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20 November 2017

Health Sector Workers Network

Email: fyi-request-6624-71520628@requests.fyi.org.nz;

Dear Health Sector Workers Network,

RE Official information request CDHB 9711

I refer to your email dated 2 October 2017 requesting the following information under section 12 of the Official Information Act from Canterbury DHB.

1. What is the financial value of efficiency gains made in the 2016/2017 financial year?

Canterbury DHB does not have an efficiency programme as such. As part of our on-going processes, we regularly review and seek to improve efficiency opportunities.

With the continued constraints on Government funds, we recognise the need to maximise value from our limited resources and continuously identify and reduce unnecessary cost and waste. Please note that this does not entail a purely financial focus on achieving efficiencies, rather, we seek to deliver services in more effective and efficient ways, reduce waste and duplication, and make the best use of our resources.

Our vision is of an integrated system that supports people to stay well and provides the right service, in the right place at the right time. When people are supported to stay well, they need fewer hospital-level interventions and spend less time in hospital. This not only results in better health outcomes for the individual but also reduces demand and frees up health resources.

Over the past few years Canterbury DHB has seen a significant reduction in hospital bed utilisation despite the challenges from holding the unenviable status of enduring New Zealand's most catastrophic natural disaster. This has not only saved thousands of bed days but also enabled thousands of people who would otherwise have been admitted into hospitals with acute medical conditions to receive treatment and care in their own homes.

Please find attached as **Appendix 1** our Benefits Realisation Report, September 2017.

2. What were the 2016/2017 financial year budgeted and actualised personnel costs by service and personnel category?

The budgeted and actual 2016/17 personnel cost by Personnel Category is as follows:

PERSONNEL COST BY CATEGORY	ACTUAL \$M	BUDGET \$M
Medical Personnel	213.4	210.7
Nursing Personnel	284.9	282.0
Allied Health Personnel	110.7	110.4
Support Personnel	21.8	21.7
Management/Administration Personnel	91.9	92.8
Total	722.7	717.6

The actual 2016/17 personnel cost by Division is as follows:

PERSONNEL COST BY DIVISION	ACTUAL \$M
Rural Hospitals	25.3
Older Persons Health & Rehab	80.0
Medical & Surgical; Womens & Childrens	423.3
Hospital Support & Labs	33.0
Mental Health	92.6
Community Public Health	9.2
Subsidiaries	19.0
Support & Governance	40.3
Total CDHB	722.7

Notes:

- a) Personnel cost by service is not easily obtainable due to some staff costs being shared between service areas. We have therefore provided personnel costs by Division.
- b) We are declining to provide a response for the budgeted and actualised personnel costs by service under section 18(f) of the Official Information Act - i.e. "... that the information requested cannot be made available without substantial collation or research".

3. What were the predicted savings or efficiency gains expected for personnel costs for the 2016/2017 financial year by FTE and financial value, stratified by service and personnel category?

To the best of our ability, Canterbury DHB manages personnel costs [including Individual Employment Agreements] within the parameters of our annual budgets. These budgets are developed as part of the annual planning process for Canterbury DHB.

4. What is the planned financial value of efficiency gains for the 2017/2018 financial year?

Please refer to our response to question 1 above.

5. What are the current predicted savings for personnel costs for the 2017/2018 financial year? (For example – what is the anticipated financial value that will be included in the efficiency gains data for the 2017/2018 financial year if personnel costs keep to budget)

Please refer to our response to question 1 above.

I trust that this satisfies your interest in this matter.

Yours sincerely



Carolyn Gullery
General Manager
Planning, Funding & Decision Support

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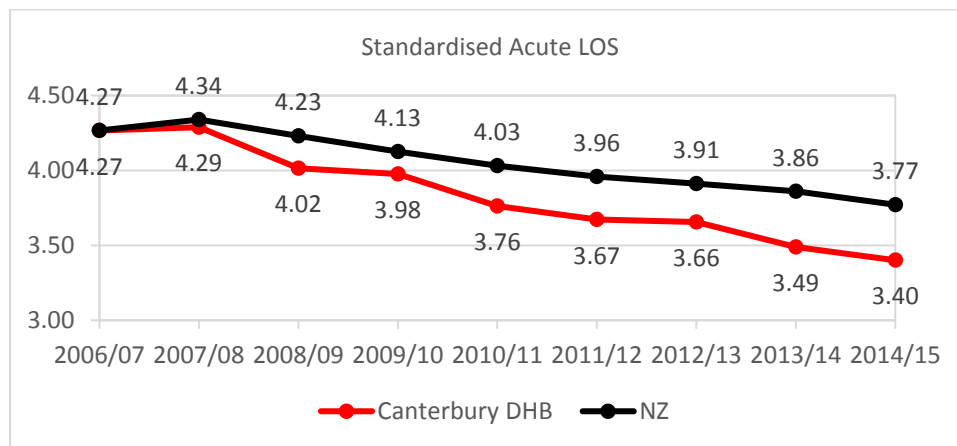
Benefits: Progress against the DBC

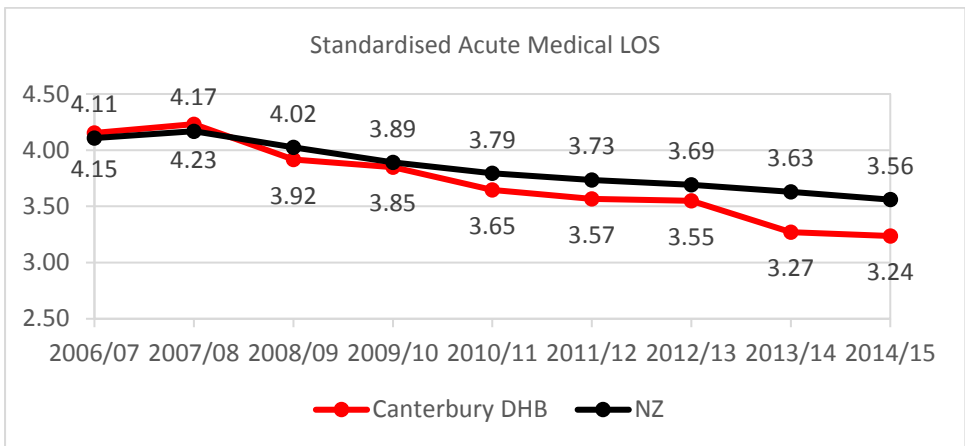
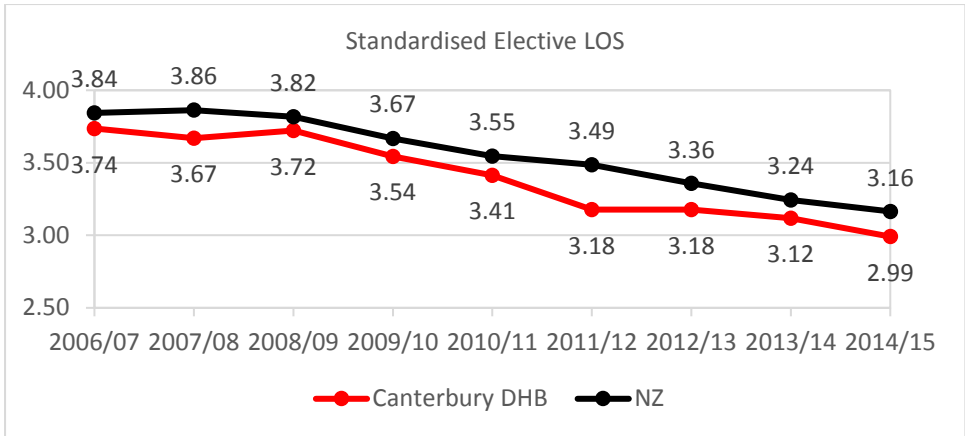
This section provides a summary of three areas of quantifiable benefits in patient care outlined in the Detailed Business Case (DBC). These represent the major benefits that can be addressed through development of the model of care as new facilities are developed. Further details about these are provided in subsequent sections. According to the available data, benefits are updated either annually, quarterly or monthly.

AVERAGE LENGTH OF STAY

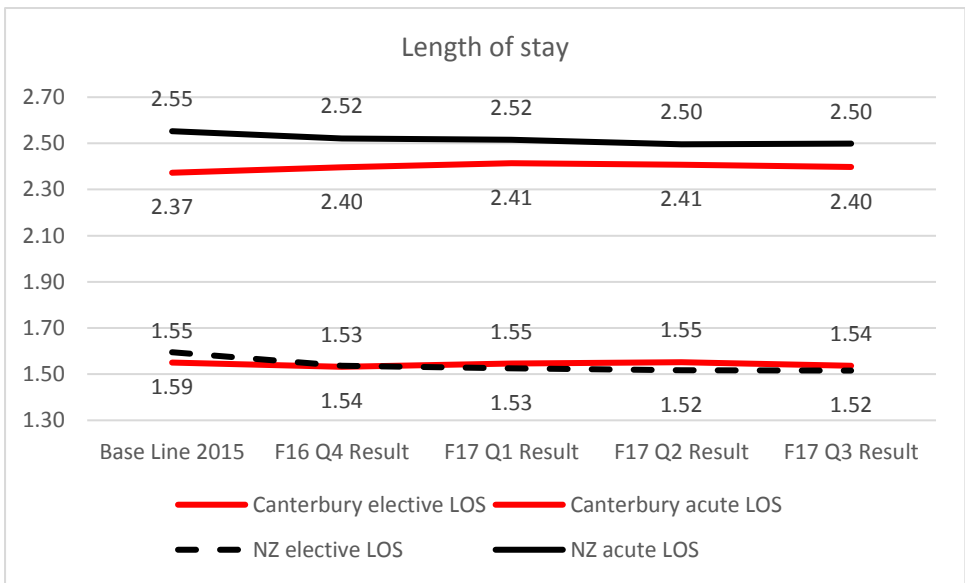
After accounting for demographic growth assumptions in the DBC indicated that demand would be modifiable to create efficiencies in length of stay of five percent for general medicine, cardio/respiratory, acute general surgery, elective general surgery, acute orthopaedic surgery and elective orthopaedic surgery. A further step change of two percent would be achievable in 2019 when both Burwood and Christchurch hospital rebuilds are operational.

In 2014/15 compared with 2011/12 (baseline for the DBC) the standardised acute length of stay had decreased by eight percent, the elective length of stay decreased by 6.2 percent and the acute medical length of stay decreased by 10.2 percent (shown in figures below). This is achieving better than projected benefits and shows stronger performance than national changes.





