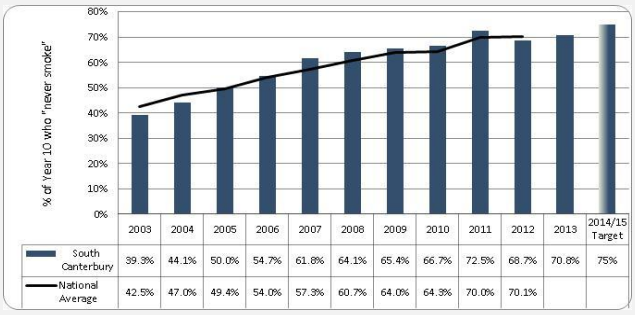
[2] *The 2011 result is only for the second half of the 2011 year (i.e. July to December) due to MoH data availability.*

Fewer young people take up tobacco smoking.

- *Most smokers begin smoking by 18 years of age, and the highest prevalence of smoking is amongst younger people. Reducing smoking prevalence is therefore largely dependent on preventing young people from taking up smoking.*
- *A reduction in the uptake of smoking is seen as a proxy measure of successful health promotion and engagement and a change in the social and environmental factors that influence risk behaviours and support healthier lifestyles.*

Data sourced from national Year 10 ASH Survey.[3]

The percentage of 'never smokers' among Year 10 students.



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014/15 Target
South Canterbury	39.3%	44.1%	50.0%	54.7%	61.8%	64.1%	65.4%	66.7%	72.5%	68.7%	70.8%	75%
National Average	42.5%	47.0%	49.4%	54.0%	57.3%	60.7%	64.0%	64.3%	70.0%	70.1%		

Output Subsets: SHORT TERM PERFORMANCE MEASURES 2014/15

Health Promotion and Education Services These services inform people about risks and support them to be healthy. Success is measured by greater awareness and engagement, reinforced by programmes that support people to maintain wellness, change personal behaviours and make healthier choices.	**Notes**	**Actual 2011/12**	**Actual 2012/13**	**Target/Est. Delivery 2014/15**	**2012/13 National Average**
Percentage of babies breast-fed (exclusive and full) in the district at 6 weeks of age	C,Q [1]	73% (2011)	70%	≥ 73%	65%
Percentage of babies breast-fed (exclusive and full) in the district at 3 months of age	C,Q [1]	54% (2011)	56%	≥ 58%	55%
Percentage of babies breast-fed (exclusive and full) in the district at 6 months of age	C,Q [1]	26% (2011)	25%	≥ 28%	24%
No. of people in South Canterbury accessing smoking cessation programmes	V [2]	1205	873	≥ 500	-
Percentage of people who receive brief invention to quit smoking in the hospital setting	C	96%	98.8%	≥ 95%	95.8%
Percentage of people who receive brief invention to quit smoking in the primary care setting	C	35.4%	76%	≥ 90%	56.9%
No. of Green Prescription referrals	V [3]	360	385	≥ 520	-
Percentage of education settings engaged with WAVE	C [4]	≥99%	99%	≥ 99%	-
Family Violence Intervention Programme Evaluation Audit score of hospital responsiveness to child abuse above the national benchmark score of 70	Q [5]	91	96	≥91	-
Family Violence Intervention Programme Evaluation Audit score of hospital responsiveness to partner abuse above the national benchmark score of 70	Q [5]	92	92	≥92	-

[1] The proportion of women breastfeeding is seen as a measure of service quality, demonstrating the effectiveness of consistent, collective health promotion messages delivered during the antenatal period and the value of breast feeding support during the post natal period. Data is sourced from Plunket via the Ministry of Health. Results exclude data from Arowhenua Whānau Services.

[2] These volumes relate to DHB funded programmes and the target for 2014/15 is targeted at people with specialised needs. Others will be referred to programmes such as Quitline.

[3] The Green Prescription initiative is a way to improve the health of New Zealanders. This service is provided on referral to Sport Canterbury for adults and focuses on sustaining physical activity to improve health outcomes.

[3] *The ASH survey is run by Action on Smoking and Health and provides an annual point prevalence data set: www.ash.org.nz.*

[4] WAVE stands for "Well-being and Vitality in Education". It is a health promotion initiative that works collaboratively between education, health and Sport Canterbury and works across all levels of education to help create and support healthy environments.

[5] The Family Violence Intervention Programme audits compliance against the National Guidelines for Partner and Child Abuse and contract specifications for this service.

Population Based Screening These services are mostly funded and provided through the National Screening Unit and help identify people at risk of illness earlier. They include breast and cervical screening. The DHB's role is to encourage uptake, as indicated by high coverage rates.	**Notes**	**Actual 2011/12**	**Actual 2012/13**	**Target/Est. Delivery 2014/15**	**2012/13 National Average**
Percentage of enrolled women aged 25 – 69 years who have had a cervical screen in the last three years	T [6]	75.8%	76.1%	≥ 80%	76.72%
Percentage of Māori enrolled women aged 20 – 69 years who have had a cervical screen in the last three years	T [6]	66.25%	69.50%	≥ 80%	
Percentage of enrolled women aged 45 – 69 years who have had breast screening mammography as part of the national mammography screening programme in the last two years	T [6]	81.4% (50 – 69 years)	84.3% (45 – 69 years)	≥70%	71.93% (45 – 69 years)
Percentage of Māori enrolled women aged 45 – 69 years who have had breast screening mammography as part of the national mammography screening programme in the last two years	T [6]	80% (50 – 69 years)	77.6% (45-69 years)	≥ 70%	64.74% (45 – 69 years)
No. of B4 School Checks completed	V [7]	652	816	≥ 613	-
Percentage of eligible population provided with a B4 School Check	C [7]	95.58%	100%	≥ 90%	
No. of 'high needs' B4 School Checks completed	V [7]	74	87	≥ 62	-
Percentage of eligible 'high needs' population provided with a B4 School Check	C [7]	100%	100%	≥ 90%	

[6] These national screening programmes screen women for signs of breast and cervical cancer to enable early treatment to reduce the rate of associated mortality. Result for cervical screening total population is based on NCSP data, whereas results for the Māori population are taken from the Primary Performance Programme where the age band is 20 – 69 years. The age band for data reporting from the National Cervical Screening Programme changed in 2012 from 50-69 to 45-69. All results for mammography are taken from Breast Screen Aotearoa data.

