

Canterbury

District Health Board

Te Poari Hauora o Waitaha

SUMMARY ANNUAL REPORT

1 JULY 2004 – 30 JUNE 2005





This summary financial report has been extracted from the full financial report dated 26 September 2005 and cannot provide as complete an understanding as the full financial report. The full report can be found on our website, www.cdhb.govt.nz

Our Vision – Ta Matou Matakite

To promote, enhance and facilitate the health and well-being of the people of the Canterbury district

Ki te whakapakari, whapamaanawa me te whakahaere i te hauora
Mo te orakapai o ke takata o te rohe o Waitaha

Values – A matou uara

Care and respect for others
Manaaki me te kotua i etahi

Integrity in all we do
Hapai i a matou mahi katoa i ruka i te pono

Responsibility for outcomes
Kaiwhakarite i ka hua

Ways of Working – Ka huari mahi

Be people and community focused
Arotahi atu ki ka takata me ka iwi whanau

Demonstrate innovation
Whakaatu whakaaro hihiko

Engage with our stakeholders
Tuu atu ki ka uru



CONTENTS

Chairman's Report	02
Board Members	04
The Year in Review	05
Highlights and Achievements	08
Chief Medical Officer – Dr Nigel Millar	14
Executive Director of Nursing – Mary Gordon	15
Executive Director of Māori and Pacific Health – Hector Matthews	16
Other Priority Areas	18
Primary Health Organisations	20
Hospital and Specialist Service Division	22
Community Contracts	28
Statement of Objectives and Service Performance 2004 – 2005	29
Summary of Financial Statements 2004 – 2005	41
Glossary of Terms	46
Directory	Inside Back Cover

CHAIRMAN'S REPORT



Syd Bradley,
Chairman

The year ending 30 June 2005 has been one of sound and continuous improvement for the Canterbury District Health Board (CDHB). We have continued to meet our contracted volumes and targets for our community as agreed to with the Minister of Health in our business plan. At the same time we broke even

financially. In this particular sector that is an outstanding result for a highly complex tertiary board. In part this is due to sound fiscal policy setting by the board and the efficient implementation of that policy by management, clinicians and support staff.

Such an excellent result does not happen without considerable effort by everyone in the public health services and accountability chain. This includes much improved monitoring of performance at all levels of the organisation and sound clinical and staff responses, based on improving relevant data and investment into frontline systems that assists them to reverse negative trends and meet patient service obligations and operating budgets. The year ahead will continue to have this focus on continuous improvement.

Following the local body elections the Minister appointed several new members to the board and others were elected by the community. It is to their credit that these members have taken up new responsibilities and mastered a significant learning curve while continuing the good governance of the organisation.

Retiring board members left a very sound platform from which the new board has been able to govern and monitor performance. I thank them for this and their significant contribution as the inaugural members of the CDHB in very challenging transitional circumstances.

Population based funding, operational budgets and meeting specific and measurable funded service contracts

have been a useful, fair and pragmatic catalyst and discipline for the board and staff to use positively – in the main to facilitate the review of our overheads and several of our primary and secondary public health services. In a rationed and constrained environment with high public expectations this must also include our total operating cost base. This is a base that needs to be well understood and managed fairly and productively.

Frontline operational systems investment and consolidation have been a feature of the last three years. They will continue to be a built-in feature as we enhance and consolidate their utilisation and design. We have given, and will continue to give priority to our operating costs as we strive to maximise our productivity performance in providing services for the benefit of our community within our share of population based funding. Objective and accurate frontline operating systems will fairly present the information that is urgently needed to address improved performance opportunities – they will also confirm how well we are doing and eliminate subjective and uninformed debate.

As the largest District Health Board in the country we have an obligation and the ability to lead the way, be operationally match-fit and contribute to the affordability and long term sustainability of public health services for our community.

The continuing priority of investing in frontline systems and processes to provide good data to enable planning to match accurate patient demand predictions to resources will continue to receive priority through the next three to five years. The prime objective is to give frontline staff the tools to do the complex and demanding job we ask of them to ensure that we achieve effective utilisation of the valuable health dollars made available to us for the benefit of our community.



The Board will not resile from investing and applying commercial best practice for public good benefit in these critical frontline support system areas.

A further focus and objective as a funding body with a provider arm has been to take demand pressure off our hospitals. This work has been, and will continue to be given priority. It will also require innovative funding changes and risks involving operational change to give demand relief. The Emergency Department bears testament to this need. This flows through into our entire hospital and primary services, where significant change must evolve in a planned and consultative way that directly involves secondary and primary health providers.

Hospital and primary provider staff must be involved in this critical work from the outset. The benefits to the community must also be well communicated. This will not be a revolution of change and disruption but a practical challenge for all those involved to think the opportunities through and contribute to a process of change that can demonstrate clear benefits to both our public health consumers and our operating costs.

The emerging role of Planning and Funding as an independent party will be a critical aspect of facilitating operational and funding changes between our two provider arms. Maintaining safety, quality, and consumer convenience, involving agreed innovation and carrying some risk will be the key ingredients for success. It will also focus capability on service changes and monitoring operational performance in the provision of services to ensure that the board and its community achieve value for money in terms of the services they fund.

We have achieved some major building milestones this year. The most important was the long awaited completion of Christchurch Women's Hospital, which was officially opened in May by the Prime Minister. This \$79.8m

building is a credit to everyone involved in its development. It was also completed in a construction environment that was very challenging. This is a credit to all concerned and delivers the great message that the public health sector can get it right if it employs the right skills and experience and applies commercial best practice disciplines for public benefit.

Next year we will see the completion of The Stage 2 Refurbishment Plan at Burwood Hospital and the start of the new Diabetes and Home Dialysis Centre to be constructed on the Christchurch Hospital campus.

My last word goes to our primary health providers and their staff who continue to reposition themselves to take forward the critical primary health strategy. They remain an example to us all of how to take on board major change with little high-profile recognition. They do this with minimum fuss and get on with the job in an area of health that is critical to the present and future effective delivery of public health services. While posing a major challenge, their future growth and development, supported by service and funding changes, will be an exciting phase in the life and accountabilities of this and future boards for the benefit of the greater community of Canterbury.

In conclusion, I commend the board, our hospital provider, contracted primary providers and their combined staff for their ongoing commitment to public health services, and acknowledge the assistance of the Minister's Office and the Ministry of Health staff, their expertise and advice.

Syd Bradley
Chairman
Canterbury District Health Board

BOARD MEMBERS



Syd Bradley, Chairman (re-appointed), has been closely involved in the governance of the health sector for 15 years, and has chaired the Canterbury District Health Board for the past four years.



Jo Kane (elected) is a Waimakariri District councillor and Deputy Mayor, who believes in the basic responsibility to protect family health, and the right to wellbeing of all.



Olive Webb, Deputy Chairman (elected), is a clinical psychologist with over 30 years' experience and works as a health and disability consultant around New Zealand. She has served on the Canterbury District Health Board for four years and is committed to rural health issues and delivery.



Laurence Malcolm (elected) is a doctor and former professor of community health. He has served on World Health Organisation committees and is internationally recognised as an expert in health and medical care.



David Morrell (elected) has served on the Canterbury District Health Board for three years, and is well known for his time as Christchurch City Missioner. He is committed to more accessible and affordable health services for everyone.



Neville Fagerlund (appointed) is a chartered accountant in public practice with 30 years' experience. He has provided financial and commercial advice to community health organisations and providers for several years.



Robin Booth (elected) is a self-employed builder/renovator and author who has served three years on the Canterbury District Health Board. He has a strong interest in community health and preventative medicine.



Karen Guilliland (re-appointed) is Chief Executive of the New Zealand College of Midwives. She is a member of the Pharmac board and Deputy Chairperson of the Health Workforce Advisory Committee.



Alister James (elected) served 20 years as a City Councillor and is a lawyer with a particular interest in the effective delivery of adolescent, mental health, alcohol and drug treatment services.



Norman Dewes (re-appointed) is the chief executive of the urban Maori authority based in Canterbury. He has a background in education, social work, sport and recreation, and is particularly experienced in helping unemployed into the workforce.



Heather Carter (elected) trained and worked as a psychotherapist and is now a workplace and personal development consultant. Women's health and senior health are her particular interests.

THE YEAR IN REVIEW



Jean O'Callaghan,
Chief Executive

The year 2004/05 will go down in the annals of the Canterbury District Health Board (CDHB) for its significant achievements, notable amongst which was the opening of Christchurch Women's Hospital, a facility that not only brings the best in health technology and design, but is also an architectural landmark for the city.

The move from the old Colombo Street site to the Riccarton campus was a major logistical exercise for the whole hospital staff that was carried out with precision and without any issues, the result of months of detailed planning. Congratulations are due to everyone who was involved in all areas of the project, from initial planning to construction, design concepts, artwork, technologies, telecommunications, equipment – the list is almost endless.

It was one event that attracted positive publicity in all its stages and this contributed to the high level of enthusiasm. The official function on 6 May was the 'icing on the cake' and the Prime Minister Rt Hon Helen Clark was full of praise for the hospital and the fact that the project came in 'on time' and 'within budget'.

Since then, the last few months have been a settling-in period for hospital staff in a new environment and on a new campus, which they share with Christchurch Hospital. This has already enabled some savings to be generated with some positive spin-offs for areas like waste management.

It was not just facilities that brought plaudits to the CDHB this year. We achieved local and national recognition with some quality innovations by our staff. Intensive Care Specialist, Dr Geoff Shaw and biomedical engineers, Richard Dove and Kathryn Greenfield won the CDHB's Supreme Award in the Quality & Innovation Awards in August (2004) for their project on reducing over-sedation in critically ill patients. They went on to win the individual award in the National Health Awards in June 2005. At the same time, 'The Purpose & Goals of Energy Management,' an excellent innovation by Alan Bavis and Brendon Groufsky from the Maintenance & Engineering team at Christchurch Hospital won the CDHB's Hospital & Specialist Award in August and went on to win another prize in the National Health Awards.

It was a tremendous achievement for Canterbury to

not only take away two major national awards but to have four of the 25 finalists selected from the 21 District Health Boards (DHBs) in New Zealand, including one from the Nurse Maude Association and another from Christchurch Hospital. I congratulate everyone for their inspiration and integrity of purpose in always looking for improvements that will help our patients and people who come into



the health system.

The third high profile activity that will help keep the CDHB at the top of the innovation ladder not only this year but in future years, is the initiative 'Improving the Patient Journey' due to be launched in July but which has been in the planning and formulating phase for several months now. Led by the Executive Director of Nursing, Mary Gordon and supported by a very good project management team, 'Improving the Patient Journey' is akin to a strategic direction that is focused on the individual and the individual's needs. To get to that point, we need to reassess the system not only within hospitals but externally as well. It is an ambitious project but one that I have confidence will be very successful.



At the start of the year, we knew it would be a challenge to successfully complete another twelve months with a break-even financial position. However, I am particularly delighted that we have achieved this. It has not been easy for many staff and I thank everyone for their commitment to looking at better ways of working that have not only given us a good financial result but have enabled us to be more innovative and creative in our management. As the CDHB enters its third year of adhering to the Population Based Funding Formula, it will become more difficult but no less achievable.

Sound financial management is always central to any organisation's success, but I count as equally successful, the superb way in which staff have responded to the call to look at how we can have a path of continuous improvement for our patients. While this can seem like a never-ending emphasis on frontline staff, it is the good work of administrators, telecommunications personnel, information services, laboratory technicians, legal advisers,



security staff, orderlies, cleaners and many others that enable that improvement to happen.

One of the major milestones this year was the introduction of all CDHB premises and facilities to the reality of becoming smokefree environments. I have supported this project from the outset and believe we are contributing to the health and wellbeing of our community by taking such a strong stance. Our next step on the healthy lifestyle trail will be to encourage a higher level of physical activity and better nutrition in our community. This is an important national strategy and the CDHB will continue to work at how we can play our part in encouraging people to make healthy choices.

There were many improvements to our facilities this year. The Minister of Health, Hon Annette King officiated at the opening of the new Laurel Whitford Charitable Trust Information & Learning Centre, part of the refurbished Oncology Department at Christchurch Hospital. The Paediatrics Department had a much needed facelift and we opened the new Acute Stroke Unit also at Christchurch Hospital. The newly refurbished Respiratory Physiology Laboratory was opened this year as was the Gastroenterology Unit. It was an important year for midwives with their centennial celebration and for all CDHB nurses who received a much needed increase in their salaries.

Amongst its many activities this year, the CDHB joined with other DHBs around New Zealand in the implementation of the Meningococcal B Vaccination Programme and the associated introduction of the National Immunisation Register.

These two projects started towards the end of the financial year in Canterbury and as a result bore the brunt of some critical media attention. Nevertheless, the large team of public health nurses and the primary care health teams swung into action and to date have achieved an excellent result.

The success of the programme is due to the ongoing good relationship between primary providers in Canterbury. Even now, five years since DHBs were established in New Zealand, there is still a lack of understanding about the role of DHBs. We are a funder of health in Canterbury, as well as a provider (through the Hospital & Specialist Service). This means that we are responsible for funding all public community health in our region including primary care. As Primary Health Organisations (PHOs) have started to impact more on primary care, they are taking on additional tasks like working with Non-Governmental Organisations (NGOs) to explore ways in which communities can be better resourced for their health needs.

There are four PHOs in Canterbury, funded by the CDHB, and they have worked collaboratively this year to identify projects that will help make a difference. An example of this is the Ashburton Health Services Review which will go out for consultation in August this year. The Rural Canterbury PHO is keen to have some involvement in this review.

We have embarked on a number of reviews this year in an effort to ensure that we continue to fund and provide the best services possible within the funding available. Aged Care Services are presently being reviewed and a new strategy will be developed in the coming year. We have also taken a



EACH DAY IN CANTERBURY
APPROXIMATELY:

15 BABIES
ARE BORN



closer look at the way in which the Child Adolescent & Family Service is provided, with a proposal for change currently out for consultation. A review of rural health services in Canterbury is almost completed. A proposal to change midwifery services in rural Canterbury earlier this year was rejected by the affected communities and as a result the CDHB Board decided not to proceed with the project.

In addition to the many reviews that we have undertaken this year, approval was given by the CDHB Board and the Minister of Health for the construction of a new Home Dialysis and Diabetes Centre to be built on the Christchurch Hospital campus, and for Stage 2 of the Burwood Hospital refurbishment programme.

We have hosted workshops, forums, seminars and conferences on many health subjects this year. Foremost amongst these was the first Australasian Home Haemodialysis Workshop opened by the Associate Minister of Health, Hon Ruth Dyson. With over 200 delegates present, it was an ideal opportunity to discuss issues related to home dialysis, its history and current developments in treatment.

This summary annual report gives a detailed picture of the achievements of the CDHB this financial year, based on its strategic direction and its workplans. It is a testimony to the hard work and initiative of our staff. I commend it to you and hope that it gives you another insight into the workings of the CDHB and its success in the year just past.

At the year's end, I have resigned my role as Chief Executive to take up a position in the UK. I leave the CDHB in good heart

and in a sound financial position. After four very challenging years, I believe we have the best Health Board in New Zealand. We have wonderful staff of whom I have been very proud. We provide an excellent service within our hospitals and we contribute through our funding, monitoring and support to an excellent health system in Canterbury. Undoubtedly there can always be improvements and we strive to make these happen through our strategic plan, our priorities and the many projects and workplans that are implemented on a daily basis.

What people often do not appreciate is the tremendous capability of the CDHB to meet its goals and objectives and how successfully it does this. Media have a tendency to focus on the negative and as a result many of our achievements have not made the headlines. The fact is that we have continued to meet our targeted volumes for surgical procedures and the details of this are presented in this summary annual report.

As Chief Executive I have received more bouquets than brickbats this year from grateful patients who have been delighted and amazed at the wonderful care and attention they have received. We can always do better and I am confident that the next five years of the CDHB will be as motivating and successful as the first five.

Jean O'Callaghan
Chief Executive.

HIGHLIGHTS AND ACHIEVEMENTS



OPENING OF THE NEW CHRISTCHURCH WOMEN'S HOSPITAL

In May this year a new era of women's healthcare began in Canterbury with the completion of the \$78.9m Christchurch Women's Hospital on Riccarton Avenue.

The new 134-bed hospital was formally opened on 6 May 2005 at a ceremony attended by Prime Minister, Rt Hon Helen Clark and Minister of Health, Hon Annette King.

The 20,816m² ten level building took two years to complete. Its design involved extensive planning and consultation with clinical staff, community groups and consultancies. The end result is a family-friendly hospital that delivers excellent services in a welcoming environment.

Research shows that pleasant surroundings and an ability to see the outside world improves patient wellbeing. With this in mind, considerable thought went into the furnishings, artwork and overall environment of the new hospital.