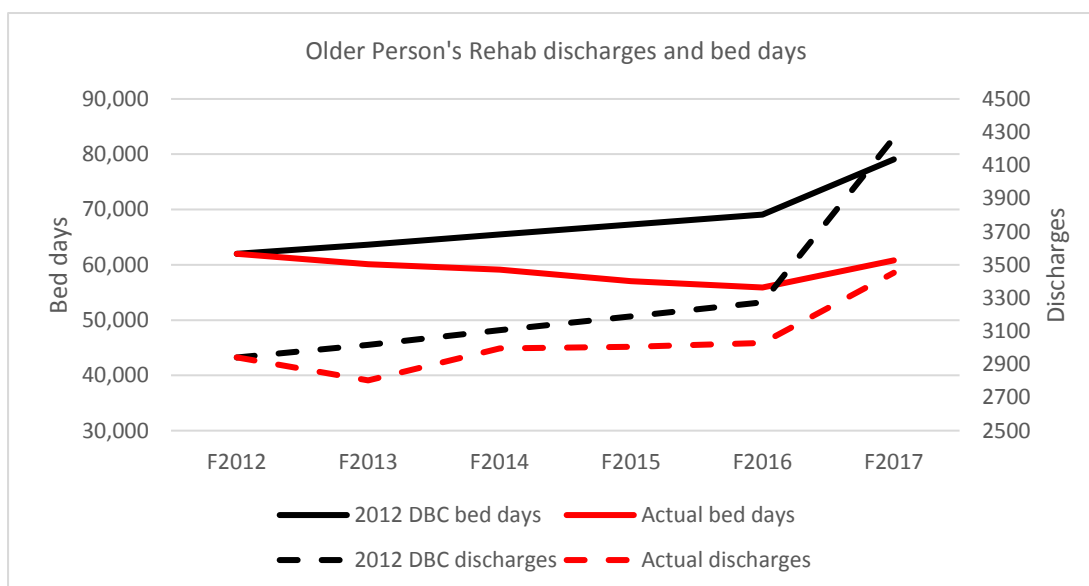
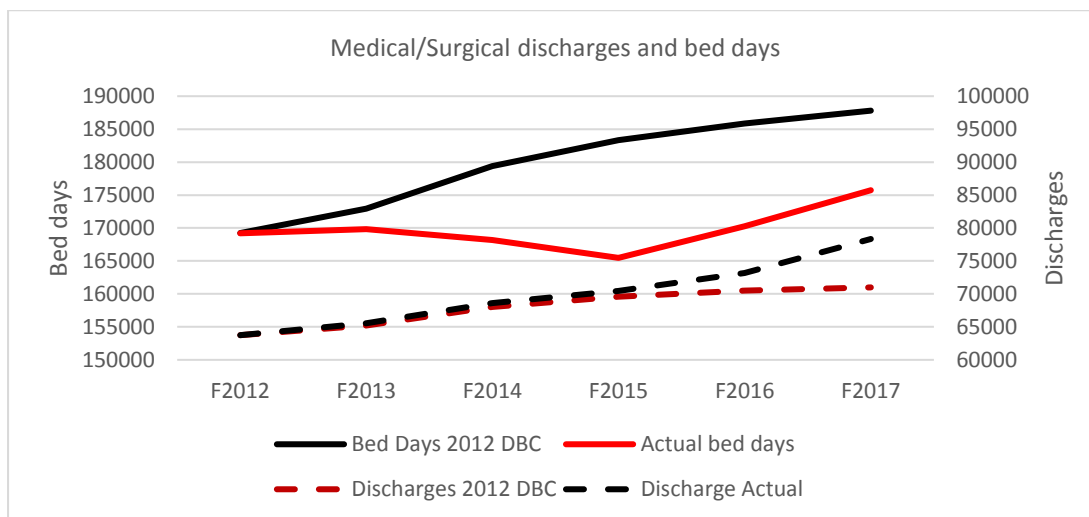
In 2015/16 the national measure for length of stay was altered to account for day cases with limited longitudinal comparison yet available. Progress against this measure continues to be monitored longitudinally with both surgical and medical acute length of stay relatively flat. This will be monitored closely as it appears to be a symptom of demand exceeding capacity.



BED DAYS ACTIVITY

Bed days are a combination of changes in discharge rate and changes in length of stay. Apart from the DBC assumption of decreased length of stay of five percent across all specialities, assumptions were made for intervention rates with demand efficiencies of five percent for general medicine, cardio/respiratory, two percent for acute general surgery and acute orthopaedic surgery (and 0% for elective general surgery and elective orthopaedic surgery). In all, the combined actual increase in beds days across medical/surgical and older person's rehab from 2011/12 to 2016/17 is 5,309 bed days (2.3%) despite significant population growth. This has resulted from a reduction of 6.9 percent in medical/surgical bed days and 23.1 percent fewer bed days for older person's rehab compared with the 2011/12 DBC. Note: older person's rehab bed days has increased as planned following the opening of the Burwood redevelopment.

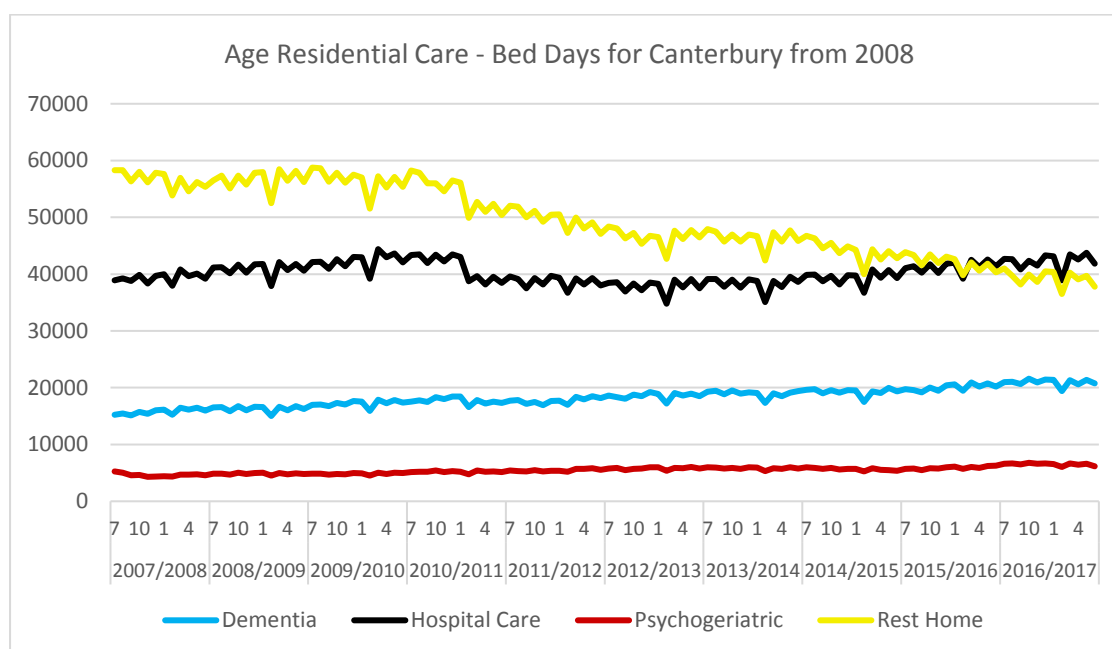
The Canterbury health system has significantly out-performed the DBC bed day assumptions.



AGED RESIDENTIAL CARE UTILISATION

Utilisation of ARC in Canterbury has been high relative to other DHBs. Through a series of interventions the DBC assumes that Rest Home bed days per population will reduce to the national average by 2020. Other ARC bed types are not assumed to reach the national average in the 10 year forecast period.

Rest Home level care has achieved 207,040 fewer bed days in 2016/17 compared with 2009/10, while bed days in Hospital level care have decreased slightly (477). On a population rate basis, Canterbury's aged residential care utilisation has fallen below South Island rates. Canterbury's rest home bed utilisation has gone from 4.0% above the South Island rate (including Canterbury) in 2009/10 to 4.3% below in 2016/17 for over 65s. At the same time, Canterbury's hospital bed day population rate has moved from 10.6% above the whole of South Island rate to 1.3%. The rate of rest home and hospital level bed days have fallen by 41.7% and 16.1% respective between 2009/10 and 2016/17.



Background

This report provides the eleventh three-monthly brief update on the benefits realisation first presented in November 2014 which outlined a series of indicators of the outcomes identified in the investment logic map for Canterbury's major capital investments. This summary presents the indicators and provides commentary on recent trends and the impacts of any changes.

The three key directions in Canterbury's Health Services vision for future health services are:

- Further development of services that support people to take increased responsibility for their health and a change of approach within existing services to support this
- Development of primary health care and community services' capacity and capability to support people in a community based setting and provide a point of ongoing continuity
- Freeing up secondary care based specialist resources to be responsive to episodic events, more complex cases and the provision of advice and support to primary care.

Redeveloping facilities was identified as a necessary enabler to meet the future need of the Canterbury Health System in a 2010 Business Case.

The earthquakes of 2010 and 2011 have had a major impact on the people of Canterbury as well as the Canterbury Health System. While the health system has been able to maintain and deliver innovative services to address the emerging needs of our population, there remain a number of significant challenges and successes; we still have broken buildings, and stretched capacity and we have a population that is more fragile and more likely to require support from our health system, particularly for mental health services. The ongoing delivery of care and services in buildings that don't comply with new building codes while we repair and redevelop our building stock requires balance with the immediate harm caused by denying our population access to services.

The ongoing uncertainty is draining the community's resilience and related health issues are emerging. We face further challenges to meet our population's needs with sub-standard housing, crowded, damp and cold conditions. We look forward to occupying new/redeveloped facilities in the coming months.

The opening and occupation of the redeveloped Burwood Campus has delivered the first major hospital build within the broader investment program. While realising the advantages of this new infrastructure will take time, transition has been smooth and new practices are being established.