[7] The B4 School Check is the final core Well Child/Tamariki Ora check, which children receive at age four. It is free and includes vision, hearing, oral health, height and weight. The check allows health concerns to be identified and addressed early in a child's development.

Immunisation These services reduce the transmission and impact of vaccine-preventable diseases including unnecessary hospitalisations. The DHB works with primary care and allied health professionals to improve the provision of immunisations across all age groups both routinely and in response to specific risk. A high coverage rate is indicative of a well-coordinated, successful service.	**Notes**	**Actual 2011/12**	**Actual 2012/13**	**Target/Est Delivery 2014/15**	**2012/13 National Average**
Percentage of 8 months old fully immunised on time	T,C	92%	88%	≥ 95%	90.1%
Percentage of 2 years old fully immunised on time.	T,C	94%	94%	≥ 95%	92%
Percentage of the eligible population receiving the flu vaccination	C	66.79%	68%	≥ 70%	
No. ≥ 65 year olds immunised for pneumonia	C [8]	736	391	≥180	-
No. of HPV vaccinations completed for consenting adolescents through the school based programme.	V [9]	NEW	130 (2013)	115 (2014)	-

[8] This immunisation programme commenced in 2011. The planned volumes for the first two years of this programme were set at 850/year to address the back log and then reducing to 180/year ongoing. The vaccine is expected to last 5 years.

[9] The measure is based on young women 12 - 18 who have been provided with all three doses through the school based programme commenced in 2013. The timing of this measure is a calendar year.

Output Class

2.3 Early Detection and Management

Output class description

Early detection and management services maintain, improve and restore people's health by ensuring that people at risk or with disease onset are recognised early, their need is identified, long-term conditions are managed more effectively and services are coordinated - particularly where people have multiple conditions requiring ongoing interventions or support.

These services are by nature more generalist, usually accessible from multiple providers and a number of different locations. They include general practice, primary and community services, personal and mental health services, Māori and Pacific health services, pharmacy services, community radiology and diagnostic services and child oral health services.

Some of these services are demand-driven, such as pharmaceuticals and laboratory tests, and services are provided with a mix of public and private funding and may include co-payments for general practice services and pharmaceuticals.

Why is this output class significant for us?

New Zealand is experiencing an increasing prevalence of long-term conditions, so called because once diagnosed people usually have them for the rest of their lives. Some population groups suffer from these conditions more than others, and prevalence also increases with age.

By promoting regular engagement with health services, we support people to maintain good health through earlier diagnosis and treatment, which provides an opportunity to intervene in less invasive and more cost-effective ways associated with better long-term outcomes. These services also support people to better manage their long-term conditions and avoid complications, acute illness and crises. The integration of services to meet Government expectations for 'better, sooner, more convenient health services' presents a unique opportunity to reduce inefficiencies across the health system and provide access to a wider range of publicly funded services closer to home.

Providing flexible and responsive services in the community, without the need for a hospital appointment, will support people to stay well and reduce the overall rate of admissions, particularly acute emergency and avoidable hospital admissions. Reducing the diversion of critical resources into managing acute demand will have a major impact in freeing up hospital and specialist services for more complex and planned interventions.

The effect of these outputs is demonstrated in the following medium term impact measures.

IMPACT MEASURES MEDIUM TERM (3-5 YRS)

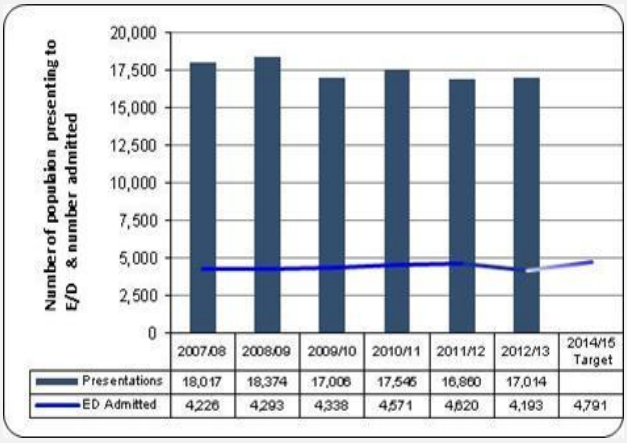
Over the next three years, we seek to make a positive impact on the health and wellbeing of the South Canterbury population and contribute to achieving the longer-term outcomes we seek. The following headlines indicators will be used to evaluate the effectiveness and quality of the services the DHB funds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

People access care urgent care when they need it.

- *Supporting people to seek early intervention and providing alternative urgent care pathways will ensure people are able to access the right treatment and support when they need it, which is not necessarily in hospital Emergency Departments.*
- *Early and appropriate intervention will not only improve health outcomes for our population, but will also reduce unnecessary pressure on our hospitals.*
- *A reduction in the proportion of the population presenting to the Emergency Department (ED) and an increase in the number admitted can be seen as a proxy measure of the availability and uptake of alternative community options to more appropriately manage and support people. A higher percentage of admissions for those who present to ED indicate that people are attending ED appropriately and that those who could be attended to in primary and community care systems are using the correct pathways of health care.*

Data sourced from individual DHBs.[4]

The percentage of the population presenting at ED and number admitted.