All the beds and curtains in the double rooms are positioned in such a way that even if one woman closes her curtains, the other still gets to enjoy the view. Curtain and bedspread fabrics feature leaf motifs that take their inspiration from the views over Hagley Park and the Christchurch Botanic Gardens.

The hospital houses an art collection comprising 150 original pieces and more than 200 prints. Much of the artwork has been created by Canterbury artists, including staff and past patients at Christchurch Women's.

The new hospital has the very best in infection control measures and systems, including sensor taps, automatic doors, negative pressure isolation rooms, new sluices and venetian blinds between two layers of glass to reduce dust. It also has the very latest in technology, including high speed data networking and wireless technology.

The building is designed to withstand Christchurch's largest predictable earthquake and has an advanced and sophisticated base isolation system. A combination of lead rubber bearings, wire tie-downs and pot bearings all work towards ensuring that, in the event of an earthquake, the building will remain standing. The hospital also has its own power and medical gas supplies, as well as two separate emergency power generators and an 80 tonne emergency water supply located at the top of the building.



Level 1: Day Surgery Unit

For the first time Christchurch has a purpose-built day surgery unit within the public health system. While it is located within Christchurch Women's, the unit is part of Christchurch Hospital and services the whole community.

Level 2: Gynaecology Services

Gynaecology services are now all located on the one floor, creating better flow and efficient use of space. The unit has 33 beds, including two high dependency unit beds and two isolation rooms.

There is an acute gynaecology assessment centre with a five bed examination area offering a 24 hour acute assessment service.

Level 2 also houses the brachytherapy suite and three colposcopy treatment areas which provide care on an outpatient basis.

Level 3: Birthing Suite

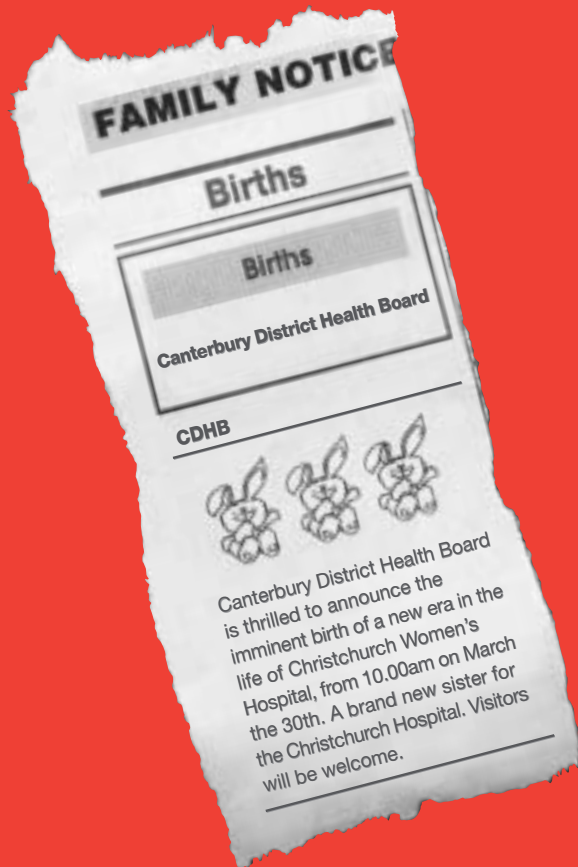
The birthing suite has 14 rooms, two of which have birthing pools. There are two high dependency unit beds and five assessment areas, plus two operating theatres and a recovery area. Obstetrics and gynaecology consultants' offices and the university department are also situated on this floor.

Level 4: Neonatal Service

Ante-natal and post-natal services are now located on the one floor and form the main neonatal tertiary referral centre for the South Island. There are 42 cots, including nine for intensive care, with 90 neonatal nurses working a variety of full-time and part-time positions. More space means a better environment for staff and families, and standardising cot space has improved consistency across the unit.

Level 5: Maternity Unit

With enviable views out over Hagley Park and ensuites in every room, the Maternity Unit is a beautiful area. The unit provides care for ante-natal and post-natal women and babies and has 45 beds in single and double rooms, along with two isolation rooms. The Lactation Consultant's room is also located on this floor, as are the House Surgeons' and Registrars' rooms.





MENINGOCOCCAL B IMMUNISATION PROGRAMME

The Meningococcal B immunisation programme, the largest immunisation programme ever undertaken in New Zealand, began in Canterbury in June 2004. The Ministry of Health is spending \$200 million nationwide on vaccinating all children aged from six weeks to 19 years in an effort to control the specific strain of Group B meningococcal which has reached epidemic proportions in New Zealand.

New Zealand is in its 15th year of a Meningococcal B disease epidemic with more than 5670 cases and 228 deaths since 1991. For every 100 cases of meningococcal disease, four die, 20 are maimed and disfigured, and 76 recover with appropriate treatment. The epidemic strain accounts for about 75% of all confirmed meningococcal cases and without vaccine intervention it is expected the epidemic will continue for approximately ten more years.

Ministry of Health 2003 statistics show one in every 66 Pacific children, one in every 117 Maori children and one in every 438 children of European or other descent will get meningococcal disease by the time they turn five. It is not known why some people who come into contact with meningococcal bacteria get sick and others do not. However, it is a false perception that a healthy lifestyle means immunisation is not required. While research shows that good housing, diet and lifestyle choices help reduce

the risk of disease, they are not real alternatives and are not valid reasons to avoid vaccination. Healthy children living in ideal conditions still remain at risk of death and disability from meningococcal disease.

In Canterbury, the target was to immunise more than 90% of the 122,000 children and youth aged six weeks to 19 years. To date, the immunisation programme has been successful with the majority of Canterbury school children and over half of eligible pre-schoolers being immunised. Additional work is being carried out to encourage 18 – 19 year olds to make the most of this free immunisation opportunity, as the uptake by this group has been slower.

NATIONAL IMMUNISATION REGISTER

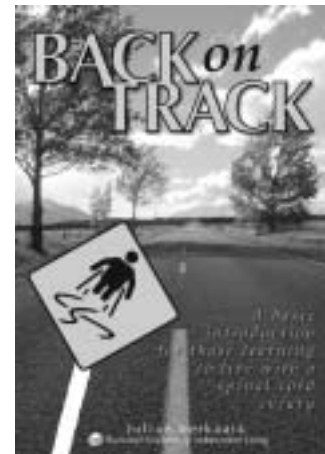
The Ministry of Health is using the Meningococcal B immunisation programme as an opportunity to roll out the National Immunisation Register (NIR), a database of children on the national general immunisation schedule. The register provides a means of tracking a child so that no matter where they might move within the country, their immunisations will be recorded. By November 2005, every child born in Canterbury will automatically go on the NIR.

The NIR is an essential support tool for the Meningococcal B immunisation programme, both in primary care and for the school-based programme, as it will help



EACH DAY IN CANTERBURY
APPROXIMATELY:

200 PEOPLE VISIT
EMERGENCY
DEPARTMENT



in monitoring the safety and effectiveness of the new vaccine as well as measuring how many children are vaccinated. The NIR will also assist New Zealand to improve its immunisation coverage, protecting individuals and communities against recurring epidemics.

QUALITY AND INNOVATION AWARDS

The second annual Canterbury District Health Board (CDHB) Quality and Innovation Awards attracted 22 projects which were honoured at an awards ceremony on 30 August, 2004. The awards are designed to publicly acknowledge the excellent quality, innovation and improvement initiatives generated by CDHB staff and providers.

This year the awards were broken into two categories – Hospital and Specialist Services and Primary Care, and Community and Contracted Providers.

The Supreme Award was won by a project that reduces over-sedation in critically ill patients, developed by Christchurch Intensive Care Specialist, Dr Geoff Shaw and biomedical engineers, Richard Dove and Kathryn Greenfield from the Medical Physics and Bioengineering Department.

The project shared first-equal prize in the Hospital and Specialist Services Award with an energy management project by the Christchurch Hospital's Maintenance and Engineering Department.

The winner of the Community and Contracted Providers

Category was a series of four seminars on palliative care education for health carers, developed by the Hospice Palliative Care Service of the Nurse Maude Association. Other winners were:

- A project developed by members of Cardiology, Ward 26, Christchurch Hospital, that examines ways of safely decreasing the average length of stay for patients assessed as having chest pain of a non-cardiac cause.
- A Discharge Letter Process Review designed by Lyn Clark, Clerical Supervisor, Department of General Medicine at Christchurch Hospital to reduce the time between the patient being discharged and the discharge letter reaching their GP.

CANTERBURY DISTRICT HEALTH BOARD GOES SMOKEFREE

As part of a commitment to providing a healthy environment for employees, patients and visitors, all CDHB buildings, grounds, offices and vehicles are now smokefree.

Staff and community consultation groups have shown overwhelming support for the policy, which came into effect in October 2004. The policy also bans the sale or advertisement of tobacco products on CDHB property.

Limited smoking areas have been designated for staff, patients, visitors and contractors up until the end of October 2005, after which time all areas will be totally smokefree.

A smoking cessation programme is available to all staff and patients who have indicated they wish to have assistance to stop smoking.

LAUNCH OF PATIENT HANDBOOK

The Burwood Spinal Trust, in collaboration with the New Zealand Spinal Trust, recently launched a unique patient handbook entitled 'Back on Track' for spinal patients in their early rehabilitation phase.

Edited by Julian Verkaaik, the book provides professional advice as well as comments and stories from past 'graduates' of spinal services in New Zealand.

'Back on Track' is provided free to all new patients of Burwood and Auckland spinal units.

NEW IMAGING MACHINES FOR EYE DEPARTMENT

The Eye Department at Christchurch Hospital recently purchased sophisticated new imaging equipment – a digital retina camera and three viewing stations, and a Stratus Ocular Coherence (OCT) imaging system. This equipment is used for early diagnosis and treatment of a number of common eye conditions, including medical retinal diseases, eye complications of diabetes and damage from glaucoma.

EXTENSION TO GASTROENTEROLOGY DEPARTMENT

A \$2.63m extension of the Gastroenterology Department at Christchurch Hospital was opened by Hon Annette King, Minister of Health in February 2005.

The expanded department includes a bronchoscopy unit for the Department of Respiratory Medicine, as well as three endoscopy units for the Department of Gastroenterology and Endoscopic Surgery.

With some of the most up-to-date endoscopic equipment available, including a capsule endoscopy (or pill camera) donated by the Liver and Digestive Diseases Trust, Christchurch Hospital's Gastroenterology Department is now one of the best facilities in Australasia. It undertakes about 5,000 gastroenterology procedures each year.

ACUTE STROKE UNIT

A new Acute Stroke Unit has been established on the top floor of Christchurch Hospital. The facility complements the existing stroke rehabilitation unit at the Princess Margaret Hospital which opened three years ago.

Every year 700 – 800 new cases of stroke occur in Canterbury.

RESPIRATORY PHYSIOLOGY LAB OPENS

A new Respiratory Physiology Laboratory opened in March 2005. It is a state-of-the-art facility incorporated within the Canterbury Respiratory Services at Christchurch Hospital.

NEW PAEDIATRICS FACILITY

During the year CDHB grouped all child-related treatments in one area by creating a new paediatrics facility at Christchurch Hospital. Opened in November 2004, it is the only tertiary centre for paediatric surgery, neurology, oncology, haematology and burns in the South Island. The unit is serviced by three paediatric surgeons, 11 specialist paediatricians and four neonatologists.

CT SCANNER INSTALLED AT RADIOLOGY

This year the Christchurch Hospital's Radiology Department installed a new \$1.6m GE VCT 64 multi-slice scanner. The scanner, the first of its kind in New Zealand, offers considerable advantages for clinicians and patients, including more comfortable breath hold for patients, reduced image acquisition times, improved image resolution and the ability to view in 3D all parts of the body. In addition, it has software that helps radiologists in the diagnosis for complex processes such as CT colonography.

The new scanner's coverage speed allows clinicians to capture whole organs in a second, the heart in five beats, or go from head to toe in less than 10 seconds.

STATE-OF-THE-ART LINEAR ACCELERATOR FOR ONCOLOGY

A \$3.5m state-of-the-art Linear Accelerator was installed in Oncology Services at Christchurch Hospital in June 2005. The Linear Accelerator enables more accurate and effective treatment of cancer using radiation. It has on-board imaging which takes diagnostic quality images immediately before treatment starts, allowing minute shifts of the patient to administer the treatment with pinpoint accuracy. The machine is also capable of delivering computer-controlled beams of non-uniform intensity from several directions, which combine to give a treatment volume that maximises the dose of radiation to the tumour and minimises the dose to adjacent areas.



CHIEF MEDICAL OFFICER – DR NIGEL MILLAR

Since his appointment in July 2003, Dr Nigel Millar has focused on enhancing the level of clinical input into decisions made at executive management level.



Dr Nigel Millar

Over the last year, clinical staff have had a greater role to play in determining the direction and the development of services provided by the Canterbury District Health Board (CDHB).

The Clinical Board, which replaced the former Clinical Advisory Committee, has proven to be an important tool in bridging the gap between management and clinical staff. It has provided advice and solutions and, most importantly, has shown that we all have the same goals. While the Clinical Board has changed significantly over the last year, it still needs to develop further. In particular, we need to keep addressing the balance of people participating to ensure that key clinical leaders and decision-makers within the hospital play a more active role.

We have seen strong progress in the development of Primary Health Organisations (PHOs) which have responded well to the challenges of becoming established. We have always had a good working relationship with primary health care providers and this is further enhanced under the new PHO structure.

I am very pleased to be involved in 'Improving the Patient Journey', an organisation-wide review co-led by Mary Gordon, Executive Director of Nursing and myself. This project examines how and why patients come into hospital and what systems we have in place to ensure quality care while they are there. By focusing on the patient experience we will be able to make more efficient use of time and resources. We will also be able to ensure that people are doing the appropriate job for their skill level. While the project is likely to deliver cost savings, its primary driver is to examine how we can deliver improved care in an increasingly complex health environment.

Patient safety is always a priority for the CDHB and recently we developed a 'No Blame Incident/Accident Reporting Policy' that empowers our staff to handle adverse events and offers even more transparency to our processes for managing situations where actual or potential harm occurs to patients. While safety is an area that is always open to improvement, in most cases errors result from poorly designed processes that put staff in situations

where problems can occur. By focusing on the 'what' and the 'how' with less emphasis on the 'who', we will gain a better understanding of contributing factors, so that we can prevent errors occurring in the future.

We are continually faced with the challenge of how we, as a tertiary health provider, relate to provincial centres. People like and expect a local service, but they also want a world-class service and it is hard to reconcile the two. Our rural hospitals, and other South Island District Health Boards (DHBs) in general, struggle to attract specialist medical staff. It is not feasible for every hospital to cover every specialisation. Apart from the sheer cost, clinical specialists need a steady flow of work to maintain their skill levels and they are unlikely to achieve this unless they work in larger centres.

Paediatric Surgery is an outstanding example of a successful specialisation model, with the CDHB's Paediatric Surgeons providing services for the rest of the South Island. Other specialisations could potentially follow this model, however there is no easy solution to the issues of reconciling patient expectations with staffing and resourcing realities. This is something that we, and the other South Island DHBs, will be working through.

We are also dealing with challenges around the re-organisation of our workforce and at the moment we are focusing specifically on Resident Medical Officers. Traditional models are no longer appropriate for our modern workforce, where workloads have increased dramatically, public expectations are higher and Resident Medical Officers, despite their title, are now shift workers rather than actual residents within the hospital. While this is a national issue, we simply cannot afford to wait around for someone else to solve the challenges for us. We need to come up with our own initiatives and plan to work consultatively to secure a positive outcome for all parties.

Looking to the year ahead, I will be focussing much of my time on the 'Improving the Patient Journey' project, as we continue to develop our workforce and services to achieve a more patient-oriented perspective on quality control.

EXECUTIVE DIRECTOR OF NURSING – MARY GORDON

Three years on from her appointment as Executive Director of Nursing, Mary Gordon continues to develop and refine the structure and direction of the Canterbury District Health Board's (CDHB's) nursing workforce.



Mary Gordon

When I accepted this position one of my key responsibilities was to look at ways of strengthening and improving the way our nursing staff interact – not only with patients and other medical staff, but also with each other, across departments, hospitals and the health sector as a whole.

I have been very encouraged by the progress we have made in all areas. Directors of nursing from the CDHB and from the primary care sector now meet regularly, we have much improved communication channels within our workforce and we are doing some excellent work in nurse-led services that is showing real benefits for our region.