REALISING THE BENEFITS

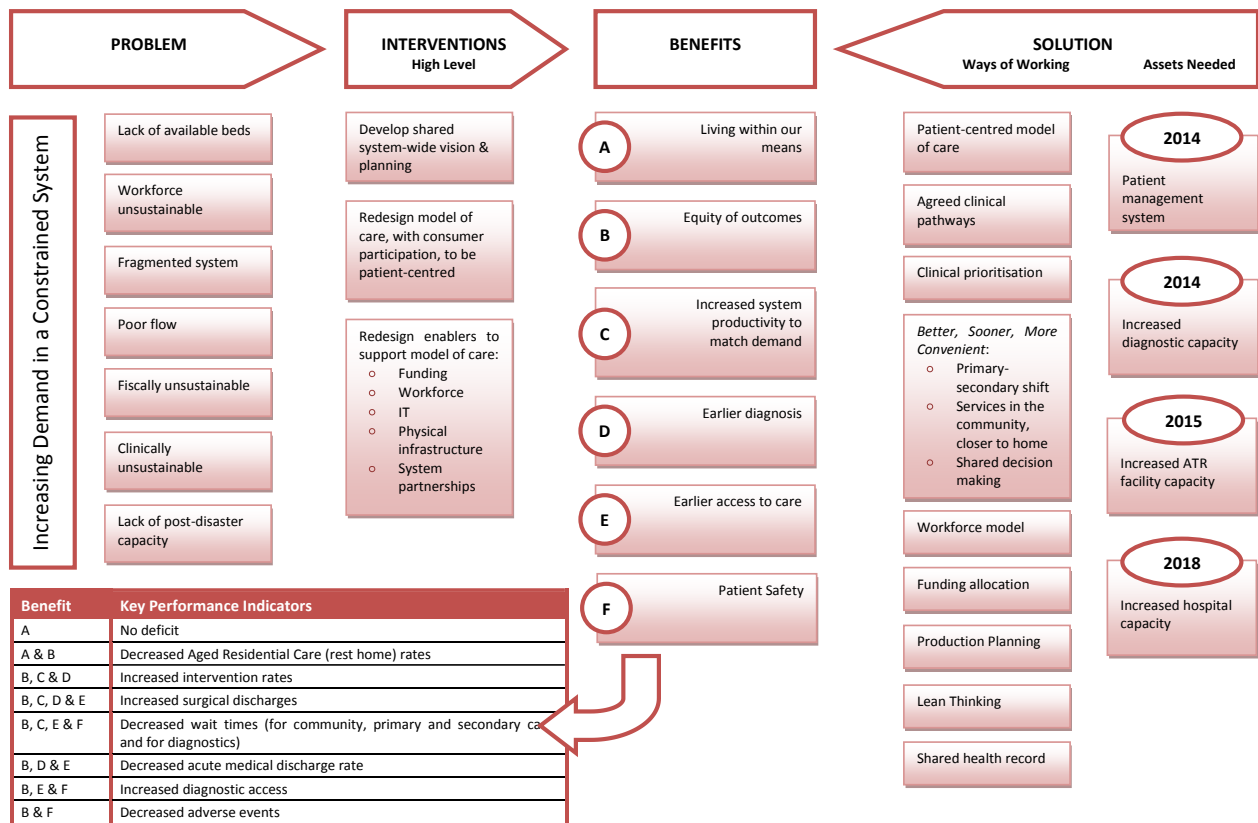
The benefits to be realised from the facilities redevelopment program are directly linked to the objectives for the health system. Benefits realisation focuses on ensuring that the full hypothesised benefits of the projects, primarily improved health service provision, are achieved.

Designing the best-fit benefits realisation approach has been undertaken alongside the development of a 'whole of system' outcomes framework for the Canterbury Health System. The DBC and the associated Investment Logic Map developed to support the Business Case underpin the benefits realisation approach.

It should be recognised that the new facilities are an enabler in a transformational journey that commenced well before the development of the Business Cases and as such will continue after the commissioning of the

new buildings. In this context the benefits should be viewed as accruing from an integrated strategy for transformation that goes beyond the implementation of the new facilities.

Investment Logic Map



What we've achieved

The following section represents a report on the Key Performance Indicators identified in the *Investment Logic Map*. This is in addition to the work we are undertaking to manage the increased earthquake-related demand (especially mental health and emergency services) which were not anticipated in the Business Cases.

NO DEFICIT

Situation

Canterbury has to manage within its financial means in a post-earthquake environment. Although external review of our financials has confirmed that Canterbury was on track to achieve a surplus in 2010/11 prior to the February earthquake, there has been earthquake costs totalling \$107 million over the four years following the earthquake; Canterbury has delivered a cumulative deficit of \$84 million which has been deficit funded by the Ministry of Health.

Since 2015/16 Canterbury's financial position has been explored through two external reviews conducted by PwC which have consistently indicated Canterbury DHB's operating expenditure is well managed but depreciation, interest and capital charge are having and will continue to have a significant impact for the foreseeable future. Stage 2 of the PwC financial review focused on financial and system sustainability has been analysed and a number of strategies have been implemented to ensure operational efficiencies of 0.8% are achieved in 2017/18 (achieving cumulative annual efficiencies of 0.8% each year will be extremely challenging in light of Canterbury's falling share of the national funding pool).

The expected funding path in the DBC has not eventuated as Health has received a lower funding growth rate than advised by the National Health Board in 2012. While achieving operational efficiencies has mitigated the lower funding path, the fall in national share of the funding pool has created deficits in 2016/17 and forecast in 2017/18.

What did we do about it?

Over the past five years Canterbury has developed new service delivery models, funding and contracting mechanisms that minimise the financial risks and enable the continuation of service delivery despite constrained theatre and bed capacity. Most community services are now capacity contracted and elective services are creatively purchased which in aggregate are 13 to 17 percent below national pricing.

Furthermore the PwC review and other recent analysis has demonstrated Canterbury is relatively efficient in its service delivery in comparison with similar DHBs. This finding is consistent with recent reports from Treasury which Canterbury DHB the fifth most efficient DHB and is within five percent of the best DHB, and the Australasian benchmarking group, Health Round Table, which rated Canterbury as the most efficient of the larger DHBs.

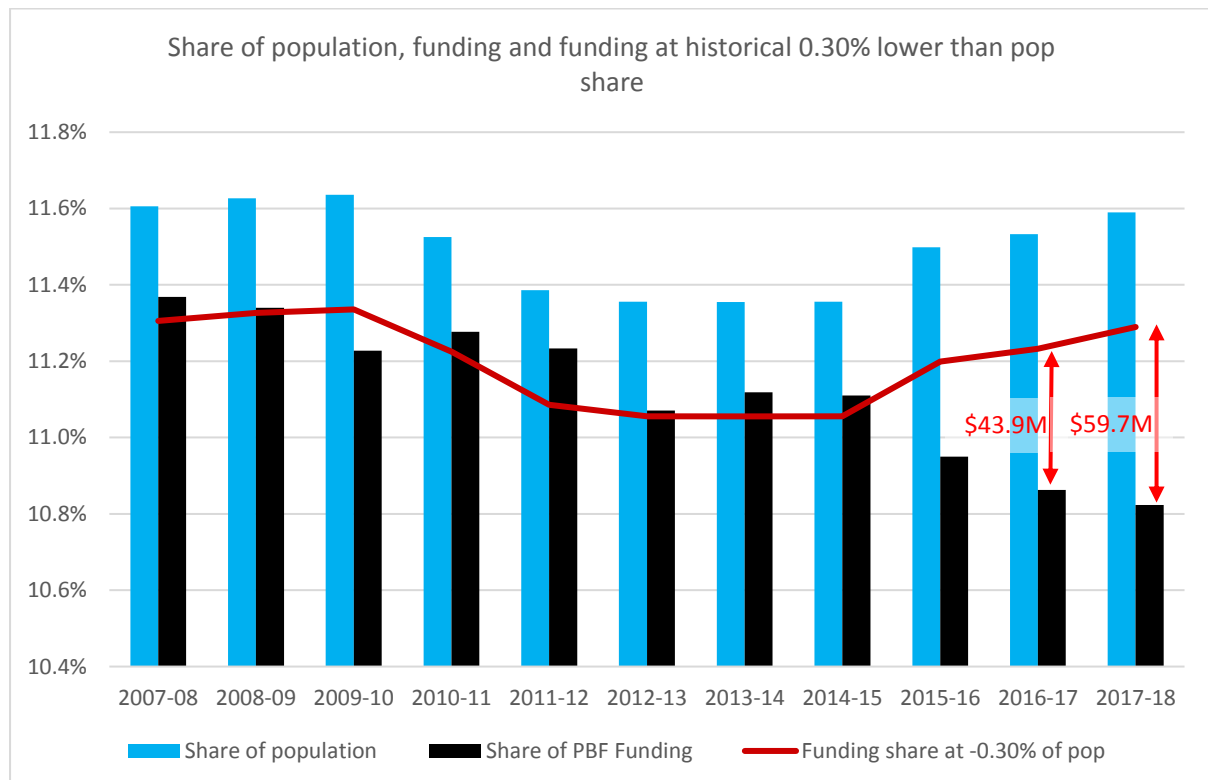
The predicted post-disaster increase in mental health demand has resulted in services running at or over capacity. To meet the mental needs of Canterbury's population, the DHB has continued to develop its model of care with a community focus investing in mental health services from other funding envelopes to better

address the needs with timely intervention. The population’s extraordinary post-disaster mental health need has been recognised with the Government providing an additional \$20 million over four years.

Performance against KPI

Canterbury’s budgeted deficit for 2017/18 is \$53 million.

While Canterbury’s population share has increased since 2014/15 our funding share has significantly decreased; the historical differential of approximately 0.30% between population share and funding share has expanded to 0.77%. This change represents real revenue decreases of \$43.9 million in 2015/16 and \$59.7 million (greater than the deficits in each of these years).



Over the last six years (2011/12 to 2017/18) Canterbury’s funding has increased by \$220 million or 19.2%. However, if had increased at the national average of 23.7%, funding over the last six years would have increased by \$292 million.

DECREASED AGED RESIDENTIAL CARE RATES

Situation

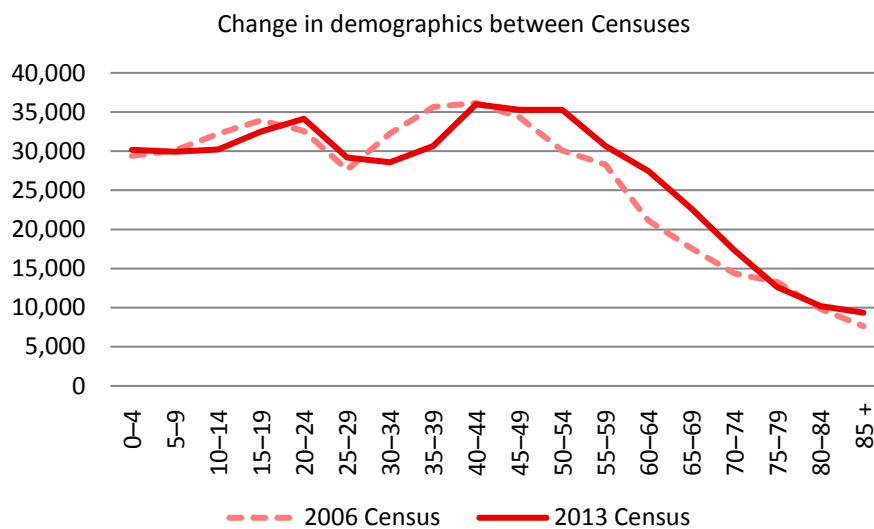
Canterbury lost 635 aged residential care (ARC) beds post-quake. Due to a large scale private investment there is now an oversupply of capacity which has allowed a return of respite capacity. Canterbury has historically had a high proportion of older people in ARC, which was identified as a measure to be reduced as part of our investment logic approach.