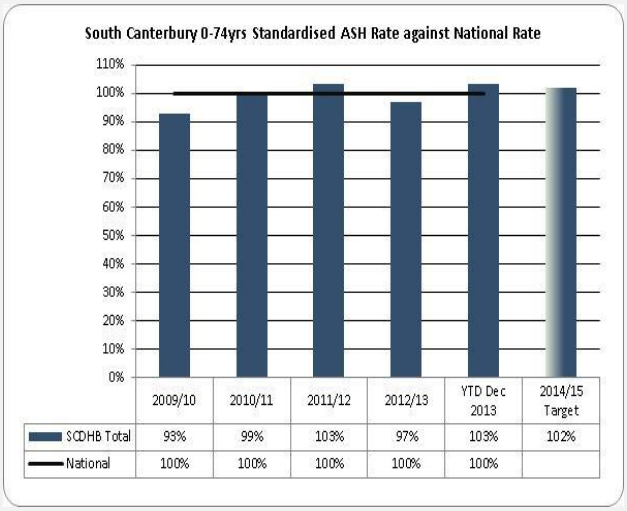
	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2014/15 Target
Presentations	18,017	18,374	17,006	17,545	16,860	17,014	
ED Admitted	4,226	4,293	4,338	4,571	4,620	4,193	4,791

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

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

Data sourced from the Ministry of Health. [5]

The rate of avoidable hospital admissions per 100,000 population (<75).



	2009/10	2010/11	2011/12	2012/13	YTD Dec 2013	2014/15 Target
SCDHB Total	93%	99%	103%	97%	103%	102%
National	100%	100%	100%	100%	100%	

[4] *'Presenting' and 'Admitted' are defined by the Ministry of Health national ED health target.*

Children have improved oral health.

- *Oral health is an integral component of lifelong health and impacts a person's comfort in eating and ability to maintain good nutrition, self esteem and quality of life.*
- *Good oral health not only reduces unnecessary complications and hospital admissions, but also signals a reduction in a number of risk factors, such as poor diet, which has lasting benefits in terms of improved nutrition - helping to keep people well.*
- *Māori and Pacific children are more likely to have decayed, missing or filled teeth. As such, improved oral health is also a proxy measure of equity of access and the effectiveness of services in targeting those at risk.*

Data sourced from Ministry of Health.

The percentage of children caries-free at age 5 (no holes or fillings).

	2006	2007	2008	2009	2010	2011	2012	2014 Target	2015 Target
TOTAL	50.9%	59.3%	59.8%	64.1%	60.1%	58.0%	61.0%	62%	68%
Māori	43.5%	25.0%	40.4%	44.4%	32.8%	31.0%	49.0%	62%	68%

Output Subsets: SHORT TERM PERFORMANCE MEASURES 2014/15

Primary Health Care These services are offered in local community settings by a primary care team including general practitioners (GPs), registered nurses, nurse practitioners and other primary healthcare professionals, aimed at improving, maintaining or restoring people's health. High levels of enrolment with general practice are indicative of engagement, accessibility and responsiveness of primary care services.	**Notes**	**Actual 2011/12**	**Actual 2012/13**	**Target/ Est. Delivery 2014/15**	**2012/13 National Average**
No. people in the district enrolled with a Primary Care Provider	V	55,995	56,272	≥ 56,000	-
Percentage of eligible people enrolled in the Care Plus Programme	C [1]	83.5%	81.46%	≥ 82%	-
No. Aoraki HealthPathways in place	Q [2]	139	265	500	-
Percentage of newborns enrolled with a GP within three months of birth	T	NEW	NEW	88% by December 2014	-
Avoidable Hospital Admission (ASH) 0 – 74 years (Total) rate.	Q [3]	103 %	97%	≤102%	

[1] Care Plus aims to improve chronic care management, reduce inequalities, improve primary health care teamwork and reduce the cost of services for high-need primary health users.

[2] Aoraki HealthPathways website contains clinical pathways which provide general practice with information on referrals, specialist advice, diagnostic tools, GP procedure subsidies and patient handouts.

[3] Some admissions to hospital are seen as preventable through appropriate early intervention. These admissions provide an indication of the access and effectiveness of primary care and an improved integration between primary and secondary services.

[5] This measure is based on the national DHB performance indicator SI1 and covers hospitalisations for 26 identified conditions including asthma, diabetes, angina, vaccine-preventable diseases, dental conditions and gastroenteritis. It is defined as the standardised rate per 100,000 population, and the target is set to maintain performance at below 95% of the national rate.

Long Term Conditions Programme These services are targeted at people with high need due to long-term conditions and aim to reduce deterioration, crises and complications. Success is demonstrated through identification of need, regular monitoring and outcomes that demonstrate good conditions management. A focus on early intervention, self-management strategies and additional services available in the community will help to reduce the negative impact of long-term conditions and the need for hospital admission.	**Notes**	**Actual 2011/12**	**Actual 2012/13**	**Target/ Est. Delivery 2014/15**	**2012/13 National Average**
No. of patients who have completed the Multi-condition Rehabilitation Programme	V[4]	NEW	NEW	≥ 70%	-
No. of patients enrolled in the Diabetes Encounter Programme	V[5]	NEW	NEW	≥ 150	-
Percentage of the eligible population who have had their cardiovascular risk checked in the last 5 years	C[6]	44.1%	64.4%	≥ 90%	67.1%

[4] The multi-condition rehabilitation programme provides a rehabilitation programme for persons with a wide range of long term conditions including cardiac, diabetes and respiratory.