We are now in the final year of the Aranui Nursing Project, a pilot programme that looks at ways to improve access to primary healthcare services in high-needs areas. While this type of service is not appropriate for all areas of the community, overseas research indicates that advanced nursing practice provides a valuable service in high-needs communities where access to healthcare is an issue. Evidence shows that nurses working within the community can engage with people who might otherwise not visit an outpatients' clinic or a GP. Real benefits can be achieved in managing chronic disease such as diabetes.

Preliminary findings from the Aranui Nursing Project show that access to healthcare has been improved within the target population. The challenge now is to focus on how we can best integrate this project into a sustainable model of care within primary care.

One of this year's highlights was designing and implementing a Professional Development and Recognition Programme (PDRP) for clinical nurses. Developed in partnership with the New Zealand Nurses Organisation (NZNO), the programme recognises and rewards nurses who demonstrate proficient or expert levels of clinical practice. What makes this all the more of an achievement is the fact that the programme was designed and implemented within three months and was completed in partnership with the West Coast District Health Board. No other District Health Board (DHB) in the country has been able to achieve this in the same timeframe, let alone two DHBs working together.

As part of our continuing commitment to our future workforce, we are very pleased to involve The Nurse Maude District Nursing Association in our graduate programme. Now in its fourth year, the graduate programme encourages staff retention by providing recently qualified nurses with support and guidance. The West Coast District Health Board has also indicated its interest in joining the programme and our focus in the future will be on increasing the number of graduates in both the

CDHB and in primary, community and aged care areas.

Another highlight of the year was the South Island Nursing Leadership Development Workshop, organised and hosted by Canterbury nursing leaders. The workshop was open to all directors of nursing and charge nurses in the South Island, and registrations exceeded capacity. Another workshop is scheduled for September 2005.

Our annual Nursing Awards were held during the nursing showcase which ran in conjunction with International Nurses' Day on 12 May. Twenty-one awards were presented to nurses from throughout the region who had been nominated by their peers for their exceptional skills or contribution to nursing practice.

This year we began the 'Improving the Patient Journey' project, a review of the way we design and manage patient care processes throughout the continuum of care. The project currently involves seven main programmes:

- **Diagnostic phase** – an organisation-wide assessment to establish measures of performance and improvement
- **Emergency Department** – implementing the External Review recommendations
- **Operating Theatre** – implementing the Theatre Utilisation Study recommendations as well as improving access to acute theatre
- **After Hours Model of Care** – developing an 'Out of Hours' multidisciplinary night team, auditing the activity of the afternoon and weekend shifts, and developing a clinical handover model
- **General Surgical Acute Patient Flow**
- **Capacity Planning** – forecasting patient activity with the aim of matching resources to demand
- **Radiology Review** – with the review now complete, the focus is on implementing the recommendations.

While there is a team leading this project, 'Improving the Patient Journey' is very much a partnership between all areas of the Hospital and Specialist services. It is an exciting opportunity to design and develop processes and services that meet today's healthcare needs.

In the coming year we will be working with Christchurch Polytechnic Institute of Technology, our local education provider, in its review of the nursing curriculum. As part of this, we will be developing our strategy to enhance postgraduate nursing education opportunities within Canterbury. We will continue to develop our nurse-led roles and services for patient management and will also be focusing on increasing graduate numbers. This is part of a wider commitment to ensuring that our nursing workforce meets the needs of the future.

EXECUTIVE DIRECTOR OF MĀORI AND PACIFIC HEALTH – HECTOR MATTHEWS

As part of its ongoing commitment to Māori Health, the Canterbury District Health Board (CDHB) appointed its first Executive Director of Māori Health in June 2004 – Hector Matthews of Te Rarawa and Te Aupōuri descent. Hector's title changed to Executive Director of Māori and Pacific Health in March 2005 to reflect the responsibilities of the role.



Hector Matthews

With my appointment, Māori and Pacific people now have a voice at executive management level. That is not to say that Māori and Pacific people were overlooked before, nor does it mean that there are going to be sweeping changes. However, my involvement at the 'decision-making level' does help to add a new perspective to the strategic direction of Māori and Pacific people's health in Canterbury.

Consultation is a major part of my role and I spend a significant part of my week talking directly with the people I represent. It is a process of matching demands with what is achievable and I believe my role helps to provide some credibility within these consultations. There is, after all, no such thing as a single 'Māori perspective', just as there is no one Pākehā perspective, nor one female perspective. Ngāi Tahu and Māori in general are not a single homogenous group and in order to be successful we need to recognise and address this.

Over the last year the CDHB has undertaken several activities designed to improve the health status and outcomes for our Māori and Pacific populations.

Specifically, we are making steady progress in our Whakamahere Hauora Māori Ki Waitaha, the CDHB's Māori Health Plan. The plan was recently reviewed, reconfirming many of the key issues facing our district. These include the need to:

- develop and grow our Māori workforce
- increase cultural awareness throughout all health services
- improve chronic disease management
- strengthen access to health information and to specialist and secondary care.

Over the past year we have concentrated on implementing and completing key projects aimed at supporting each of the five directional priorities outlined in the plan:

- **Direction 1:** Improving Māori health status
- **Direction 2:** Finding better ways of working
- **Direction 3:** Working together with Māori
- **Direction 4:** Developing Canterbury's health care workforce
- **Direction 5:** Being a leader in Māori hospital and health care services.

A key project is the meningococcal B vaccination programme which has specific actions to target Māori and Pacific populations. We have been working hard to change views on immunisation and it is encouraging to see that 90% of parents at Canterbury's two Kura Kaupapa Māori have consented to having their children vaccinated.

Chronic disease management is a priority health issue for Canterbury and another project within our Māori Health Plan. Diabetes is a significant chronic disease affecting Māori and Pacific populations and one of the mainstays of diabetes care is lifestyle management. Recently a two year pilot project began, involving Māori and Pacific lifestyle advisers delivering healthy lifestyle services to community groups and families.

Our provider arm has also begun projects in each division to improve the quality of our ethnicity data collection. Accurate ethnicity data collection provides much stronger evidence of health need and enables us to plan and target our services appropriately.

During the year, Hauora Mātauraka, CDHB's Māori Health Promotion team, has been focussing on the root causes of health issues. They are taking a proactive rather than reactive approach that is aimed at reducing the need for medical intervention. For example, the team has been involved in campaigns to help Māori women stop smoking. Along with several other community groups, they were significantly involved in organising and supporting the 10th Annual Māori Sports Festival held at Aranui High School in March 2005. The festival is one of the few Māori events in the region that is entirely smoke-free and promotes health, nutrition and activity.

As part of our commitment to improving cultural awareness within health services we have established a Māori Health team at Christchurch Hospital to work within Paediatrics and Oncology – two high-needs areas for Māori and Pacific people. The team supports staff within these units to facilitate relationships and achieve better health outcomes for patients. In the future, we hope to extend these services to the Emergency Services Department and Cardiology.

Our Whānau Room in Christchurch Hospital frequently has very high occupancy and in March 2005 we opened a new Whānau Room at The Princess Margaret Hospital.



EACH DAY IN CANTERBURY
APPROXIMATELY:

100 PEOPLE
ARE ADMITTED
TO HOSPITAL



The support by the CDHB for Māori participation and recognition of Māori processes during the opening of the new Christchurch Women’s Hospital was warmly appreciated by many of our staff.

I am a member of Te Herenga Hauora o Te Waka o Aoraki / South Island Māori Managers group and collectively we are addressing the need for more clinically qualified Māori and Pacific people. We have been working with the Ministry of Health’s Māori Provider Development Scheme to help our workforce providers improve the quality of services that they deliver, and we will continue to invest resources into this as we work towards strengthening our Māori workforce.

The Ministry of Health also has a Pacific Providers’ Development Fund to build Pacific provider capacity, quality and workforce. We are working closely with our Pacific providers to assist their applications for this funding and support their development. We recently began a review of the Pacific Health Plan and we have held meetings with the Pacific Community Reference Group, facilitated by the Ministry of Pacific Affairs.

In the year ahead, we must continue to challenge ourselves to find ways of improving access to health services for Māori and Pacific people. We need to ensure that services are appropriate and accessible in order to address the health inequalities that exist for these populations.

OTHER PRIORITY AREAS

PRIORITY AREA: CHILD AND YOUTH HEALTH

Child health is a priority area for the Canterbury District Health Board (CDHB). There are approximately 86,000 children aged 0–14 years living in Canterbury, including 10,500 tamariki, 2,500 Pacific children and 3,500 Asian children.

During the year the Child Health and Disability Action Plan/ Mahere o te Hauora Tamariki me te Hauatanga (2004-2007) was implemented. The plan outlines the ten priorities for improving children's health in Canterbury which include: access to services, child health information, hearing, immunisation, injury prevention, mental health, nutrition and physical activity, oral health, parenting and smoke-free environments.

These priorities have generated 67 actions to improve child health outcomes. Some examples of these are:

- Establishment of a Child and Youth Mortality Committee focused on reducing the numbers of preventable deaths
- A pilot programme in twelve Early Childhood Centres designed to improve the health and wellbeing of pre-school children
- Roll out of the meningococcal B vaccination programme and establishment of a National Immunisation Register
- Establishment of a Child Health Information Strategy Working Group to look at how best to improve child health information systems in Canterbury
- A project to obtain better information about the Strengthening Families collaborative case management process, in order to improve the outcomes for families/whanau who live in high risk environments.

The CDHB also has a Child Health Strategy Group that oversees the implementation of activities to improve children's health within the region.

The Youth Health Plan currently being developed will look at how the CDHB can best meet the needs of young people over the age of 14.

PRIORITY AREA: DISEASE PREVENTION AND MANAGEMENT

Reducing the incidence and impact of diabetes, cancer and cardiovascular (heart) disease.

Cancer

When all forms of cancer are grouped together, it is the leading cause of death and a major cause of hospitalisation in Canterbury

and New Zealand. It is the highest cause of death for women and the second highest cause for men.

The CDHB works very closely with the Cancer Society and other community providers to promote health initiatives that reduce cancer, such as improving nutrition, promoting smoke-free lifestyles and increasing exercise. This collaborative approach to cancer services is highlighted in the success of the Cancer Society/Laural Whitford Charitable Trust Information and Learning Centre at Christchurch Hospital. Established in partnership with the Cancer Society, the centre provides on-site support and information to cancer patients and their families. Since its opening in October 2004, more than 1000 people have passed through the centre, which also offers professional development resources for health professionals.

Other collaborative initiatives include the launch of the Cancer Society's Colossal Colon, a five metre long fibreglass colon designed to help educate the public on the importance of a healthy lifestyle in preventing bowel cancer. Bowel cancer causes 15% of all cancer deaths in New Zealand and is strongly linked to a poor diet.

The CDHB is also working with the Cancer Society and the Otago University School of Medicine to help the Tissue Bank become financially self-sufficient.

Treatment availability and costs are continuing challenges for the CDHB and, together with the Cancer Society and PHOs, all parties are looking at ways to improve patient flow from diagnosis through treatment to cure or palliative care.

Diabetes

Diabetes is a major health issue in Canterbury, with Diabetes New Zealand estimating there could be as many as 31,000 people with the disease in the region. Canterbury has one of the highest rates of diagnosis for Type 1 diabetes in young people under 20 years. Furthermore, the increasing rate of obesity has meant that Type 2 diabetes, most frequently diagnosed in middle and older ages, is on the increase and is now being seen in children and youth.

The CDHB continues to support the Local Diabetes Team (a representative group of health professionals, community providers and patients) in its work to report on annual diabetes screening and management targets. This year the team has also approved three new projects – an update of the Young People with Diabetes Audit, an

exhibition stand at the Christchurch A&P Show in November 2005 and a pilot programme of Diabetes Detection in ten Pegasus Health practices.

In order to maximise their resources and effectiveness, the Nutrition and Physical Activity Team of Community and Public Health, Diabetes Life Education, and Pacific Health Promotion merged their services at the end of last year. All three providers had been working on similar, population-based interventions to promote healthy eating and increase physical activity – key factors in reducing the number of new cases and managing diabetes in people already affected.

Future plans for the CDHB's Diabetes Services include the construction of new premises adjacent to the Christchurch Hospital campus. The new building will house a shop and meeting rooms for Diabetes Christchurch (the local branch of Diabetes New Zealand), along with a meeting and education area incorporating a demonstration kitchen to teach people good nutrition. An enlarged diabetes clinic will provide much improved patient facilities.

Cardiovascular (Heart) Disease

Cardiovascular disease includes coronary heart disease, other diseases of the heart and circulation, and stroke. Coronary artery disease is the leading cause of death in New Zealand.

Following on from last year's Memorandum of Co-operation, CDHB and the National Heart Foundation have been examining ways of working together to improve heart health in the region.

The Under 5s Project, promoting the Healthy Heart Award programme in Canterbury, has had another successful year. The Heart Foundation, Community and Public Health and Hauora Matakura all worked collaboratively on this nutrition and physical activity initiative which addresses childhood obesity.

Canterbury has been chosen as one of five pilot sites for the National Heart Foundation's Heart Guide Aotearoa programme – a home-based, Phase II rehabilitation programme scheduled to begin next year. Mortality and morbidity rates in patients who have completed a full course of Phase II rehabilitation are reduced by 25%.

The Heart Guide Aotearoa programme encourages people to complete Phase II rehabilitation by offering hospital or home-based rehabilitation. The programme will be delivered by practice nurses in six large practices in Christchurch and the surrounding area, linking patients back into primary care for ongoing management.

Another initiative for next year is a primary care based cardiovascular risk assessment project based in Rangiora. This project will look at the health status of the whole population, as determined by their GPs. Information will be gathered in a standardised way and will help shape the health promotion needs of the whole community.

Challenges for the year ahead include curbing and stabilising childhood obesity rates through community, school and early childhood centre programmes. If current obesity trends continue, 29% of New Zealand's adult population will be obese by 2011. This, in turn, will lead to increased rates of many chronic diseases including heart disease, Type II diabetes, hypertension and stroke, gallstones and some cancers.

There will also be a focus on increasing the numbers of partnerships, collaborations and alliances across the health sector in order to develop further initiatives to reduce the risk of heart disease.

PRIORITY AREA: OLDER PERSONS' HEALTH

Since the Ministry of Health's devolution of funding for age related disability services in October 2003, the CDHB has assumed responsibility for all planning and funding for health and disability services for older people. This includes rest home services, continuing care hospitals, dementia care, psychogeriatric care, respite care, carer support and other community services for the elderly such as day care.

Part of the CDHB's response to this shift has been the development and implementation of a Managed Bed Policy designed to ensure better management of beds in aged residential care. The aim is to ensure adequate service volume for frail elderly and to promote sector viability. Rest homes and hospitals are now required to complete a Request for Proposal (RFP) that is initiated by the DHB before more beds can be approved.

The Board has also been proactive in ensuring that frail elderly receive the right care at the right place at the right time by ceasing to accept hospital level care being delivered in rest homes.

The CDHB has successfully managed a period of change resulting from national adjustments to income and asset testing thresholds for aged residential care. Innovative contracting solutions were developed to ensure a continuum of care for those people affected at the date of the changeover.

A single contract for Support Care services is being developed to improve administrative efficiencies and raise quality of care for people requiring palliative care in residential care.

One of the Board's priorities has been the development of the Healthy Aging, Integrated Support Strategy which will be implemented, subject to Board approval. A Project Manager has been seconded to develop the strategy with a focus on significant consultation with the community and sector expert groups. The strategy will be in alignment with the Government's Health of Older People Strategy which prompts a move to older people aging in their own homes, as opposed to residential care.

Looking ahead, the Older Persons' Health Strategy will be implemented, pending approval, over the next five years, with practical support to promote aging at home rather than in residential care. In the future more flexible, home-based support packages will enable people to stay in their homes for longer. These packages will include greater day care options and respite services to support home-based care and a more holistic approach to care delivery. The CDHB's plan is to build on communication processes within the community and set up a robust database to monitor improvements and assist with trend analysis, planning and service development.

PRIMARY HEALTH ORGANISATIONS

PARTNERSHIP HEALTH CANTERBURY TE KEI O TE WAKA PHO – CHAIR: MICHAEL McEVEDY

Partnership Health Canterbury is the largest PHO in New Zealand and the youngest in Canterbury. Launched in April 2004, we encompass about 85% of the Christchurch and Selwyn areas. Our enrolled population of 336,000 is serviced by 109 general practices that belong to six independent practitioner associations or other types of primary care organisations.

This year we have focussed our efforts on two main areas – encouraging healthy lifestyles and improving access to health services.

Together with organisations such as Sport Canterbury, the Cancer Society, The National Heart Foundation (Canterbury), Hauora Matakauraka, Community and Public Health and He Oranga Pounamu, we have developed a Health Promotion Plan which provides support for initiatives such as smoking cessation programmes and programmes to reduce obesity in children.