What did we do about it?

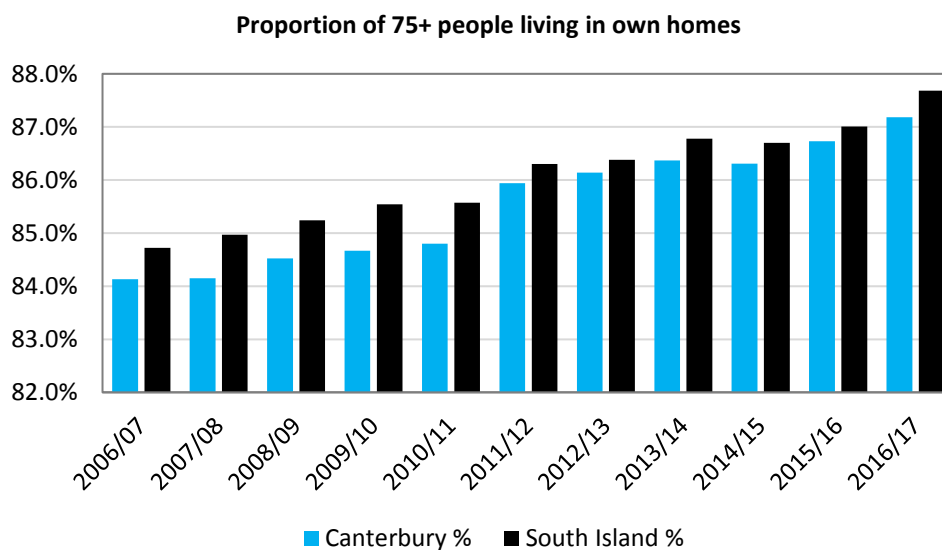
Canterbury has invested in new models of care (integrated district nursing and restorative home-based support and CREST in particular) which had been designed to keep people well and healthy in their own home and reduce the rate of entry to ARC.

Performance against KPI

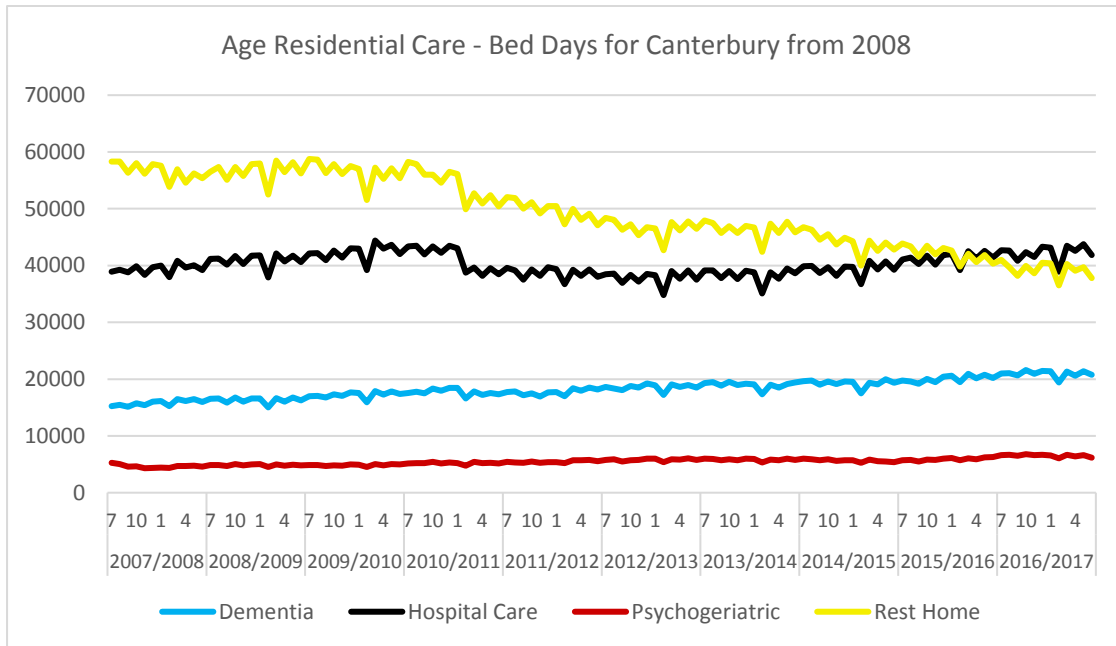
Canterbury continues to have an increasing aged population and has the largest DHB populations of over 65 years and over 75 years in absolute numbers, however while remaining above average these proportions of national share have slightly reduced as the national population also ages.



However the rate at which people are entering aged residential care has declined and there are over 560 fewer people in rest home and hospital level care than in 2009/10. This represents a reduction in the proportion of people aged over 75 years in institutional care as well as a reduction in absolute numbers.



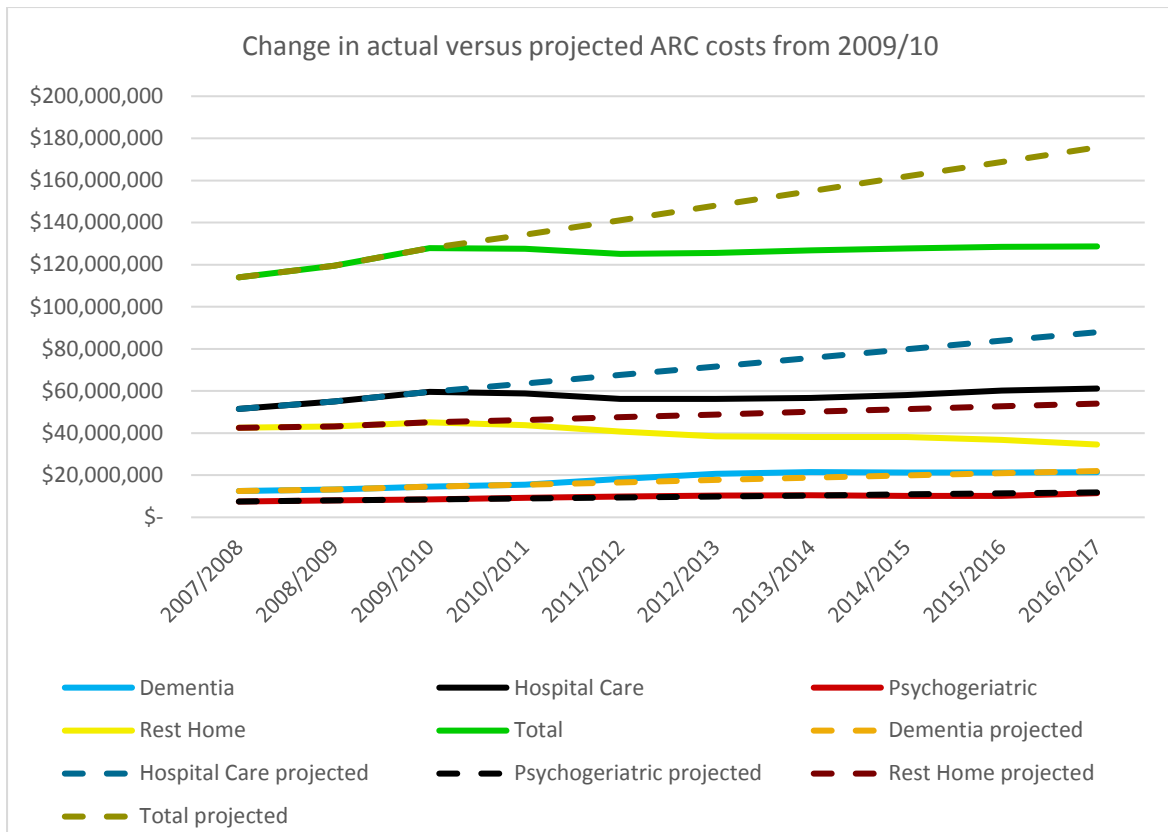
The length of stay on entry has also reduced from 50% remaining in care at 26 months in 2006 to 50% being in care under 12 months.



What does this mean?

The combined interventions have meant expenditure on Aged Residential Care has plateaued since 2010 despite price increases each year. The annualised foregone expenditure for 2017 were \$26.7M for hospital level and 19.4M for rest home level based on projections from 2009/10.

The Detailed Business Case proposed Canterbury would decrease Rest Home bed days from 27% above the national average in 2011/12 back to the national level by 2020. This has been achieved in advance.