[5] The Diabetes Encounter Project works with newly diagnosed diabetics, those commencing insulin in the community or those persons within general practice, with known diabetes whom are not engaged with primary care, therefore have either poor glycaemic control, or unknown glycaemic control. The patient receives intensive input in a planned way from their GP, Practice Nurse and the Clinical Nurse Specialist Diabetes. The aim of this input is to get good glycaemic control within a short time frame.

[6] This refers to CVD risk assessments undertaken in primary care in line with the expectations of the PHO Performance Programme and the 'More heart and diabetes checks' health target.

Oral Health These services are provided by registered oral health professionals to help people maintain healthy teeth and gums. High enrolment indicates engagement, while timely examination and treatment indicates a well functioning, efficient service.	**Notes**	**Actual 2011**	**Actual 2012**	**Target/Est. Delivery 2014/15**	**2012/13 National Average**
Percentage of children under five years enrolled in DHB funded dental services.	C	76.7%	76.7%	≥ 83%	63%
Percentage of adolescents accessing DHB funded oral health services.	C	91.4%	88.6%	≥ 91%	71.6%
Percentage of children caries free at five years of age.	C	58%	60.18%	≥ 62%	60%
Oral Health Decayed, Missing and Filled Teeth score at year eight.	C	1.29	1.20	≤ 1.1	1.20
Percentage of enrolled preschool and primary school children overdue for their scheduled examination	T	6%	9%	≤ 10%	-

Pharmacy As long term conditions become prevalent, demand for pharmaceuticals will likely increase. The LTC service has been introduced to provide a greater hands-on role of community patient's pharmaceutical management. To improve service quality in the hospital setting we have also introduced medicines interventions monitoring along with medicines reconciliation to reduce the number of New Zealanders harmed each year by medication errors in our hospital.	**Notes**	**Actual 2011/12**	**Actual 2012/13**	**Target/Est. Delivery 2014/15**	**2012/13 National Average**
No. of medicines reconciliations completed	Q[7]	NEW	NEW	40%	-

[7] Medicine reconciliation is about obtaining the most accurate list of patient medicines, allergies and adverse drug reactions and comparing this with the prescribed medicines and documented allergies and adverse drug reactions. Any discrepancies are then documented and reconciled. Prioritised inpatients have medicine reconciliation completed within 24 hours of admission. Prioritised patients are patients on medical, ICU, surgical and AT&R wards. The target is 30% by Q2 and 40% by year end.

Community Referred Tests & Diagnostic Services These are services to which a health professional may refer a person to help diagnose a health condition, or as part of treatment. They are provided by personnel such as laboratory technicians, and radiographers. To improve performance, we will target improved primary care access to diagnostics without the need for a hospital appointment to improve clinical referral processes and decision making. Community referred laboratory tests are demand driven.	**Notes**	**Actual 2011/12**	**Actual 2012/13**	**Target/ Est. Delivery 2014/15**	**Current National Average**
No. community referred laboratory tests	V[8]	215,695	252,873	Est. 245,000	-
No. community referred radiology examinations	V[9]	11,249	10,067	Est. 10,500	-
Percentage of accepted referrals for a MRI scan receive their scan within six weeks	T	NEW	84%	80%	52%
Percentage of accepted referrals for a CT scan receive their scan within six weeks.	T	NEW	87%	90%	79%
Percentage of people accepted for an urgent diagnostic colonoscopy who receive their procedure within two weeks.	T	NEW	NEW	75%	-
Percentage of people accepted for a diagnostic colonoscopy who receive their procedure within six weeks	T	NEW	NEW	60%	-
Percentage of people waiting for a surveillance colonoscopy will wait no longer than 12 weeks beyond the planned date.	T	NEW	NEW	60%	

[8] This volume is demand driven.

[9] This volume is demand driven.

Output Class

2.4 Intensive Assessment and Treatment Services

Output class description

Intensive assessment and treatment services are usually complex services provided by specialists and other health care professionals working closely together. These services are therefore usually (but not always) provided in hospital settings, which enable the co-location of clinical expertise and specialist equipment. These services include ambulatory services, inpatient and outpatient services and emergency or urgent care services.

We provide an extensive range of intensive treatment and complex specialist services for our population and we also fund some intensive assessment and treatment services for our population that are provided by other DHBs. A proportion of these services are driven by demand which we must meet, such as acute and maternity services. However, others are planned services for which provision and access are determined by capacity, clinical triage, national service coverage agreements and treatment thresholds.

Why is this output class significant for us?

Equitable, timely access to intensive assessment and treatment can significantly improve people's quality of life either through early intervention (e.g. removal of an obstructed gallbladder so that the patient does not have repeat attacks of abdominal pain) or through corrective action (e.g. major joint replacements). Responsive services and timely treatment support improvements across the whole system and give people confidence that complex intervention is available when needed. People are then able to establish more stable lives, resulting in improved public confidence in the health system.

As an owner and provider of these services, we are also concerned with the quality of the services being provided. Quality improvement in service delivery, systems and processes will improve patient safety, reduce the number of events causing injury or harm and provide improved outcomes for people in our services. Adverse events and delays in treatment, as well as causing harm to patients, drive unnecessary costs and redirect resources away from other services. Appropriate and quality service provision will reduce readmission rates and better support people to recover from complex illness and / or maximise their quality of life.