We have been working to identify priority populations who do not access general practice at all ('the missing') or who do not access it as frequently as their health status warrants ('the missing out'). As part of a series of initiatives to draw these people back into the health system, a joint project with Aranui High School has been developed and we are also targeting people in the Linwood / Ferry Road area with nurse-led services. The intention is to expand this programme to the whole of Partnership Health.

We have successfully implemented Care Plus which is a programme of co-ordinated care targeted at people with very high health needs.

Our focus for next year will be on looking at the ways we communicate with our communities and our providers as we work towards improving population health and reducing inequalities in primary health care access and delivery.

HURUNUI KAIKOURA PHO – CHAIR: JOHN CHAFFEY

The Hurunui Kaikoura PHO was established in January 2004. We cover a large area – about 200km from north to south, and nearly the same distance in width. Yet despite its vast area, the number of estimated enrolled population is relatively small at only 12,500.

Within the PHO there are six medical practices, the largest of which are Kaikoura and Amberley, with 3,360 and 3,750 patients respectively. The remaining four practices are equivalent to solo doctor practices. Two of these are owned by the communities of Amuri and Hanmer Springs and employ doctors on contract. These two practices, along with Cheviot and Hurunui at Waikari, are fortunate to have health centre buildings owned by the Hurunui District Council. The council also owns two houses, two flats and a cottage for health professionals.

One of the challenges we face is that both Kaikoura and Hanmer Springs attract thousands of visitors annually who can put a huge strain on the health resources of the area, especially after hours. Our district also contains over 400km of state highways that attract their own share of accidents.

The provision of primary health care in this region is reliant on special funding and the goodwill of doctors who serve rural areas. Service organisations such as Lions Clubs play a big role in fund raising to supply specialist equipment and some of the areas have medical trusts which help financially.

Until we get more specialist funding we will be focusing our efforts on co-ordinating our work with that of outreach centres from various government agencies so that there is no wasted effort. We will be looking specifically at the health issues that affect the district and, in the future, we will implement initiatives to improve our communities' health status by encouraging healthier lifestyles.

RURAL CANTERBURY PHO – CHAIR: DR WINSTON MCKEAN

Established in October 2003, the Rural Canterbury PHO covers the area of Ashburton and the Waimakariri District Councils and part of Banks Peninsula, with an enrolled population of 77,100.

A challenge for us in our rural areas, is making sure that our enrolled population understands the roles and responsibilities of their PHO. To that end, a number of brochures on this topic have been prepared and forwarded to each household in the rates notices from local councils.

The focus of primary health care is shifting as we incorporate a Health Promotion model into general practice. Part of our role as a PHO is to encourage people to accept responsibility for their own health. We are also taking part in an initiative involving a number of organisations and councils in Canterbury to motivate the public to exercise more and adopt healthy diets.

Community consultation meetings have been held in each area and, through this process, the community has indicated that there is a need for a co-ordinated rural primary mental health service. Funding was obtained from the Ministry of Health and these services will be running by 1 December 2005.

Another example of an initiative resulting from community consultation meetings is the implementation of co-ordinated diabetic care in the Ashburton area, and associated programmes to encourage more exercise and healthy eating in the Waimakariri area. This is a start to a more comprehensive approach to improving the health status of our residents.

Looking to the future, we will be running a Well Man check programme, and a six month After Hour Telephone Triage pilot initiative will begin in September 2005. Currently we have a number of Memoranda of Understanding with other primary care providers and we look forward to working with these providers more closely in the coming year.

CANTERBURY COMMUNITY PHO (CCPHO) – CHAIR: MALO IOANE

Launched on 1 July 2003, the Canterbury Community PHO (CCPHO) is an Access formula funded PHO, designed to make primary health care more affordable and accessible for low income and high health need groups. We are also one of the smallest, with fewer than 6000 people enrolled, over 50% of whom are of either Maori, Pacific or refugee origin and reside in the lower decile regions in Christchurch.

The CCPHO is focused on offering primary health care services to urban Christchurch's high-needs population. Affordable and accessible GP and Practice Nurse Services are provided through the Union and Community Health Centre and Piki Te Ora. The CCPHO membership is also made up of other community providers such as the Family Planning Association, Hepatitis C Resource Centre Te Waipounamu, NZ Aids Foundation, New Zealand Prostitutes Collective, Royal NZ Plunket Society Canterbury, 198 Youth Health Trust, Te Rito Arahī, He Waka Tapu, Mental Health Foundation, Tangata Atumotu, Te Amorangi Richmond, Epilepsy NZ and Te Runanga O Nga Maata Waka.

This year the CCPHO supported the Care Plus programme at their GPs services. This project focused on increasing the involvement of practice nurses in patient care and establishing realistic health care plans around the needs of individual patients. The health care plans were monitored and findings from the programme indicate that over time patients became more confident at making informed decisions about their own healthcare and were therefore able to reduce the number of times they needed to visit a GP.

We have also worked hard to promote access and raise awareness of the free oral health services available to young adolescents. We now have statistics to benchmark the oral health status of this group which will enable us to track the improvement in their oral health as the services are accessed.

Diabetes management, smoking cessation, well child/Tamariki Ora health checks, mental health management and cardiovascular disease have also been priorities for us this year.

The CCPHO will continue to be vulnerable to the effects

of a very mobile population and its limited resources. However we head into the new financial year in a good financial state, something that could not have been achieved without effective and efficient operational management systems in place.

The CCPHO will continue to roll out new services, seek innovative ways to improve health outcomes within its enrolled population and further develop its model of primary health care.



STRATEGIC HEALTH INVESTMENT FUND

The fund, established by Canterbury District Health Board in 2002, aims to address health priorities. Availability of the fund is determined annually and \$2m was allocated in 2004/05 to the following initiatives:

- Deep Vein Thrombosis assessment and treatment
- Canterbury Asthma Society's preschool asthma programme, 'Baxter Bear'
- Child health and wellbeing in Early Childhood Centres
- Implementing and evaluating a pilot of the InterRAI-MDS geriatric assessment tool
- Research into respite services for mothers with mental illness.
- Oral Health Services for the elderly
- Establishing the Acute Stroke Unit at Christchurch Hospital.
- Medication Management Project – a pilot targeting 'at risk' patients
- Elder Care Canterbury research to identify health information needs of older people
- Community co-ordinators to help organise services for the elderly
- The Pacific Trust Canterbury's Pacific Child and Family Support Service
- The Aranui Nursing Project – a three year pilot to improve access to primary healthcare services in high-needs areas
- The Under Fives Healthy Heart programme in early childhood centres, promoting the benefits of healthy food and physical activity.

HOSPITAL AND SPECIALIST SERVICE DIVISION

INTRODUCTION

After consultation with staff, the Canterbury District Health Board (CDHB) recently underwent a shift from facilities to service-based management. In order to improve the overall performance of the Hospital & Specialist Service Division, a management structure that can support clinical teams more effectively was required.

The new structure incorporates six service-focussed divisions who report to the General Manager, Hospital and Specialist Service.

- Medical/Surgical
- Older Persons' Health and Rehabilitation
- Mental Health
- Rural Hospitals
- Women's and Children's Health
- Hospital Support and Laboratories.

The new structure reflects the CDHB's continued commitment to providing effective, efficient and patient-focussed services.



MEDICAL & SURGICAL SERVICES DIVISION – SHELLY PARK

Under the new Hospital and Specialist Services structure, the Medical/Surgical division incorporates many of the services that were provided by the previous Christchurch Hospital Division. The division employs 2,415 full-time staff, most of whom work at Christchurch Hospital.

In the year in review, the Medical/Surgical Division at Christchurch Hospital discharged 36,274 patients; 19,422 patients went through its theatres; 22,980 procedures (including theatre operations) were conducted and 220,932 outpatients visited clinics.

Undoubtedly one of the highlights of this year was the opening of the Day Surgery Unit in the new Christchurch Women's Hospital on Riccarton Avenue. This is Christchurch's first purpose-built day surgery within the public health system. There are five theatres – one for ophthalmology cases, another for gynaecology and a third for paediatrics minor operations. The remaining two theatres will be designated at a future date. As the surgical list of Day Surgery is separate, it is unaffected by the acute surgical demands of Christchurch

Hospital and already there has been significant improvement in patient flow. A separate day surgery admissions area has also improved the patient experience and we are now looking at how to reduce waiting times even further by staggering operations at different times of the day.

During the year the Internal Medicine Cluster, incorporating amongst others Cardiology, Respiratory, Dermatology, Gastroenterology, General Medicine and Nephrology, developed several new or replacement services. These include the Acute Stroke Unit, the Endoscopy Unit, the Respiratory Function Laboratory and the Non-invasive Ventilation Service. Other initiatives have also commenced, including the After Hours project examining how services are provided in the evenings and on weekends, and planning for an Acute Medical Unit which works in conjunction with the Emergency Department (ED).

Dermatology, Neurology and Respiratory Medicine have done excellent work in reducing waiting lists.

Christchurch Hospital continues to get the best results in the country for the Part I FRACP examinations for medical registrars. This is testament to the quality of the clinical experience and training provided at Christchurch.

Another highlight for the Medical/Surgical Division was the success of Dr Rudy Hidajat and his team in their design of a faster and more efficient computer reporting system for the Farnsworth-Munsell (FM) colour vision test. At Computerworld's Excellence Awards, this project was awarded a Highly Commended certificate in the 'Innovative Use of Technology' section. This project has also been entered in the Asian Hospital Management Awards for 2005.

The Emergency Department has experienced increases in all aspects of its business over the last year. Patient volumes, the complexity of cases and length of stay all rose, with 67,000 patients passing through the service and a 38% increase in Triage 1 (the most serious) cases. There has, however, been a reduction in the lower triage categories which reflects the successful collaboration between the department and primary care organisations.

Recommendations from the external Brennan Review into the Emergency Department continue to be implemented. The department is also trialling a Rapid Assessment Team (RAT) nurse who is working with the RAT doctor to fast-track less acute cases. The limitations of the department's physical environment remain a challenge, as does recruitment and retention. However initiatives are underway to alleviate these

problems, including a future department redesign.

Radiology recently conducted a review of its services and is now implementing recommendations. The demand for imaging and the complexity of the work continues to grow as diagnostic imaging becomes increasingly important to the CDHB's clinical services. Helping meet this need is a new \$1.6m GE VCT 64 multi-slice scanner, the first of its kind in New Zealand.

The Air Retrieval Service had a 10% increase in patient numbers over the last year (371 in total). The service provides clinical staff and co-ordination for both acute and non-acute inter-hospital transfer of patients by air ambulance – predominantly from other South Island hospitals, but also from some North Island centres.

In the year in review the Ministry of Health's Elective Services Innovations Fund (ESIF) funded three initiatives:

- Upskilling General Practitioners to use the cataract score tool
- Appointing a General Practitioner Medical Officer Special Scale (MOSS) to upskill a General Practitioner in diagnostic bowel investigations
- An exercised-based programme for patients with intermittent claudication, aimed at reducing leg pain and the need to refer patients to hospital.

This year also saw the relocation of the New Zealand Blood Services Blood Bank from Canterbury Health Laboratory to Christchurch Hospital. The move was an opportunity to review blood prescribing, ordering and delivering and resulted in improvements in the utilisation of this precious resource.

Looking ahead, recruitment and retention will continue to be a challenge for the Medical/Surgical Division. We are focusing on ways to improve support for our clinicians as we address our future staffing needs. This being said, we are also excited by the opportunities this presents us. As we examine what skill sets we require to provide the level of care expected of a tertiary healthcare provider, both now and in the future, we remain focused on providing quality clinical care and streamlining the processes to support the patient experience.



Vince Barry

OLDER PERSONS' HEALTH AND REHABILITATION – VINCE BARRY

As part of wider structural changes within the CDHB, an Older Persons' Health and Rehabilitation division has been created that integrates existing services at The Princess Margaret Hospital and Burwood Hospital.

This move away from location-focussed services to a population-needs based service means we can offer a more efficient and effective service through improved channels of communication, co-operation and consolidating resources.

The CDHB is also reviewing how it can most effectively provide health services for older people. A sector expert group is working to create an Older Persons' Health Services Strategy which will be delivered to the Board later this year. The underlying philosophy of the Older Persons' Health Services Strategy is to try to keep older people healthy and independent for as long as possible.

Currently there are approximately 60,000 older people in

Keep warm this winter





EACH DAY IN CANTERBURY
APPROXIMATELY:

20 PEOPLE
HAVE DIABETES
TESTS



Canterbury, with this number set to rise to 96,250 by 2021. Canterbury also has the highest number of people aged 85 years and over. This brings its own challenges for the region, as research indicates that health costs rise significantly for people 85 years and older, and for those in the last year of their life.

Balancing medical and rehabilitation needs is a continuing challenge for our services and we will be examining ways to address this. While Burwood and The Princess Margaret Hospital need to maintain their responsiveness to the requirements of Christchurch Hospital, increasingly we are shifting our focus to a more community-oriented model of support. The objective is to reduce the number of people requiring specialist health services and we are working with community providers to ensure there are sufficient community services and a sustainable carer workforce to meet demand.

In May 2005 Older Persons' Health was awarded a Certificate of Accreditation by Quality Health New Zealand. It was the culmination of a lengthy and labour-intensive process to show commitment to, and delivery of safe and best practice care to the division's clients.

Another highlight for the year was the development of a health promotion pilot programme targeting healthy lifestyle and good nutrition in those over 65 years. Its aim is to provide healthy, independent older New Zealanders with relevant, practical and scientifically valid information on how to promote and maintain their health and wellbeing through good nutrition.

The Older Persons' Health Service continues to pilot the InterRAI MDS-HC assessment and care planning tool which helps to provide a standardised assessment of older people's

functional, psychological, social and environmental needs. The system is already showing benefits by strengthening the continuum of care for Older Persons and will soon be piloted by community health providers.

Significant work has been undertaken with ACC and the Spinal Services over the 12 months to establish a clear service description and specification which can form the basis of a pricing model.

Burwood Hospital has been gearing up for the Orthopaedic Initiative and over the past twelve months has responded positively to the expectation of increased surgical activity around major joint surgery.

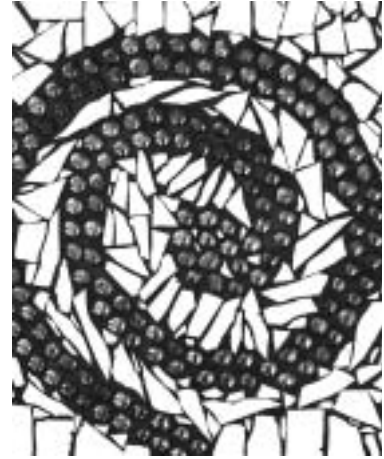
Next year we will also begin construction of new facilities at Burwood Hospital, including four theatres, 12 special care beds, eight recovery beds and a 30 bed surgical ward.

The challenge 'in the future' will be to ensure that sufficient workforce is available to meet the needs of the people accessing Burwood Services. The specialisation that exists in Spinal, Brain Injury and Pain Management means that there is a restricted workforce available.

SPECIALIST MENTAL HEALTH SERVICES – VINCE BARRY

For Specialist Mental Health Services, the year in review has been one of consolidation as we concentrated on developing and confirming our strategic direction. We have paid particular attention to ensuring best possible clinical practice, encouraging consumer and family/whanau participation, and establishing processes to counter discrimination.

Specific projects are already underway which are helping



EACH DAY IN CANTERBURY
APPROXIMATELY:

40 PEOPLE
HAVE ELECTIVE
SURGERY

us to achieve these directions, for example the Access Canterbury Project, which encourages better coordination of services between Specialist Mental Health Services and General Practices. A full-time staff member has been working with GPs to support patients in the community and we are now looking at ways to integrate this model of care into the PHOs.

Other projects include the continued development of our consumer and family advisory teams. Consumer participation is one of the cornerstones of the Specialist Mental Health Services. The Consumer Advisory Group has existed since 1993 in various forms and appointed its first consumer advisor in 1996. The Group provides regular feedback to the Specialist Mental Health Services and was recently involved in a project that helps people who need the service to take a proactive approach to how they want to be managed.

Specialist Mental Health Services has also launched a monthly consumer satisfaction survey that provides valuable feedback on how our services are meeting consumer needs.

The CDHB employs three Family/Whanau Advisers to help minimise the impact and distress of a consumer's ongoing mental illness on their family/whanau. This year the advisers were involved with the Ministry of Health's 'Creating Partnerships' training that emphasises the importance of family/whanau involvement in the continuum of care. Outcomes have been developed into three modules that will soon be rolled out to staff across the division. The advisers also continue to play a role in the orientation of new Specialist Mental Health Services and Non-Governmental Organisation (NGO) staff.