INCREASED INTERVENTION RATES

Situation

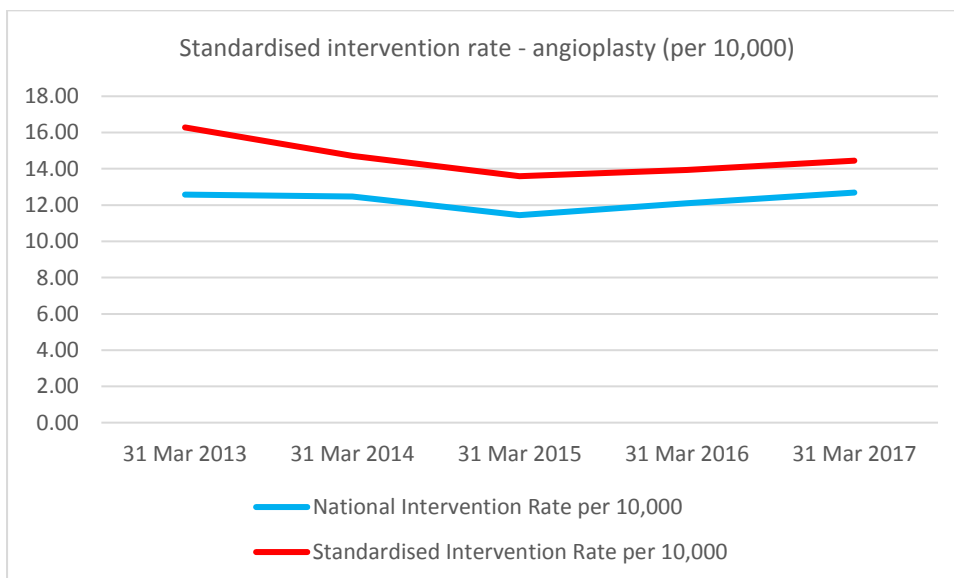
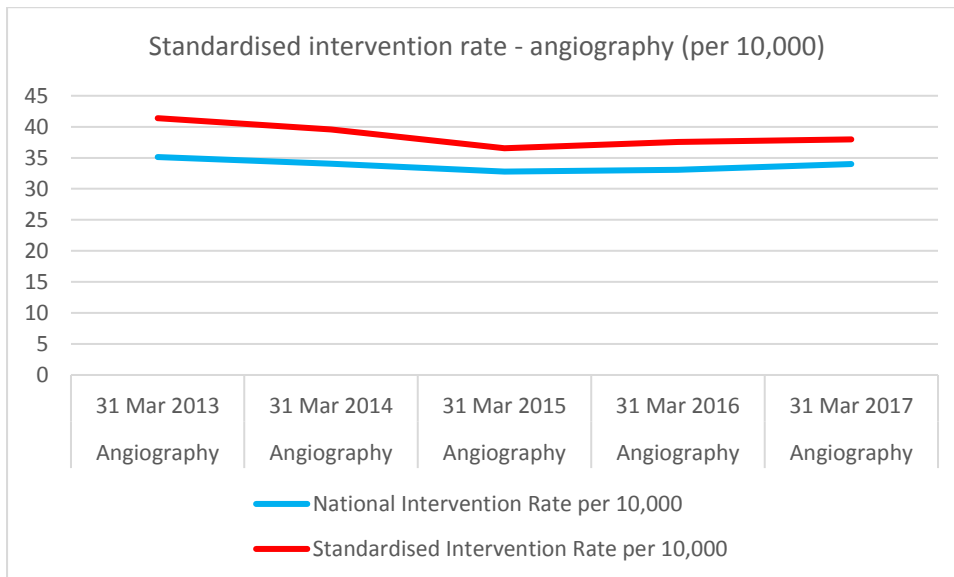
Ensuring an increasing focus on planned care underpinned the investment logic map, particularly over winter when acute demand is highest increasing the risk of cancelling surgery. This has been addressed by increasing the range and level of community interventions (e.g. Acute Demand Management Services, CREST, Medication Management, and Community Falls Prevention) to reduce acute admissions and allow greater planned activity.

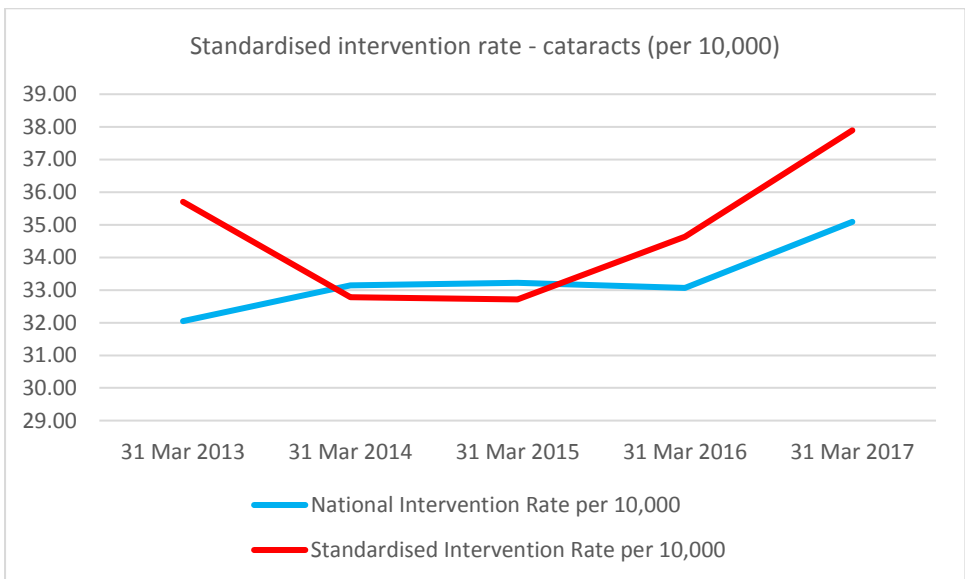
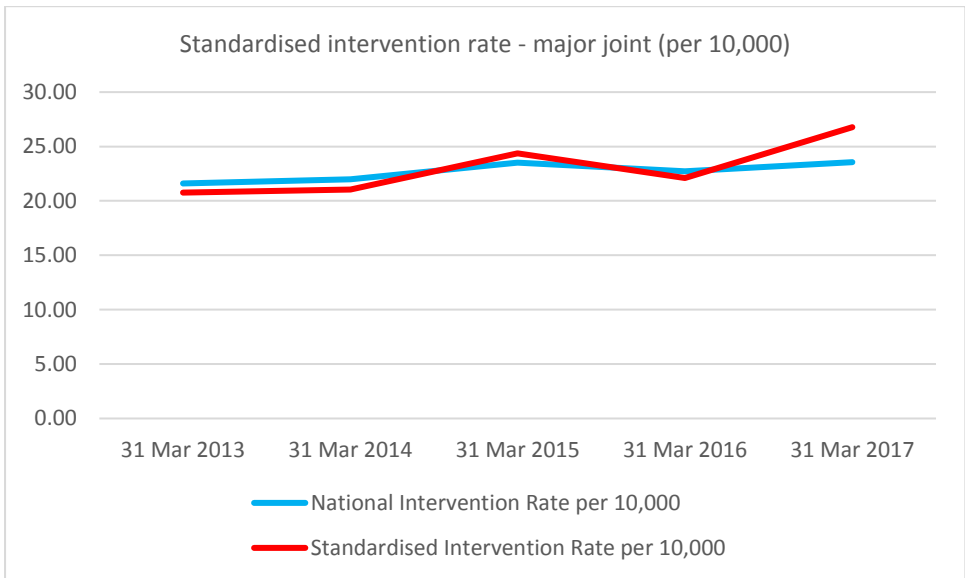
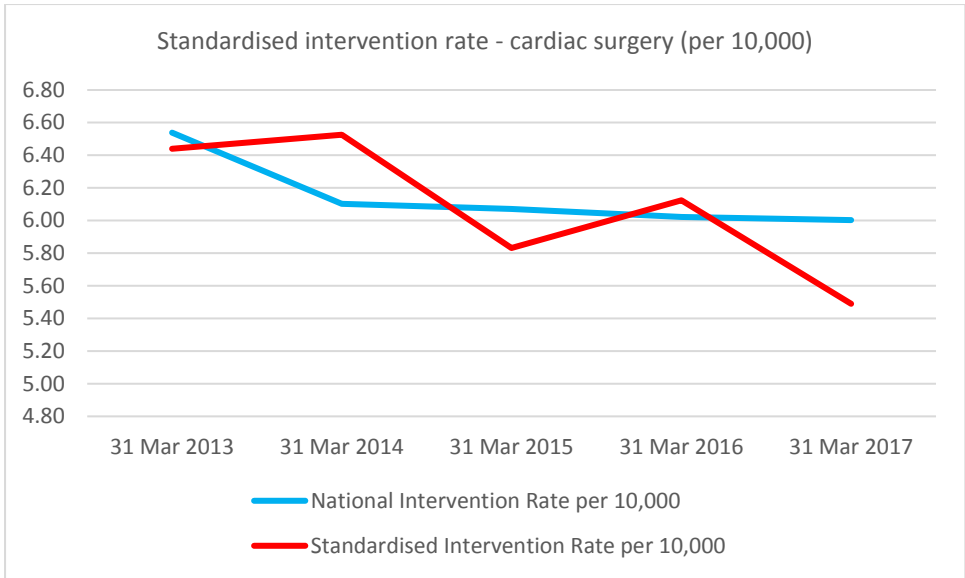
What did we do about it?

Canterbury is severely constrained by the number of theatres available for surgery. The Electives Recovery Programme outsourcing was established to ensure sufficient theatre time and capacity in key areas to improve intervention rates. In house theatre utilisation has been maximised resulting in annual growth in the proportion of outsourcing (now 14% of all elective surgery) to guarantee improved intervention rates. However this ability to further increase outsourcing is now being limited by the complexity of surgery that means it cannot be performed in the private system. Increased attention on important pathways such as fractured neck of femur and major joint surgery have been the focus of new approaches under the enhanced recovery after surgery initiative.

Performance against KPI

Canterbury's intervention rates are significantly above national rates for angiography, angioplasty, cataracts and major joints (which has improved in recent years). Only cardiac surgery is below national intervention rates.





What does this mean?

Canterbury's intervention rates have meant people in Canterbury have better access to elective surgical services resulting in Canterbury DHB achieving the Health Target volumes each year.

INCREASED SURGICAL DISCHARGES

Situation

Bed capacity at Christchurch Hospital was reduced post-quake resulting in increased risk of cancelling surgery over winter (as above).

The Intensive Care Unit is running at maximum capacity, preventing some elective surgery and blocking patient flow.

What did we do about it?

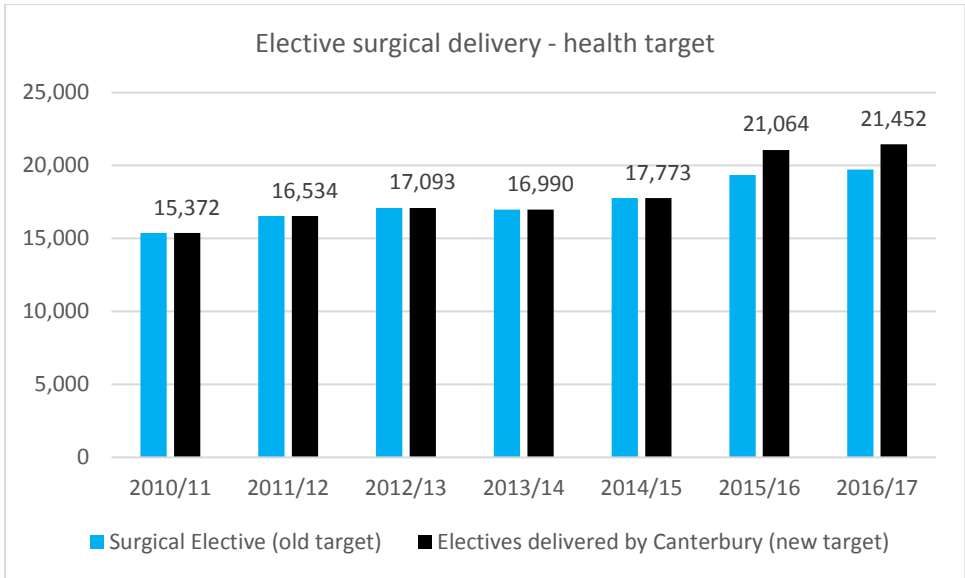
Our Electives Recovery Programme was implemented, including establishing outsourcing contracts for elective surgery with private hospitals including leased theatres where our staff perform the surgery.