Government has set clear expectations for the delivery of elective surgical volumes, a reduction in waiting times for treatments and increased clinical leadership to improve the quality of care. In meeting these expectations, we are introducing innovative clinically led service delivery models and reducing waiting time within our hospital services.

The effect of these outputs is demonstrated in the following medium term impact measures.

IMPACT MEASURES MEDIUM TERM (3-5 YRS)

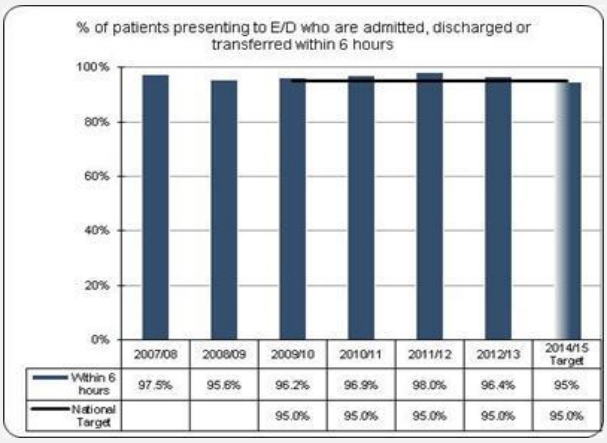
Over the next three years, we seek to make a positive impact on the health and wellbeing of the South Canterbury population and contribute to achieving the longer-term outcomes we seek. The following headlines indicators will be used to evaluate the effectiveness and quality of the services the DHB funds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

People have shorter waits for treatment.

- *Emergency Departments (EDs) are important components of our health system and a barometer of the health of the hospital and the wider system.*
- *Long waits in ED are linked to overcrowding, negative outcomes, longer hospital stays and compromised standards of privacy and dignity for patients. Enhanced performance will not only improve outcomes by providing early intervention and treatment but will improve public confidence and trust in health services.*
- *Solutions to reducing ED wait times need to address the underlying causes of delay, and therefore span not only the hospital but the whole health system. In this sense, this indicator is indicative of how responsive the system is to the urgent care needs of the population.*

Data sourced from individual DHBs.[6]

The percentage of patients presenting in ED who are admitted, discharged or transferred within six hours.



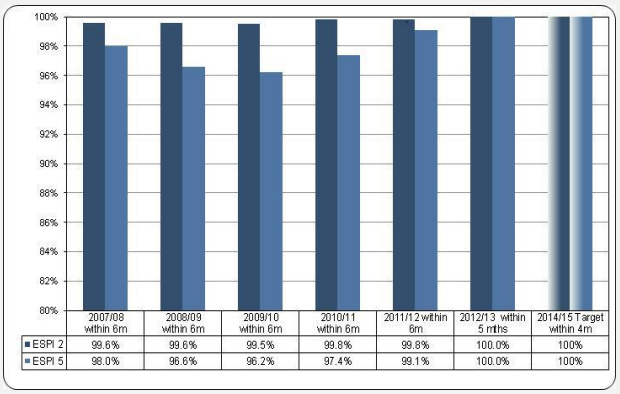
People have increased access to elective services.

- *Elective (non-urgent) services are an important part of the healthcare system: these services improve the patient's quality of life by reducing pain or discomfort and improving independence and wellbeing.*
- *Timely access to services and treatment is considered a measure of health system effectiveness and improves health outcomes by slowing the progression of disease and maximising people's functional capacity.*
- *Improved performance against this measure requires effective use of resources so wait times are minimised, while a year-on-year increase in volumes is delivered. In this sense, this indicator is indicative of how responsive the system is to the needs of the population.*

Data sourced from Ministry of Health.[7]

The time people wait from referral to First Specialist Assessment (ESPI 2).

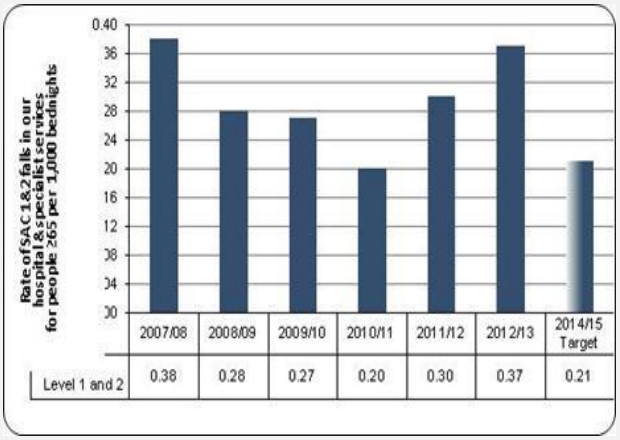
The time people wait from commitment to treat until treatment (ESPI 5).



People stay safe in hospital.

- *Adverse events in hospital, as well as causing avoidable harm to patients, reduce public confidence and drive unnecessary costs. Fewer adverse events provide an indication of the quality of services and systems and improve outcomes for patients in our services.*
- *The rate of falls is particularly important, as these patients are more likely to have a prolonged hospital stay, loss of confidence and independence and an increased risk of institutional care.*
- *A key factor in reducing adverse events is the engagement of staff and clinical leaders in improving processes and championing change. Achievement against this measure is therefore also seen as a proxy indicator of an engaged and capable workforce with the capacity and capability to improve service delivery.*

The rate of SAC level 1 and 2 falls in South Canterbury Hospitals.