We are currently taking part in a national patient journey pilot that examines how we achieve meaningful change and improvement in patient care delivery. The pilot, entitled 'Single Point of Entry' is a part of the Priorities for Action – Access and Responsiveness that were identified through the Strategic and Operational planning process. 'Single Point of Entry' focuses on Adult Community Specialist Mental Health Services Information gathered from this pilot and will help us to improve our services.

A collaborative effort by the South Island District Health Boards resulted in the establishment of a Maori Mental Health Strategy to improve access to mainstream services for Maori. The new strategy hopes to increase the number of Maori able to access services from 2.26% in 2002 to 3.96% by 2006. Projects include establishing a suitable reporting framework, reviewing ethnicity data collection procedures and developing a regional training package for Tangata Whairoa me Whanau that empowers them to participate at all levels of mental health. A focus of the strategy is to improve communication and information-sharing between Kaipapa Maori Mental Health providers and the District Health Boards.

Other highlights of the year include achieving certification and accreditation for our services, and hosting members from the International Mental Health Leaders conference. This three-day event was an opportunity to showcase our well-led and well-resourced services to an international audience.

By focussing on information-gathering and research we are creating a base from which to plan for the future. Our challenge is to remain responsive to primary healthcare providers as we work together to achieve the best health outcomes for

consumers of our Specialist Mental Health Services.

With the platform of our strategic directions in place and Priorities for Action identified, the next two to three years will involve some significant changes to the Specialist Mental Health Services' service delivery model.



Garth Bateup

RURAL HEALTH SERVICES – GARTH BATEUP

The Hospital and Specialist Services management restructure during the last year resulted in our name changing from 'Ashburton and Community Health Services' to 'Rural Health Services'. We are responsible for the services provided by rural hospitals in Ashburton, Akaroa, Darfield, Ellesmere, Kaikoura, Oxford and Waikari – a large area with a diverse range of needs.

Admissions to Ashburton Hospital were at about the same level as in the previous three years, while Akaroa, Darfield, Ellesmere, Kaikoura, Oxford and Waikari were kept relatively busy meeting the demands for care of patients transferring from Christchurch hospitals.

All hospitals in the Rural Health Service gained certification in October 2004 and six of the rural hospitals received accreditation – Oxford and Kaikoura for the first time and Waikari, Darfield, Akaroa and Ellesmere for the second time. While accreditation is a voluntary peer review process, it is an internationally recognised endorsement of the overall quality, safety and standard of our services and care.

We continue to participate in the Quality Health New Zealand Clinical Indicators programme, with favourable results. As part of the programme we collect and submit an extensive range of indicators every six months. We are then benchmarked against approximately 100 hospitals and services of similar size in New Zealand and Australia.

Difficulty in recruiting house surgeons for Ashburton Hospital continues to be an issue. Up until now we have filled the gaps by employing locums, and by calling on the support of senior medical staff, without whose commitment we would have been unable to maintain our services, particularly after hours. In order to find a long-term solution we recently initiated a review of Clinical Services and have developed a proposed model of care that will ensure appropriate and sustainable health services in the Ashburton community. We are committed to providing a wide range of local services so that people do not need to travel to Christchurch unnecessarily.

We continue to develop our relationship with the Rural Canterbury PHO and have several joint projects either in the planning stages or currently underway. In Ashburton, for example, the PHO has set up a Diabetes Life Education service and has contracted one of our nurse specialists to work there part-time. As part of our review of Clinical Services we are also examining ways to manage admissions to Ashburton Hospital by enhancing our chronic case management programme with community health providers.

We will soon initiate a review of services and facilities in Kaikoura. While Kaikoura has a small population base, it has an influx of visitors who place strain upon the existing systems,

particularly after hours. The current facilities require updating in order to meet these needs.

In the coming months we will continue to work on the review of Clinical Services which will be submitted to the Board by the end of the year. Our challenge for next year will be implementing the new model of care through a series of projects recommended by this review.



Pauline Burt

WOMEN'S AND CHILDREN'S HEALTH – PAULINE BURT

With the management restructure within Hospital and Specialist Services came the merger of Women's and Children's Health. Both divisions have been dominated this year by the relocation of Christchurch Women's from Colombo Street to the new Riccarton Avenue site. The new building represents some of the very latest in design and technology, and has improved the flow within and between departments.

Being part of the Christchurch Hospital campus has made collaboration and communication between departments much easier. However, it has also brought its own challenges as we merge our services. While some eventualities were planned for, others became apparent only once the move was complete. We are continuing to work through processes and find solutions that suit all parties.

A highlight for Women's and Children's Health this year was hosting the week-long Women's and Children's Hospitals of Australasia conference in Christchurch. It was an opportunity to showcase the new Christchurch Women's as an example of the very latest in technology and facilities.

Another highlight was acceptance into the American-based Children's Oncology Group which gives our Paediatrics Department access to a huge base of research and information. Membership requires us to meet a number of exacting standards.

The Paediatrics Department itself has undergone some changes, with a recent refurbishment. For the first time all child-related treatments are now grouped together at Christchurch Hospital, forming a specialist centre for the whole of the South Island. Other new initiatives within Children's Health include the introduction of video conferencing in Children's Haematology and Oncology. Patients and their families who otherwise have to travel significant distances for their appointments can now see their doctors via video conferences.

For the year ahead, budget has been approved for several new positions, including a Paediatric Neurologist, additional Obstetrics and Gynaecology consultants and a Clinical Director Obstetrics. We are also working with staff to ensure that we maximise efficiency by matching patient presentations and admissions to appropriate staffing numbers and skill sets.

While there are some obvious synergies between Women's and Children's Health, they are also very different areas of medicine, each with their own specific needs and challenges. It is a balancing act to bring them together and we will continue to look at how we integrate them into an effective division.



EACH DAY IN CANTERBURY
APPROXIMATELY:

50 CHILDREN
HAVE DENTAL
CHECKS



**HOSPITAL SUPPORT AND
LABORATORIES – MICHAEL AITKEN**
Canterbury Health Laboratories

Under the new structure of the Hospital & Specialist Service, Canterbury Health Laboratories (CHL) has been amalgamated with Maintenance and Engineering services to create the Hospital Support and Laboratories Division. This new division encompasses approximately 450 staff and approximately \$50m of expenditure.

CHL is a major tertiary laboratory which is responsible for providing laboratory diagnostic services for patients under the care of the CDHB. Twenty-three public and private pathology laboratories throughout New Zealand also refer samples to CHL for more specialised testing.

During the year in review CHL contributed \$1.4m external revenue for the CDHB, an amount that has been growing by about 15% per annum since the mid-1990s. This revenue allows us to retain our tertiary focus, keeping our specialist areas clinically and financially viable.

For 10 of the last 12 months we have hit the National Cervical Screening Programme target of processing 15,000 samples a year. New technology has been introduced to assist the laboratory with this workload. We were also recently awarded a contract to conduct a nationally-co-ordinated training programme for pathologists, scientists and technicians involved in processing and interpreting cervical smears.

New Zealand District Health Boards are currently looking at ways of reducing costs by reviewing the role played by

private and public laboratories in the provision of community and hospital testing. The challenge for CHL is to retain our specialist testing from around the country while maintaining and potentially expanding our laboratory services both to the CDHB and to the wider community.

Maintenance and Engineering Services

The Maintenance and Engineering Services Unit recently undertook a review of the services it provides across CDHB facilities. This was a challenging process for staff but has provided greater understanding of how our services meet demands and where there is potential for improvement. Maintenance and Engineering Services is currently implementing the outcomes of this review, which include centralising resources and providing 24/7 services rather than an on-call after hours service. Several services that were contracted out will now be brought back in-house.

A highlight for the Maintenance and Engineering Services was winning the Hospital and Specialist Services award at the second annual CDHB Quality and Innovation Awards for their project on energy management at Christchurch Hospital. Managing energy use in Christchurch Hospital is similar to managing the requirements of a small town of about 4,900 homes. Through careful monitoring and trialling of new technology, the department has managed to make a saving of nearly \$170,000 over the past year. The aim is now to get to a stage where the savings on some projects will help fund other maintenance work, such as the planned replacement of old chillers with new 400kW ones.

COMMUNITY CONTRACTS

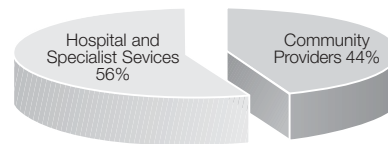
In addition to the secondary and tertiary health services provided by Canterbury District Health Board's (CDHB's) Hospital and Specialist Services, the CDHB also has approximately 900 service agreements with community health providers. The largest of these providers include Partnership Health Primary Health Organisation (PHO), Pegasus Health, The Nurse Maude Association and Richmond Fellowship. These service agreements cover a wide range of services, including:

- Primary care
- Mental health
- Aged care
- Palliative care
- Home based support
- Personal health
- Maori health
- Pacific health
- Referred services

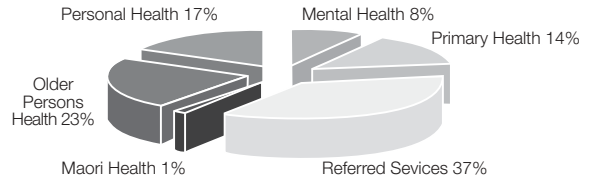
With the ongoing implementation of the Ministry of Health's Primary Care Strategy and the ongoing development of PHOs in Canterbury, there have been further opportunities for the CDHB to work closely with primary health providers to improve the health and wellbeing of our population. Details of the services provided by community contracts are provided elsewhere in this report.

The diagrams indicate how funding is allocated between the CDHB's secondary and tertiary services, and the community health providers.

Breakdown of funding between Hospital and Specialist Services and Community Providers



Breakdown of funding between Community Providers



Based on 2001 Census Data.

STATEMENT OF OBJECTIVES AND SERVICE PERFORMANCE
1 JULY 2004 – 30 JUNE 2005



STATEMENT OF OBJECTIVES AND SERVICE PERFORMANCE 2004/05

The Canterbury District Health Board (CDHB) continues to develop measures for the Statement of Service Performance that are appropriate to the needs of our stakeholders within Parliament and within our community. These measures and associated performance targets will continue to be reflected in future District Strategic Plans and reported in subsequent Statements of Service Performance.

The aim of the Statement of Intent is to demonstrate how the CDHB's activities impact on its primary objective of "improving the health and wellbeing of people living in Canterbury". The measures included in the 2003-2006 Statement of Intent reflect activity in the priority areas identified in the CDHB's 2001 Strategic Plan, *Towards a Healthier Canterbury: Directions 2006*.

1. Strategic Priorities and Directions

To achieve its primary objective, to improve the health and wellbeing of people living in Canterbury, the CDHB determined in 2001 to focus on achieving improved outcomes in the following priority areas:

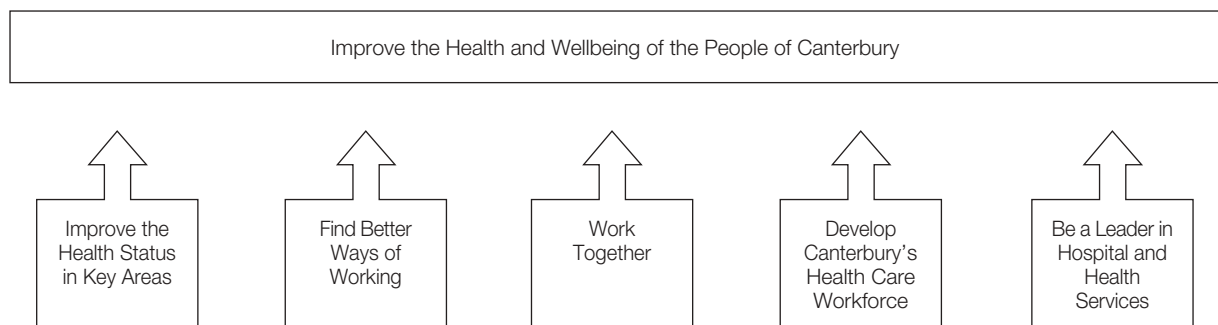
- Child and Youth Health
- Primary Health
- Maori Health
- Mental Health
- Disease Prevention and Management
 - Cardiovascular (Heart) Disease
 - Diabetes
 - Cancer.

The performance measurements, outlined in the Statement of Intent and in this Statement of Objectives and Service Performance document, are loosely grouped under the output classes:

- Funding and Performance
- Provider-Hospital and Specialist Services
- Governance.

In improving health outcomes in these priority areas, as well as in our other areas of work, the CDHB has focused its efforts on five core directions:

- *Improving the health status of our community* – to improve the health outcomes for specific groups in our community.
- *Finding better ways of working* – to get the maximum improvement in health status for our community within the available funding and resources.
- *Working together* – to ensure the right service is provided at the right time to obtain the maximum possible health gains for our community.
- *Developing Canterbury's health care workforce* – to ensure that we have the appropriate workforce to meet the health needs of the people of Canterbury.
- *Being a leader in Hospital and Health Services* – to ensure the best possible level of care is provided to maximise the health outcomes for the people of Canterbury.



2. Service Objectives and Measures

2.1 Funding and Performance: Strategic Plan Health Priorities

2.1.1 Child and Youth Health

Objective:	Brief Description:			
Improved health status for Canterbury's children and youth. (Long term)	Keeping children and youth healthy gives them a better chance of becoming healthy adults. The CDHB has developed a Child Health and Disability Action Plan to address the health issues of the children of Canterbury. The targets for 2004/05 given here come from the District Annual Plan (note: the immunisation indicator from previous years has not been included due to data quality issues).			
Objective 2004/05	Performance Measure	Performance Targets	Results 2004/05	(95% Confidence intervals for discharge rates) 2003/04
Reduced number of low birth weight babies	Percentage of babies born in public hospital with low birth weight.	<ul style="list-style-type: none"> • Maori < 7.0% • Pacific < 4.7% • Total < 6.0% 	<ul style="list-style-type: none"> • Maori 6.0% • Pacific 3.9% • Total 4.5%¹ 	(3.5---10.1) (8.4%) (1.2---10.5) (4.5%) (3.9---5.3) (6.1%) It is preferable that fewer babies are born with low birth weight, hence for this indicator, lower is better. The CDHB achieved its targets for all groups.
Minimised impact on hearing loss in children	Percentage of children passing school entry hearing tests.	<ul style="list-style-type: none"> • Maori 90.0% • Pacific 86.0% • Total 94.0% 	<ul style="list-style-type: none"> • Maori 93.2% • Pacific 89.7% • Total² 95.2% 	(91.6%) (86.8%) (95.3%)
Improved child oral health	Average proportion of Missing or Filled teeth of Form 2 (year 8) children (<i>Total permanent teeth missing or filled due to caries (holes) divided by the number of children seen by the school dental service in the period</i>).	<ul style="list-style-type: none"> • Total 1.6 	<ul style="list-style-type: none"> • 1.58 	(1.6) There were 8,374 permanent teeth filled for 5,296 young people giving a mean MF score of 1.58. ³ It is preferable that there are fewer permanent teeth filled or missing due to holes (caries), hence for this indicator, lower is better. The CDHB achieved its target for this indicator.
	Percentage of children caries free (no fillings or holes in teeth) at age 5.	<ul style="list-style-type: none"> • Total 52% 	51%	(52%) There were 2,418 children at their first publicly funded dental service after their 5th and before their 6th birthday with primary dentition free of caries, with no fillings and with no teeth missing due to caries, out of a total of 4,724 children at their first publicly funded dental service after their 5th and before their 6th birthday. Thus the percentage of children caries free at age 5 is 51% ⁴ , which was marginally short of the target. A major factor impacting on the CDHB's performance on this measure is the low proportion of Canterbury's population receiving optimally fluoridated water supplies. The CDHB agreed a 'position statement' on fluoridation in 2003 and this is available on its website www.cdhb.govt.nz.

2.1.2 Primary Health

Objective:	Brief Description:			
Reduced barriers to primary health care. (Long term)	Reducing the barriers to good primary health care helps people stay well resulting in improved health status. During the 2004/05 year the CDHB focused its primary care activities on the following: <ul style="list-style-type: none"> • Implementation of the Government's primary health care strategy via the development of Primary Health Organisations (PHO) within Canterbury for those populations with the greatest barriers to primary health care. • Implementation of CDHB's rural health action plan of May 2002. 			
Objective 2004/05	Performance Measure	Performance Targets	Results 2004/05	(95% Confidence intervals for discharge rates) 2003/04
PHO Development Support the development of 4 PHOs within the Canterbury Region (two representing rural communities, one representing lower socio-economic groups in urban Christchurch and one other urban PHO).	Ethnicity data being collected by PHOs.	100% of PHO practices collecting ethnicity data by 1 April 2005	<ul style="list-style-type: none"> • 100% Target Achieved	
	Services to improve access in place in all PHOs.	All PHOs have implemented Services to Improve Access plans by 1 January 2005	All PHOs have Services to Improve Access with the exception of Hurunui Kaikoura PHO, which serves 3% of the CDHB's population. <i>Note: Services to Improve Access reduce barriers to first contact services for groups with the highest health needs.</i>	

¹ Data is from the National Minimum Data Set, 1 April 2004 – 31 March 2005

² Data is from the National Audiology Centre

³ Data is from the CDHB Crown Funding Agreement report Quarter 3 2004/05 and covers the 2004 school year.