We introduced the Orthopaedic Non-Weight Bearing Model of Care for non-weight bearing patients (after neck of femur, or NOF, surgery). Access to dedicated acute theatre lists for orthopaedics was increased to reduce pre-operative waiting (especially for fractured NOFs). This has reduced the requirement for beds and delivered a better outcome for patients by providing faster access to surgery and less time in hospital.

More recently, our focus has been on developing Enhanced Recovery After Surgery (ERAS) processes for hip and knee replacement which have resulted in improved patient pathways and less waiting.

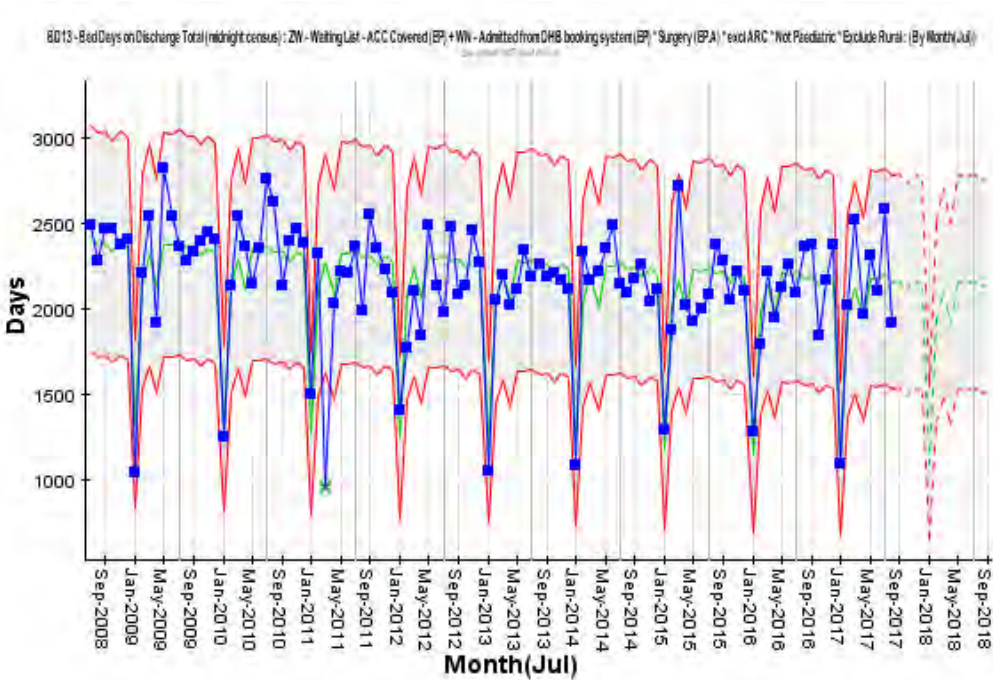
Performance against KPI

Canterbury has delivered more elective surgery to its population. This has been achieved despite the substantial removal of minor interventions such as Avastin and simple skin lesions from the analysed elective surgery volumes.



Updated with new (2015/16) health target definition

There has been an overall 39.6% increase in health target elective surgery delivery between 2010/11 to 2016/17. The planned electives have increased 28.3% during this period which has been accomplished with a 3.0% reduction in bed days.



Despite difficulties earlier Canterbury achieved its elective target of a 550 target uplift and surpassed this by over 400 electives in 2016/17. However, achieving the increasing demand remains challenging due to system constraints – there are insufficient theatres and hospital beds in Canterbury to deliver the services for our population until the opening of the Acute Services Building. In addition, we are reaching limits for outsourcing both in terms of capacity and ability to cope with complexity among our private sector partners. Canterbury aims to achieve targets this year by increased outsourcing.

What does this mean?

The large increase in elective surgery maintained within a similar bed day level demonstrates internal efficiencies of over 40% across this time.

REDUCED WAITING TIMES

Situation

Capacity constraints in all parts of the system put pressure on achieving wait times. This applies to theatre capacity, bed capacity, outpatient capacity and diagnostic capacity.

What did we do about it?

HealthPathways, ERMS (electronic request management system) and more recently HealthOne have contributed to ensuring that only priority people are referred to secondary care and much of the required care is now delivered in a community-based setting. These tools support a model of care with improved triage and enables hospital clinicians to provide advice without seeing the patient face-to-face.

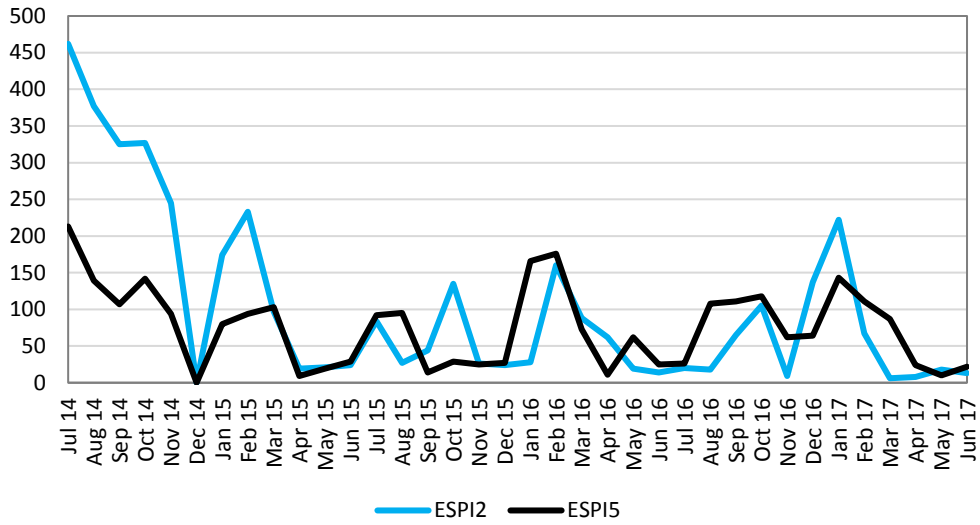
The impact of these initiatives so far is:

- Medical specialists see 79 people for FSA for every 100 people seen nationally and 31% of all recorded virtual FSAs are conducted in Canterbury – a more efficient use of time
- Surgical specialists see 77 people for FSA for every 100 people seen nationally and deliver 25% of all virtual FSAs
- Almost 11,000 procedures were delivered in general practice in 2016/17 funded by the DHB
- General practice accessed 45,227 radiology investigations delivered free in the community without their patients needing an FSA.

Performance against KPI

Aligned to national direction Elective Services Performance Indicator (ESPI) Waiting Times in Canterbury have been reduced with fewer patients waiting 120 days for First Specialist Assessment and Treatment (ESPI 2) and resulting treatment (ESPI 5).

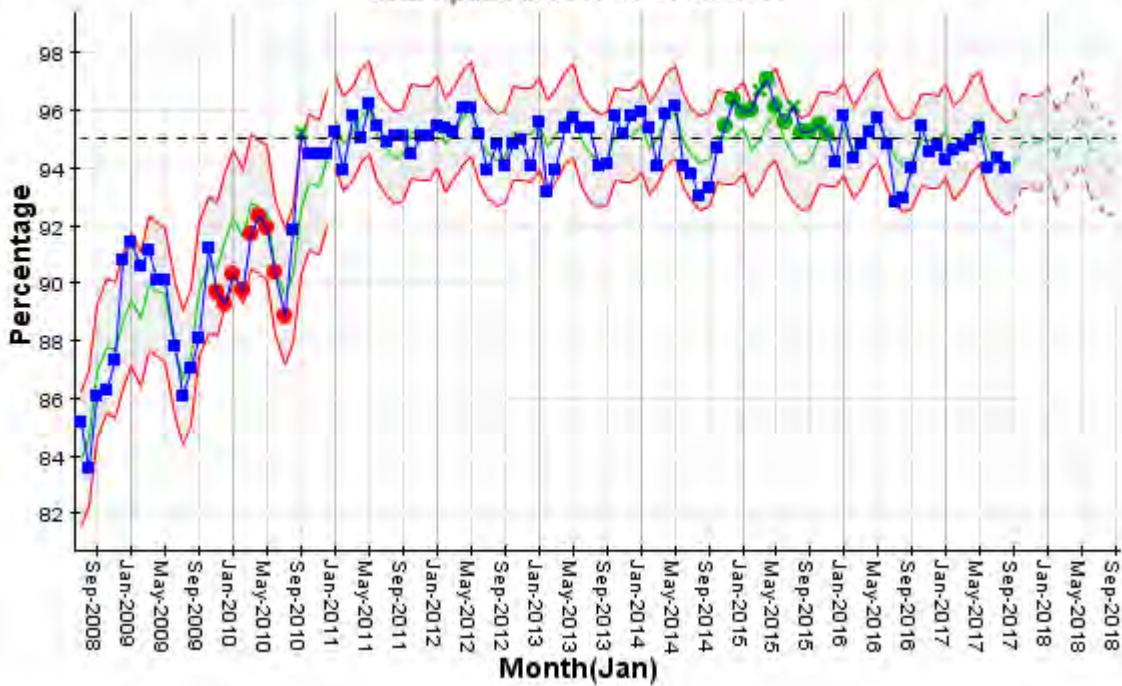
ESPI 2: Number of people waiting >120 days for FSA