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

[7] *The Elective Services Patient Flow Indicators (ESPIs) have been established nationally to track system performance and DHBs receive summary reports from the Ministry of Health on a monthly basis. National average performance data is not made available. Historical data is against a six month target, while the target reduces to 5 months for 2013/14 and 4 months from January 2015.*

Data sourced from individual DHBs.[8]

Output Subsets: SHORT TERM PERFORMANCE MEASURES 2014/15

Acute Services These are medical or surgical services for illnesses that have an abrupt onset or progress rapidly creating an urgent need for care. For more complex acute conditions, hospital based services include emergency services, acute medical and surgical services and intensive care services. Productivity measures such as length of stay are balanced with outcome measures such as readmission rates to indicate the quality of service provision.	**Notes**	**Actual 2011/12**	**Actual 2012/13**	**Target/ Est. Delivery 2014/15**	**2012/13 National Average**
No. of patients seen at ED that are not admitted	V	10,926	12,821	≥10,705	-
Percentage of patients discharged or transferred from ED within 6 hours	T	96.5%	96.4%	≥95%	93.5%
No. of acute medical/surgical patients discharged from Timaru Hospital.	V	6,885	6,527	≤6,200	-
Standardised length of stay for acute patients.	T[1]	NEW	4.73 (2012)	≤4.32	-
Standardised readmission rate.	Q[1]	10.38	10.37	≤7.1%	10.32%)
Percentage of patients requiring radiation or chemotherapy who receive this treatment within four weeks	T	100%	100%	100%	100%
Percentage of patients referred with a high suspicion of cancer wait 62 days or less to receive their first treatment (or other management) by July 2016	T	NEW	NEW	85%	
Percentage of older patients assessed for the risk of falling	Q[2]	NEW	96% (Dec. 2013)	90%	87% (Dec. 2013)
Percentage of older patients assessed as at risk of falling who received an individualised care plan that addressed these risks	Q[2]	NEW	93% (Dec. 2013)	90%	80% (Dec. 2013)
Number of falls in the hospital categorised as a SAC 1 or 2	Q[2]	14	16	≤9	-
Percentage of complaints responded to within 23 working days	Q	81%	65%	90%	-
Percentage of compliant moments of hand hygiene	Q[3]	NEW	72% (Dec. 2013)	70%	71% (Dec. 2013)
Hospital acquired blood stream infection rate	Q[3]	0.8	0.8	0.6	-
Percentage of ICU central line insertions fully compliant with bundle	Q[4]	NEW	100% (Dec. 2013)	90%	93% (Dec. 2013)
Number of central line acquired bacteraemia	Q	NEW	2	0	-
Percentage of operations where all three parts of the surgical safety checklist were used	Q[4]	NEW	92% (Dec. 2013)	90%	89% (Dec. 2013)

[8] *The Severity Assessment Code (SAC) is a numerical score given to an incident, based on the outcome of the incident and the likelihood that it will recur. Level 1 and 2 incidents are those with highest consequence and likelihood. Data reported is per 1,000 inpatient bed days.*

[1] Productivity measures like length of stay are balanced with outcome measures such as readmission rates to indicate the quality of service provision.

[2] Measures relating to falls assessment and falls prevention plans are HQSC Safety Markers. SAC refers to the Severity Assessment Code assigned to an adverse event based of the degree of harm caused and the likelihood of the reoccurrence of a similar event.

[3] Hand Hygiene is one of the HQSC Safety Markers. A low incidence of hospital acquired infections can be reflective of effective infection control procedures. This measure is per 1,000 inpatient bed days.

[4] This is a HQSC Safety Marker.

Elective Services These are services for people who do not need immediate hospital treatment and are 'booked' or 'arranged' services. This includes surgery and specialist assessments. National Elective Services Patient Flow Indicators (ESPIs) are indicative of a successful and responsive service, addressing increasing needs and matching commitments to capacity.	**Notes**	**Actual 2011/12**	**Actual 2012/13**	**Target/ Est. Delivery 2014/15**	**2012/13 National Average**
Total no. of elective First Specialist Assessments (FSA)	V	8,539	8,558	≥9,165	-
No. non contact secondary services surgical FSAs	V, T[5]	584	714	≥700	-
No. non contact secondary services medical FSAs	V, T[5]	274	368	≥560	-
No. of Cost Weight Deliveries CWDs	V	3,663	3,690	≥3,595	-
No. of elective surgical discharges (incl. cardiology & dental)	V	3,039	3,064	≥2,887	-
No. Health Target surgical elective discharges	V[6]	2,730	2,790	≥2,634	-
Standardised length of stay for elective patients.	T[7]	NEW	3.77	≤3. 40	-
Elective theatre time utilisation	Q[8]	84.4%	83.3%	≥85%	-
Did Not Attend (DNA) rate for medical/surgical	Q	3.3%	3.1%	≤3.3%	-

[5] Non-contact FSAs are those where specialist advice and assessment is provided without the need for a hospital appointment, increasing capacity across the system, reducing wait time for patients and taking waste and duplication out of the system.

[6] This number counts elective surgery volumes based on the national health target definition (excludes cardiology and dental volumes).

[7] Productivity measures like length of stay are balanced with outcome measures such as readmission rates to indicate the quality of service provision.

[8] This is the sum of occupancy time for all patients in an elective session, calculated as a percentage of the scheduled session duration.