⁴ Data is from the CDHB Crown Funding Agreement report Quarter 3 2004/05 and covers the 2004 school year.

Objective 2004/05	Performance Measure	Performance Targets	Results 2004/05 (95% Confidence intervals for discharge rates) 2003/04
	Percentage of CDHB population enrolled with PHOs.	95% of CDHB's census population is enrolled with PHOs by 1 July 2005	As at 1 July 2005 there were 431,878 people enrolled with a PHO. The 2005 population projection from Statistics NZ for 2005 is 459,670. Based on this 94% of CDHB's population was enrolled with a PHO as at 1 July 2005. On the basis that population projections contain a certain amount or error, it is considered that this result is equal to target.
	PHO plans support CDHB health gain priority areas.	PHO Health Promotion and Services to Improve Access plans are consistent with CDHB health gain priority plans	Target achieved. PHO Health Promotion Plans and Services focus on nutrition, physical activity, and smoking cessation. These are consistent with CDHB's health gain priority areas – Child and Youth, Maori, Primary Health, Mental Health, and Disease Management (Diabetes, CVD, Cancer).
Improved retention of Rural GPs: Maintain reasonable on-call rosters for rural GPs. Every GP with a rural ranking of 35 points or more to work no more than 1 in 4 weekends.	Percentage of GPs with a rural ranking of greater than 35 point, who work no more than a 1 in 4 weekend roster (unless by choice).	<ul style="list-style-type: none"> 100% 	<ul style="list-style-type: none"> 100% Target Achieved (100%)
Reduce Ambulatory Sensitive Admissions. Ambulatory sensitive admissions are admissions that are potentially preventable by appropriate primary care. This measure provides an indication of access to, and effectiveness of, primary care. (Ambulatory means hospital outpatient or GP care)	Standardised discharge rates for ambulatory sensitive admissions 0 to 4 years of age.	<ul style="list-style-type: none"> Maori 6.7% Pacific 6.7% Total 6.7% 	<ul style="list-style-type: none"> Maori 7.2% (6.2---8.3) (6.6%) Pacific 10.4% (8.0---13.4) (10.6%) Total 7.8%⁵ (7.4---8.2) (7.8%) <p>The 95% confidence interval for Maori covers the range from 6.2 to 8.3, which includes the target. In addition, the rate for Pacific people involves relatively low numbers and, as can be seen from the confidence interval, the true rate may be as low as 8.0.</p> <p>Actions to improve performance on this indicator are embodied within the CDHB's Child Health Action Plan, Maori Health Plan, and Pacific Health Action Plan. The Child Health Action Plan lists the following 10 key child health priorities; Access to Services, Child Health Information, Hearing, Immunisation, Injury Prevention, Mental Health, Nutrition and Physical Activity, Oral Health, Parenting, and Smokefree Environments.</p> <p>Some specific initiatives resulting from these plans that will potentially impact on performance against this indicator are:</p> <ul style="list-style-type: none"> Pacific Immunisation Outreach Service (targets 0-5 years) Mother and Pepi services (targets 0-2 years) Development of a Pacific Peoples immunisation database is underway Continued operation of a Pacific Health Clinic Well Child/ Tamariki Ora services.
	Standardised discharge rates for ambulatory sensitive admissions 5 to 14 years of age.	<ul style="list-style-type: none"> Maori 1.7% Pacific 1.7% Total 1.7% 	<ul style="list-style-type: none"> Maori 1.5% (1.2---1.9) (1.5%) Pacific 2.7% (1.9---3.9) (2.1%) Total 1.7%⁶ (1.7---1.8) (1.6%) <p>The rate for Maori is better than the target and the rate for 'total' is equal to target indicating a good result for this measure. The rate for Pacific people, while higher than the target, relates to only 29 admits. The confidence interval for this group is also very wide.</p> <p>Actions to improve performance on this indicator are embodied within the CDHB's Child Health Action Plan and Pacific Health Action Plan. The Child Health Action Plan lists the following 10 key child health priorities; Access to Services, Child Health Information, Hearing, Immunisation, Injury Prevention, Mental Health, Nutrition and Physical Activity, Oral Health, Parenting, and Smokefree Environments</p> <p>Some specific initiatives resulting from these plans that will potentially impact on performance against this indicator are:</p> <ul style="list-style-type: none"> Pacific Immunisation Outreach Service (targets 0-5 years) Mother and Pepi services (targets 0-2 years) Development of a Pacific Peoples immunisation database is underway Continued operation of a Pacific Health Clinic Well Child/ Tamariki Ora services.
	Standardised discharge rates for ambulatory sensitive admissions 15 to 25 years of age.	<ul style="list-style-type: none"> Maori 1.1% Pacific 1.1% Total 1.1% 	<ul style="list-style-type: none"> Maori 1.1% (0.8---1.5) (1.1%) Pacific 1.4% (0.8---2.4) (1.3%) Total 1.2%⁷ (1.1---1.3) (1.2%) <p>The rate for Maori is equal to the target, while the rate for 'total' is slightly above the target. The Pacific peoples rate is higher than the target, however this the rate relates to only 24 admissions and the confidence interval for this value includes the target, as do the confidence intervals for the rates of the other three groups.</p>

⁵ Data is from the National Minimum Data Set, 1 April 2004 – 31 March 2005

⁶ Data is from the National Minimum Data Set, 1 April 2004 – 31 March 2005

⁷ Data is from the National Minimum Data Set, 1 April 2004 – 31 March 2005

2.1.3 Maori Health

Objective:	Brief Description:		
Whanau Ora Maori families supported to achieve their maximum health and wellbeing. (Long Term)	Evidence of Maori health disparities is well known and compelling and to address these health disparities, the CDHB has developed a Maori Health Plan (July 2002), <i>Whakamahere Hauora Maori Ki Waitaha</i> . This plan identifies a number of strategic issues, namely: <ul style="list-style-type: none"> • Support of the Governments commitment to the Treaty of Waitangi, • Maori Participation in health planning, service provision and the workforce, • Effective, culturally appropriate and high quality services, • Monitoring of Maori health outcomes, • Working across sectors. During the 2004/05 year the CDHB has continued to focus its efforts on the above as well as improved data quality to support future developments, and reducing health disparities for Maori.		
Objective 2004/05	Performance Measure	Performance Targets	Results 2004/05
Monitoring of Maori health outcomes. Current collection of ethnicity data is a significant barrier to achieving this objective. The DHB therefore plans to continue to implement accurate Ethnicity Data Collection throughout CDHB.	Improved ethnicity reporting. The percentage of discharges classified with the following ethnicity groups: <ul style="list-style-type: none"> • Maori • Other • Not stated Improved ethnicity reporting will result in fewer people classified as 'other' or 'not stated'. Classification of people under these categories contributes to under reporting of groups such as Maori (measured against census population) and limits CDHB's ability to monitor health outcomes accurately.	Ethnicity reporting targets <ul style="list-style-type: none"> • Maori 7.5% • Other less than 2.5% • Not stated less than 1.0% 	Percentage of discharges from CDHB hospitals with the following ethnicity reported <ul style="list-style-type: none"> • Maori 6.0% • Other 5.0% • Not stated 2.7% 2004/05 targets had been set aiming to reduce the percentage of people classified as 'other' or 'not stated', and increase the percentage classified as Maori. <p>Actions to improve this result include an Ethnicity Data Implementation Plan and recent completion of the appointment of Ethnicity Data Team Leaders for each Hospital and Specialist Services division. The aim over 2005/06 is to establish Ethnicity Data Teams and to action the Implementation Plan throughout the CDHB.</p>
Monitoring of Maori health outcomes. Continued ...	During 2004/05 CDHB intended to develop an integrated health outcome and performance monitoring framework aligning its Maori Health Plan " <i>Whakamahere Hauora Maori Ki Waitaha</i> " with the MoH Maori Health Strategy " <i>He Korowai Oranga</i> " and the Maori Health Action Plan " <i>Whakatataka</i> ". Continuing work that started in 2003/04.	Completion of monitoring framework by June 2005	A proposed monitoring performance framework was completed in May 2005 as a result of a review of CDHB Strategic Maori Health plan – <i>Whakamahere Hauora Maori ki Waitaha</i> . The proposed framework was taken out for consultation with the Maori community to see if it provided a clear picture of what has occurred for Maori health since 2002. Discussion occurred and support given from the community on the proviso that CDHB look to capture more disease specific information in the future.
			The performance monitoring framework uses a scorecard that summarises CDHB's five Maori health directions and the number of short, medium and long term projects identified to progress Maori health over the next 5 years. The scorecard grades the level of progress on each project (ie: development, ongoing and completed). At this stage 42 of the 59 key projects within our current plan are under way with a remaining 17 to work on.
Reduced health inequalities: Maori Service Development in priority areas eg. Diabetes, Cancers, Cardiovascular disease, Child Health etc	Refer to the relevant section of this document. Where data is available Maori specific targets have been provided.	See relevant Performance Indicators	CDHB has made progress in improving performance against targets set for Maori for the following indicators; <ul style="list-style-type: none"> • Diabetes management (section 2.1.7) • Low birth weight babies (section 2.1.1) Performance for other diabetes and child health indicators needs further improvement. Child health will be addressed through the implementation of CDHB's Child Health Action Plan. The CDHB is working with PHOs, the Diabetes Centre, Community & Public Health and the Local Diabetes Team to improve knowledge and awareness of good self-management of diabetes.

2.1.4 Mental Health

Objective:	Brief Description:		
Improved Health Status for Canterbury Residents who have a serious ongoing mental illness. (Long Term)	About 3% of New Zealanders have a serious ongoing mental illness, which requires specialist care and treatment by a range of health and social service providers. The CDHB continues towards implementing the Mental Health Strategy and Blueprint for Mental Health Services and the Youth Suicide strategies and guidelines. In addition, the CDHB has completed its own Mental Health Strategic Plan (June 2004), which has had its first year of implementation in 2004/05.		
Objective 2004/05	Performance Measure	Performance Targets	Results 2004/05 2003/04
Mental Health Volume Delivery (Hospital & Specialist Services): 100% delivery of Mental Health Volumes.	Actual funding delivered as a percentage of the value of Hospital and Specialist Services Mental Health funding in the CDHB District Annual Plan (DAP).	<ul style="list-style-type: none"> 100% delivery of contracted volumes 	<ul style="list-style-type: none"> 99% of contracted volumes were delivered. (99%) Measurement of performance reflects the actual volume of services delivered multiplied by the relevant prices, expressed as a percentage of the total contracted funds. Overall CDHB performance shows a small under-delivery. This relates mainly to clinical psychologist vacancies within some Child and Youth services. Active recruitment within these areas has been ongoing and reflects a national shortage. <i>Note: In measuring performance, adjustment is made to vacant FTE positions where cover has been provided.</i>
Mental Health Service Funding: Mental Health Services Funding expenditure to the level specified by the Mental Health "ring-fence".	Contracted funding as a percentage of the Mental Health Target.	<ul style="list-style-type: none"> 100% allocation of funding 	<ul style="list-style-type: none"> 100% allocation of the ring-fenced funding to providers (100%)
Improved access to Mental Health Services: The New Zealand Mental Health Strategy sets targets for access to treatment and support services for people of different age groups with severe mental illness.	Percentage of people within each age group accessing mental health treatment and support services. <i>Note: these targets are set in line with estimated proportions of people with mental illnesses for each age group and ethnicity. The higher the percentage is, the more people there are accessing services. The CDHB aims to improve access to services and so higher percentages are favourable.</i>	Maori <ul style="list-style-type: none"> 0-19 years: 0.50% 20-64 years: 1.30% 65+ years: 0.28% Other <ul style="list-style-type: none"> 0-19 years: 0.65% 20-64 years: 1.00% 65+ years: 0.19% Total <ul style="list-style-type: none"> 0-19 years: 0.65% 20-64 years: 1.10% 65+ years: 0.20% 	This data is currently unavailable. Recent MHINC data submission issues mean that CDHB information needs to be resubmitted before final figures can be produced.

2.1.5 Disease Prevention and Management – Cardiovascular (Heart) Disease

Objective:	Brief Description:		
Improved health status for Canterbury's Residents who are at risk of developing or have developed Cardiovascular disease. (Long Term)	Cardiovascular disease has been identified by the CDHB as a priority area for improving the health status of the people of Canterbury. The CDHB developed a strategy for the management of Cardiovascular disease in the <i>Canterbury Heart Health Strategy</i> . However this was completed after the objectives and measures were set for the DAP and Statement of Intent targets. Therefore the relevant accountabilities to the Minister of Health, as outlined in the DAP, along with the target level of Cardiac Surgery were used as measures of the CDHB's performance during the 2004/05 year.		
Objective 2004/05	Performance Measure	Performance Targets	Results 2004/05 2003/04
Reducing the Impact of Cardiovascular Disease.	Percentage of people with certainty who waited for no more than 6 months for coronary artery bypass graft.	<ul style="list-style-type: none"> 100% 	52% (58%)
	Delivery of target levels of Cardiac Surgery for key procedures (Cardiac Valves and Coronary Artery Bypasses with Grafts). <i>Note: Cardiac Valves and Coronary Bypass with Grafts are counted using the following Diagnostic Related Groups (drgs); F03Z, F04A, F04B, F05A, F05B, F06A, and F06B.</i>	<ul style="list-style-type: none"> 1500cwd delivered by 31 December 2004 3000cwd delivered by June 30 2005 	3000cwd (100%)* The CDHB met the target delivery for Cardiac surgery. The 2004/05-year reflects the first year where cardiac surgery has been funded using cwd rather than cases. <i>Note: Cost weighted discharges (cwd) are a relative measure of the cost of different types of surgery ie; cataract procedures have lower cwd than hip replacements.</i>
	Percentage of people with certainty who waited for no more than 6 months for an angioplasty.	<ul style="list-style-type: none"> 100% 	97% (99%)

2.1.6 Disease Prevention and Management – Cancer

Objective:	Brief Description:		
Improved health status for Canterbury's Residents who are at risk of developing or have developed Cancer. (Long Term)	Cancer has been identified by the CDHB as priority area for improving the health status of the people of Canterbury. The CDHB is currently in the process of implementing the National Cancer Control Strategy Action Plan for the management of Cancer in Canterbury. When completing the DAP and Statement of Intent specific service objectives and measures were not established, hence the relevant accountability to the Minister of Health, as outlined in the DAP, were used as measures of performance during the 2004/05 year.		
Objective 2004/05	Performance Measure	Performance Targets	Results 2004/05 2003/04
Reducing the impact of Cancer.	<p>Improved Access to Radiation Therapy.</p> <p>Delay to radiotherapy is defined as the time between the specialist decision to commence radiotherapy and the start of treatment.</p> <p>Patients who need radiotherapy are categorised into 4 groups:</p> <p>Group A - Ideally treated within 24 hours</p> <p>Group B - Ideally treated within 2 weeks</p> <p>Group C - Ideally treated within 4 weeks</p> <p>Group D - These patients have planned radiation treatment because they are taking part in a trial or because there are given protocols. These patients have to wait until a given time to start treatment which is not usually within 4 weeks.</p>	<p>Improved performance during the year with target for the month of June (year end) of:</p> <ul style="list-style-type: none"> • 100% of patients in Group A started treatment on time • 100% of patients in Group B started on time • 95% of patients in Group C started on time (within 4 weeks) • 5% of patients in Group C waited 4-8 weeks • 0% of patients in Groups A, B, or C waited 8-12 weeks • 0% of patients in Groups A, B, or C waited longer than 12 weeks <p><i>Note: these targets do not include Priority 'D' patients who have combined chemotherapy and radiation treatments. The start date for radiation treatment for these patients depends on their treatment schedule.</i></p>	<ul style="list-style-type: none"> • 100% of Group A patients started treatment on time during 11 months of the year – with the exception of June when there were no Group A patients. (100%) • 52% of patients in Group B started on time (52%) • 79% of patients in Group C started on time (72%) • 15% of patients in Group C waited 4-8 weeks (22%) • 0% of patients in Group A waited 8-12 weeks (0%) • 3% of patients in Group B waited 8-12 weeks (0%) • 2% of patients in Group C waited 8-12 weeks (7%) • 0% of patients in Group A waited longer than 12 weeks (0%) • 3% of patients in Group B waited longer than 12 weeks (0%) • 3% of patients in Group C waited longer than 12 weeks (0%) <p>The CDHB has continued to seek to achieve the goal of 100% of patients being treated within 4 weeks. The reasons for delay are related primarily to lack of suitably qualified workforce in the sector. Delays are also due to other illnesses and/or treatments, the need for further tests, and specific start dates for protocol reasons.</p> <p><i>Note: these figures do not include 17 category D patients as they all have specific start dates for protocol reasons. Therefore this group of patients started treatment on time but not all of them started within 4 weeks.</i></p>