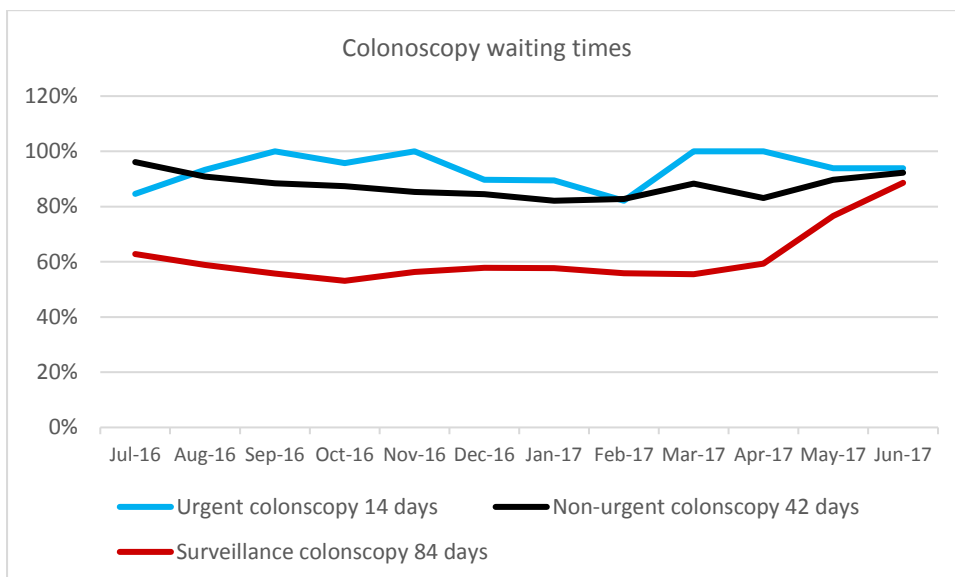
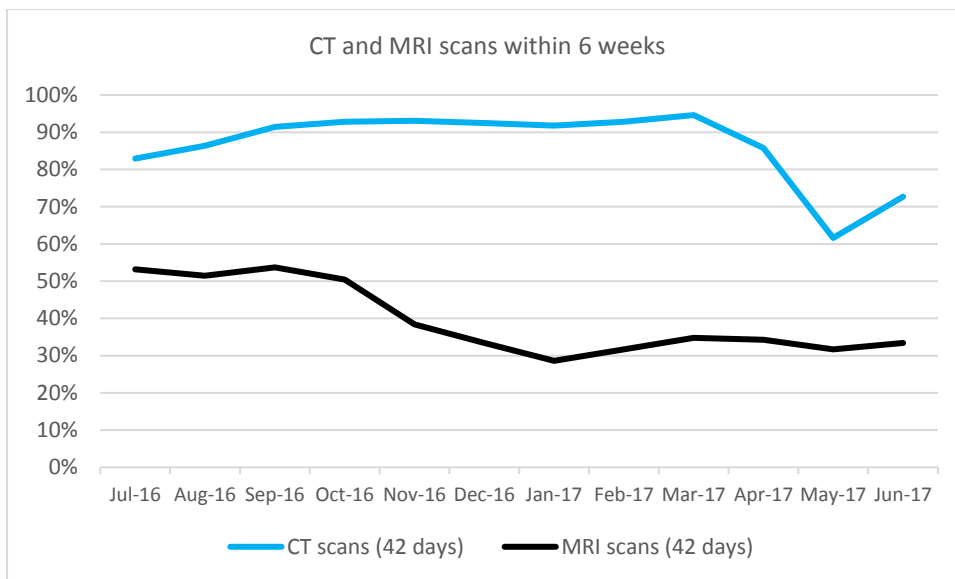
In all but a few quarters since 2010 Canterbury achieved the ED Waiting Time National Health Target of 95% of people either discharged or admitted within six hours.

EDC - % of all patients in ED within 6 hours : (By Month(Jan))

Data Updated: 2017-09-04 06:03:41



Canterbury has focused on high productivity in the provision of diagnostics to our population. Waiting times for non-urgent CT and MRI scans have been under pressure as volumes have grown and recruitment of staff has long lead times. Colonoscopy waiting times have shown improved performance.



What does this mean?

People in Canterbury are being seen quickly. This approach is ‘best for patient, best for system’ meaning timely treatment, less waste and rework and greater potential for people to regain functional abilities in their lives. More rapid access also impacts on the anxiety people have while waiting for their diagnostics and increased trust in the system.

DECREASED ACUTE MEDICAL DISCHARGE RATE

Situation

After the 2011 earthquakes, there was a reduction in medical beds. While some capacity has been restored, there are fewer total hospital beds today than pre-quake. Our ARC capacity was also under pressure with

frequent blocked patient flow from Assessment, Treatment and Rehabilitation (AT&R) which in turn blocked flow from General Medicine, stretching the capacity of the entire system.

The lack of flow meant unplanned medical services (or acute demand) put at risk delivery of planned health care (e.g. electives). Meanwhile, services had to prepare for post-quake populations with greater health need as a result of increased deprivation, poor housing and winter.

The importance of managing acute demand is recognised in the IPIF program with acute bed days being one of the four system level measures being monitored from July 2016.

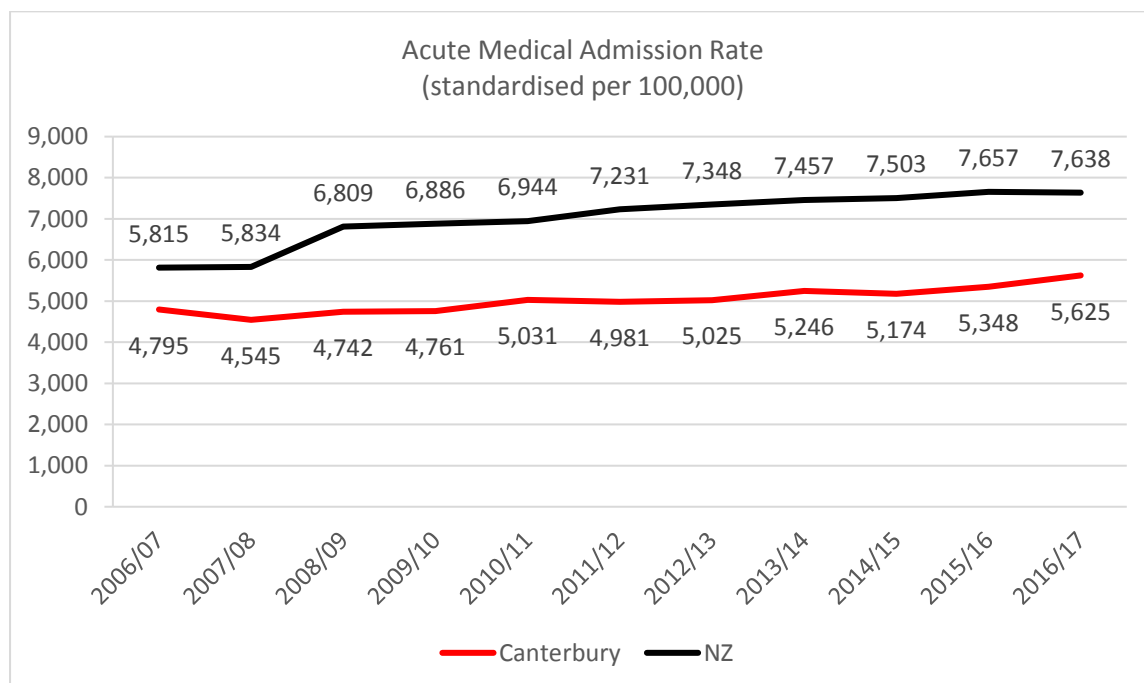
What did we do about it?

Our Acute Demand Management Services (ADMS) were enhanced and ramped up to increase community capability and capacity to manage acutely unwell patients and reduce unplanned admissions and bed demand. Medical ward beds were reconfigured and AMAU was extended as key strategies to cope with acute medical admissions.

The Community Rehabilitation Enablement and Support Team (CREST) was introduced to increase supported discharge options and reduce acute and ARC admissions and readmissions – particularly among the older population. A new triage and diversion system was designed to send Ambulance and ED patients to the primary care After Hours Clinics to further decrease acute demand from people who could be better supported in the community.

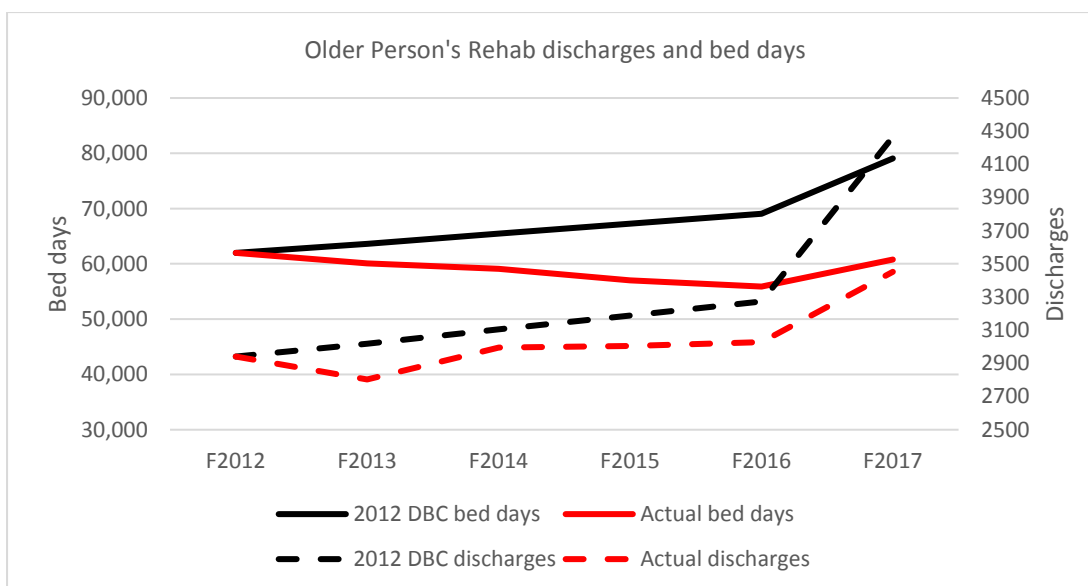
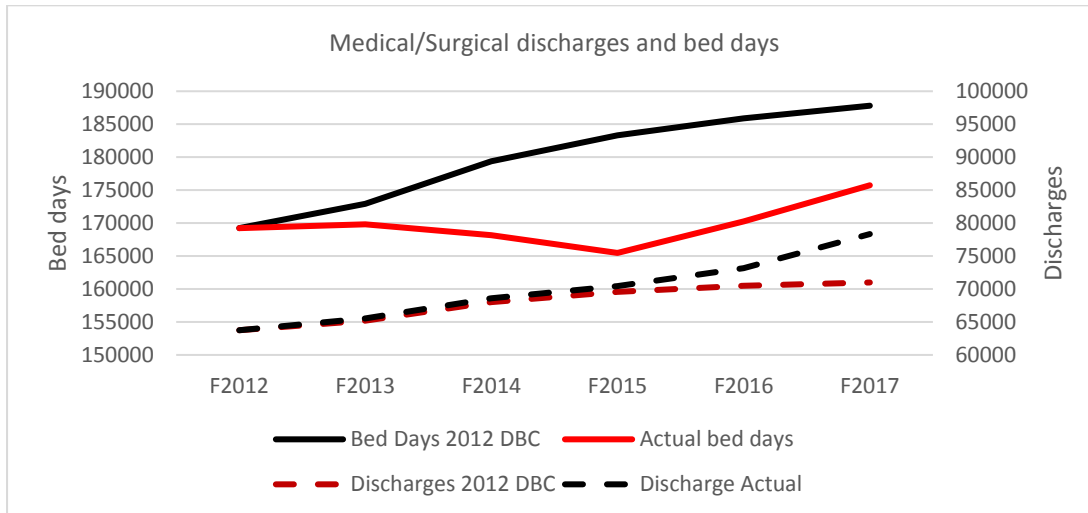
Performance against KPI

Canterbury has continued to maintain its relatively low rate of acute medical admissions. While national acute admission rates have grown significantly, increases in Canterbury have been modest.