Maternity Services These services are provided to women and their families through pre-conception, pregnancy, childbirth and for the first months of a baby's life. These services are provided in home, community and hospital settings by a range of health professionals, including midwives, GPs and obstetricians and include: specialist obstetric, lactation, anaesthetic, paediatric and radiology services. We will monitor volumes in this area to determine	**Notes**	**Actual 2011/12**	**Actual 2012/13**	**Target/Est. Delivery 2014/15**	**2012/13 National Average**

access and responsiveness of services.					
No. deliveries in the SCDHB Maternity Unit	V[9]	544	621	≤550	-
Percentage of births delivered by Caesarean Section	Q	23.6%	26.5%	≤23%	-
Post natal average length of stay	T	2.5days	2.5 days	≥2.5days	-
Baby Friendly Hospital Accreditation is maintained	Q[10]	Yes	Yes	Yes	-

[9] Result indicates no. of babies born

[10] The Baby Friendly Hospital Initiative is a worldwide programme of the World Health Organisation and UNICEF. It was established in 1992 to encourage maternity hospitals to deliver a high standard of care and implement best practice in relation to infant feeding for pregnant women and mothers and babies. An assessment and accreditation process recognises those that have achieved the required standard.

Assessment, Treatment and Rehabilitation Services (AT&R) These are services provided to restore functional ability and enable people to live as independently as possible. Services are delivered from a specialist inpatient unit, outpatient clinic and also in the home environment.	**Notes**	**Actual 2011/12**	**Actual 2012/13**	**Target/ Est. Delivery 2014/15**	**2012/13 National Average**
No. of ATR bed days utilised > 65years	V	4,559	3,528	≤4,000	-
No. of ATR bed days utilised <65years	V	435	457	288.91	-
No. of ATR bed days utilised - psycho-geriatric	V	471	602	≤650	-
No. of AT&R outpatient attendances	V	546	358	≥450	-
No. of AT&R domiciliary visits	V	2,774	2,288	≥2,700	-

Specialist Mental Health Services These are services for the most severely affected by mental illness or addictions. They include assessment, diagnosis, treatment, rehabilitation and crisis response when needed. Utilisation and wait times are monitored to ensure service levels are maintained and to demonstrate responsiveness to need.	**Notes**	**Actual 2011/12**	**Actual 2012/13**	**Target/ Est. Delivery 2014/15**	**2012/13 National Average**
Percentage of young people (aged 0 – 19) who have accessed specialist mental health services.	C	4.7% (Mar-12)	5.29%	5%	3.0% (Mar – 12)
Percentage of people (aged 20 – 64) who have accessed specialist mental health services.		3.8% (Mar-12)	3.58%	3.6%	3.5% (Mar-12)
Percentage of people (aged 65+) who have accessed specialist mental health services.	C	0.6% (Mar-12)	0.45%	1%	2.2% (Mar-12)
Percentage of people 0 – 19 referred for non-urgent mental health services seen within three weeks.	T[11]	80.8% (Sept 12)	79.2%	80%	76%
Percentage of people 0 – 19 referred for non-urgent mental health services seen within eight weeks.	T[11]	91.2% (Sept 12)	94.5%	95%	93%
Percentage of people 0 – 19 referred for non-urgent addiction services seen within three weeks.	T[12]	74.4% (Sept 12)	100%	80%	72.8%
Percentage of people 0 – 19 referred for non-	T[12]	97.4%	100%	95%	87.8%

urgent addiction services seen within eight weeks.		(Sept 12)			
Percentage of child and youth with a transition (discharge) plan.	C[13]	NEW	NEW	95%	-

[11] Results reflect the total for provider arm performance only.

[12] Results reflect the total for provider and NGO performance.

[13] Relapse prevention/resiliency planning helps to minimise the impact of mental illness, improving outcomes for clients. Clients with enduring serious mental illness are expected to have an up-to-date plan identifying early warning signs and what action to take. This result excludes those with addictions only.

Output Class

2.5 Rehabilitation and Support Services

Output class description

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

Support services also include palliative care services for people who have end-stage conditions. It is important that they and their families are appropriately supported, so that the person is able to live comfortably, have their needs met in a holistic and respectful way and die with appropriate end of life care irrespective of the setting where this occurs. Delivery of these services is likely to include coordination with many other organisations and agencies and may include public, private and part-funding arrangements.

Why is this output class significant for us?

Services that support people to manage their needs and live well, safely and independently in their own homes are considered to provide a much higher quality of life, as a result of people staying active and positively connected to their communities. This is evident by less dependence on hospital and residential services and a reduction in acute illness, crisis or deterioration leading to acute admissions or readmission into hospital services. Even when returning to full health is not possible, timely access to responsive support services enables people to maximise function and independence.

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

Living in ARRC has been associated with a more rapid functional decline than 'ageing in place' and is a more expensive option. Resources can be better utilised providing appropriate levels of support to people to help them stay in their own homes and to moderate the need for residential care and hospital level services.

We have taken a 'restorative' approach and have introduced individual packages of care to better meet people's needs, including complex care packages for people assessed as eligible for ARRC who would rather stay in their own homes. With an ageing population, it is vital we monitor the effectiveness of these services, and we use the InterRAI (International Residential Assessment Instrument) tool to ensure people receive equitable access to clinically appropriate support services that best meet their needs.

The effect of these outputs is demonstrated in the following medium term impact measures.

IMPACT MEASURES MEDIUM TERM (3-5 YRS)

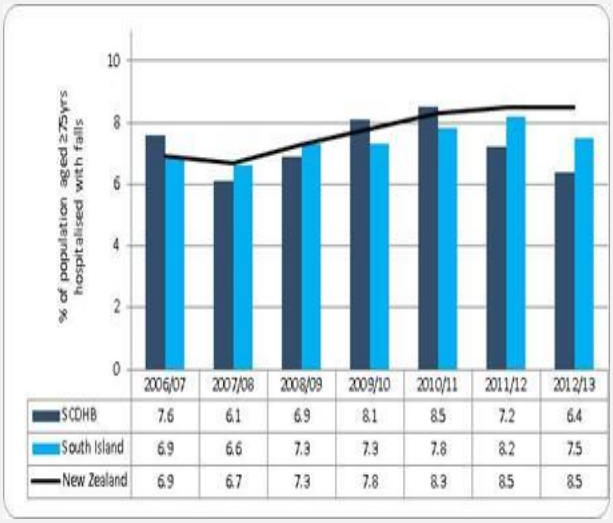
Over the next three years, we seek to make a positive impact on the health and wellbeing of the South Canterbury population and contribute to achieving the longer-term outcomes we seek. The following headlines indicators will be used to evaluate the effectiveness and quality of the services the DHB funds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

Fewer people are admitted to hospital as a result of a fall.