2.1.7 Disease Prevention and Management - Diabetes

Objective:	Brief Description:
Improved health status for Canterbury's residents who are at risk of developing or have developed Diabetes. (Long Term)	<p>Diabetes has been identified by the CDHB as a priority area for improving the health status of the people of Canterbury. To achieve this objective a number of areas for action exist, namely:</p> <ul style="list-style-type: none"> • Health promotion, • Early detection, • Effective treatment, • Patient knowledge/information. <p>In Canterbury the greatest benefit is considered to be gained through a range of actions, which include early diagnosis and treatment of eye problems, foot problems and improved access for Maori (refer Local Diabetes Team (LDT) Annual Report 2003 for a full list of priorities). During the 2004/05 year, the CDHB primarily focused its activities on improving performance in the level of retinal screening while continuing to encourage the detection and management of Diabetes within the community. The CDHB has concerns about the data presented below and is of the opinion that these figures understate the numbers of people having annual diabetes reviews who had their eyes screened in the last two years.</p>

Objective 2004/05	Performance Measure	Performance Targets	Results 2004/05	2003/04
Improved Diabetes Detection: Increasing the proportion of people with diabetes who receive annual checks and the associated primary care.	The percentage of the expected number of people with diagnosed diabetes who had an annual review during the year (expected numbers of people with diabetes: Maori: 1,192 Total: 12,142). Number of diabetes annual checks	Percentage receiving annual reviews during the 2004 year <ul style="list-style-type: none"> • Maori 80% • Total 81% Number of annual checks during 2004 <ul style="list-style-type: none"> • Total 9,827 	<ul style="list-style-type: none"> • Maori 41% • Total 80% The CDHB was very close to the target for Total but has yet to meet its target for Maori. Work continued with Maori to improve the case detection rate through providing extra hours for a Maori health nurse at the Diabetes Centre and targeted screening programmes and education provided through Community and Public Health.	(42%) (77%)
Early diagnosis and treatment of eye problems: Increase the proportion of people with diabetes who have had their eyes screened in the last two years.	The percentage of people having annual diabetes reviews who have had their eyes screened in the last two years.	<ul style="list-style-type: none"> • Maori 45% • Total 65% 	<ul style="list-style-type: none"> • 41% • 48% The rate for other ethnicities has improved from 2003. Work continues with the Eye Department and other groups, including community optometrists, to provide an eye screening service that is patient centred, convenient and based in the community. This forms part of the review of the Ophthalmology Department currently underway. The CDHB is working with the LDT to address and improve the data collection and measurement process. Approximately 4500 retinal screens are provided by the CDHB each year. Over the two year period for this indicator this is approximately 9000 screens which should provide at least 88% coverage of people with diabetes in Canterbury.	(42%) (45%)
Improved Diabetes Management: Reducing the proportion of people with diabetes who have relatively poor control of their diabetes.	The percentage of people having annual diabetes reviews who had poor diabetes control (HBA1c>8%).	<ul style="list-style-type: none"> • Maori 40% • Total 23% 	<ul style="list-style-type: none"> • Maori 40% • Total 24% The CDHB met the target for Maori and came very close to meeting the target for other ethnicities. Work continues with PHOs, the Diabetes Centre, Community and Public Health and the LDT to improve knowledge and awareness of good self-management of diabetes.	(42%) (26%)

2.1.8 Elective Services

Objective:	Brief Description:		
Improved health status for Canterbury's residents via the provision of services in a timely manner within the available resources for those with the greatest level of need. (Medium Term)	Access to outpatients services and elective surgery has been an ongoing issue for the CDHB. The funding and the human resources available are limited and are not sufficient to meet all of the demand for health services. We must therefore prioritise services. The CDHB intends to continue the implementation of the Governments policies in relation to elective services which include: <ul style="list-style-type: none"> • The provision of timely access to specialist assessment and elective surgery. • The delivery of a level of publicly funded service which is sufficient to ensure access to elective surgery before patients reach a state of unreasonable distress or ill health. 		
Objective 2004/05	Performance Measure	Performance Targets	Results 2004/05 2003/04
Improved access to first specialist assessment: Reduced waiting lists for first specialist assessments so that all appropriately referred patients can be assessed within appropriate timeframes.	Percentage of patients who receive their First Specialist Assessment (FSA) within six months of referral. <i>Note: a FSA is the first appointment a patient has with a specialist following referral.</i>	<ul style="list-style-type: none"> • 100% of patients who have an FSA in 2004/05 have it within six months of referral 	<ul style="list-style-type: none"> • 94% (97%) <p>Of the new patients seen during the year, 94.2% waited less than 6 months, leaving 5.8% who waited longer than 6 months. This is slightly higher than the previous year. The CDHB will continue to seek to achieve the target level of performance.</p> <p>At the end of the year there were 1,676 people whom we had not seen who had waited longer than 6 months. This reflects approximately two weeks work at current activity levels.</p>
	Delivery of a level of publicly funded FSA volumes at the levels specified in the CDHB DAP.	<ul style="list-style-type: none"> • 27,550 FSA completed by 31 December 2004 • 55,100 FSA completed in total by 30 June 2005 	<ul style="list-style-type: none"> • 54,398 (99%) (53,729) <p>Although the DAP target was not reached the volume of FSAs delivered in 2004/05 was very close to the target and, when compared with 2003/04, delivery has increased by 669 FSAs or 1.2%.</p>
Improved certainty of treatment: Provide certainty to elective surgical patients as to whether they will/will not receive access to publicly funded inpatient surgery. Provide access in a timely manner.	Percentage of patients provided with certainty of treatment receiving treatment within 6 months.	<ul style="list-style-type: none"> • 100% 	<ul style="list-style-type: none"> • 87% (84%)
Surgical Volume Delivery: Delivery of the level of surgery specified in the CDHB DAP.	Percentage given certainty. <i>(The number of treated patients with certainty as a percentage of all patients receiving elective surgery during the period)</i>	<ul style="list-style-type: none"> • 90% 	<ul style="list-style-type: none"> • 65% (78%)
	Case weighted discharges delivered as specified in the CDHB DAP. <i>(Case weighted discharges (cwd) are a relative measure of the cost of different types of surgery- eg cataract procedures have a lower cost weight than hip replacements)</i>	<ul style="list-style-type: none"> • 17,100cwd delivered by 31 December 2004 • 34,359cwd by 30 June 2005 * <p>*The original target in the 2004/07 SOI did not include Dental (240 cwd)</p>	<ul style="list-style-type: none"> • 34,074 cwd delivered year-end (34,547) <p>Delivery was very close to the target (0.8%). In addition to the volumes delivered by the provider-arm Hospital and Specialist Services, CDHB also has contracts with private providers. These include Canterbury Orthopaedic Services (1465cwd delivered in 2004/05) and St George's Hospital (215cwd of cardiac surgery). The contract with Canterbury Orthopaedic Services has made an important contribution to CDHB's performance on the Orthopaedic Initiative to increase the number of hip and knee replacements. This contract was increased to cover shortfall in provider-arm delivery.</p>

2.2 Provider Hospital and Specialist Service Measures

2.2.1 Hospital Safety and Effectiveness

Objective:	Brief Description:		
As a leader in hospital and health care services the CDHB aims to be an efficient and effective provider and maximise the health status of Canterbury's residents within the available resources.	The CDHB is a major provider of Health Services (as well as the funder of the majority of hospital and community Personal and Family Health Services and Mental Health services) to Canterbury residents. As a provider of health services the CDHB must ensure that it operates in an effective and efficient manner.		
Objective 2004/05	Performance Measure	Performance Targets	Results 2004/05 2003/04
Improved performance as a Good employer. Initiate systems and processes to promote a good working environment that encourages a management style that is more open, inclusive and transparent and that fosters a true partnership between staff, and between staff and management.	Sick Leave Rate (as per balanced scorecard)	<ul style="list-style-type: none"> 3.2% of contracted hours 	<ul style="list-style-type: none"> 3.2 Target achieved <p>(3.3%)</p>
	Work Place Injuries per 1,000,000 hours (as per balanced scorecard)	<ul style="list-style-type: none"> 17 per 1 million hours 	<ul style="list-style-type: none"> 11.2 Target achieved <p>(18.1)</p>
	Staff Retention and Turnover (as per balanced scorecard)	<ul style="list-style-type: none"> Less than 10% turnover 	<ul style="list-style-type: none"> 14.0% Target not achieved. <p>(12.4%)</p>
Patient Satisfaction.	Inpatient – Overall Satisfaction (as per balanced scorecard)	<ul style="list-style-type: none"> Greater than 95% 	<ul style="list-style-type: none"> 90% (89%) <p>The CDHB has slightly improved its levels of satisfaction from last year and produced a high level of patient satisfaction at 90%.</p>
	Outpatient – Overall Satisfaction. (as per balanced scorecard)	<ul style="list-style-type: none"> Greater than 95% 	<ul style="list-style-type: none"> 90% (90%) <p>The CDHB continues to maintain a high level of patient satisfaction at 90%.</p>
Improved Quality. Achieve and maintain Quality Health New Zealand Accreditation for all DHB Hospitals. (Long term)	<p>Maintain accreditation at Ashburton, Akaroa, Ellesmere, Waikari, Darfield, Burwood and Christchurch Women's Hospitals.</p> <p>Achieve accreditation for Christchurch, Kaikoura, and Oxford Hospitals along with the Mental Health and Older Persons Health Services.</p>	<p>100% of facilities maintain current accreditation status</p> <p>Achieve accreditation for Christchurch, Kaikoura, and Oxford Hospitals along with the Mental Health and Older Persons' Health Services</p>	<p>The CDHB has achieved this target. The accreditation status of these facilities is as follows:</p> <ul style="list-style-type: none"> Rural Health Services (Ashburton & Community Health Services) Ashburton Health Services: Accreditation awarded 28th May 2002. This is their fourth 3-year accreditation having been accredited since 1993. Community Hospitals (Akaroa, Darfield, Ellesmere, Kaikoura, Oxford and Waikari): Accreditation awarded 13th February 2004. This is the second accreditation for Akaroa, Darfield, Ellesmere and Waikari and the first for Kaikoura and Oxford. Rural Health Services are certified from March 2004 until March 2007 (3 years). Burwood Hospital Burwood's second 3-year accreditation was awarded May 2004. Certified for 1 year from September 2004 until September 2005. Christchurch Hospital & Corporate Services Christchurch Hospital (including Corporate Services) was surveyed by Quality Health NZ for their first accreditation survey and certification audit in June 2004. Accreditation was awarded in February 2005. Certified for 2 years from September 2004 until September 2006. Technical Services, Medical Physics and Bio-engineering were successful in re-certification against the AS/NZ Standard ISO9001: 2000. Mental Health Services (MHS) & The Princess Margaret Hospital (TPMH) Accreditation awarded November 2004. The PMH Certified from September 2004 until September 2007 (3 years), MHS Certified from September 2004 until September 2006 (2 years). Women's Health Division (WHD) Quality Health NZ confirmed the continued Accreditation status for Women's Health Division facilities and services. This is the second 3-year accreditation successfully completed by WHD. Certified from November 2003 until November 2005 (2 years). Laboratory and Support Services Canterbury Laboratories has been accredited with IANZ (ISO: 15189) since 1994.

Objective 2004/05	Performance Measure	Performance Targets	Results 2004/05	2003/04
Maintain appropriate levels of Clinical Quality within CDHB Hospitals.	Hospital Acquired Bacteraemia Rate per 100 inpatient days.	Hospital Acquired Bacteraemia Rate per 100 inpatient days <ul style="list-style-type: none"> • Less than 0.2 	<ul style="list-style-type: none"> • 0.13 Target achieved <i>Note: performance now reflects measurement of all CDHB hospitals except Mental Health division</i>	(0.12)
	IV Medication Error Rate per 1000 inpatient days.	<ul style="list-style-type: none"> • Less than 1.9 	<ul style="list-style-type: none"> • 1.8 Target achieved <i>Note: performance now reflects measurement of all CDHB hospitals</i>	(2.0)
	Patient Falls per 100 inpatient days.	<ul style="list-style-type: none"> • Less than 4.5 	<ul style="list-style-type: none"> • 5.48 The total falls rate includes many minor events, which cause little or no harm. Analysis of the total falls data set is useful as a means to understand patterns of circumstances which are associated with falls and therefore to drive quality improvement. However, it does not relate directly to the harm caused by falls, the overall rate being influenced more by reporting practices. The CDHB has been working to increase the reporting rate of falls and therefore supports an increase in overall fall numbers as a sign of increased reporting. In consideration of its increased focus on reporting falls, in future years the CDHB will include in the falls rate only those which are associated with moderate or serious injury. In this way it will provide a direct measure of injury caused by falls. <i>Note: performance now reflects measurement of all CDHB hospitals.</i>	(5.2)
Monitor levels of attendance at Christchurch Hospital's Emergency Department.	Number of attendances.	<ul style="list-style-type: none"> • No target set, included for information purposes only 	<ul style="list-style-type: none"> • 67,599 	(65,750)
Reduce wait times for people attending Christchurch Hospital's Emergency Department.	Percentage of people seen within expected wait time by triage.	<ul style="list-style-type: none"> • Triage 1 100% • Triage 2 80% • Triage 3 70% 	<ul style="list-style-type: none"> • Triage 1 98% • Triage 2 50% • Triage 3 44% The targets for this indicator have not been met. However, the clerical process for recording of time seen by doctor has been improved and this has resulted in the Triage 1 target being met for the last three quarters. The CDHB is currently implementing the 'Improving the Patient Journey' Project; the goal of which is to reduce unnecessary waits and delays for patients. This project includes several initiatives within the emergency department. These will assist with improved performance on this measure in 2005/06 and beyond.	(93%) (55%) (46%)

2.3 Governance

2.3.1 Good Governance

Objective:	Brief Description:
To provide good governance to ensure that health services meet the needs of Canterbury people while staying within available funding.	The CDHB is responsible for deciding what health services are needed in Canterbury and how best to use the funding received from the Government. These decisions are made with the involvement of stakeholders and the community to achieve the best outcomes for the people of Canterbury.