There has been a reduction in unplanned occupied beds (medical, surgical and AT&R) since the earthquakes, while the associated discharges have increased indicating greater efficiency within our services.

The assumptions about growth after accounting for demographic growth in the detailed business case (DBC) relied on modified demand efficiencies for intervention rates of 5% for general medicine, cardio/respiratory, 2% for acute general surgery and acute orthopaedic surgery (and 0% for elective general surgery and elective orthopaedic surgery) and length of stay efficiencies of 5% for all specialties, with a further step change of 2% in 2019.



What does this mean?

The ability to prevent or slow unplanned demand growth is a strength of the Canterbury Health System and an outlier nationally. Between 2006/07 and 2016/17 acute medical admissions grew by 17 percent in Canterbury compared with 31 percent nationally. If Canterbury performed at the national average there would be approximately 13,000 more acute medical admissions.

The financial impact of an increased admission rate can be modelled; assuming an average national length of stay of 3.56 days (excluding day cases), 109 additional beds would be required, equating to approximately \$30M in 2016/17.

Against the ambitious DBC assumptions, Canterbury admissions to medical/surgical were higher in 2016/17 than forecast by 10.3 percent, however to medical/surgical bed days were 6.9 percent below forecast (and had only grown 3.9% since the 2011/12 DBC baseline). In addition, admissions to older person's rehab were 19.1 percent lower in 2016/17 than forecast and bed days were 23.1 percent below the DBC forecast (and had decreased by 2.0 percent since the 2011/12 DBC baseline). This represents a total decrease of 1,212 bed days since 2012 despite the opening of more capacity at Burwood Hospital.

The reduced demand for acute medical beds has averted significant capital expenditure costs in the hospital redevelopment programme.

INCREASED ACCESS TO DIAGNOSTICS

Situation

Following a rationalisation of private providers post-quake, the expectation of delivery of radiological diagnostics continues to increase. The need to repair the facilities of the remaining provider over time put the maintenance of service delivery at risk.

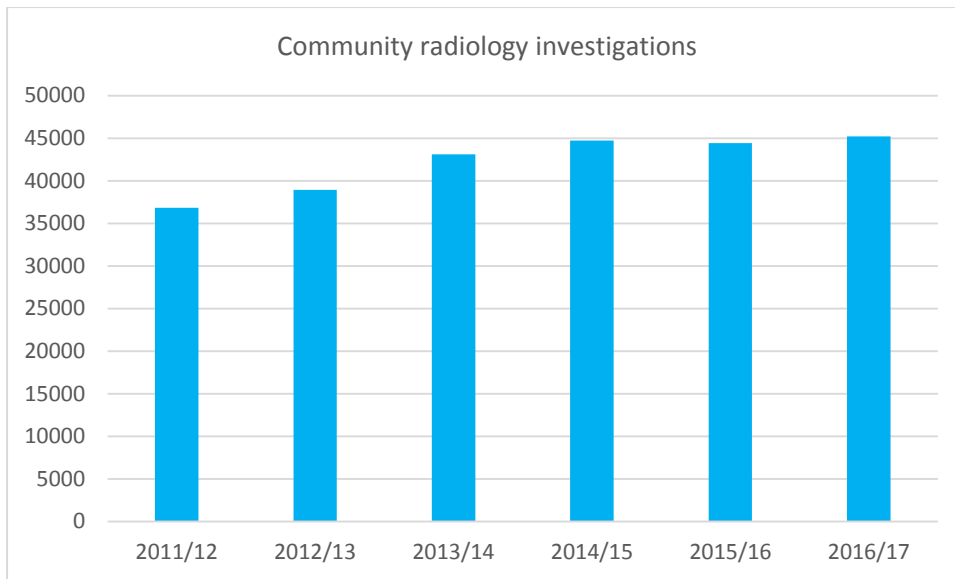
What did we do about it?

We purchased the kit (at book value), took over the lease and employed the staff from the closing private radiology provider. This provided much needed staff resources and a second MRI machine as well as other useful equipment. The ability to deliver diagnostics from a second site has been invaluable in maintaining access to outpatient and community referred diagnostics. HealthPathways has provide an agreed mechanism for ensuring appropriate access to radiology services.

With the Burwood Hospital redevelopment, expanded radiology services will be provided from this site using both new and existing kit as well as staff from Merivale.

Performance against KPI

Direct access to community radiology via general practice has been a strength of the Canterbury Health System with over 40,000 investigations now conducted each year.



What does this mean?

Direct access to radiology from general practice (through an active referral triage process) has been enabled by HealthPathways to support clinical practice and reduce wait times resulting in better outcomes.

DECREASED ADVERSE EVENTS

Situation

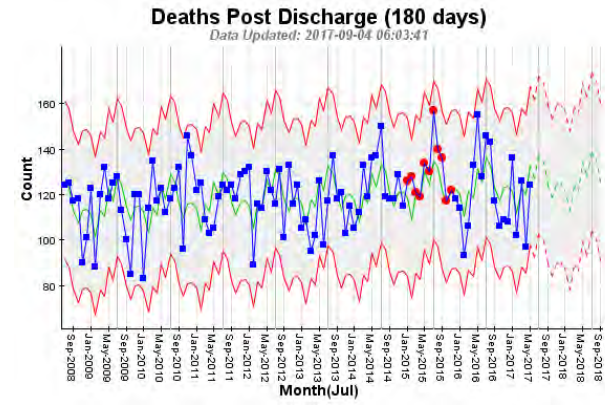
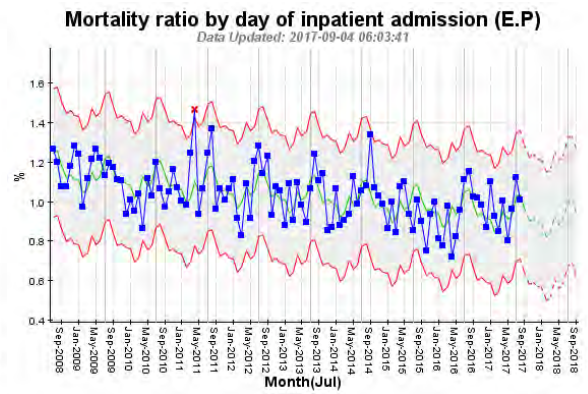
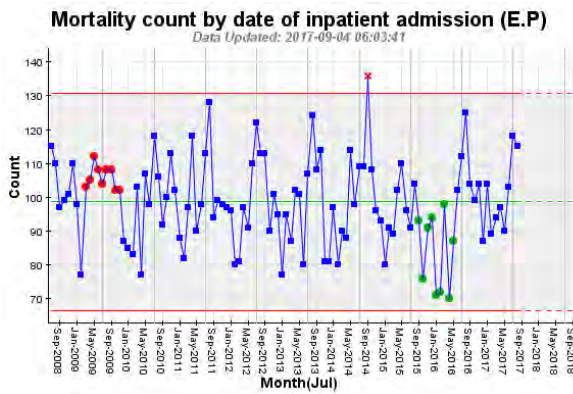
Capacity constraints in all parts of the system, building damage and the complexity of delivering services in broken buildings, temporary accommodation with associated moves and decanting across multiple sites has put pressure on reducing adverse events.

What did we do about it?

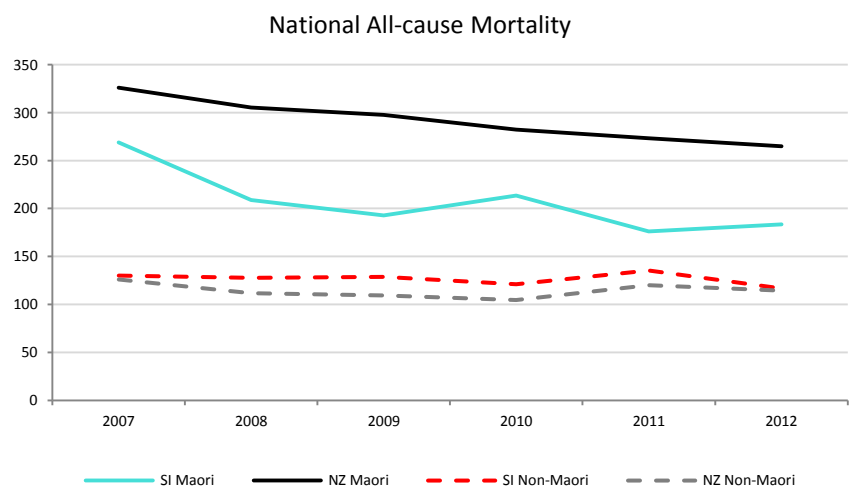
Canterbury has been a leading participant in all of the national quality and safety improvement programmes.

Performance against KPI

Mortality KPIs have been closely monitored over time.



Rate of all-cause mortality under 65 (age-standardised) demonstrates Canterbury Maori are better off than Maori in other parts of New Zealand while non-Maori have similar rates.



What does this mean?

The balancing metric of mortality is important to the Canterbury Health System due to the focus on community care. The low acute medical admission rate means there is a concentration of acuity in our hospitals as only those who require hospital level care are admitted and those less complex patients remain in the community. To date hospital mortality measures do not reflect unintended effects despite greater risk and increased complexity.

Monitoring community mortality will also provide warning signs as we push the boundaries of what can be treated in the community.