- *Around 22,000 New Zealanders (75+) are hospitalised annually as a result of injury due to falls. Compared to people who do not fall, those who do experience prolonged hospital stay, loss of confidence and independence and an increased risk of institutional care.*
- *With an ageing population, a focus on reducing falls will help people to stay well and independent and will reduce the relative demand on acute and aged residential care services.*
- *The solutions to reducing falls address various health issues and associated risk factors including: medications use, lack of physical activity, poor nutrition, osteoporosis, impaired vision and environmental hazards.*
- *A reduction in falls can therefore be seen as a proxy measure for improved health service provision for older people.*

Data sourced from National Minimum Data Set.

The percentage of the population (75+) admitted to hospital as a result of a fall.



	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13
SCDHB	7.6	6.1	6.9	8.1	8.5	7.2	6.4
South Island	6.9	6.6	7.3	7.3	7.8	8.2	7.5
New Zealand	6.9	6.7	7.3	7.8	8.3	8.5	8.5

Output Subsets: SHORT TERM PERFORMANCE MEASURES 2014/15

Palliative Care These are services that improve the quality of life of patients and their families facing life-threatening illness, through the prevention and relief of suffering by means of early intervention, assessment, treatment of pain and other supports.	**Notes**	**Actual 2011/12**	**Actual 2012/13**	**Target/Est. Delivery 2014/15**	**2012/13 National Average**
No. of clients receiving palliative care in the home	V	NEW	98	est. 150	-
No. clients accessing a South Canterbury Hospice bed	V	144	115	≥150	-

Needs Assessment & Support These are services that determine a person's eligibility and need for publicly funded support and the best mix of supports based on the person's strengths, resources and goals. The supports are delivered by an integrated team in the person's own home or community. The delivery of assessments and the use of evidence-based tools indicate quality, equity of access and responsiveness.	**Notes**	**Actual 2011/12**	**Actual 2012/13**	**Target/Est. Delivery 2014/15**	**2012/13 National Average**
Percentage of InterRAI first assessments completed within target timeframe	T[1]	85%	92%	90%	-
Percentage of InterRAI reviews completed within target timeframe	T[1]	NEW	91.5%	85%	-

[1] InterRAI is a comprehensive clinical assessment tool that has been rolled out nationally to ensure consistency of assessments.

Home & Community Support These are services designed to support people to continue living in their own homes and to restore functional independence. They may be short or longer-term in nature. An increase in the number of people being supported is indicative of increased capacity in the system, and success is measured against decreased or delayed entry into residential or hospital services.	**Notes**	**Actual 2011/12**	**Actual 2012/13**	**Target/Est. Delivery 2014/15**	**2012/13 National Average**
No. people (total) supported by Home Based Support Services.	V[2]	981	965	1000	-
No. high and complex dementia patients supported by Home Based Support Services	V[2]	NEW	15	20	-
No. of domiciliary district nursing visits delivered	V[3]	41,397	33,345	32,087	-
Readmission rate for patients ≥ 75 years	Q	12.8% (Sept-12)	13.8%	10.1%	9.7% (Sept-12)

[2] Home Based Support Services are services delivered in the person's home to assist them to remain at home.

[3] The reduction in domiciliary district nursing visits is as a result of data integrity issues being addressed.

Residential Care Services These services are provided to meet the needs of a person who has been assessed as requiring long-term residential care in a hospital or rest home indefinitely. With an ageing population, a decrease in the number of subsidised bed days is seen as indicative of more people being successfully supported to continue living in their own homes and is balanced against the level of home-based support.	**Notes**	**Actual 2011/12**	**Actual 2012/13**	**Target/Est. Delivery 2014/15**	**2012/13 National Average**
No. subsidised residential care bed days	V[4]	177,221	173,205	est. 184,601	-

[4] This volume is demand driven.

Respite & Day Care These services provide people with a break from a routine or regimented programme so that crisis can be averted or so that a specific health need can be addressed. Services are provided by specialised organisations and are usually short-term in nature. They may also include support and respite for families, caregivers and others affected. Services are expected to increase over time, as more people are supported to remain in their own homes.	**Notes**	**Actual 2011/12**	**Actual 2012/13**	**Target/Est. Delivery 2014/15**	**2012/13 National Average**
No. people accessing day care	V	187	147	≥150	-
No. people accessing dementia day care	V	NEW	13	≥14	-
Percentage of respite bed days utilised	C	85%	97%	≥95	-
Percentage of dementia respite bed days utilised	C	94%	99%	≥90	-

2.6 2014/15 Budgeted Financial Expectations by Output Class

REVENUE	TOTAL $'000
Prevention	3,517
Early detection and management	39,861
Intensive assessment and treatment	108,745
Support and rehabilitation	31,044
Grand Total	**183,167**

EXPENDITURE	TOTAL $'000
Prevention	3,517
Early detection and management	40,161
Intensive assessment and treatment	108,428
Support and rehabilitation	30,993
Grand Total	**183,099**
Surplus/(Deficit)	**68**