Objective 2004/05	Performance Measure	Performance Targets	Results 2004/05	2003/04
Break even. Manage expenditure (including funding to external providers) within available funding.	CDHB expenditure on health services is within the funding it receives and that its operating result, after interest, depreciation and capital charge, for 2004-05, is breakeven.	Net operating result = Breakeven or better	<ul style="list-style-type: none"> \$0.3M Target met. The CDHB achieved a slight surplus of \$0.3M for 2004/05	(((\$1.2m))

3. Summary of Revenues and Expenses by Output Class

	Funding \$'000	Governance & Funding Admin \$'000	Provider \$'000	In-House Elimination \$'000	Total District Health Board \$'000
Revenue					
MoH Revenue	869,927	3,291	543,704	(516,735)	900,187
Patient Related Revenue			27,851		27,851
Other			14,550		14,550
Total Revenue	869,927	3,291	586,105	(516,735)	942,588
Expenditure					
Personnel		2,085	367,598		369,683
Depreciation		16	39,503		39,519
Interest			4,183		4,183
Capital Charge			21,862		21,862
Other	869,808	875	153,032	(516,735)	506,980
Total Expenditure	869,808	2,976	586,178	(516,735)	942,227
Net Surplus/(Deficit)	119	315	(73)	-	361

SUMMARY OF FINANCIAL STATEMENTS
1 JULY 2004 – 30 JUNE 2005

This summary financial report has been extracted from the full financial report dated 26 September 2005 and cannot provide as complete an understanding as the full financial report. The full report can be found on our website, www.cdhb.govt.nz



STATEMENT OF FINANCIAL PERFORMANCE FOR THE YEAR ENDED 30 JUNE 2005

	Group			Parent	
	Actual 30/06/05 \$'000	Budget 30/06/05 \$'000	Actual 30/06/04 \$'000	Actual 30/06/05 \$'000	Actual 30/06/04 \$'000
OPERATING REVENUE					
Ministry of Health Revenue	900,187	856,333	811,362	893,545	805,320
Patient Related Revenue	27,851	24,074	24,462	27,795	23,862
Other Revenue	14,550	13,255	13,657	13,268	12,841
TOTAL REVENUE	942,588	893,662	849,481	934,608	842,023
OPERATING EXPENSES					
Employee Costs	369,683	353,661	346,910	362,441	340,029
Treatment Related Costs	98,947	90,436	90,207	102,148	93,248
External Service Providers	353,053	335,898	299,921	353,053	299,921
Depreciation	39,519	34,419	32,652	38,570	31,663
Interest Expense	4,183	5,236	4,035	4,183	3,987
Other Expenses	55,062	50,612	53,689	52,489	51,436
TOTAL OPERATING EXPENSES	920,447	870,262	827,414	912,884	820,284
OPERATING SURPLUS BEFORE CAPITAL CHARGE	22,141	23,400	22,067	21,724	21,739
Capital Charge Expense	(21,862)	(23,400)	(23,306)	(21,862)	(23,306)
SURPLUS/(DEFICIT) BEFORE TAXATION	279	-	(1,239)	(138)	(1,567)
Tax Benefit / (Expense)	82	-	(2)	-	-
NET SURPLUS / (DEFICIT) FOR THE YEAR	361	-	(1,241)	(138)	(1,567)

STATEMENT OF MOVEMENTS IN EQUITY FOR THE YEAR ENDED 30 JUNE 2005

	Group			Parent	
	Actual 30/06/05 \$'000	Budget 30/06/05 \$'000	Actual 30/06/04 \$'000	Actual 30/06/05 \$'000	Actual 30/06/04 \$'000
TOTAL EQUITY AT BEGINNING OF THE PERIOD:	199,344	210,085	211,585	198,741	211,308
TOTAL RECOGNISED REVENUES AND EXPENSES:					
Net surplus / (deficit) for the period	361	-	(1,241)	(138)	(1,567)
OTHER MOVEMENTS	361	-	(1,241)	(138)	(1,567)
Contribution from/(back to) Crown	-	-	(11,000)		(11,000)
	-	-	(11,000)	-	(11,000)
TOTAL EQUITY AT END OF THE PERIOD	199,705	210,085	199,344	198,603	198,741

STATEMENT OF FINANCIAL POSITION AS AT 30 JUNE 2005

	Group			Parent	
	Actual as at 30/06/05 \$'000	Budget as at 30/06/05 \$'000	Actual as at 30/06/04 \$'000	Actual as at 30/06/05 \$'000	Actual as at 30/06/04 \$'000
CROWN EQUITY					
General Funds	148,174	159,174	148,174	148,312	148,312
Revaluation Reserve	77,717	77,717	77,717	77,717	77,717
Retained Earnings	(34,591)	(34,200)	(34,326)	(35,734)	(34,740)
Trust Reserve	8,405	7,394	7,779	8,308	7,452
TOTAL EQUITY	199,705	210,085	199,344	198,603	198,741
REPRESENTED BY:					
CURRENT ASSETS					
Cash and Bank	10,109	154	-	9,682	-
Receivables and Prepayments	16,341	20,488	27,476	15,795	27,074
Stocks	6,594	7,000	6,806	6,543	6,751
TOTAL CURRENT ASSETS	33,044	27,642	34,282	32,020	33,825
CURRENT LIABILITIES					
Bank Overdraft	-	-	835	-	1,446
Creditors and Accruals	74,361	69,709	68,281	74,215	68,080
Owing to the Ministry of Health	7,371	5,700	5,810	7,371	5,810
Staff Entitlements due within 1 year	44,389	28,500	38,035	43,554	37,404
Provisions due within 1 year	22,540	14,000	14,722	22,540	14,623
Loans due within 1 year	-	-	42,600	-	42,600
TOTAL CURRENT LIABILITIES	148,661	117,909	170,283	147,680	169,963
NET WORKING CAPITAL	(115,617)	(90,267)	(136,001)	(115,660)	(136,138)
NON CURRENT ASSETS					
Investments	311	378	292	1,829	2,196
Fixed Assets	382,467	394,051	375,137	379,665	372,758
Surplus Property	9,300	2,800	9,300	9,300	9,300
Restricted Assets	8,405	7,394	7,779	8,308	7,452
TOTAL NON CURRENT ASSETS	400,483	404,623	392,508	399,102	391,706
NON CURRENT LIABILITIES					
Provisions	6,511	4,271	5,113	6,189	4,827
Deferred Tax	-	-	50	-	-
Loans repayable after 1 year	78,650	100,000	52,000	78,650	52,000
TOTAL NON CURRENT LIABILITIES	85,161	104,271	57,163	84,839	56,827
NET ASSETS	199,705	210,085	199,344	198,603	198,741

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 30 JUNE 2005

	Group			Parent	
	Actual 30/06/05 \$'000	Budget 30/06/05 \$'000	Actual 30/06/04 \$'000	Actual 30/06/05 \$'000	Actual 30/06/04 \$'000
CASH FLOW FROM OPERATING ACTIVITIES					
Cash was provided from:					
Receipts from Ministry of Health	905,739	856,333	845,726	898,843	838,385
Other Receipts	46,670	35,079	32,062	45,590	30,608
Interest Received	1,268	279	595	1,384	682
	953,677	891,691	878,383	945,817	869,675
Cash was applied to:					
Payments to Employees	354,144	353,161	335,069	347,012	328,338
Payments to Suppliers	498,730	477,446	450,281	499,337	451,126
Interest Paid	4,023	5,415	4,345	4,023	4,297
Taxes Paid	-	-	3	-	-
Capital Charge	20,301	23,400	21,166	20,301	21,166
GST - net	1,934	-	(1,959)	1,949	(1,917)
	879,132	859,422	808,905	872,622	803,010
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	74,545	32,269	69,478	73,195	66,665
CASH FLOWS FROM INVESTING ACTIVITIES					
Cash was provided from:					
Sale of Assets	70	9,000	2,132	70	2,132
Decrease in Investments	-	-	-	-	1,214
	70	9,000	2,132	70	3,346
Cash was applied to:					
Increase in Investments & Restricted Assets	645	-	299	489	-
Purchase of Assets	47,076	61,000	52,071	45,698	51,040
	47,721	61,000	52,370	46,187	51,040
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES	(47,651)	(52,000)	(50,238)	(46,117)	(47,694)
CASH FLOWS FROM FINANCING ACTIVITIES					
Cash was provided from:					
Loans Raised	-	20,000	52,000	-	52,000
	-	20,000	52,000	-	52,000
Cash was applied to:					
Loans Repaid	15,950	-	56,780	15,950	56,780
Equity repaid to Crown	-	-	11,000	-	11,000
	15,950	-	67,780	15,950	67,780
NET CASH INFLOW/(OUTFLOW) FROM FINANCING ACTIVITIES	(15,950)	20,000	(15,780)	(15,950)	(15,780)
Overall Increase/(Decrease) in Cash Held	10,944	269	3,460	11,128	3,191
Opening Cash Balance	(835)	(115)	(4,295)	(1,446)	(4,637)
CLOSING CASH BALANCE	10,109	154	(835)	9,682	(1,446)

GLOSSARY OF TERMS

Accreditation	Achievement against a national system of standards.
ALOS	Average Length of Stay.
Audit	The verification of performance against predetermined standards or contracts by a process of inspections, interviews and appraisal of documentation.
Brachytherapy	Type of radiation therapy in which radioactive materials are placed in direct contact with the tissue being treated.
Brackenridge Estate Limited	A wholly owned subsidiary of Canterbury District Health Board, providing residential care services. to people with intellectual disability and high dependency needs, including day programmes.
CAPEX	Capital expenditure budget.
Cardiothoracic	Relating to the heart or chest.
Community	A collective of people identified by their common values and mutual concern for the development and wellbeing of their group or geographical area.
CNS	Clinical Nurse Specialist.
Cohort	Generational group as defined in demographics, statistics, or market research: "The cohort of people aged 30 to 39... were more conservative" (American Demographics).
Consultation	The process of seeking the views of individuals or groups. These include both providers and health service users.
COSE	Co-ordinator of Services for the Elderly.
CPH	Community and Public Health.
CPI	Consumer Price Index.
Credentiailling	Credentiailling in the New Zealand context is defined as 'a process used to assign specific clinical responsibilities to health professionals on the basis of their training, qualifications, experience and current practice, within an organisational context.' Credentiailling is part of a wider organisational quality and risk management system designed primarily to protect the patient.
CSPIN	Christchurch Social Policy Interagency Network.
CTA	Clinical Training Agency.
CWD - Cost Weighted Discharges	Measure of patient's relative utilisation of resources.
DAA	Designated Audit Agency.
Disability	Incapacity caused by congenital state, injury or age-related condition expected to last six months or more. A disability may or may not be associated with the need for assistance.
Disparity (or deprivation)	Socio-economic or health inequality or difference relative to the local community or wider society to which an individual, family or group belongs.
District Health Boards	District Health Boards are organisations being established to protect, promote and improve the health and independence of a geographically defined population. Each District Health Board will fund, provide or ensure the provision of services for its population.
DOSA	Day of Surgery Admission.
DSD	Disability Services Directorate.
DSP	District Strategic Plan.

DSS	Disability Support Services.
DVT	Deep Vein Thrombosis.
EEO	Equal Employment Opportunities.
EMT	Executive Management Team.
Equity	Equity means fairness.
Evaluation	Assessment against a standard. Evaluations can assess both the process (of establishing a programme to deliver an outcome) and outcomes (ultimate objectives).
FTE	Full time equivalent.
Funding Agreement	This is the agreement the Crown enters into with any person or entity under which the person or entity agrees to provide or arrange the provision of services in return for payment. For District Health Boards, this will include the District Health Board Annual Plan, funding schedules and the District Health Board Statement of Intent.
General Surgery	General and Vascular Surgery at Christchurch Hospital provides tertiary services to general, vascular and transplant services. Approx 60% acute workload. Treats mainly non-deferrable malignant life and limb threatening disease of upper and lower gastro-intestinal system, breast, endocrine and perivascular systems, primarily malignant disease.
Goal	A high level strategic statement.
Gynaecology	Disease and hygiene of women.
HbA1c	Haemoglobin A1c; also known as glycated haemoglobin. The level of HbA1c reflects the average blood glucose level over the past 3 months.
Health Needs	This can be either: 1) what an individual requires to achieve or maintain health; or 2) an estimation of the programmes required to improve the health of populations.
Health Needs Assessment	A process designed to establish the health requirements of a particular population.
Health Outcomes	A change in the health status of an individual, group or population which is attributable to a planned programme or series of programmes, regardless of whether such a programme was intended to change health status.
Health Policy	A formal statement or procedure within institutions (notably government) that defines priorities and the parameters for action.
Health Status	A description and/or measurement of the health of an individual or population.
HOPS	Health of Older People Strategy.
HPCA	Health Practitioners Competency Assurance.
HWAC	Health Workforce Advisory Committee.
IDF	Inter District Flow.
IPAs	Independent Practitioners Association.
Iwi	Tribe.
KPIs	Key Performance Indicators.
LOS	Length of Stay.
LTCCP	Long Term Council Community Plan.
Medical Credentialling	Medical credentialling refers to the process of permitting an individual physician to practise in a particular hospital, clinic or other medical practice setting.
MoU	Memorandum of Understanding.
MPIA	Ministry of Pacific Island Affairs.
NASC	Needs Assessment & Service Coordination.
Neurosurgery	Surgery of the nervous system.
NIR	National Immunisation Register.
Objective	Objectives state what is to be achieved and cover the range of desired outcomes to achieve a goal.
OPF	Operational Performance Framework.
OPH	Older Persons Health.
Ophthalmology	Eye surgery.
Orthopaedic	Prevention or correction of injuries or disease of the skeletal system and associated muscles, joints and ligaments.
Otolaryngology	Ear, nose throat surgery.
PACS	Picture Archiving and Communications System.

Pacific Peoples	The population of Pacific Island ethnic origin (for example, Tongan, Niuean, Fijian, Samoan, Cook Island Maori, and Tokelauan) incorporating people of Pacific Island ethnic origin born in New Zealand as well as overseas.
Partnership	The relationship of good faith, mutual respect and understanding, and shared decision making between the Crown and Maori.
Performance Indicator	A measure that shows the degree to which a strategy has been achieved.
Population Based Funding (PBF)	Population based funding involves using a formula to allocate each District Health Board a fair share of the available resources so that each board has an equal opportunity to meet the health and disability needs of its population.
Population Health	The health of groups, families and communities. Populations may be defined by locality, biological criteria such as age or gender, social criteria such as socio-economic status, or cultural criteria such as Whanau.
Population Health Outcomes	Used to describe a change in the health status of a population due to a planned programme or series of programmes, regardless of whether such programmes were intended to change health status.
Population Health Status	The level of health experienced by a population at a given time. This may be measured by separately identifying patterns of death and illness in a population or by means of one or more measures.
PCO	Primary Care Organisation.
Primary Care	Primary health care means essential health care based on practical, scientifically sound, culturally appropriate and socially acceptable methods. It is universally accessible to people in their communities, involves community participation, is integral to, and a central function of the country's health system, and is the first level of contact with the health system.
PHO	Primary Health Organisation.
Public Health	The science and art of preventing disease, prolonging life and promoting health and efficiency through organised community effort. Winslow, 1920 (Institute of Medicine, 1988). A collective effort to identify and address the unacceptable realities that result in preventable and avoidable health outcomes, and the composite of efforts and activities that are carried out by people committed to these ends. Turnock, 1997.
Quality Assurance	Formal process of implementing quality assessment and quality improvement in programmes to assure people that professional activities have been performed adequately.
RMO	Resident Medical Officer.
Secondary Care	Specialist care that is typically provided in a hospital setting.
SIMHN	South Island Mental Health Network.
Strategy	A course of action to achieve targets.
Target	A specific and measurable aim relating to an objective.
Tertiary Care	Very specialised care often only provided in a smaller number of locations.
TOR	Terms of Reference.
Tikanga	Customary practice, rule.
TLA	Territorial Local Agencies.
Treaty of Waitangi	New Zealand's founding document. It establishes the relationship between the Crown and Maori as tangata whenua (first peoples) and requires both the Crown and Maori to act reasonably towards each other and with utmost good faith.
Urology	Diagnosis and treatment of diseases of the urinary tract and urogenital system.
WAP	Work Action Plan.
Well-child/Tamariki ora services	Term used to describe all activities that promote health and prevent disease that are undertaken in the primary care setting for children and their families and whanau.
Wellness	A dimension of health beyond the absence of disease or infirmity and including social, emotional and spiritual aspects of health.
Whanau	Extended Family.
WHD	Women's Health Division.
WMRS	Workforce Management and Reporting System.

DIRECTORY

CANTERBURY DISTRICT HEALTH BOARD

Syd Bradley (Chair)
Robin Booth
Heather Carter
Norman Dewes
Karen Guilliland
Neville Fagerlund
Alister James
Jo Kane
Laurence Malcolm
David Morrell
Olive Webb

FINANCE, AUDIT & RISK COMMITTEE

Neville Fagerlund (Chair)
Syd Bradley
Alister James
Jo Kane
David Morrell
Olive Webb

HOSPITAL ADVISORY COMMITTEE

David Morrell (Chair)
Heather Carter
Norman Dewes
Karen Guilliland
David Kerr
Winston McKean
Laurence Malcolm
Trevor Read
Bill Tate
Alison Wilkie
Syd Bradley (ex officio)
Neville Fagerlund (ex officio)
Olive Webb (ex officio)

COMMUNITY & PUBLIC HEALTH & DISABILITY SUPPORT ADVISORY COMMITTEE

Olive Webb (Chair)
Robin Booth
Richard Buchanan
Heather Carter
Ruth Jones
Jo Kane
Laurence Malcolm
John Musgrove
Alison Wilkie
Syd Bradley (ex officio)
Neville Fagerlund (ex officio)
David Morrell (ex officio)

CHIEF EXECUTIVE

Jean O'Callaghan

EXECUTIVE MANAGEMENT TEAM

Jean O'Callaghan (Chair)
Vivienne Allan (Communications Manager)
Evon Currie (General Manager Community & Public Health)
Murray Dickson (General Manager Corporate Services)
Dr Karleen Edwards (General Manager Planning & Funding)
Mary Gordon (Executive Director of Nursing)
Hector Matthews (Executive Director Maori and Pacific Health)
Dr Nigel Millar (Chief Medical Officer)
Jock Muir (General Manager Hospital & Specialist Service)
Lynn Smillie (Group Manager Human Resources)
Wei Yoon (General Manager Finance)

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AUDITOR

Audit New Zealand on behalf of the Auditor General

BANKERS

Westpac
Bank of New Zealand